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# **COVID-19 BUSINESS INTERRUPTION INSURANCE LOSSES: THE CASES FOR AND AGAINST COVERAGE**

CHRISTOPHER C. FRENCH\*

The financial consequences of the government-ordered shutdowns of businesses across America to mitigate the COVID-19 health crisis are enormous. Estimates indicate that small businesses have lost \$255 to \$431 billion per month and more than 44 million workers have been laid off. When businesses have requested reimbursement of their business interruption losses from their insurers under business interruption policies, their insurers have denied the claims. The insurance industry also has announced that business interruption policies do not cover pandemic losses, so they intend to fight COVID-19 claims “tooth and nail.” More than 450 lawsuits throughout the country already have been brought against insurers, including dozens of class actions. Legislators in several states have proposed legislation that would require insurers to pay business interruption claims regardless of whether the claims are covered by the wording of the policies. In the absence of a government bailout, the losers of this epic insurance battle—either insurers or their insureds’ businesses—will likely face bankruptcy. Thus, the financial consequences of this battle, and its implications for America’s economy, cannot be overstated.

This is the first scholarly Essay to discuss the arguments for and against business interruption policies covering COVID-19 business interruption losses. In doing so, it sets forth the strongest arguments on each side of the fight regarding the meaning of the applicable policy language in the context of the existing caselaw and the purpose of business interruption insurance. It also addresses the insurance industry’s claim that pandemic losses are not covered by business interruption policies because such losses are simply uninsurable. Finally, it discusses the competing public policies that support each side.

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## I. INTRODUCTION

COVID-19 has brought havoc on the world. As of June 30, 2020, over 500,000 people had died worldwide, including more than 126,000 deaths in the United States.<sup>1</sup> Not only is this new iteration of the SARS virus deadly like its predecessor, but it is also highly contagious due to its ability to be transmitted through the air and on surfaces where it can survive for hours or days depending upon the type of surface material.<sup>2</sup> Indeed, the virus was detected on a contaminated cruise ship seventeen days after the ship had been evacuated.<sup>3</sup>

Governors across the country issued stay-at-home orders, which prevented countless businesses from operating and caused massive layoffs. By June 11, 2020, over 44 million people in the U.S. had applied for unemployment benefits since the pandemic hit the country with full force in March.<sup>4</sup> The unemployment rate in the U.S. reached Great Depression numbers that have been projected to average at least 15 percent during the second and third quarters, and the gross domestic product (GDP) has been projected to be down at least 12 percent in the second quarter.<sup>5</sup> In addition to staggering losses by large businesses, small businesses were estimated to be losing \$255 to \$431 billion per month due to the government-ordered

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<sup>1</sup> Sarah Almukhtar, et al., *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. TIMES (last updated June 30, 2020, 8:00 AM), <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>.

<sup>2</sup> *New Coronavirus Stable for Hours on Surfaces: SARS-CoV-2 Stability Similar to Original SARS Virus*, U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L INST. OF HEALTH (Mar. 17, 2020), <https://www.nih.gov/news-events/news-releases/new-coronavirus-stable-hours-surfaces>.

<sup>3</sup> See Leah F. Moriarty, et al., *Morbidity and Mortality Weekly Report (MMWR)*, CDC (Mar. 27, 2020), [https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e3.htm?s\\_cid=mm6912e3\\_w](https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e3.htm?s_cid=mm6912e3_w) ("SARS-CoV-2 RNA was identified on a variety of surfaces in cabins of both symptomatic and asymptomatic infected passengers up to 17 days after cabins were vacated on the Diamond Princess . . .").

<sup>4</sup> Tiffany Hsu, *Sobering Jobs Outlook: 'We're Expecting a Long Haul'*, N.Y. TIMES (June 11, 2020), <https://www.nytimes.com/2020/06/11/business/economy/unemployment-claims-coronavirus.html>.

<sup>5</sup> Phill Swagel, *CBO's Current Projects of Output, Employment, and Interest Rates and a Preliminary Look at Federal Deficits for 2020 and 2021*, CBO (Apr. 24, 2020), <https://www.cbo.gov/publication/56335>.

shutdowns.<sup>6</sup> The United States Department of Labor estimates that 40 percent of businesses never reopen after experiencing a disaster.<sup>7</sup> Of those that reopen, at least 25 percent fail within two years.<sup>8</sup>

To avoid such a fate, most large businesses and approximately 40 percent of small businesses purchase business interruption insurance, which is intended to cover lost revenues and other monetary damage caused by business interruptions.<sup>9</sup> Many businesses have been paying premiums on such policies for years.<sup>10</sup> Naturally, these businesses turned to their insurers for help when faced with the devastating losses caused by COVID-19. In response, the insurance industry announced that COVID-19 business interruption losses are not covered by their policies and that pandemic losses are simply uninsurable.<sup>11</sup> The insurance industry also claimed that property insurers only collect approximately \$6 billion per month in premiums which would bankrupt the industry if they were required to cover the losses.<sup>12</sup> Consequently, according to the CEO of one of the world's largest insurers,

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<sup>6</sup> Press Release, Am. Prop. Cas. Ins. Ass'n, APCIA Releases New Business Interruption Analysis (Apr. 6, 2020) (available at <http://www.pciaa.net/pciwebsite/cms/content/viewpage?sitePageId=60052>).

<sup>7</sup> John Grossmann, *A Business Ponders Whether its Location is Perfect, or a Disaster*, N.Y. TIMES (Dec. 7, 2011), <https://www.nytimes.com/2011/12/08/business/smallbusiness/a-business-tries-to-decide-whether-its-location-is-perfect-or-a-disaster.html>.

<sup>8</sup> *Id.*

<sup>9</sup> Suzanne Barlyn, *U.S. Insurers Want Taxpayers to Back Pandemic Coverage for Businesses*, REUTERS (April 29, 2020), <https://www.reuters.com/article/us-health-coronavirus-insurance-pandemic/u-s-insurers-want-taxpayers-to-back-pandemic-coverage-for-businesses-idUSKCN22B1J8>.

<sup>10</sup> See, e.g., Alexia Elejalde-Ruiz, *Business Owners Bleeding Money During the Coronavirus Shutdown May Expect Insurance to Cover Their Losses. But Often They're in for a Shock*, CHI. TRIB. (April 16, 2020), <https://www.chicagotribune.com/coronavirus/ct-coronavirus-business-interruption-insurance-lawsuits-20200416-b5kl3xaweja7refbqfr4cpkp3u-story.html> (reporting that one policyholder asked, "How could they take our fees for 10 years and then not pay out?" after being told of the insurer's position).

<sup>11</sup> See Am. Prop. Cas. Ins. Ass'n, *supra* note 6 ("Many commercial insurance policies, including those that have business interruption coverage, do not provide coverage for communicable diseases or viruses such as COVID-19. Pandemic outbreaks are uninsured because they are uninsurable."); see also Julia Jacobs, *Arts Groups Fight Their Insurers Over Coverage on Virus Losses*, N.Y. TIMES (May 5, 2020), <https://www.nytimes.com/2020/05/05/arts/insurance-claims-coronavirus-arts.html>.

<sup>12</sup> See Am. Prop. Cas. Ins. Ass'n, *supra* note 6.

“[t]he industry will fight [paying COVID-19 business interruption claims] tooth and nail.”<sup>13</sup>

By June 22, 2020, the insurance industry’s blanket denial of coverage for COVID-19 business interruption losses had spawned over 450 lawsuits, including dozens of class actions, across the country.<sup>14</sup> It also prompted legislators in at least eight states to propose legislation that would require insurers to pay the claims regardless of the policy language at issue.<sup>15</sup>

In the absence of a government bailout for the losers of this epic battle, court determinations regarding which parties will suffer the financial losses caused by COVID-19 business interruptions will determine the fate of the insurance industry and many large and small businesses. Thus, the financial stakes for insurers, small and large businesses, and America’s economic future could not be higher.

This Essay sets forth the arguments for and against business interruption policies covering COVID-19 business interruption losses. It is the first Essay to do so. It intends to make the strongest arguments each side has regarding the meaning of the applicable policy language when read in the context of existing caselaw with the purpose of business interruption insurance in mind. Although the actual wording of the policies is important, which courts decide the cases will also be critical to the outcomes. This is

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<sup>13</sup> Jacobs, *supra* note 11; see also Evan G. Greenberg, *What Won’t Cure Corona: Lawsuits*, WALL ST. J. (April 21, 2020), <https://www.wsj.com/articles/what-wont-cure-corona-lawsuits-11587504920> (“Some businesses and policy makers think business-interruption coverage should pay out for the pandemic’s damage, even though those risks aren’t covered in these policies, nor were premiums collected for the exposure . . . . If implemented, it would bankrupt the insurance industry to prop up other parts of the economy.”).

<sup>14</sup> See, e.g., *Covid Coverage Litigation Tracker*, University of Pennsylvania Carey Law School (as of June 22, 2020), <https://cclt.law.upenn.edu/>; Jim Sams, *Number of Federal COVID-19 Business Interruption Lawsuits at 101 and Rising*, CLAIMS J. (May 21, 2020), <https://www.claimsjournal.com/news/national/2020/05/21/297180.htm>; Elejalde-Ruiz, *supra* note 10; Leslie Scism, *Politicians Push Insurers to Resolve Mounting Disputes Over Covid-19 Losses*, WALL ST. J. (April 13, 2020), <https://www.wsj.com/articles/politicians-push-insurers-to-cover-business-losses-11586794059>; Jacobs, *supra* note 11.

<sup>15</sup> See, e.g., Elejalde-Ruiz, *supra* note 10; Huw Jones & Carolyn Cohn, *Forced Pandemic Payouts Risk Financial Instability: Insurance Regulators*, REUTERS (May 7, 2020), <https://www.reuters.com/article/us-health-coronavirus-insurance-regulato/forced-pandemic-payouts-risk-financial-instability-insurance-regulators-idUSKBN22J225>.

because insurance disputes are governed by state law and the law can vary considerably from state to state.<sup>16</sup> In analyzing these issues, this Essay also addresses the insurance industry's claim that pandemics are uninsurable, and it weighs the competing public policies that support each side.

## II. BUSINESS INTERRUPTION INSURANCE

Business interruption insurance protects a business' income stream when its operations are shut down by a covered peril. The purpose of business interruption insurance is to return the policyholder to the position it would have occupied if the covered peril had not occurred.<sup>17</sup>

Typically, business interruption insurance is purchased as part of an "all risk" property insurance policy. All risk property policies are the broadest form of property insurance available because they cover all losses the policyholder suffers unless the peril causing the loss is specifically excluded.<sup>18</sup> Unlike the policy language used in some other lines of

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<sup>16</sup> See, e.g., Peter J. Kalis et al., POLICYHOLDER'S GUIDE TO THE LAW OF INSURANCE COVERAGE §26.03[B] (1st ed. 1997 & Supp. 2020) ("Insurance contracts are interpreted according to state law. Not surprisingly, the manner in which the courts of the various states address similar interpretive issues can vary widely from one state to the next."); Larry Kramer, *Choice of Law in Complex Litigation*, 71 N.Y.U. L. REV. 547, 553–54 (1996) ("Conflicts scholars don't fight bitterly about the differences among approaches [to determining choice law] because we disagree about their aesthetic qualities. We fight because the differences matter in terms of outcomes.").

<sup>17</sup> Cont'l Ins. Co. v. DNE Corp., 834 S.W.2d 930, 934 (Tenn. 1992) (citing Nw. States Portland Cement Co. v. Hartford Fire Ins. Co., 360 F.2d 531 (8th Cir. 1966)) ("The purpose of business interruption insurance is to protect the insured against losses that occur when its operations are unexpectedly interrupted, and to place it in the position it would have occupied if the interruption had not occurred."). See also Gregory D. Miller & Joseph D. Jean, *Effect of Post-Loss Economic Factors in Measuring Business Interruption Losses: An Insured's and Insurer's Perspectives*, in NEW APPLEMAN ON INSURANCE: CURRENT CRITICAL ISSUES IN INSURANCE LAW 25, 25 (2010) ("Business interruption insurance, at its core, is intended to place the insured in the position it would have been in had it not suffered a loss."); Jon C. Rice, *Business Interruption Coverage in the Wake of Katrina: Measuring the Insured's Loss in a Volatile Economy*, 41 TORT TRIAL & INS. PRAC. L.J. 857, 857 (2006) ("The purpose of business interruption coverage is to place the insured in the position it would have occupied had no interruption occurred.").

<sup>18</sup> See, e.g., Jeff Katofsky, *Subsiding Away: Can California Homeowners Recover from Their Insurer for Subsidence Damages to Their Homes?*, 20 PAC. L.

insurance—often identical from insurer to insurer because the insurers all use the same policy form drafted by the Insurance Services Office, Inc. (ISO)—the policy language in business interruption insurance policies can vary from insurer to insurer.<sup>19</sup> Despite some variations from insurer to insurer, the language in business interruption policies, like other lines of insurance, is drafted by insurers and then sold on a take-it-or-leave-it basis.<sup>20</sup>

#### A. POTENTIALLY APPLICABLE COVERAGES

Under most business interruption policies, there are four policy provisions that potentially provide coverage for COVID-19 business interruption losses. Because the language used by insurers can vary, however, the four examples set forth below are just that—examples.

The first potential source of coverage arises under the basic insuring agreement, which states, “We will pay for the actual loss of Business Income you sustain due to the necessary suspension of ‘your operations’ . . . caused by direct physical loss of or damage to covered property . . . .”<sup>21</sup> Under this language, business interruption coverage is triggered if the policyholder’s business is interrupted because of physical loss or damage to some or all of

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J. 783, 785 (1989) (“In an ‘all-risk’ policy, *all losses except those specifically excluded are covered*. This is the broadest form of coverage and has been so interpreted by the courts.”) (emphasis in original).

<sup>19</sup> See, e.g., *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 772 (1993) (“Defendant Insurance Services Office, Inc. (ISO), [is] an association of approximately 1,400 domestic property and casualty insurers. . . . [ISO] is the almost exclusive source of support services in this country for [Commercial General Liability (CGL)] insurance. ISO develops standard policy forms and files or lodges them with each State’s insurance regulators; most CGL insurance written in the United States is written on these forms.”) (internal citations omitted); *U.S. Fire Ins. Co. v. J.S.U.B., Inc.*, 979 So.2d 871, 879 n.6 (Fla. 2007) (“[ISO] is an industry organization that promulgates various standard insurance policies that are utilized by insurers throughout the country. . . .”).

<sup>20</sup> See, e.g., James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995, 996 (1992) (“[T]here is little, if any, freedom to negotiate the standardized language of the insurance contract that determines the scope of coverage.”); Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 125 (2007) (“[I]n some lines of insurance, all insurance companies provide identical coverage on the same take-it-or-leave-it basis.”).

<sup>21</sup> Complaint Exhibit A at 68, *JDS 1455, Inc. v. Society Insurance*, No. 1:20-cv-02546 (N.D. Ill. Apr. 24, 2020) [hereinafter *Business Owners Policy*].

the policyholder's property that the policyholder needs to generate income for the business. If a tornado rips the roof off a policyholder's restaurant, for example, then the restaurant will cease operations until repairs can be completed. This type of event, where it is obvious the policyholder's property has been tangibly damaged, is an example of where business interruption coverage is commonly triggered. Notably, however, the term "damage" and the phrase "direct physical loss of or damage" are not defined in the policy, so there is no basis in the policy language itself to conclude that tangible, physical damage is required in order to trigger coverage.

The second potential source of coverage is the Civil Authority provision, which states, "When a Covered Cause of Loss causes damage to property other than property at the [policyholder's business], we will pay for the actual loss of Business Income you sustain . . . caused by action of civil authority that prohibits access to the described premises . . . ." <sup>22</sup> Under this language, if a civil authority prevents a policyholder from doing business due to "damage" to someone else's property, then coverage is triggered. Again, "damage" is undefined, but a classic example of this scenario is a downed powerline on the street in front of a business that prompts local officials to close the business until the powerline is repaired.

The third potential source of coverage is the Contingent Properties provision, which provides, "We will pay for the actual loss of Business Income you sustain due to physical loss or damage at the premises of a 'dependent property' or a 'secondary dependent property' caused by or resulting from any Covered Cause of Loss . . . ." <sup>23</sup> Under this coverage, a policyholder's business interruption losses are covered if they are caused by a supplier or a customer's inability to do business with the policyholder due to physical loss or damage at the supplier's or customer's own properties. Although "physical loss or damage" is again undefined, an example of this scenario is a corn processing plant that is unable to operate its business because its corn supplier's business is hit by a tornado. Thus, the supplier is unable to deliver corn needed for the policyholder's corn processing operations.

The fourth potential source of coverage is the Contamination provision, which states, "If your 'operations' are suspended due to 'contamination,' [then] we will . . . pay for the actual loss of Business Income . . . you sustain caused by (a) 'Contamination' that results in an action by a public health or other governmental authority that prohibits access to the

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<sup>22</sup> *Id.* at 85.

<sup>23</sup> *Id.* at 72.



[policyholder’s business] . . . .”<sup>24</sup> Contamination is defined as “a . . . dangerous condition in your . . . premises.”<sup>25</sup> Unlike the other three business interruption coverage provisions that are predicated upon “physical loss or damage” to some property—either the policyholder’s or a third party’s—contamination coverage is triggered by a “dangerous condition” at the policyholder’s premises.

## B. POTENTIALLY APPLICABLE EXCLUSIONS

There are also two exclusions in some business interruption policies that may be applicable to COVID-19 claims. The first is the “virus” exclusion, which ISO introduced in 2006 following the SARS outbreak. The key portion of the exclusion states, “We will not pay for loss or damage resulting from any virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease.”<sup>26</sup> In seeking regulatory approval for the exclusion, the insurance industry stated that “[a]lthough building and personal property arguably could become contaminated (often temporarily) by such viruses and bacteria, . . . property policies have not been a source of recovery for losses involving contamination by disease-causing agents . . . .”<sup>27</sup> Although it specifically referenced the SARS virus when seeking approval of the virus exclusion, the insurance industry stated that the exclusion was not limited to just that virus because “the universe of disease-causing organisms is always in evolution.”<sup>28</sup>

The second potentially applicable exclusion is the “pollution” exclusion. This exclusion commonly states, “We will not pay for loss or damage caused by or resulting from the discharge, dispersal, seepage, migration, release or escape of ‘pollutants’ . . . .”<sup>29</sup> Pollutants is defined as “any solid, liquid, gaseous or thermal irritant or contaminant, including

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<sup>24</sup> *Id.* at 71.

<sup>25</sup> *Id.* at 72.

<sup>26</sup> INSURANCE SERVICES OFFICE, ISO FORM CP 01 40 07 06 - EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA 8 (ISO Circular July 6, 2006) [hereinafter ISO Circular], <https://www.propertyinsurancecoveragelaw.com/files/2020/03/ISO-Circular-LI-CF-2006-175-Virus.pdf>.

<sup>27</sup> *Id.* at 10.

<sup>28</sup> *Id.* at 5.

<sup>29</sup> Business Owners Policy, *supra* note 21, at 82.

smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.”<sup>30</sup>

### III. RULES OF INSURANCE POLICY INTERPRETATION

#### A. BASIC RULES

Insurance policies arguably are not really contracts because they are non-negotiable, and the purchaser generally does not get a chance to review the policy before purchasing it. They nonetheless are generally treated by courts as contracts when disputes arise regarding the meaning of policy language.<sup>31</sup> The interpretation of policy language is a question of law for courts to determine.<sup>32</sup> The policy language that grants coverage is construed broadly, while provisions that exclude or limit coverage are construed narrowly.<sup>33</sup> Exclusionary language should not be interpreted in a way that

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<sup>30</sup> *Id.* at 31.

<sup>31</sup> *See, e.g.,* *Sonson v. United Servs. Auto. Ass’n*, 100 A.3d 1, 2, 5 (Conn. App. Ct. 2014) (“Standardized contracts of insurance continue to be prime examples of contracts of adhesion . . . . The interpretation of a contract presents a question of law subject to de novo review.”) (citations omitted) (internal quotation marks omitted); *Pryor v. Colony Ins.*, 414 S.W.3d 424, 430 (Ky. Ct. App. 2013) (“[M]ost insurance policies are contracts of adhesion . . . . To ascertain the construction of an insurance contract, one begins with the text of the policy itself.”).

<sup>32</sup> *See, e.g.,* STEVEN PITT, ET AL., 2 COUCH ON INSURANCE § 21:3 (3d ed. 2016) (“As a general rule, the construction and effect of a written contract of insurance is a matter of law, to be determined by the court and not by the jury.”) (citation omitted); ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 133 (5th ed. 2012) (“[T]he interpretation of [an insurance] contract is a question of law and is therefore reserved to the court.”).

<sup>33</sup> *See, e.g.,* *Powell v. Liberty Mut. Fire Ins. Co.*, 252 P.3d 668, 672 (Nev. 2011) (quoting *Nat’l Union Fire Ins. v. Reno’s Exec. Air, Inc.*, 682 P.2d 1380, 1383 (Nev. 1984)) (“While clauses providing coverage are interpreted broadly so as to afford the greatest possible coverage to the insured, clauses excluding coverage are interpreted narrowly against the insurer.”).

allows it to swallow the basic coverage provided by the policy.<sup>34</sup> Courts also attempt to interpret the policy as a whole, reconciling all of its provisions.<sup>35</sup>

In construing policy language,<sup>36</sup> courts do so with the purpose of the insurance in mind—the way a layman would understand the policy language.<sup>37</sup> This means that courts often refer to standard dictionaries when

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<sup>34</sup> See, e.g., *Harris v. Gulf Ins. Co.*, 297 F. Supp. 2d 1220, 1226 (N.D. Cal. 2003) (rejecting insurer’s interpretation of an exclusion in policy because it “would render the coverage provided by the policy illusory.”); *Alstrin v. St. Paul Mercury Ins. Co.*, 179 F. Supp. 2d 376, 398 (D. Del. 2002) (rejecting insurer’s interpretation of an exclusion where, if applied, “there would be little or nothing left to that coverage,” because “[n]o insured would expect such limited coverage from a policy . . . .”); *Titan Indem. Co. v. Newton*, 39 F. Supp. 2d 1336, 1348 (N.D. Ala. 1999) (finding coverage even though “[t]he limitations of [the] policy completely swallow up the insuring provisions.”); *Bailer v. Erie Ins. Exch.*, 687 A.2d 1375, 1380 (Md. 1997) (“If the exclusion totally swallows the insuring provision, the provisions are completely contradictory. That is the grossest form of ambiguity . . . .”).

<sup>35</sup> See, e.g., *Rothenberg v. Lincoln Farm Camp, Inc.*, 755 F.2d 1017, 1019 (2d Cir. 1985) (“[A]n interpretation that gives a reasonable and effective meaning to all the terms of a contract is generally preferred to one that leaves a part unreasonable or of no effect.”); *Fireman’s Fund Ins. Co. v. Allstate Ins. Co.*, 234 Cal. App. 3d 1154, 1169 (1991) (quoting *State Farm Mut. Auto. Ins. Co. v. Crane*, 217 Cal. App. 3d 1127, 1132 (1990)) (“In short, an insurance contract is to be construed in a manner which gives meaning to all its provisions in a natural, reasonable, and practical manner, having reference to the risk and subject matter and to the purposes of the entire contract.” (citation omitted)).

<sup>36</sup> The terms “interpretation” and “construction” are used interchangeably when it comes to interpreting insurance policies. Technically, interpretation involves attempting to discern the parties’ mutual intent regarding the language, while construction involves discerning the legally binding effect of the language. Because there is no mutual intent to discern when it comes to understanding an insurance policy, insurance policies technically are construed by courts, not interpreted. See, e.g., Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1109–10 (2006). Nonetheless, in this Essay, the terms are used interchangeably because courts and commentators often use the term interpretation when discussing the construction of policy language.

<sup>37</sup> See, e.g., *Fageol Truck & Coach Co. v. Pac. Indem. Co.*, 117 P.2d 669, 671 (Cal. 1941) (quoting *Cutting v. Atlas Mut. Ins. Co.*, 85 N.E. 174, 175 (Mass. 1908) (the policy “must be given ‘such a construction . . . as, if fairly warranted, will best carry out the object for which the contract was entered into, namely, that of securing indemnity to the insured for the losses to which the insurance relates.’”) (omission in original); *Glidden v. Farmers Auto. Ins. Ass’n*, 312 N.E.2d 247, 250 (Ill. 1974) (a policy should be interpreted “in the particular factual setting

construing the policy language, as opposed to using technical meanings or the insurance industry's own understanding of the terms.<sup>38</sup>

As discussed in the next part, in addition to these basic rules of contract interpretation, courts have developed some special rules regarding the interpretation of policies. These special rules have been created due to the imbalance of power and knowledge that favors insurers during the creation and sale of insurance policies. Additionally, these rules address the public policies implicated by insurance's role as a social safety net—it is intended to compensate injured parties and protect policyholders from suffering devastating losses they cannot financially bear individually.

#### B. CONTRA PROFERENTEM

The doctrine of *contra proferentem* provides that any ambiguities in contract language should be construed against the drafter.<sup>39</sup> Because insurers draft the policies, the doctrine dictates that ambiguities should be construed against insurers.<sup>40</sup> In many states, the ambiguity test is whether the policy

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in which the contract was issued.”); *Century Bank v. St. Paul Fire & Marine Ins. Co.*, 482 P.2d 193, 194 (Cal. 1971) (Policy “language is to be construed in accord with the reasonable understanding of a layman . . . .”); *Pac. Indem. Co. v. Interstate Fire & Cas. Co.*, 488 A.2d 486, 488 (Md. 1985) (“In [interpreting policy language], we accord words their ordinary and accepted meanings. The test is what meaning a reasonably prudent layperson would attach to the term.”); *Kissil v. Beneficial Nat’l Life Ins. Co.*, 319 A.2d 67, 70 (N.J. 1974) (“The policy should be read as the ordinary policyholder would understand it.”).

<sup>38</sup> See, e.g., *Scott v. Cont’l Ins. Co.*, 44 Cal. App. 4th 24, 29 (1996) (“In seeking to ascertain the ordinary sense of words, courts in insurance cases regularly turn to general dictionaries.”); *JERRY & RICHMOND*, *supra* note 32, at 138 (“In affording terms their ordinary meaning, courts frequently consult standard English language dictionaries.”).

<sup>39</sup> See, e.g., *Boardman*, *supra* note 36, at 1121 n.64 (quoting 17A C.J.S. *Contracts* § 337 (2003)) (“The language of a contract will be construed most strictly or strongly against the party responsible for its use . . . .”).

<sup>40</sup> See, e.g., *Crane v. State Farm Fire & Cas. Co.*, 485 P.2d 1129, 1130 (Cal. 1971) (“Any ambiguity or uncertainty in an insurance policy is to be resolved against the insurer.”); *Crawford v. Prudential Ins. Co. of Am.*, 783 P.2d 900, 904 (Kan. 1989) (quoting *Fowler v. United Equitable Ins. Co.*, 438 P.2d 46, 48 (Kan. 1968)) (“Since an insurer prepares its own contracts, it has a duty to make the meaning clear, and if it fails to do so, the insurer, and not the insured, must suffer.”); *Ethan J. Leib & Steve Thel, Contra Proferentem and the Role of the Jury in Contract Interpretation*, 87 TEMP. L. REV. 773, 774 n.4 (2015) (quoting *Phillips v. Lincoln Nat’l Life Ins. Co.*, 978 F.2d 302, 312 (7th Cir. 1992) (“[T]he *contra*

language can be reasonably interpreted in different ways.<sup>41</sup> If the policyholder and insurer both have reasonable interpretations, then the policy language should be construed in favor of coverage because it is deemed ambiguous.<sup>42</sup> And, as is often the case when it comes to standardized policy language that is interpreted by numerous courts across the country, if the same language has been interpreted in different ways by different courts, then the inconsistencies may be treated as indicia that the policy language is ambiguous.<sup>43</sup>

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*proferentem* rule . . . is followed in all fifty states and the District of Columbia, and with good reason. Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence.") (alterations in original).

<sup>41</sup> See, e.g., *New Castle Cty. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 243 F.3d 744, 750 (3d Cir. 2001) (quoting *New Castle Cty. v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 174 F.3d 338, 344 (3d Cir. 1999) ("The settled test for ambiguity is whether the provisions in controversy are reasonably or fairly susceptible of different interpretations or may have two or more different meanings."); *Bonner v. United Servs. Auto. Ass'n*, 841 S.W.2d 504, 506 (Tex. Ct. App. 1992) ("The court must adopt the construction of an exclusionary clause urged by the insured as long as that construction is not unreasonable, even if the construction urged by the insurer appears to be more reasonable or a more accurate reflection of the parties' intent.").

<sup>42</sup> *Id.*

<sup>43</sup> See, e.g., *Crawford v. Prudential Ins. Co. of Am.*, 783 P.2d 900, 908 (Kan. 1989) ("[T]he reported cases are in conflict, the trial judge and the Court of Appeals reached different conclusions and the justices of this court [disagree] . . . . Under such circumstances, the clause is, by definition, ambiguous and must be interpreted in favor of the insured."); *Allstate Ins. Co. v. Hartford Accident & Indem. Co.*, 311 S.W.2d 41, 47 (Mo. Ct. App. 1958) ("Since we assume that *all* courts adopt a reasonable construction, the conflict is of itself indicative that the word as so used is susceptible of at least two reasonable interpretations, one of which extends the coverage to the situation at hand."); *Cohen v. Erie Indem. Co.*, 432 A.2d 596, 599 (Pa. Super. Ct. 1981) ("The mere fact that [courts do not agree on the meaning of the language] . . . creates the inescapable conclusion that the provision in issue is susceptible to more than one interpretation.").

## C. REASONABLE EXPECTATIONS DOCTRINE

Another interpretive rule, unique to insurance policies, is the “reasonable expectations doctrine.”<sup>44</sup> Although courts use different versions of the reasonable expectations doctrine, one version provides that the policyholder should receive the coverage that it reasonably thought it had purchased, even if the claim is not covered under the express terms of the policy language.<sup>45</sup>

Courts can justify the creation and use of the reasonable expectations doctrine on several grounds. For one, policyholders need protection from policy language that unfairly favors insurers because policyholders have no input into the drafting of the policy language and typically do not get to see the policy language before purchasing a policy.<sup>46</sup> Indeed, the Restatement (Second) of Contracts specifically recognizes that courts can refuse to enforce terms contained in standardized insurance policies that a policyholder would reject if it could.<sup>47</sup> Thus, the policy language is not

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<sup>44</sup> See, e.g., BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES §1.04[b], at 34–48 (19th ed. 2019) (identifying courts in forty-two states that have expressed support for, or applied a form of, the reasonable expectations doctrine).

<sup>45</sup> See, e.g., *AIU Ins. Co. v. Superior Court*, 799 P.2d 1253, 1264 (Cal. 1990) (insurance policies should be interpreted broadly to “pro[te]ct the objectively reasonable expectations of the insured.”); *Nat’l Mut. Ins. Co. v. McMahon & Sons, Inc.*, 356 S.E.2d 488, 495–96 (W. Va. 1987) (the reasonable expectations doctrine dictates that a policy be construed in a manner that a reasonable person standing in the shoes of the insured would expect the language to mean, even though painstaking examination of the policy provisions would have negated those expectations); ROBERT E. KEETON, ALAN I. WIDISS & JAMES M. FISCHER, *INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES* §§ 6.3(a)(5), at 538 n. 98 (2d ed. 1988) (“In general, courts will protect the reasonable expectations of applicants, insureds, and intended beneficiaries regarding the coverage afforded by insurance contracts even though a careful examination of the policy provisions indicates that such expectations are contrary to the expressed intention of the insurer.”).

<sup>46</sup> See, e.g., Eugene R. Anderson & James J. Fournier, *Why Courts Enforce Insurance Policyholders’ Objectively Reasonable Expectations of Insurance Coverage*, 5 CONN. INS. L.J. 335, 363 (1998); Boardman, *supra* note 36, at 1120; Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 968 (1970); Randall, *supra* note 20, at 107.

<sup>47</sup> See RESTATEMENT (SECOND) OF CONTRACTS § 211(3) cmt c. (AM. LAW INST. 1981) (recognizing that some terms in standardized contracts should not be enforced if the other party would have rejected the term if it could and specifically

always controlling because the policyholder's expectations regarding the coverage it is purchasing is not based upon the policy language itself and it has no ability to reject the policy language.

Additionally, public policy supports the doctrine. Because policyholders are required to buy some lines of insurance (e.g., auto insurance),<sup>48</sup> and they need other types of insurance in order to avoid financial ruin when catastrophic events occur (e.g., health insurance and business interruption insurance), insurance serves the necessary function of a social safety net in order to compensate injured parties for their losses.<sup>49</sup> Insurance policies should be interpreted expansively to advance these public policies.

Finally, state statutes enable insurance regulators to reject policy language that is unreasonable, unfair, ambiguous, or contrary to public policy.<sup>50</sup> Courts similarly should do so when needed.

#### IV. THE CASE FOR INSURERS

##### A. COVID-19 BUSINESS INTERRUPTION LOSSES ARE NOT CAUSED BY "PHYSICAL LOSS OF OR DAMAGE TO PROPERTY"

According to insurers, COVID-19 business interruption losses are not covered because their policies unambiguously require that the losses be caused by "physical loss of or damage to property" in order to be covered. This means theft or tangible, physical damage to property must cause the business interruption. COVID-19 business interruption losses are not caused

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listing insurance policies as a type of standard contract that needs to be regulated due to the risk of insurers overreaching).

<sup>48</sup> See, e.g., JERRY & RICHMOND, *supra* note 32, at 924–25; Anderson & Fournier, *supra* note 46, at 368; Randall, *supra* note 20, at 125.

<sup>49</sup> See, e.g., St. Paul Fire & Marine Ins. Co. v. Jacobson, 826 F. Supp. 155, 163–64 (E.D. Va. 1993) (discussing public policy of compensating innocent victims outweighs public policy of not permitting coverage for intentional actions); St. Paul Fire & Marine Ins. Co. v. Asbury, 720 P.2d 540, 542 (Ariz. Ct. App. 1986) (noting Arizona public policy favors compensating injured persons); Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653, 668 (2013) (discussing insurance's role as a public utility); Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1497 (2010) (discussing the socially important role that insurance plays).

<sup>50</sup> See, e.g., KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION* 143, 146 (6th ed. 2015); Randall, *supra* note 20, at 146.

by theft or tangible, physical damage to property. To the contrary, the losses have been caused by government orders shutting businesses down in order to slow the spread of the virus and reduce the number of people simultaneously getting sick and dying. No property has been physically lost or damaged such that business operations were suspended as a result. Consequently, business interruption insurance, which covers business interruption losses due to theft or tangible, physical property damage, does not cover COVID-19 business interruption claims.

To support this argument, insurers can cite numerous cases in which courts have held that “physical loss of or damage” requires either theft or tangible injury to property.<sup>51</sup> According to the reasoning of these cases, losses that result from business interruptions caused by the fear of illness or death are not the result of tangible, physical loss or damage. Consequently, COVID-19 business interruption losses are not covered.

B. COVID-19 BUSINESS INTERRUPTION LOSSES ARE EXCLUDED BY THE POLLUTION AND VIRUS EXCLUSIONS

Even if COVID-19 business interruption losses were somehow considered the result of physical loss or damage to property, insurers argue such claims still would not be covered because the pollution and virus exclusions bar such claims. The pollution exclusion states a “loss . . . caused by or resulting from the discharge, dispersal, seepage, migration, release or escape of ‘pollutants’” is not covered.<sup>52</sup> “Pollutants” are defined as “any solid, liquid, gaseous . . . irritant or contaminant . . . .”<sup>53</sup> The COVID-19 virus, and its transmission, qualifies as a solid, liquid or gaseous irritant or contaminant. Thus, losses caused by the virus are excluded from coverage by the pollution exclusion.

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<sup>51</sup> See, e.g., *Dickie Brennan & Co. v. Lexington Ins. Co.*, 636 F.3d 683 (5th Cir. 2011) (finding that business interruption losses incurred by operators of New Orleans restaurants due to a mandatory evacuation of the city prior to the arrival of Hurricane Gustav were not caused by direct physical loss of or damage to property); *Source Food Tech., Inc. v. U.S. Fid. & Guar. Co.*, 465 F.3d 834 (8th Cir. 2006) (deciding that business interruption losses resulting from embargo due to “mad cow disease” that prevented insured from shipping uncontaminated beef were not caused by physical loss); *United Air Lines, Inc. v. Insurance Co. of Pa.*, 439 F.3d 128, 129 (2d Cir. 2006) (determining the airline could not show that its lost earnings resulted from physical damage to its property or from physical damage to an adjacent property when government shut down airport following 9/11 terrorist attack).

<sup>52</sup> See Business Owners Policy, *supra* note 21, at 82.

<sup>53</sup> See *id.* at 31.



Even more applicable, however, is the virus exclusion. The virus exclusion was specifically created to exclude coverage for losses caused by viruses. The COVID-19 virus is a variation of the virus that causes SARS, which is one of the viruses specifically listed in the ISO Circular that explained what was intended to be covered by the exclusion.<sup>54</sup> Thus, for policies that contain a virus exclusion, there should be no question that the virus exclusion applies to COVID-19 business interruption losses.

### C. PANDEMIC CLAIMS ARE UNINSURABLE CORRELATED LOSSES

Insurers also argue that the reason pandemic claims, such as COVID-19 business interruption losses, are not covered by their policies is because the losses associated with pandemics are uninsurable correlated risks.<sup>55</sup> Correlated risks are losses caused by perils that result in numerous losses occurring in the same geographic area at approximately the same time.<sup>56</sup> Because many types of natural catastrophes, such as floods and earthquakes, are considered correlated risks, private insurers generally refuse to insure them.<sup>57</sup> Private insurers avoid insuring correlated risks because of insurers' alleged inability to accurately predict when, where, and how many losses associated with the peril will occur.<sup>58</sup> This uncertainty makes it difficult to establish actuarially sound premiums and spread the risk across a large enough pool of insureds with diverse risk profiles.<sup>59</sup>

Pandemics are an extreme type of correlated risk because they happen on a world-wide basis. As such, insurers purportedly did not intend

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<sup>54</sup> See ISO Circular, *supra* note 26.

<sup>55</sup> See Am. Prop. Cas. Ins. Ass'n, *supra* note 6 ("Pandemic outbreaks are uninsured because they are uninsurable.").

<sup>56</sup> See Véronique Bruggeman et al., *Insurance Against Catastrophe: Government Stimulation of Insurance Markets for Catastrophic Events*, 23 DUKE ENVTL. L. & POL'Y F. 185, 187 (2012); J. David Cummins, *Should the Government Provide Insurance for Catastrophes?*, FED. RES. BANK ST. LOUIS REV., 337, 342–43 (July 2006); Adam F. Scales, *A Nation of Policyholders: Governmental and Market Failure in Flood Insurance*, 26 MISS. C. L. REV. 10–11 (2006).

<sup>57</sup> See, e.g., *Correlated Risks*, WORLD FINANCE (June 30, 2010), <http://www.worldfinance.com/home/risk-encyclopaedia/correlated-risks> [<https://perma.cc/CQ3D-865A>].

<sup>58</sup> *Id.*

<sup>59</sup> See Bruggeman et al., *supra* note 56, at 187.

to cover them under business interruption policies and did not charge a premium for them.<sup>60</sup>

D. PUBLIC POLICY DICTATES INSURERS SHOULD NOT BE REQUIRED TO PAY COVID-19 BUSINESS INTERRUPTION LOSSES

According to the insurance industry, it would be bad public policy to require insurers to pay COVID-19 business interruption losses.<sup>61</sup> The insurance industry makes two arguments to support its position.

One, because the policies unambiguously do not cover pandemic business interruption losses, courts would need to rewrite the policies or ignore the clear language in them in order to find coverage. This would violate the public policy that favors enforcing contracts as written. Public policy favors enforcing contracts due to freedom of choice and to ensure that parties' rights and obligations are predictable.<sup>62</sup> Failing to enforce the policies as written would vitiate this public policy.

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<sup>60</sup> See Am. Prop. Cas. Ins. Ass'n, *supra* note 6; Greenberg, *supra* note 13. Whether a portion of the premium charged by insurers for the all risk policies that cover business interruption losses was intended to cover pandemic risks is, of course, a factual issue, but the premium charged for an all risk policy covers *all risks*, except risks that are expressly excluded. If a risk, such as pandemics, is not excluded, then it is covered regardless of whether insurers specifically considered the risk when creating the premium rate. Moreover, premium rates are not based upon an aggregation of premium amounts charged for each of the countless risks covered by all risk policies. Rather, they are based upon broad factors, such as the value of the property insured, the type of materials used in the construction of the property (e.g., brick versus lumber), the nature of the activities conducted in the property (e.g., welding versus office administration), the presence of risk reduction measures in or near the property (e.g., fire sprinklers and fire hydrants), and the location of the property (e.g., a high crime area versus a low crime area). See, e.g., *How to Get an Affordable Commercial Property Insurance Policy*, NATIONWIDE, <https://www.nationwide.com/lc/resources/small-business/articles/property-insurance-rates>; *How to Calculate Commercial Property Insurance Rates*, EK INSURANCE, <https://ekinsurance.com/commercial-property/how-to-calculate-commercial-property-insurance-rates.html>.

<sup>61</sup> See Am. Prop. Cas. Ins. Ass'n, *supra* note 6; Greenberg, *supra* note 13.

<sup>62</sup> See, e.g., MICHAEL HUNTER SCHWARTZ & DENISE RIEBE, *CONTRACTS: A CONTEXT AND PRACTICE CASEBOOK* 5 (2009) ("[P]redictability promotes our free market economy by providing certainty for those involved in exchanging goods and services. If a merchant knows the legal consequences of her negotiating efforts or of the language she selects for her contracts, she can act accordingly. This

Two, requiring insurers to cover all COVID-19 business interruption losses would bankrupt the insurance industry.<sup>63</sup> Property-casualty insurers collect approximately \$6 billion a month in premiums. The American Property Casualty Insurance Association estimates that the monthly COVID-19 business interruption losses just for businesses with 100 or fewer employees is \$255 to \$431 billion per month, for which no premiums allegedly have been charged or collected.<sup>64</sup> The net worth of property-casualty insurers is only approximately \$800 billion.<sup>65</sup> Consequently, the insurance industry simply cannot afford to cover the losses. Although the insurance industry should not be expected to provide financial security to people and businesses in the event of a pandemic, it is an important industry that should be preserved to help pay for less significant losses caused by other perils. Thus, it would be bad public policy to allow the insurance industry to become bankrupt, especially by forcing insurers to pay claims they contend are not covered by their policies.

#### V. THE CASE FOR POLICYHOLDERS

##### A. COVID-19 BUSINESS INTERRUPTION LOSSES WERE CAUSED BY “CONTAMINATION”

For policyholders with business interruption coverage for losses caused by “contamination,” COVID-19 business interruption losses should be covered. Some policies expressly cover business interruption losses caused by “contamination” that “results in an action by a . . . governmental authority that prohibits access to the described premises . . . .”<sup>66</sup> “Contamination” is defined as a “dangerous condition in your . . . premises.”<sup>67</sup> There should be little dispute that the government-ordered shutdowns of the policyholders’ businesses were the result of dangerous

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predictability encourages people to enter into contracts, secure in the knowledge that those contracts will be enforced.”); Eric A. Posner, *A Theory of Contract Law Under Conditions of Radical Judicial Error*, 94 NW. U.L. REV. 749, 751 (2000) (“Long-term contracts raise a straightforward, but seemingly intractable problem: in the long term events are so hard to predict, that parties will not be able to allocate future obligations and payments in a way that maximizes the value of their contract.”).

<sup>63</sup> See Greenberg, *supra* note 13.

<sup>64</sup> See Am. Prop. Cas. Ins. Ass’n, *supra* note 6; Greenberg, *supra* note 13.

<sup>65</sup> See Am. Prop. Cas. Ins. Ass’n, *supra* note 6.

<sup>66</sup> See Business Owners Policy, *supra* note 21, at 82.

<sup>67</sup> *Id.* at 31.

conditions at the policyholders' places of business—potentially infected property, employees and customers—that created a risk of illness and death if business operations continued.

B. COVID-19 BUSINESS INTERRUPTION LOSSES WERE CAUSED BY “PHYSICAL LOSS OF OR DAMAGE TO PROPERTY”

Under the rules of policy interpretation, COVID-19 business interruption losses are covered because they were caused by government orders shutting down policyholders' businesses due to “physical loss of or damage” to the policyholders' property. The phrase “physical loss of or damage” is undefined, so it should be interpreted expansively as a layperson would understand the phrase.<sup>68</sup> It should also be interpreted in accordance with the reasonable expectations of policyholders.<sup>69</sup> Finally, any ambiguities in the meaning of the phrase should be construed against insurers and in favor of policyholders.<sup>70</sup>

Applying these rules of policy interpretation to the policy language at issue, government orders shutting down businesses because of actual or threatened COVID-19 contamination either in the air or on surfaces of the policyholders' properties constitutes “physical loss of or damage to property.” First, if there is actual contamination of a policyholder's business premises with COVID-19, then there should be little dispute that the property is unusable in that condition because there is a substantial risk of people getting sick and dying. Some of the government shutdown orders were expressly issued because COVID-19 contamination was “*causing property loss and damage*.”<sup>71</sup>

Second, even if the properties do not have tangible, physical damage, policyholders have still suffered physical loss or damage if they cannot use their properties because it would be unsafe to do so. Numerous courts have reached this conclusion in a variety of contexts.

For example, the Third Circuit has held the presence of e-coli bacteria in a well that supplied water to an insured house could constitute

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<sup>68</sup> See cases cited *supra* note 37.

<sup>69</sup> See cases cited *supra* note 45.

<sup>70</sup> See sources cited *supra* notes 39–40.

<sup>71</sup> See, e.g., Bill de Blasio, New York City Mayor, Emergency Exec. Order No. 101, 1 (Mar. 17, 2020) (“WHEREAS, this order is given because of the propensity of the virus to spread person-to-person and also because the virus is causing property loss and damage . . . .”) (emphasis in original), <https://www1.nyc.gov/assets/home/downloads/pdf/executive-orders/2020/eo-101.pdf>.

physical loss or damage to the house if it made the house useless or uninhabitable even though the well itself was not covered by the policy.<sup>72</sup> Similarly, other courts have held the presence of wildfire smoke,<sup>73</sup> ammonia,<sup>74</sup> or carbon dioxide<sup>75</sup> in insured properties rendered the properties unsafe and thus, business interruption coverage was triggered even though no tangible, physical injury to the properties had occurred.

The Colorado Supreme Court held gas beneath a church that rendered the property unsafe for occupancy constituted a “physical loss” of the church even though the church had not suffered a tangible, physical injury.<sup>76</sup> Another court held the loss in value of a house that became unsafe due to a nearby landslide was also covered even though the house itself was not physically damaged by the landslide.<sup>77</sup> Other courts have held a foul odor present in a property can constitute physical loss or damage—if the property needs to be remediated to remove the odor or becomes

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<sup>72</sup> *Motorists Mut. Ins. Co. v. Hardinger*, 131 F. App’x 823, 826–27 (3d Cir. 2005).

<sup>73</sup> *See Oregon Shakespeare Festival Ass’n v. Great Am. Ins. Co.*, No. 1:15-cv-01932-CL, 2016 WL 3267247, at \*7-8 (D. Or. June 7, 2016) (holding that a theater event cancelled due to wildfire smoke was covered because “the infiltration of smoke into the interior of the theater is a covered ‘physical loss of or damage to property’”).

<sup>74</sup> *See Gregory Packaging, Inc. v. Travelers Prop. Cas. Co. of Am.*, No. 2:12-cv-04418, 2014 WL 6675934, at \*6 (D.N.J. Nov. 25, 2014) (finding that a business interruption caused by “ammonia discharge inflicted ‘direct physical loss of or damage to’ . . . facility . . . because the ammonia physically rendered the facility unusable for a period of time.”).

<sup>75</sup> *See Matzner v. Seaco Ins. Co.*, No. 96-0498-B, 1998 WL 566658, at \*3 (Mass. Super. Aug. 12, 1998) (deciding that loss of use of an apartment due to buildup of carbon monoxide in the building was covered because “the phrase ‘direct physical loss or damage’ is ambiguous [and can include more than] tangible damage to the structure of insured property.”).

<sup>76</sup> *See Western Fire Ins. Co. v. First Presbyterian Church*, 437 P.2d 52, 55 (Colo. 1968) (deciding that loss of use of church due to dangerous buildup of gas beneath church that rendered it uninhabitable constituted “direct physical loss”).

<sup>77</sup> *See Hughes v. Potomac Ins. Co. of D.C.*, 199 Cal. App. 2d 239, 249 (Cal. App. 1962) (finding that a house that had not been physically damaged by a landslide was covered because it was unsafe to use as a result of the loss of lateral support soil).

uninhabitable due to the odor—even though the insured property itself did not suffer a tangible, physical injury.<sup>78</sup>

Courts have also held that government orders to evacuate properties due to a potential threat, such as a hurricane,<sup>79</sup> building collapse,<sup>80</sup> or a riot,<sup>81</sup> can trigger business interruption coverage. Similarly, courts have held the inability to access insured property can trigger business interruption coverage even though the insured property itself did not suffer any tangible, physical damage.<sup>82</sup> Finally, one court has held that “physical damage”

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<sup>78</sup> See *Essex Ins. Co. v. BloomSouth Flooring Corp.*, 562 F.3d 399, 406 (1st Cir. 2009) (“we are persuaded both that odor can constitute physical injury to property . . . [and] that an unwanted odor permeated the building and resulted in a loss of use of the building . . . .”); *Mellin v. N. Sec. Ins. Co., Inc.*, 115 A.3d 799, 805 (N.H. 2015) (finding that the loss of use of a condo due to cat urine odor coming from a neighboring property was covered because “physical loss may include not only tangible changes to the insured property, but also changes that are perceived by the sense of smell and that exist in the absence of structural damage.”); *Farmers Ins. Co. of Oregon v. Trutanich*, 858 P.2d 1332, 1336 (Or. 1993) (finding that the cost to remove an odor in a house from a meth lab constituted “a direct physical loss.”).

<sup>79</sup> See *Assurance Co. of Am. v. BBB Serv. Co.*, 593 S.E.2d 7, 9 (Ga. App. 2003) (holding Wendy’s restaurants could recover business interruption coverage when ordered to shut down and evacuate due to Hurricane Floyd even though the hurricane did not ultimately cause tangible physical damage to the restaurants); *Houston Cas. Co. v. Lexington Ins. Co.*, No. CIV.A. H-05-1804, 2006 WL 7348102, at \*6 (S.D. Tex. June 15, 2006), (holding business interruption due to government-ordered evacuation in anticipation of Hurricane Floyd was covered even though insured property did not suffer a tangible physical injury), *report and recommendation adopted sub nom.* No. H-05-1804, 2006 WL 8446160 (S.D. Tex. July 11, 2006).

<sup>80</sup> See *Hampton Foods, Inc. v. Aetna Cas. & Sur. Co.*, 787 F.2d 349, 352 (8th Cir. 1986) (deciding that business interruption loss due to government-ordered evacuation of a building due to the risk of collapse was a covered business interruption loss if the policyholder could prove its lost profits even though none of the policyholder’s property had a tangible physical injury).

<sup>81</sup> See *Allen Park Theatre Co. v. Michigan Millers Mut. Ins. Co.*, 210 N.W.2d 402, 403 (Mich. App. 1973) (holding loss of use of theaters due to a government shutdown order in response to riots was covered even though there was no tangible physical damage to the theaters); *Sloan v. Phoenix of Hartford Ins. Co.*, 207 N.W.2d 434, 436-37 (Mich. App. 1973) (same); *Southlanes Bowl, Inc. v. Lumbermen’s Mut. Ins. Co.*, 208 N.W.2d 569, 570 (Mich. App. 1973) (holding loss of use of bowling alleys, restaurants, taverns, snack bars, cocktail lounges and motels due to a government shutdown order in response to riots was covered even though there was no tangible physical damage to the properties).

<sup>82</sup> See *Fountain Powerboat Indus., Inc. v. Reliance Ins. Co.*, 119 F. Supp. 2d 552, 557 (E.D.N.C. 2000) (“Loss sustained due to the inability to access

occurred when a soft drink product had an off-taste and thus was unsalable even though the product was safe to drink.<sup>83</sup>

Thus, in the COVID-19 context, because the threat of serious illness or death at the policyholders' business premises was so high, governments shuttered businesses. Following the reasoning of the cases discussed above, the policyholders suffered "physical loss of or damage to property" even if COVID-19 was not proven to be present in their businesses. The risk of people getting sick and dying from being in the policyholders' business premises was so high that the business premises were rendered uninhabitable and unusable. That is enough to trigger coverage.

Third, policyholders reasonably expect coverage under business interruption policies when their business operations are interrupted due to catastrophic events beyond their control. Indeed, that is the very reason businesses purchase business interruption insurance. Imagine business owners' surprise when they learned from their insurers that, after paying premiums for business interruption coverage year after year, their business interruption loss claims were denied, and they likely would need to file for bankruptcy if the government does not bail them out. Because policyholders typically do not get to see the policy language before they buy business interruption insurance, their expectations regarding the scope of coverage is not based on the policy language itself.<sup>84</sup> Instead, it is based on the type of insurance being purchased (e.g., business interruption insurance) and the nature of their businesses. People buy business interruption insurance to cover their lost revenues when their business operations are interrupted for reasons beyond their control. Consequently, when their businesses were ordered to shut down due to COVID-19, the business owners reasonably expected their business interruption insurance would cover the losses.

Fourth, the presence of the virus exclusion in some policies is proof that policies that do not contain the exclusion cover COVID-19 losses. If all risk policies did not cover business interruption losses caused by viruses because viruses cannot cause "physical loss or damage to property," then the virus exclusion would be unnecessary. There is no need to exclude losses caused by perils which are not covered under the insuring agreement

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the [insured] facility and resulting from a hurricane is a covered event with no physical damage to the property required.").

<sup>83</sup> See *Pepsico, Inc. v. Winterthur Int'l Am. Ins. Co.*, 24 A.D.3d 743, 744 (N.Y. App. 2005) (off-tasting product that could not be sold was a covered loss under all risk policy even though the product was not physically injured).

<sup>84</sup> See *supra* note 46 and accompanying text.

language of a policy in this first instance. Thus, the rule of policy interpretation which dictates that policies should be construed as a whole, reconciling all the policy provisions, dictates that business interruption losses caused by viruses can constitute “physical loss of or damage.” Otherwise, the virus exclusion would be unnecessary surplusage with no purpose.

Indeed, in other contexts, courts have reached the same conclusion. For example, in *United States Fire Insurance Co. v. J.S.U.B, Inc.*,<sup>85</sup> the Supreme Court of Florida had to consider whether construction defects could constitute covered occurrences under the basic insuring agreement language in commercial general liability policies. The policies at issue also contained “business risk” exclusions that purported to exclude coverage for defective work done by the policyholder. In finding construction defects could be covered occurrences, the court reasoned that the presence of the business risk exclusions in the policies proved construction defects could be covered because the exclusions would be unnecessary surplusage otherwise:

If . . . [construction defects] are never CGL “occurrences” for purposes of the initial coverage grant, then the business risk exclusions are entirely unnecessary. . . . Why would the insurance industry exclude damage to the insured’s own work or product if the damage could never be considered to have arisen from a covered occurrence in the first place?<sup>86</sup>

Thus, the very presence of the virus exclusion in some policies proves that coverage for business interruption losses caused by viruses is provided by policies that do not contain the exclusion.

### C. THE POLLUTION AND VIRUS EXCLUSIONS DO NOT APPLY

#### 1. Pollution Exclusion

The pollution exclusion does not apply to COVID-19 business interruption losses because the exclusion is so broadly worded that it could be interpreted to swallow almost all the coverage provided by the policy. Consequently, because exclusions are considered ambiguous if they can be interpreted in a way that swallows the basic coverage provided by the policy,

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<sup>85</sup> 979 So. 2d 871 (Fla. 2007).

<sup>86</sup> *Id.* at 886–87 (quoting *Am. Family Mut. Ins. Co. v. Am. Girl, Inc.*, 673 N.W.2d 65, 78 (Wis. 2004)).



the pollution exclusion is not applicable to COVID-19 claims.<sup>87</sup> “Pollutant” is defined to include “any solid, liquid, gaseous or thermal irritant or contaminant . . . .”<sup>88</sup> All materials are either a solid, liquid or gas. And, depending upon its application, almost everything can be an irritant or contaminant. Thus, if applied literally the way insurers advocate, then almost no coverage is provided under property policies due to the presence of the pollution exclusion. Such a result is not permitted under insurance law.

As one court has noted, the language in the pollution exclusion is so broad that nearly everything that causes a loss could be excluded: “the terms ‘irritant’ and ‘contaminant’ are virtually boundless, for ‘there is no substance or chemical in existence that would not irritate or damage some person or property.’”<sup>89</sup> Further, as another court stated, the literal application of the exclusion would lead to absurd results:

Applying these definitions in a “purely literal interpretation . . . surely stretch[es] the intended meaning of the policy exclusion,” and could lead to absurd results “contrary to any reasonable policyholder’s expectations.” For example, “[t]aken at face value, the policy’s definition of a pollutant is broad enough that it could be read to include items such as soap, shampoo, rubbing alcohol, and bleach insofar as these items are capable of reasonably being classified as contaminants or irritants.”<sup>90</sup>

Consequently, because the coverage provided by the policy cannot be illusory,<sup>91</sup> the exclusion must be ambiguous and, thus, it should be interpreted narrowly in favor of the policyholder.

Numerous courts have reached the same conclusion when interpreting similarly worded pollution exclusions.<sup>92</sup> In doing so, many of

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<sup>87</sup> See cases cited *supra* note 34.

<sup>88</sup> Business Owners Policy, *supra* note 21, at 94.

<sup>89</sup> *Nautilus Ins. Co. v. Jabar*, 188 F.3d 27, 30 (1st Cir. 1999) (quoting *Pipefitters Welfare Educational Fund v. Westchester Fire Ins. Co.*, 976 F.2d 1037, 1043 (7th Cir.1992)).

<sup>90</sup> *Mellin v. N. Sec. Ins. Co., Inc.*, 115 A.3d 799, 806 (N.H. 2015) (quoting *Nautilus Ins. Co. v. Jabar*, 188 F.3d 27, 30 (1st Cir. 1999), and *Century Sur. Co. v. Casino W., Inc.*, 329 P.3d 614, 617 (Nev. 2014)).

<sup>91</sup> See cases cited *supra* note 34.

<sup>92</sup> See, e.g., *MacKinnon v. Truck Ins. Exch.*, 73 P.3d 1205, 1216 (Cal. 2003) (“[Because the insurer’s] broad interpretation of the pollution exclusion leads to

them also have noted that the pollution exclusion was intended to apply only to environmental contamination caused by industrial waste disposal activities, so they declined to apply the exclusion in other contexts.<sup>93</sup>

## 2. Virus Exclusion

For some COVID-19 business interruption losses, the virus exclusion does not apply because the policies at issue simply do not contain the exclusion. For claims under policies that do contain a virus exclusion, policyholders may argue the exclusion should not apply because insurers obtained regulatory approval of the exclusion by misrepresenting the coverage provided under existing all risk property policies in the absence of the exclusion. Specifically, when seeking regulatory approval of the exclusion, ISO represented that “[a]lthough building and personal property arguably could become contaminated (often temporarily) by . . . viruses and

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absurd results and ignores the familiar connotations of the words used in the exclusion, we do not believe it is the interpretation that the ordinary layperson would adopt.”); *Keggi v. Northbrook Prop. & Cas. Ins. Co.*, 13 P.3d 785, 790 (Ariz. Ct. App. 2000) (concluding pollution exclusion was at best ambiguous regarding whether bacteria was a “contaminant” under pollution exclusion). *See also* *Westport Ins. Corp. v. VN Hotel Grp., LLC*, 761 F. Supp. 2d 1337, 1344 (M.D. Fla. 2010) (“*Legionella* bacteria are not ‘pollutants,’ and the Pollution Exclusion is inapplicable.”), *aff’d*, 513 F. App’x 927 (11th Cir. 2013); *Johnson v. Clarendon Nat. Ins. Co.*, No. G039659, 2009 WL 252619, at \*13 (Cal. Ct. App. Feb. 4, 2009) (discussing that mold is not a “pollutant” under pollution exclusion).

<sup>93</sup> *See, e.g., MacKinnon*, 73 P. 3d at 1216 (quoting *Motorists Mut. Ins. Co. v. RSJ, Inc.*, 926 S.W.2d 679, 681 (Ky. Ct. App. 1996) (“The drafters’ utilization of environmental law terms of art (‘discharge,’ ‘dispersal,’ . . . ‘release,’ or ‘escape’ of pollutants) reflects the exclusion’s historical objective—avoidance of liability for environmental catastrophes related to intentional industrial pollution.”); *Stoney Run Co. v. Prudential-LMI Commercial Ins. Co.*, 47 F.3d 34, 39 (2d Cir. 1995) (noting that the pollution exclusion did not apply to carbon monoxide in a building that killed some occupants because the exclusion was only intended to apply to industrial environmental pollution); *Island Assoc., Inc. v. ERIC Group, Inc.*, 894 F. Supp. 200, 203 (W.D. Pa. 1995) (“[A]n insurer that wishes to exclude ‘everyday activities gone slightly awry’ from coverage cannot rely on a broad reading of a pollution exclusion clause.”); *Thompson v. Temple*, 580 So.2d 1133, 1134 (La. App. 4 Cir. 1991) (“Pollution exclusion clauses are intended to exclude coverage for active industrial polluters, when businesses knowingly emitted pollutants over extended periods of time.”). *See also* OSTRAGER & NEWMAN, *supra* note 44, at 1699–1703 (discussing cases where courts refused to apply the pollution exclusion to claims that were not traditional environmental claims).

bacteria, . . . property policies have not been a source of recovery for losses involving contamination by disease-causing agents . . . .”<sup>94</sup>

Policyholders may argue ISO’s statement in this regard is not accurate. By 2006 when the virus exclusion was introduced, numerous courts across the country had held that losses involving contamination by “disease-causing agents” could constitute covered physical loss or damage if the contamination “eliminated or destroyed” the function of the property or rendered the property “useless or uninhabitable.”<sup>95</sup> If courts were to determine that regulatory approval of the virus exclusion was obtained based upon a misrepresentation by the insurance industry that property policies had not been a source of recovery for claims based upon “disease-causing agents” that rendered a property unusable, then the exclusion could be voided.<sup>96</sup>

Courts declining to enforce an exclusion based upon insurers’ misrepresentations during the regulatory approval process regarding an exclusion’s impact on the existing coverage provided by policy forms has some precedent. For example, during the extensive litigation regarding the meaning of the “sudden and accidental” or “qualified” pollution exclusion, the supreme courts in several states refused to enforce the exclusion because they concluded the insurance industry had made misrepresentations during

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<sup>94</sup> ISO Circular, *supra* note 26, at 6.

<sup>95</sup> *Motorists Mut. Ins. Co. v. Hardinger*, 131 F. App’x 823, 826–27 (3d Cir. 2005) (noting that the presence of e-coli in a well could constitute physical loss if it rendered the home useless or uninhabitable); *Cooper v. Travelers Indem. Co. of Illinois*, No. C-01-2400-VRW, 2002 WL 32775680, at \*5 (N.D. Cal. Nov. 4, 2002) (“[T]he closure of the tavern on February 17, 1999 [due to e-coli contamination of well] was a necessary suspension of [policyholder’s] operation of the tavern that resulted from direct physical damage to the property at the insured premises.”); *Port Auth. of New York & New Jersey v. Affiliated FM Ins. Co.*, 311 F.3d 226, 236 (3d Cir. 2002) (“[T]he policies cover ‘physical loss,’ as well as damage. When the presence of large quantities of asbestos in the air of a building is such as to make the structure uninhabitable and unusable, then there has been a distinct loss to its owner.”); *Shelter Mut. Ins. Co. v. Maples*, 309 F.3d 1068, 1071 (8th Cir. 2002) (noting that an uninhabitable house that had to be demolished due to presence of mold could be a covered loss).

<sup>96</sup> See RESTATEMENT (SECOND) OF CONTRACTS § 164(1) (AM. LAW INST. 1981) (“If a party’s manifestation of assent is induced by either a fraudulent or a material misrepresentation by the other party upon which the recipient is justified in relying, the contract is voidable by the recipient.”).

the regulatory approval process for the exclusion.<sup>97</sup> Specifically, the courts found that insurers misrepresented the intended impact the exclusion would have on coverage for pollution claims under commercial general liability policies.<sup>98</sup> If a similar conclusion were reached regarding the virus exclusion, then some courts might refuse to enforce the exclusion.

#### D. PANDEMIC LOSSES ARE NOT UNINSURABLE

The insurance industry's contention that "pandemic outbreaks are uninsured because they are uninsurable" is belied by the fact some insurers currently sell policies that specifically cover pandemic losses.<sup>99</sup> For example, the organizers of the Wimbledon tennis championship reportedly have been paying almost \$2 million a year for insurance to cover the cancellation of the tennis event due to a pandemic since the SARS outbreak in 2003.<sup>100</sup> Wimbledon reportedly will receive a \$141 million insurance payout due to the cancellation of the event this year as a result of COVID-19.<sup>101</sup> The British Open golf tournament was also cancelled due to COVID-19, and it similarly is covered by insurance.<sup>102</sup>

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<sup>97</sup> See, e.g., *Sunbeam Corp. v. Liberty Mut. Ins. Co.*, 781 A.2d 1189, 1192–93 (Pa. 2001) ("Thus, having represented to the insurance department, a regulatory agency, that the new language in the 1970 policies—'sudden and accidental'—did not involve a significant decrease in coverage from the prior language, the insurance industry will not be heard to assert the opposite position when claims are made by the insured policyholders."); *Morton Int'l, Inc. v. General Accident Ins. Co. of Am.*, 629 A.2d 831, 875 (N.J. 1993) (applying regulatory estoppel to prevent the insurers from taking a position regarding the meaning of "sudden and accidental" that was inconsistent with their representations to state insurance commissioners); *Joy Techs., Inc. v. Liberty Mut. Ins. Co.*, 421 S.E.2d 493, 500 (W. Va. 1992) (applying same regulatory estoppel).

<sup>98</sup> See cases cited *supra* note 97.

<sup>99</sup> See *Am. Prop. Cas. Ins. Ass'n*, *supra* note 6.

<sup>100</sup> *Wimbledon Shows How Pandemic Insurance Could Become Vital for Sports, Other Events*, INS. J. (April 13, 2020), <https://www.insurancejournal.com/news/international/2020/04/13/564598.htm>.

<sup>101</sup> *Id.*

<sup>102</sup> See, e.g., *Cindy Boren & Matt Bonesteel, British Open Canceled For The First Time Since World War II*, *Wash. Post* (April 6, 2020), <https://www.washingtonpost.com/sports/2020/04/06/british-open-canceled-first-time-since-world-war-ii/>.

In addition, since 2018, Marsh & McLennan has been selling pandemic insurance that it calls PathogenRX.<sup>103</sup> In marketing the product, Marsh & McLennan's website states:

Over the last few decades, diseases such as Zika, MERS, SARS, and now COVID-19 have had dramatic financial implications for myriad industries. . . .

. . . .

To meet the growing concerns and risks surrounding outbreaks, epidemics, and pandemics, in 2018 Marsh partnered with Munich Re and Metabiota to create PathogenRX, an integrated pandemic risk quantification and insurance solution that provides financial protection to businesses and their global operations. Using straightforward triggers such as mortality or infections in a defined area, the policy provides indemnity protection that can make an insured whole in the event of a demonstrable loss.<sup>104</sup>

Similarly, beginning in 2014, NAS Insurance Services Inc., in conjunction with Ark Specialty Program of Lloyd's of London, began selling business interruption insurance for government-ordered shutdowns due the Ebola virus.<sup>105</sup> Thus, the proposition that insurers do not and cannot insure pandemic losses because such losses are uninsurable is refuted by the fact some insurers are selling insurance specifically intended to cover pandemic losses.

E. PUBLIC POLICY DICTATES COVID-19 BUSINESS INTERRUPTION  
LOSSES SHOULD BE COVERED

There are also several public policies that support a finding of coverage for COVID-19 business interruption losses. First, insurance serves

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<sup>103</sup> See *PathogenRX: An Innovative Solution for Pandemic and Epidemic Risks*, MARSH, <https://www.marsh.com/us/campaigns/pathogenrx.html> (last visited June 17, 2020).

<sup>104</sup> *Id.*

<sup>105</sup> See Stephanie Goldberg, *NAS Offers Coverage for Ebola-Related Business Closures*, BUS. INS. (Oct. 17, 2014 12:00 AM), <https://www.businessinsurance.com/Essay/20141017/NEWS06/141019880/NAS-offers-coverage-for-Ebola-related-business-closures#>.

a quasi-public function as a social safety net by transferring risks from individuals to a larger group or community.<sup>106</sup> In the absence of insurance, most people and their businesses would be financially devastated if they: (1) were the victim of a catastrophe, (2) became unemployed for a lengthy period of time, or (3) were stricken with cancer or some other life-threatening disease. Public policy supports the transfer of such risks from the individual to a larger group. If there is no actual transfer of the risk of business interruption losses from individuals to insurers, however, then that public policy would be frustrated.

Second, compensating injured parties is another overriding societal concern. Public policy strongly favors compensating injured parties through insurance payments.<sup>107</sup> Indeed, the public policy favoring the compensation of injured parties is the primary reason automobile insurance is mandatory.<sup>108</sup> If the businesses injured by COVID-19 will not be compensated for their losses by business interruption insurance, then the public policy of compensating injured parties through insurance would be frustrated.

Third, public policy favors the enforcement of legal commitments. Insurers should honor their commitments to their policyholders when they accept premiums year after year in exchange for paying losses if and when they occur. As one court has stated, “[o]ne [public] policy is that an insurance company which accepts a premium for covering all liability for damages

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<sup>106</sup> See, e.g., Abraham, *supra* note 49, at 668; Christopher C. French, *The Role of the Profit Imperative in Risk Management*, 17 U. PA. J. BUS. L. 1081, 1092–93 (2015); Stempel, *supra* note 49, at 1497.

<sup>107</sup> See, e.g., *St. Paul Fire & Marine Ins. Co. v. Jacobson*, 826 F. Supp. 155, 163–64 (E.D. Va. 1993) (discussing that the public policy of compensating innocent victims outweighed public policy of not permitting coverage for intentional action); *St. Paul Fire & Marine Ins. Co. v. Asbury*, 720 P.2d 540, 542 (Ariz. Ct. App. 1986) (noting that the public policy favors compensating injured persons); *Hudson v. State Farm Mut. Ins. Co.*, 569 A.2d 1168, 1170–71 (Del. 1990) (refusing to void coverage for intentional wrongdoing under an automobile policy because of the competing public policy behind the state motor vehicle financial responsibility law); *Grinnell Mut. Reinsurance Co. v. Jungling*, 654 N.W.2d 530, 539, 541 (Iowa 2002) (“Compensating [the policyholder’s] innocent victims . . . outweighs the concern that [the policyholder] will unjustly benefit from coverage.”).

<sup>108</sup> See, e.g., *JERRY & RICHMOND*, *supra* note 32, at 924–25 (stating that the obvious purpose of mandatory auto insurance is to provide victims of automobile accidents with access to funds to cover their losses); ABRAHAM & SCHWARCZ, *supra* note 50, at 656–57, 706 (discussing state legislatures’ and courts’ refusal to enforce “intentional act” exclusions, “family” exclusions, and “physical contact” requirements in auto policies due to the public policy favoring the compensation of auto accident victims).

should honor its obligation.”<sup>109</sup> That means insurers, not policyholders, should bear the financial burden of losses when losses occur.

Fourth, public policy favors preventing damages and injuries from occurring. Indeed, the prevention and deterrence of injurious conduct are some of the principal public policies that underly the criminal justice and tort systems.<sup>110</sup> Injuries should be prevented if possible. That, in fact, is the very reason governors issued lock-down orders related to COVID-19—the prevention of unnecessary deaths of people due to a rapid and overwhelming spread of the virus if social distancing were not imposed. For similar reasons, numerous courts have held the costs incurred to prevent damage are covered under property policies in some situations.<sup>111</sup> If policies did not cover the costs associated with preventing imminent injuries, then policyholders would be incentivized to simply wait for the injuries to occur rather than prevent them from occurring in the first place. Public policy favors pro-action to prevent injuries, not a reaction after injuries occur.

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<sup>109</sup>Creech v. Aetna Cas. & Sur. Co., 516 So.2d 1168, 1174 (La. Ct. App. 1987).

<sup>110</sup>See, e.g., DAN B. DOBBS, PAUL T. HAYDEN & ELLEN M. BUBLICK, THE LAW OF TORTS § 14 (2d ed. 2019) (“Courts and writers almost always recognize that another aim of tort law is to deter certain kinds of conduct by imposing liability when that conduct causes harm.”); Travelers Indem. Co. v. PCR, Inc., 889 So.2d 779, 795 (Fla. 2004) (“[A]n equally basic aim of imposing liability for compensatory damages resulting from negligent conduct is to deter such conduct . . . .”); Villaman v. Schee, Nos. 92-15490, 92-15562, 1994 WL 6661, at \*4 (9th Cir. Jan. 10, 1994) (“tort law is designed in part to deter negligent conduct . . . .”); Valerie Wright, *Deterrence in Criminal Justice: Evaluating Certainty vs. Severity of Punishment*, THE SENTENCING PROJECT, 1 (Nov. 2010) (“[T]he criminal justice system as a whole provides some deterrent effect . . . .”), <https://web.archive.org/web/20171130140441/http://sentencingproject.org/wp-content/uploads/2016/01/Deterrence-in-Criminal-Justice.pdf>.

<sup>111</sup>See, e.g., Assurance Co. of Am. v. Wall & Assocs. LLC of Olympia, 379 F.3d 557, 559, 563 (9th Cir. 2004) (property policy that covered “direct physical loss involving collapse” was construed to provide “coverage not only for actual collapse but also for imminent collapse . . . .”); 401 Fourth St., Inc. v. Inv’rs Ins. Grp., 879 A.2d 166, 168, 174 (Pa. 2005) (property policy that covered “direct physical loss involving collapse” was construed to include coverage for “imminent falling down of a building or part thereof.”); Doheny W. Homeowners’ Ass’n v. Am. Guarantee & Liab. Ins. Co., 70 Cal. Rptr.2d 260, 261, 264–65 (property policy that covered “direct physical loss involving collapse” was construed to cover “imminent or actual collapse” in order to avoid “the absurdity of requiring an insured to wait for a seriously damaged building to fall . . . .”).

Insurers themselves recognize the wisdom of preventing damage and injuries before they occur. Consequently, property policies contain “sue and labor” clauses pursuant to which insurers agree to pay the costs policyholders incur to minimize a loss once the loss begins to occur.<sup>112</sup> In the business interruption context, this goal is advanced through “extra expense” coverage, which serves the same purpose as “sue and labor” clauses by reimbursing the policyholder for the costs it incurs while attempting to minimize the business interruption loss and to return the business to full operations as soon as possible.<sup>113</sup>

Thus, in the context of COVID-19 business interruption losses, it should not matter whether a policyholder’s business was shut down because it was demonstrably contaminated with the virus. As a matter of public policy, business interruption losses caused by prophylactic government orders to shut down operations also should be covered. Otherwise, policyholders would be incentivized to stay open and wait for their businesses to test positive for the virus before shutting down. Such an approach would lead to more people getting sick and dying. It also would lead to potential liabilities for the businesses that could have prevented the spread of the disease by closing instead of staying open while waiting for a positive COVID-19 test result in order to recover under their business interruption policies.

## VI. CONCLUSION

Regardless of the actual wording of the policy language, insurers will contend that the language unambiguously does not cover COVID-19 business interruption losses—either because the losses are not due to “physical loss of or damage” to property or because of the presence of the virus and pollution exclusions. They also will contend that pandemics are uninsurable losses that they never intended to cover and for which they did not collect premiums. Ultimately, they will assert that if they nonetheless are

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<sup>112</sup> See, e.g., OSTRAGER & NEWMAN, *supra* note 44, at 1546 (“It is now generally recognized that the purpose of a sue and labor clause is to provide an incentive for an insured to act to mitigate any loss or damage to the insured subject matter.”); *Albany Ins. Co. v. Anh Thi Kieu*, 927 F.2d 882, 894 (5th Cir. 1991) (“Sue and labor expenses are sums spent by the assured in an effort to mitigate damages and loss.”); *Armada Supply Inc. v. Wright*, 858 F.2d 842, 853 (2d Cir. 1988) (“Sue and labor expenses are those reasonable costs borne by the assured to mitigate the loss and thus reduce the amount to be paid by the underwriter.”).

<sup>113</sup> See Business Owners Policy, *supra* note 21, at 69–70.



required to cover such claims, then the entire property insurance industry will be bankrupted.

Policyholders, on the other hand, will contend COVID-19 business interruption losses unquestionably are covered if their policies provide “contamination” coverage and do not contain a virus exclusion. Moreover, COVID-19 business interruption losses are even covered by policies that do not include “contamination” coverage. This is because, under the rules of policy interpretation, the undefined phrase “physical loss of or damage” has been, and should be, construed to include coverage for business interruption losses caused by unsafe property conditions or government-ordered shutdowns. As such, policyholders do not need to prove there was tangible, physical damage to property caused by COVID-19 in order to recover.

Further, policyholders will argue that no exclusions in the policies apply. First, they will argue the pollution exclusion was intended to apply only to environmental pollution claims and its application in other contexts would allow the exclusion to swallow the policy’s basic coverage. Then, they will argue the virus exclusion should not be enforced because the insurance industry made misrepresentations to regulators in order to get the exclusion approved.

Policyholders will also argue that public policy favors finding coverage for COVID-19 losses in order to fulfill the purposes of insurance. Insurance is intended to serve as a social safety net to cover financially devastating losses and compensate injured parties.

Ultimately, whether COVID-19 business interruption losses are covered by insurance will be dictated by the policy language at issue and the applicable state law, which can vary considerably from state to state. Consequently, which courts decide the cases could be the most important factor in determining whether the insurance industry or their customers will be bankrupted by COVID-19 if a government bailout is not forthcoming.

# A SMART(ER) APPROACH TO INSURANCE FRAUD

JAMES DAVEY\*

## ABSTRACT

Insurance fraud is not one thing but many. For political reasons, this simple truth is often hidden, as cumulative figures describing the sum total of insurance fraud are deployed to bring about legal and administrative measures that favour the insurance industry. Rule design must recognise those apparently conflicting truths that insurance fraud is socially harmful and that the insurance industry's approach to counter-fraud is often self-serving. This paper draws on recent developments in the United Kingdom to show how incremental advances in the fight against fraud can be delivered without creating excessive opportunities for the insurance industry to limit the recovery of honest claims.

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## I. INTRODUCTION

Insurance fraud is a global issue. There is probably little else that can be said about the subject without dividing the audience. This paper seeks to break apart that polarised debate in search of new methodologies that enable us to better understand the nature and extent of insurance fraud. Much of my attention will be focused on “soft fraud” (what the U.K. calls “opportunistic fraud”), as it represents the vast majority of fraudulent claims.<sup>1</sup>

There are three overlapping reasons why a more considered approach to ‘soft fraud’ is important:

1. Fraud committed by “otherwise honest” policyholders provides a rich and diverse series of doctrinal issues, as shown by litigation in the English courts, which challenges simplistic doctrinal responses;
2. Opportunistic fraud makes up the vast majority of fraud, and measuring it accurately is vital if the extent of fraud in insurance is to be properly estimated and countered; and
3. Soft fraud is more amenable to the application of behavioural science—to “nudge” policyholders away from acting dishonestly. This provides a testbed for developing strategies that seek to prevent rather than react to insurance fraud.

These interlocking approaches go beyond the traditional call to deter on the basis of rational economic incentives. These innovations are being adopted in the United Kingdom as a result of two decades of concerted study by academics, courts and industry. The concerted effect promises substantial improvements in the industry’s response to opportunistic fraud. Unlike traditional visions of deterring insurance fraud, the image is one of persuasion rather than punishment. This has numerous advantages, not least that it reduces the industry’s unfortunate reputation as treating its customers with grave suspicion.<sup>2</sup>

English and American insurance fraud have much in common that allows these comparisons to be made. Each makes assumptions as to the efficacy of deterrence by private law rules, and there is considerable

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<sup>1</sup> *Complex Challenges Remain with Growth in Liability and Application Fraud*, IFB (Aug. 28, 2019), <https://insurancefraudbureau.org/media-centre/news/2019/complex-challenges-remain-with-growth-in-liability-and-application-fraud/>.

<sup>2</sup> See RICHARD V. ERICSON, AARON DOYLE & DEAN BARRY, *INSURANCE AS GOVERNANCE* (2003) (especially chapters 7 (Prospects as Suspects) and 9 (Claims of Fraud)).

overlap in the “working parts” of that system: issues such as materiality, reliance, and remedy are part of a shared language.<sup>3</sup>

## II. THE OPTIMAL DESIGN OF INSURANCE FRAUD RULES

In any interesting insurance law situation, there are normally at least three interests at play: the commercial interests of the insurer; the comparable interest of the insured; and the wider public interest. At times, and certainly within subrogation or liability insurance issues, we add third parties to the mix. Assume for now that we are seeking to design the optimal insurance fraud rule to apply between the insured and its underwriter. A simple model would suggest that any intervention which deters fraud by the insured is justified because fraud is inherently socially wasteful.<sup>4</sup> This is the approach that is most commonly espoused by the insurance industry. It assumes that the public interest and the commercial interest of the underwriter are aligned in a “zero tolerance” model. The most significant limiting factor is the cost of the intervention. In such case, we might as a society look to reduce the costs of deterring fraud by limiting the application of competition (“anti-trust”) law to these developments, allowing the insurance industry to take concerted action.

The lessons from more careful study of this field identify serious flaws in this model. The commercial interests of insurers do not perfectly align with the public interest in all cases. The threat of “insurance fraud rules” can be used in practice to limit legitimate claims. This is an opportunity for insurers. The risk of fraud is used as a key element in lobbying undertaken by insurers to remodel judicial rules and regulatory systems in their favour. An example of this from the English courts is

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<sup>3</sup> See Feinman’s discussion of the “moving parts” within the U.S. “false swearing” doctrine:

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 or the false swearing enables an insurer to avoid coverage only as to the portion of the claim that was misrepresented.

Jay M. Feinman, *Contract and Claim in Insurance Law*, 25 CONN. INS. L.J. 153, 188 (2018) (internal citations omitted).

<sup>4</sup> For information on wasted transaction costs, see DONALD HARRIS, DAVID CAMPBELL & ROGER HALSON, *REMEDIES IN CONTRACT & TORT* 554–57 (2d ed. 2001).

given below, but they are legion. In short, the strictness of insurance fraud rules to limit opportunistic conduct<sup>5</sup> by the insured creates the possibility of opportunistic conduct by the underwriter in response. This is a factor which must be considered when judging the effectiveness of counter-fraud measures.

The active involvement of insurers in the enforcement of counter-fraud rules through private law, criminal and quasi-criminal sanctions has not gone without notice. In the U.S., Feinman has written persuasively of the misuse of fraud rules to limit the insurers' exposure to valid claims<sup>6</sup> and Abramovsky has done likewise in respect of insurer-sponsored prosecutions.<sup>7</sup> The U.K.'s Financial Ombudsman Service has, on occasion, treated the occurrence of soft fraud as a consequence of an insurer's unrealistic demands of proof of loss rather than the customer's dishonesty.<sup>8</sup> In the U.K., the concerted use of actions for contempt of court as a means of control over insurance claims processes has received detailed attention from Hjalmarsson.<sup>9</sup> These contempt cases are judicial proceedings, instigated by insurers, for the use of false evidence by insureds during litigation and often result in custodial sanction. The limits of much of this scholarship is that it tends to assume that the opportunism ends there. In reality, things are a little more complicated than that. As recent contract scholarship shows these changes in the position of the underwriter and the insured would continue in turn, at least until a point of equilibrium is reached.<sup>10</sup>

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<sup>5</sup> I adopt here the standard definition of opportunism as "self-interest seeking with guide," drawn from OLIVER E. WILLIAMSON, *THE ECONOMIC INSTITUTIONS OF CAPITALISM: FIRMS, MARKETS, RELATIONAL CONTRACTING* 47 (1985) and readily acknowledge the uncertainties within the definition. See Clayton P. Gillette, *Legal Supervision of Commercial Opportunism*, in *CONTRACT GOVERNANCE: DIMENSIONS IN LAW & INTERDISCIPLINARY RESEARCH* (Stephan Grundmann, Florian Möselin, & Karl Riesenhuber eds., 2015).

<sup>6</sup> JAY M. FEINMAN, *DELAY, DENY, DEFEND*, ch. 10 (Delden Press, 2010); and more recently in Jay M. Feinman, *supra* note 3.

<sup>7</sup> Aviva Abramovsky, *An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards*, 98 J. CRIM. L. & CRIMINOLOGY 363, 363–427 (2008).

<sup>8</sup> James Davey, *Unpicking the Fraudulent Claims Jurisdiction in Insurance Contract Law: Sympathy for the Devil?* LLOYD'S MAR. & COM. LAW Q. 223 (2006).

<sup>9</sup> Johanna Hjalmarsson, *Fraudulent Insurance Claims as Context: Moral Support for Contempt of Court Decisions* 39 CIV. JUST. Q. 118 (2020).

<sup>10</sup> See JONATHAN MORGAN, *CONTRACT LAW MINIMALISM: A FORMALIST RESTATEMENT OF COMMERCIAL CONTRACT LAW* 137–48 (2013) ('Regulating opportunism'). Much of this scholarship owes a debt of gratitude to the work of CAROL HEIMER, *REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS* (1992).

An example might be useful here. Assume that courts impose a rule which is at the stricter end of the “false swearing” rule. In the United States, this would normally be the enforcement (under some conditions) of a contractual provision, such as:

This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.<sup>11</sup>

This enables an insurer to avoid the entirety of a claim for a relatively minor, and perhaps unnecessary, lie. Insurers might justifiably feel that it is to their commercial advantage to be stricter (“nit-picky”) in reviewing claims.<sup>12</sup> In light of this altered behaviour, a regulator, or Ombudsman, decides that this rule is too strict and imposes additional restrictions to prevent the underwriter from using this rule where disproportionate. That new restriction creates a potential opportunity for the insured to game that rule. And so on.

It is this possibility of “reflexive opportunism” through law-making that lies at the heart of this piece. In the United Kingdom, this feedback loop has been used to argue against the use of contract as an instrumental tool.<sup>13</sup> This neo-formalist turn operates on the following model: assume that all instrumental rules create a shift in legal and economic environment in which commercial actors operate. If change is dynamic in these systems, then the ultimate effect of every instrumental rule of law is unknowable because the iterative response of each party to the other’s change of position will take too many steps to reach a point of equilibrium for effective planning.<sup>14</sup> This is instrumental contract law as a chaotic system, or at least a system that is sufficiently chaotic for courts or legislators to be unable to predict outcomes.

My central claim is that English insurance law and practice has developed a more sophisticated model to counter insurance fraud through the utilisation of data and behavioural science. Rather than deny the

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<sup>11</sup> See Jay M. Feinman, *Insurance Fraud, Agency, and Opportunism: False Swearing in Insurance Claims*, INS. FRAUD SYMP. 2 (2016), <https://rucore.libraries.rutgers.edu/rutgers-lib/51227/> (tracing it back to “[t]he first paragraph of the 1943 New York Standard Fire Policy—the “165 Lines” that became the basis for many standard, legislatively adopted policies . . .”).

<sup>12</sup> Jean-Marc Bourgeon & Pierre Picard, *Fraudulent Claims and Nitpicky Insurers*, 104(9) AM. ECON. REV. 2900, 2912 (2014).

<sup>13</sup> See MORGAN, *supra* note 10, at 137–48.

<sup>14</sup> David Campbell, *The Incompleteness of Our Understanding of the Law and Economics of Relational Contract*, 2004 WIS. L. REV. 645, 651 (2004).

“feedback loop” that intervention creates, we consider those costs in the design of rules. This transformation to a smarter vision of counter-fraud action is not yet complete, but offers significantly improved outcomes in the reduction of fraud, with limited risk to the insured’s interests. These incremental improvements have been delivered in part by reducing the barriers between academics, lawyers, judges and the insurance industry. This is the purposeful pursuit of applied research by academics and the creation of lines of communication by industry and government so that research can be properly understood and implemented.

The superiority of English practice is based on three interlocking claims:

1. The shift from a contractarian to a public policy basis for determining the default rules for soft fraud has allowed for considerable development of the moving parts of insurance fraud rules (especially materiality, reliance, and remedy for breach) which appear to be more limited<sup>15</sup> in the U.S. system. This is Part II;
2. The reporting of insurance fraud, largely within the control of the insurance industry, is a classic example of insurer opportunism, with data reported in a manner designed to encourage legal and political change in the interest of insurers, and not the general good. Academic criticism of the process has highlighted the limits of the data. This is found in Part III; and
3. The doctrinal advantages developed within the U.K. system have been added to considerably by the development of a behavioural vision of opportunistic (“soft”) fraud. Changes to the “choice architecture” presented to insureds at claims (and at placement) can generate significant savings in fraud reduction. This is Part IV.

### III. A NATURAL HISTORY OF INSURANCE FRAUD RULES IN ENGLAND & WALES

English insurance law draws upon a wide range of markets to generate the hypotheticals and real-world fact patterns to inform its development. Sometimes, hard cases make good law too. Unlike the account given of U.S. law, the design of the rules to deter insurance fraud is largely non-contractual in nature.<sup>16</sup> That is, the rules do not depend on the inclusion of a specific contractual provision in the policy which is then enforced (or not) by the courts. Rather, the judiciary and the

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<sup>15</sup> I rely here on the thorough review of the U.S. position in law given in Feinman, *supra* note 11.

<sup>16</sup> Feinman, *supra* note 3, at 153.



legislature have designed rules to deter insurance fraud that operate more-or-less independently of party intention. This does not mean that contractual clauses do not exist, either to reiterate the common law position or to strengthen it, but they are a secondary source, and rarely litigated.

In relation to insurance fraud, this led to at least four distinct threads of law and policymaking, which are broadly aligned to claims from three sectors of insurance: private individuals, domestic commerce, and international commerce. This is not an absolute correlation, but claims arising from marine insurance heavily influenced the doctrines of “wilful misconduct” and “utmost good faith”; commercial fire insurance policies led to the “forfeiture” doctrine; and consumer markets encouraged the development of rules on contempt of court and the striking out of claims. These developments did not occur contemporaneously, and the threads merged and de-merged over time. There has been a noticeable intensification in the development of doctrine during the past two decades, with frequent litigation in the U.K.’s highest appellate courts. The vast majority of these cases moved from the English commercial court and on upwards through the appellate courts. The judges concerned have considerable experience in these matters from their previous work as counsel in similar cases and from the volume of litigation that flows through this court. This body of litigation represents a wide panoply of claims, from personal injury litigation to complex commercial losses.<sup>17</sup>

#### A. MARINE INSURANCE AND THE DOCTRINE OF “WILFUL MISCONDUCT”: THE U.K.’S “INTENTIONAL ACTS” EXCLUSION

Wilful misconduct is the historic basis by which maritime fraudulent claims were denied in the English courts. It has a dual effect as a rule of interpretation whereby it is assumed that insurance policies do not cover the reckless or deliberate actions of the insured and as a rule of public policy to the same effect.<sup>18</sup> Its dual nature as a canon of interpretation and as a mandatory rule of public policy is unusual and probably reflects differences in judicial reasoning prior to codification.<sup>19</sup>

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<sup>17</sup> The possibility of awarding damages against the fraudulent insured, which is an undeveloped area of law, is the subject of Katie Richards, *Time’s Up For Wholly Fraudulent Insurance Claims: The Case For New Statutory Remedies*, J. BUS. L. 580 (2020).

<sup>18</sup> *CA Blackwell (Contractors) Ltd v. Gerling General Insurance Co.*, [2007] EWCA Civ 1450, [2008] Lloyd’s Rep 529, [49].

<sup>19</sup> JONATHAN GILMAN, ROBERT MERKIN, CLAIRE BLANCHARD, & MARK TEMPLEMAN, ARNOULD: *LAW OF MARINE INSURANCE AND AVERAGE* 22–56 (19th ed. 2018 & Supp. 2020).

The statutory codification of the rule is neutral in this regard, but applies irrespective of party intention: “The insurer is not liable for any loss attributable to the wilful misconduct of the assured....”<sup>20</sup>

The rule has an important limiting factor. The placement of the wilful misconduct rule within the proximate cause doctrine restricts it to actions by the insured to bring about or fail to prevent the loss. It is not effective at controlling fraudulent actions by the insured *after* the loss has occurred, such as during the claims process, or in evidence at trial.

A recent case exemplifies the commercial and doctrinal significance of the rule. In *The Brilliante Virtuoso*,<sup>21</sup> Mr. Justice Teare oversaw a 52-day trial that resulted in a finding that the ship-owner had conspired with the master of the vessel, the chief engineer, a key figure from the local salvage company and a group of armed men to stage a fake seizure of the vessel by armed pirates. By this stage, the ship-owner was no longer a party to the litigation, and the claim was pursued on behalf of the innocent co-insured bank which had mortgaged the vessel.<sup>22</sup> During this “attack,” the vessel was sufficiently damaged by fire and explosion to be judged a constructive total loss.<sup>23</sup> This was a complex, high-stakes, fraudulent endeavour. Had the fraud been successful, the claim would have provided a full indemnity for the vessel insured in total for \$77 million, with a further \$10 million recoverable for costs.<sup>24</sup> At the time of the loss, as a result of the financial crash, the vessel’s value had reduced to closer to \$13.5 million.<sup>25</sup> The use of valued policies of this nature is viewed by many in the market as a commercial necessity—to reflect the interests of finance houses in these vessels—but it adds to the criminogenic nature of insurance.<sup>26</sup>

The precise juridical effect of the defence of wilful misconduct is important here. The “false swearing” doctrine at play in American law depends on the interpretation and enforcement of a contractual provision. The standard clause describes a remedy (“the contract is void”) which is

<sup>20</sup> Marine Insurance Act 1906, 6 Edw. 7 c. 41, § 55(2)(a) (UK).

<sup>21</sup> *Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., The Brilliante Virtuoso* [2019] EWHC 2599 (Comm), [2019] 2 Lloyd’s Rep. 485 (Eng.).

<sup>22</sup> Earlier actions in this litigation tested various issues. *See Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., The Brilliante Virtuoso* [2018] EWHC 2929 (Comm) (UK) (“whistle blower” anonymity); *Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., The Brilliante Virtuoso* [2016] EWHC 1085 (Comm) (UK) (strike-out of ship-owner’s claim); *Suez Fortune Inv. Ltd. v. Talbot Underwriting Ltd., The Brilliante Virtuoso* [2015] EWHC 42 (Comm) (UK) (nature of the loss).

<sup>23</sup> *Suez Fortune Investments Ltd.*, [2019] EWHC (Comm) 2599 at [8]–[16].

<sup>24</sup> *Id.* at [15], [160].

<sup>25</sup> *Id.* at [32].

<sup>26</sup> Euwke Faber, *Shipping and Scuttling: Criminogenesis in Marine Insurance*, 28 CRIME, L. & SOC. CHANGE 111 (1997).

familiar to English lawyers, but is one that we have discarded, for good reason.<sup>27</sup> A case like *The Brilliante Virtuoso* illustrates the problem. The co-insured Bank was in no way party to the fraud. The wilful misconduct rule does not prevent enforcement of the contract by other contracting parties, it operates as a personal bar to enforcement by those guilty of the misconduct.<sup>28</sup> The insurance policy may therefore provide cover for the effect of fraudulent conduct by one insured on innocent co-insureds. The litigation in *The Brilliante Virtuoso* was one of contractual interpretation: could the bank establish a loss within policy limits?<sup>29</sup> On the facts, it failed to do so, but under a false swearing provision, the contract would have been *prima facie* void and entirely unenforceable. The remedial clumsiness of making a policy void *ab initio* for a fraudulent claim is why English law has refused to develop a substantive doctrine of utmost good faith in performance of an insurance contract. We turn to this issue next.

#### B. THE UNCERTAIN PAST AND FUTURE OF THE DOCTRINE OF UTMOST GOOD FAITH

English case law is the source of the doctrine of utmost good faith for much of the common law world. Derived from *Carter v. Boehm*,<sup>30</sup> the application of “utmost good faith” at the claims stage has been severely limited in English law by the doctrine’s remedial consequences.

The effect of a fraudulent statement made during the presentation of an insurance claim, but prior to legal proceedings being commenced, was discussed in detail in *The Star Sea*<sup>31</sup> at the highest appellate level. These cases sought to establish—by reference to hypotheticals—how marginal cases would be decided in the future:

The presentation of a dishonest or fraudulent claim constitutes a breach of duty that entitles the insurer to repudiate any liability for the claim and, prospectively at least, to avoid any liability under the policy. Whether the presentation of such a claim should be regarded as a breach of a continuing duty under [S]ection 17 that entitles the insurer to avoid the policy with retrospective

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<sup>27</sup> *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd., The Star Sea* [2001] 1 Lloyd's Rep. 389, [64], [71].

<sup>28</sup> *Suez Fortune Investments Ltd*, [2019] EWHC (Comm) 2599, at [479].

<sup>29</sup> Peter MacDonald Eggers QC, *Third Party Aggressors as Insured Perils Under a Marine Insurance Policy*, 27 ASIA PAC. L. REV., 270–85 (2019).

<sup>30</sup> [1766] 3 Burr. 1905; 97 Eng. Rep. 1162.

<sup>31</sup> *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd., The Star Sea* [2003] 1 AC 469 (U.K.).

effect, enabling any payments made in satisfaction of previous unimpeachable claims to be recovered by the insurer, is more debatable.<sup>32</sup>

The remedy was—until recently—fixed by statute. Section 17 of the Marine Insurance Act 1906 was viewed as codifying the doctrine of utmost good faith as it applied across all aspects of insurance contract law, and stated: “A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.”<sup>33</sup>

The remedy of avoidance is that of avoidance *ab initio*: a lack of good faith would remove contractual force from the apparent agreement. Whilst this might be justified for failure to perform pre-contractual duties, in that consent might be said to be vitiated, it lacks logical force when the failure occurs during the performance of the contract. In *The DC Merwestone*,<sup>34</sup> Lord Sumption JSC expressed a clear preference for a contractual or public policy basis for deciding the consequences of a fraudulent claim:

I am inclined to agree with the view expressed by in *The Star Sea* . . . that once the contract is made, the content of the duty of good faith and the consequences of its breach must be accommodated within the general principles of the law of contract. On that view of the matter, the fraudulent claims rule must be regarded as a term implied or inferred by law, or at any rate an incident of the contract. The correct categorisation matters only because if it is a manifestation of the duty of utmost good faith, then the effect of [S]ection 17 of the Marine Insurance Act 1906 is that the whole contract is voidable *ab initio* upon a breach, and not just the fraudulent claim. If, on the other hand, one adheres to the contractual analysis, the right to avoid the contract for breach of the duty must depend on the principles governing the repudiation of contracts, and avoidance would operate prospectively only.<sup>35</sup>

The great reluctance of English courts to develop the post-contractual doctrine of utmost good faith, even in the face of a fraudulent

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<sup>32</sup> *Id.* at 110.

<sup>33</sup> Marine Insurance Act 1906, 6 Edw. 7 c. 41, § 17 (U.K.).

<sup>34</sup> *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, *The DC Merwestone* [2016] 1 AC 5.

<sup>35</sup> *Id.* at 8.

claim, led to statutory reform. After more than a century as the prime statutory source for insurance law, the Marine Insurance Act 1906 was substantially amended by the Insurance Act 2015. For contracts made after the entry into force of the 2015 Act, Section 17 has been severely pruned and now reads: “A contract of marine insurance is a contract based upon the utmost good faith.”<sup>36</sup> The duty and associated remedy of avoidance under Section 17 have been repealed, along with any analogous common law rule.<sup>37</sup> The intended purpose of this change is to reduce Section 17 to an explanatory provision, devoid of any substantive legal content.<sup>38</sup> It provides context only. The nature of insurance contracts as based on the utmost good faith could (and probably would) be used to justify the development of rules on fraudulent claims but would not be the juridical source of the rule.

### C. THE FORFEITURE DOCTRINE: THE U.K.’S “FALSE SWEARING” RULE

The limited nature of the doctrines of wilful misconduct and utmost good faith prevented their ascendance as the dominant rule for fraudulent claims. Wilful misconduct could not address fraud in the presentation of the claim, and utmost good faith lacked a credible remedy. To fill this lacuna came the “forfeiture” rule, which was substantially developed in recent years by the U.K.’s leading insurance judge of the early 21<sup>st</sup> Century: Lord Mance. Jonathan Mance is the son of a former Chairman of Lloyd’s, a member of the U.K.’s leading specialist insurance Chambers, and author of numerous books on insurance law. He retired as Deputy President of the U.K.’s Supreme Court in 2019 after twenty-five years as a judge.<sup>39</sup>

The forfeiture rule in English law is the closest analogue to the U.S. “false swearing” rule. It evolved from the practice in commercial policies of including a contractual provision denying indemnification if the claim was fraudulent.<sup>40</sup> In early policies, the provisions looked very similar to the U.S. positions, but the effect of the provisions has evolved. The crucial judicial reclassification of this clause came in *Britton v. Royal Assurance* in 1866.<sup>41</sup> The court treated the clause as merely

<sup>36</sup> Marine Insurance Act 1906, 6 Edw. 7 c. 41, § 17 (UK) (as amended).

<sup>37</sup> Insurance Act 2015, c. 4, § 14(3) (UK).

<sup>38</sup> See Baris Soyer & Andrew Tettenborn, *Mapping (Utmost) Good Faith in Insurance Law – Future Conditional?*, 132 L. Q. REV. 618 (2016); see also Margaret C Hemsworth, *The Fate of “Good Faith: in Insurance Contracts*, LLOYD’S MAR. & COM. L.Q. 143 (2018).

<sup>39</sup> 7 King’s Bench Walk, *Lord Mance*, 7KBW (2019), <https://7kbw.co.uk/barrister/lord-mance/>.

<sup>40</sup> *Britton v. The Royal Ins. Co.* [1866] 176 Eng. Rep. 843.

<sup>41</sup> *Id.*

indicative of a public policy rule, which enabled the courts to reshape it over time.<sup>42</sup> This was not simply a matter of enforcing a contractual bargain; it was implementing judicially established rules of good conduct. Parties would remain free to contract for alternative standards (within reason), but the courts established a default rule under its control. This rule is brethren to similar public policy rules on contractual illegality<sup>43</sup> and is not reliant on party consent to apply. The reshaping of the duty from a contractual to a public policy device can be seen in the judgment of Mr. Justice Wiles in *Britton*:

It is the common practice to insert in fire-policies conditions that they shall be void in the event of a fraudulent claim; and there was such a condition in the present case. Such a condition is only in accordance with legal principle and sound policy. It would be most dangerous to permit parties to practise such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed. And if there is wilful falsehood and fraud in the claim, the insured forfeits all claim whatever upon the policy.<sup>44</sup>

This opinion was vital for evolution of the English jurisdiction because English law did not develop the range of judicial limits on the enforcement of insurance policy terms seen in the United States. There is no doctrine of “reasonable expectations” in England and Wales, no doctrine of “bad faith,” and so on. In England and Wales, insurance contracts are generally subject to the same standard of contractual interpretation as any other commercial or consumer contract. This means that English law largely lacks the “public interest” element identified as crucial to insurance law by Abraham,<sup>45</sup> and in this context, by Feinman.<sup>46</sup> Insurance contract law in England is largely a version of contract law and not a system of regulation.

The precise legal basis of the forfeiture rule emerged over time, with the competing explanations offered, shaping the limits of the duty and remedy by iterative judicial processes.<sup>47</sup> The judiciary was faced

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<sup>42</sup> *Id.* at 844.

<sup>43</sup> See *Patel v. Mirza* [2017] AC 467; *ILLEGALITY AFTER PATEL V MIRZA* (Sarah Green & Alan Bogg eds., 2018).

<sup>44</sup> *Britton*, [1866] 176 Eng. Rep. at 844.

<sup>45</sup> Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653 (2013).

<sup>46</sup> Feinman, *supra* note 3.

<sup>47</sup> For a fuller account of the development of the doctrine than is possible in this piece, see James Davey & Katie Richards, *Deterrence, Human Rights and*

with a series of increasingly challenging “hard cases” in which the Draconian nature of the rule was challenged and slowly unpicked.<sup>48</sup>

The first great limit on the application of a contractual approach to insurance fraud came with the exclusion of lies told during litigation. This is significant, as it is the start of legal proceedings that marks the shift from a contractual to a litigious relationship. It is not limited to false statements made in evidence. In one of the last great House of Lords decisions before it was remade as the Supreme Court, *The Star Sea*<sup>49</sup> confirmed that once litigation had commenced, the rules of the court governed falsehoods in oral representations and in written statements, rather than the rules of the contract. The power of the court to strike out claims for fraud during litigation is considered below when considering insurance fraud in the tort system.<sup>50</sup>

The effects of the forfeiture doctrine at the claims stage is considerable, but its impact varies. It is axiomatic that the insured has no right to an indemnity under the contract where it submits an entirely fraudulent claim. The loss that never occurred, or more likely, was orchestrated by the insured, is not a loss within the policy. To say that the insured’s rights are forfeit stretches the point. There are no substantive rights to forfeit, as there was no genuine loss to indemnify.<sup>51</sup>

The rule has real teeth where the insured exaggerates its claim and seeks an indemnity greater than that permitted under the contract. In *Axa General Insurance Ltd v. Gottlieb*,<sup>52</sup> Lord Justice Mance was faced with an insured that had dishonestly exaggerated a claim on a residential property insurance policy.<sup>53</sup> The claim was a relatively complex one, with substantial repairs needed to the house after extreme weather had damaged the roof and burst water pipes.<sup>54</sup> Some elements of the claim were settled and paid relatively quickly, but others remained in negotiation.<sup>55</sup> The insured then submitted a dishonest claim for alternative accommodation (of £4,500) whilst repairs were completed. The underwriter submitted that it was therefore discharged from liability

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*Illegality: The Forfeiture Rule in Insurance Contract Law*, LLOYD’S MAR. & COM. L.Q. 314, 326 (2015).

<sup>48</sup> The forfeiture rule was perceived by Lord Justice Mance (as he then was) as “a rule which is deliberately designed to operate in a draconian and deterrent fashion” in *Axa Gen. Ins. Ltd. v. Gottlieb*, [2005] EWCA Civ 112, [2005] Lloyd’s Rep. IR 369, [31].

<sup>49</sup> *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd.* [2003] 1 AC 469.

<sup>50</sup> See *infra* “Insurance Fraud, Tort Fraud and the Overlap.” at p. 55.

<sup>51</sup> Davey & Richards, *supra* note 47, at 326.

<sup>52</sup> *Axa Gen. Ins. Ltd.* [2005] EWCA Civ 112, [2005] Lloyd’s Rep IR 369.

<sup>53</sup> *Id.* at [2].

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

for the remainder of the claim and could recover sums already advanced.<sup>56</sup>

The Court of Appeal, led by Lord Justice Mance, aligned the “forfeiture rule” with his interpretation of an express fraudulent claims clause in a previous case.<sup>57</sup> The standard English clause described the benefit under the policy as “forfeit” rather than the policy being void,<sup>58</sup> and this gave the “forfeiture rule” its label and direction of travel. To best explain the approach of the English courts, imagine an insured who combines bad luck with bad character. During the operation of a one-year insurance policy, he suffers three losses. The first and third losses—which occur at month three and month nine of the one-year term—are entirely honest in all aspects. The claim at six months is exaggerated, in that the insured seeks to wrongfully claim for an additional \$5,000 on a \$20,000 claim. *Gottlieb* seeks to answer what happens to each of the three claims, even though, strictly speaking, it is only concerned with the middle, exaggerated claim. As Lord Justice Mance explained: “To my mind, there is no basis or reason for giving the common law rule relating to fraudulent claims a retrospective effect on prior, separate claims which have already been settled under the same policy before any fraud occurs.”<sup>59</sup>

This settles the effect on the first claim, as the subsequent fraud does not affect the validity of that recovery, and it need not be repaid. The “forfeiture” is of the benefit of indemnification for the claims touched by fraud, and not earlier claims. What of the exaggerated claim at six months? Does it matter if the lie occurred only part way through

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<sup>56</sup> *Id.*

<sup>57</sup> *Ins. Corp. of the Channel Islands Ltd. v. McHugh* [1997] LRLR 94 (Eng.). The clause reads:

Fraud- If the claim be in any respect fraudulent or if any fraudulent means or devices be used by the insured or anyone acting on his behalf to obtain any benefit under this Policy or if any destruction or damage be occasioned by the wilful act or connivance of the insured all benefit under this Policy shall be forfeited.

<sup>58</sup> The move away from describing the policy as ‘void’ occurred sporadically, and over time. Counter-examples can be found: in 1831, in *Levy v. Baillie*, [1831] 131 Eng. Rep. 135, 135 the following clause was inserted in the policy: “And if there appear fraud in the claim made, or false swearing or affirming in support thereof, the claimant shall forfeit all benefit under such policy.” By contrast, *Lek v. Matthews*, [1927] 29 Ll.L.L.Rep 141, included: “if the assured shall make any claim knowing the same to be false or fraudulent as regards amount or otherwise the policy shall become void, and all claims thereunder shall be forfeited.”

<sup>59</sup> *Axa Gen. Ins. Ltd.* [2005] EWCA Civ 112, Lloyd’s Rep IR 369 at [22].



the settlement of that claim? Lord Justice Mance was clear that the entirety of that claim was forfeit, whether or not the underwriter had already settled part of those losses.<sup>60</sup>

What remained unsettled in English law was the effect on future claims. Some obiter comments suggested that the contract might be terminated, but without much discussion.<sup>61</sup> On standard contractual principles, the submission of a fraudulent claim would often be such a serious breach of contract that the agreement might be terminated on notice to this effect, but underwriters are often unaware of fraudulent conduct by insured until some time after the policy term has elapsed. Is the underwriter on risk until it takes steps to terminate the agreement? English insurance law has normally reflected the systemically weak position of insurers in monitoring compliance by insureds, and most remedies operate automatically, whereas general contract law takes the opposite approach.<sup>62</sup>

Ultimately, the precise effect of a fraudulent claim on an insurance contract is now found in Section 12 of the Insurance Act 2015.<sup>63</sup> Whilst it is not without its uncertainties, it is generally an

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<sup>60</sup> *Id.* at [32].

<sup>61</sup> [2005] Lloyd's Rep IR 369, at [19]–[20].

<sup>62</sup> *White & Carter (Councils) Ltd v. McGregor* [1962] AC 413, 427 (Eng.) per Lord Reid, on the effect of repudiatory breach of contract:

The general rule cannot be in doubt . . . If one party to a contract repudiates it . . . the other party, the innocent party, has an option. He may accept that repudiation and sue for damages for breach of contract, whether or not the time for performance has come; or he may if he chooses disregard or refuse to accept it and then the contract remains in full effect.

<sup>63</sup> The Act states:

(1) If the insured makes a fraudulent claim under a contract of insurance—

(a) the insurer is not liable to pay the claim,  
(b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and

(c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.

(2) If the insurer does treat the contract as having been terminated—

(a) it may refuse all liability to the insured under the contract in respect of a relevant event occurring after the time of the fraudulent act, and

attractive model for reform of the U.S. position. Under the new provision, the insurer is discharged from liability for the claim in question, but existing rights under the contract (for earlier claims) are untouched. The insurer may terminate the contract by notice, but the termination takes effect retroactively so that the contract ends at the moment the fraudulent action occurred. The statute does not explain whether the right to terminate is time-bound, but English law normally requires such rights to be exercised within a reasonable period from the moment the claimant discovers it has the right to terminate.<sup>64</sup>

We complete our review of the forfeiture rule by examining its final area of potential application: the lie in support of an honest claim. The application of this rule is perfectly demonstrated by the two most recent appellate decisions in the area. Both of these decisions feature Jonathan Mance as judge, the first at the height of his influence, and the latter as his lost control over the forfeiture doctrine. In *The Aegeon*, where Lord Justice Mance gave the leading judgment in the Court of Appeal, the insured's cover was subject to a marine insurance warranty that it not conduct "hot works" on the vessel.<sup>65</sup> This would preclude welding and similar activities, which generated an additional risk of fire. As part of the annual maintenance of the vessel, welding was required and so the insured requested that the warranty be waived for this purpose.<sup>66</sup> The underwriter agreed, subject to certain conditions being met prior to works commencing.<sup>67</sup> It was alleged that the insured did not wait for the conditions to be met and began welding almost immediately.<sup>68</sup> If the underwriter had been aware at the time of this

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(b) it need not return any of the premiums paid under the contract.

(3) Treating a contract as having been terminated under this section does not affect the rights and obligations of the parties to the contract with respect to a relevant event occurring before the time of the fraudulent act.

(4) In subsections (2)(a) and (3), 'relevant event' refers to whatever gives rise to the insurer's liability under the contract (and includes, for example, the occurrence of a loss, the making of a claim, or the notification of a potential claim, depending on how the contract is written).

Insurance Act 2015, c. 4, § 12 (U.K.), <https://www.legislation.gov.uk/ukpga/2015/4/section/12/enacted>.

<sup>64</sup> *Yukong Line Ltd. v. Rendsberg Investments* [1996] 2 Lloyd's Rep. 604, 608.

<sup>65</sup> *Agapitos v. Agnew, The Aegeon* [2002] 2 Lloyd's Rep. 42. The facts are as described at [5]-[11].

<sup>66</sup> *Agapitos*, [2002] 2 Lloyd's Rep.42, [5]-[11].

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

behaviour, it would have had an arguable case that it was discharged from liability as a result of breach of warranty.<sup>69</sup> The insured therefore stated within its claim that no welding had occurred before permission was granted.<sup>70</sup> On discovery of this lie, the underwriter sought to amend its defence to deny liability for fraud.<sup>71</sup> For procedural reasons, it could not do so, but Lord Justice Mance gave a fully reasoned obiter analysis on the application of the forfeiture rule to these facts.<sup>72</sup>

He took the view that lies in the presentation of an otherwise honest claim required the operation of the forfeiture rule, providing the lie was material.<sup>73</sup> His definition of materiality was complex, but well crafted. It encompassed false evidence or statements in support of a claim: “[W]hich would, if believed, have tended, objectively but prior to any final determination at trial of the parties’ rights, to yield a not insignificant improvement in the insured’s prospects—whether they be prospects of obtaining a settlement, or a better settlement, or of winning at trial.”<sup>74</sup>

The question is whether the lie, if believed, would have made a noticeable difference to the insured’s position in settling its claim. Any potential unfair advantage in the speed or level at which the claim would be settled would be material. This sets an objective standard above which the claim will be lost in its entirety.

The difficulty with this test was that courts seemed unwilling to decide that any lie was immaterial. An entirely spurious lie could be portrayed as distracting the underwriter from a real issue, creating an unfair advantage. In a remarkable step, members of the judiciary contributed to a review of the law by the U.K.’s Law Commissions expressing concern about the potential injustice the rule could create.<sup>75</sup>

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<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.* at [13]–[53].

<sup>73</sup> *Id.* at [45].

<sup>74</sup> *Id.* at [38].

<sup>75</sup> THE LAW COMMISSION & THE SCOTTISH LAW COMMISSION, INSURANCE CONTRACT LAW: BUSINESS DISCLOSURE; WARRANTIES; INSURERS’ REMEDIES FOR FRAUDULENT CLAIMS; AND LATE PAYMENT 220 (2014), [https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/03/lc353\\_insurance-contract-law.pdf](https://s3-eu-west-2.amazonaws.com/lawcom-prod-storage-11jsxou24uy7q/uploads/2015/03/lc353_insurance-contract-law.pdf). The letter was signed by Mrs. Justice Gloster DBE, Mr. Justice Burton, Mr. Justice Beatson, Mr. Justice Christopher Clarke, Mr. Justice Flaux and Mr. Justice Popplewell.

This was echoed in a first instance decision by Mr. Justice Popplewell, although he was compelled by precedent to apply the *Aegeon* rule.<sup>76</sup>

The Supreme Court was able to redefine the limits of the forfeiture rule in *The DC Merwestone*.<sup>77</sup> In an unexpected turn of events, the court overturned the version of materiality proposed in *The Aegeon*, in favour of a considerably stricter test. Lord Mance was part of the five-person panel, and the sole dissenting judge. The new test for materiality stated that: “although a lie uttered in support of a claim need not have any adverse effect on the insurer . . . it must at least go to the recoverability of the claim on the true facts.”<sup>78</sup>

This moves the moment for assessing the potential impact of the lie from the settlement process to the trial. The lie must relate to the recoverability of the claim in court. A lie which is told that is unrelated to a live issue at trial is merely a collateral lie and of no legal effect under this rule. Parties remain free to contract for stricter rules, but the court was not persuaded that it should interfere in a contractual process by which a lie was told in favour of a claim that was entirely with the contractual bargain made. The loss was insured against; the amount claimed for was an entirely honest assessment of the loss suffered. The insured foolishly told an unnecessary lie. Without an express clause to bolster the underwriter’s position, it had no defence to a demand to a pay a claim that was otherwise honest. As Lord Sumption remarked: “. . . there is an obvious and important difference between a fraudulently exaggerated claim and a justified claim supported by collateral lies. Where a claim has been fraudulently exaggerated, the insured’s dishonesty is calculated to get him something to which he is not entitled.”<sup>79</sup>

The forfeiture rule has come a long way in the 150 years since *Britton*. It has shifted from the routine enforcement of a standard contractual provision to a rule of public policy. This has altered the key components of the test, in favour of a less Draconian approach to fraud and towards a more proportionate response, particularly in respect of the remedy for breach. This drift in approach reflects concerns from academics and judges, and the less strict approach found in neighbouring

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<sup>76</sup> *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone [2013] EWHC (Comm) 1666 [64], which ultimately resulted in the Supreme Court decision above.

<sup>77</sup> *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone, [2017] AC 1.

<sup>78</sup> *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone [2016] 1 AC 5, at [36].

<sup>79</sup> *Manifest Shipping Co. Ltd. v. Uni-Polaris Insurance Co. Ltd.*, The Star Sea [2003] 1 AC 469 (UK), at [25].

principles. We turn now to a key comparator, the effect on a claim of a lie told in litigation.

#### D. INSURANCE FRAUD, TORT FRAUD AND THE OVERLAP

The forfeiture rule, for all its potential universality, was limited by the judiciary to lies told in the contractual phase of the relationship. Once the parties are engaged in litigation—and this commences with the issue of the claims form (known previously as the writ)—the forfeiture rule ceases to apply. At this point the rules of the court take over. In recent years, these have been tested most thoroughly in what might be considered indirect insurance frauds. In these cases, the lie is told as part of a claim in tort, in order to obtain a larger than deserved payout. The ultimate payor of the claim will be the liability underwriter, but there is no fraud in the relationship between the insured and the underwriter. The insured is entirely honest, but the third-party claimant is not.

In *Summers*, the Supreme Court was faced with an extraordinary example of tort fraud.<sup>80</sup> The claimant suffered a genuine injury at work and would have been entitled to around £80,000 in compensation.<sup>81</sup> However, the claimant exaggerated his symptoms to the extent that he underwent further unnecessary surgery.<sup>82</sup> His eventual claim would have recouped around £800,000 (a ten-fold increase) were it not for surveillance evidence emerging of exaggeration of his symptoms.<sup>83</sup> As the Supreme Court noted: “the driving force behind the is the defendant’s liability insurers, who say that fraudulent claims of this kind . . . are rife and should in principle be struck out as an abuse of the court’s process.”<sup>84</sup>

The court confirmed that it had judicial discretion to strike out the claim, including the honest part, but refused to do so. This might seem to remove any deterrent from the rule, but the practical effect is that the negligent employer would still pay the £80,000 for the injury suffered, but that recovery would be lost to those who had treated him for his injuries and in costs awards. He would not retain any of his award on these facts.

Conscious of the impression (rather than the reality) that the *Summers* decision might give to would-be fraudsters, statutory intervention followed swiftly.<sup>85</sup> In personal injury cases, the court must

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<sup>80</sup> *Summers v. Fairclough Homes* [2012] UKSC 26, [2013] Lloyd's Rep IR 159.

<sup>81</sup> *Id.* at [9].

<sup>82</sup> *Id.* at [3].

<sup>83</sup> *Id.* at [6].

<sup>84</sup> *Id.* At [1].

<sup>85</sup> The statute states:

now dismiss any claim where the claimant has been “fundamentally dishonest” unless the claimant would suffer “substantial injustice” if the claim was struck out. The emerging judicial practice in the application of this discretion suggests that the courts will routinely strike out claims, even where the fundamental dishonesty is only in one part of the overall recovery. In *LOCOG v. Sinfield*,<sup>86</sup> Mr. Justice Knowles responded to a claimant who had exaggerated the effect of a genuine personal injury by seeking to show that he had incurred additional costs by hiring a gardener for additional hours as fundamentally dishonest. In striking out the claim, Mr. Justice Knowles stated:

. . . [A] claimant should be found to be fundamentally dishonest . . . if the defendant proves on a balance of probabilities that the claimant has acted dishonestly in relation to the [claim] . . . and that he has thus substantially affected the presentation of his case, either in respects of liability or quantum, in a way which potentially adversely affected the defendant in a significant way . . .

By using the formulation “substantially affects” I am intending to convey the same idea as the expressions ‘going to the root’ or ‘going to the heart’ of the claim.<sup>87</sup>

Outside of personal injury, the standard judicial discretion to strike out a claim as described in *Summers* remains in force.<sup>88</sup> Whilst the court was not prepared to deprive the claimant of his cause of action in

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(1) This section applies where, in proceedings on a claim for damages in respect of personal injury (“the primary claim”)—

(a) the court finds that the claimant is entitled to damages in respect of the claim, but

(b) on an application by the defendant for the dismissal of the claim under this section, the court is satisfied on the balance of probabilities that the claimant has been fundamentally dishonest in relation to the primary claim or a related claim.

(2) The court must dismiss the primary claim, unless it is satisfied that the claimant would suffer substantial injustice if the claim were dismissed.

Criminal Justice and Courts Act 2015, (2015) § 57 (UK):

<sup>86</sup> [2018] EWHC 51 (QB) (Eng.).

<sup>87</sup> *Id.* at [62]–[63].

<sup>88</sup> *Summers v. Fairclough Homes* [2012] UKSC 26, [2013] Lloyd's Rep IR 159.

*Summers*, where a lie is made by the insured in a property insurance claim, the court is likely to strike out the claim, providing it is germane to the litigation. Lies told in litigation that are not fundamental to the claim will not deprive the claimant, even an insured, of its rights:

A regrettable but not uncommon phenomenon in the civil courts is the litigant, whether a claimant or a defendant, who thinks that he has a fairly good case but is worried that he just might lose, so he tries to improve his chances by embellishing the evidence and telling a few lies. Suppose that at the trial his lies are exposed, but the judge takes the view that he would have won the case anyway without them. Does he lose the case because he lied? The answer is: No. If his case is a good one anyway, he wins. It is deplorable that he lied, but he is not deprived of his victory in consequence.<sup>89</sup>

In addition to the potential strike-out of the claim, dishonesty in legal proceedings carries a substantial risk of an action for contempt of court. In recent years, insurers have taken orchestrated action against claimants for lies in relation to insurance claims. The judiciary has often imposed custodial sentences on those found in contempt, citing industry figures on the prevalence and magnitude of insurance fraud as a justification for doing so. As will be detailed below, it is likely that these figures are seriously misleading.

#### E. THE COMPARATIVE DEVELOPMENT OF ENGLISH LAW & AMERICAN LAW ON INSURANCE FRAUD

From the outside, the impression formed of the US law on fraudulent insurance claims is reminiscent of the position in the U.K. in the early 2000s. It is an area of immense practical importance, and of great socio-legal significance, but not a core area of study or research as a body of law. The rules are either so obvious to be unworthy of study (the insured cannot recover for the arsonical destruction of its own property) or merely a further example of the tension between the insurance policy as written and the policy as it “ought” to be. There are significant exceptions to this,<sup>90</sup> but these are rare.

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<sup>89</sup> *Agapitos v. Agnew* [2002] EWCA (Civ) 247, [58], [2003] QB 556 (Eng.).

<sup>90</sup> Jay M. Feinman, *Insurance Fraud, Agency, and Opportunism: False Swearing in Insurance Claims*, <https://rucore.libraries.rutgers.edu/rutgers-lib/51227/>.

The review of English law presented above shows a drift towards a coherent body of law of “fraudulent insurance claims.” The volume and heterogeneity of disputes in the English courts, combined with a sizeable insurance market, has generated an expert judiciary to resolve them. There are enough difficult cases for a critical mass of judicial opinions to emerge, and for principles to be shaped and reshaped. Lord Justice Mance was a colossal figure as an insurance judge in the first two decades of the twenty-first century, but was challenged on points of intense doctrinal detail by Lord Justices Waller, Rix, and Aikens, among many others. The lack of jury trials in English civil procedure is also likely to be a factor.

The tectonic shifts were away from simple principles with no limiting factors to an increasingly proportionate regime. This was not driven by a desire to replace rules with standards, but from a growing appreciation of the systemic advantages given to underwriters when insurance law was first designed in the eighteenth century. During the past two decades, English law has replaced many of the strict principles of insurance law set in the eighteenth century with more neutral positions. In some cases, the minimum thresholds to meet a duty have been lowered, in others the remedies have been reduced in severity. Overall, the sense is that the judges had come to appreciate, as Lord Justice Mance put it: “English insurance law is strict enough as it is in insurers' favour. I see no reason to make it stricter.”<sup>91</sup>

In identifying the risk that insurers will be given opportunities to limit (by chilling effect) the payment of predominantly or wholly honest claims, by the threat of alleging fraud, American law was probably ahead of English law. The precise limit of tolerance in the tests for materiality and the like can fairly be thought to represent political choice. Less convincing is that the remedy of “avoidance” has any place in this field, at least without very clear explanation of its effect. If what is meant by this in practice is forfeiture of the claim, then the U.S. should leave behind the nineteenth century clauses that inspired the “false swearing” rule and move to a twenty-first century suite of remedies. The U.K. model, with total loss of claim (where materiality is shown) and termination at the option of the insurer, but from the date of the fraud, is an excellent starting point. This is not to deny party autonomy. Parties may vary the rule within the limits of the public policy prohibition on fraudulent recovery. But the English case law reviewed above shows that the default position matters. In all of this, the search is for a rule that does not readily permit either the insured or the underwriter to take undue advantage of the rule. That is a challenge to those who draft policies, but one which is not met by the remedy of avoidance.

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<sup>91</sup> *Friends Provident v. Sirius* [2005] EWCA Civ 601 [33], (Eng.), [2005] 2 Lloyd's Rep 517, 531.



Insurance fraud is, of course, not governed solely by the courts or the contract. The politics of insurance fraud extends into the civil justice system more widely. We move at this stage from the industry's design of contractual clauses to its measurement of insurance fraud data and the misleading picture that emerges.

#### IV. ADOPTING AN EMPIRICAL APPROACH TO INSURANCE FRAUD DATA

##### A. THE "RAWLINGS" QUESTION

Insurance fraud analysis routinely starts with the estimated level of insurance fraud. The figures vary by jurisdiction, but these are often given as both the net total cost to the industry as a whole and as an average annual cost to the consumer. In the U.K., these figures are produced by the industry trade body, the Association of British Insurers (ABI), and launched with the finesse expected of an experienced lobbying organisation. The headline figures are cited and repeated in a wide range of market and legal situations, not least before the courts.<sup>92</sup> My initial focus is the accuracy of the figures, before moving on to the impact of this data set on the insurance fraud environment. Many insurance commentators are sceptical of the accuracy of these headline figures.<sup>93</sup> Feinman's chapter in *Delay, Deny, Defend* is a paradigm example of this and reminds us of the socioeconomic and political context in which these figures are generated.<sup>94</sup> With the help of some relatively simple data science, this section will improve this account. The apparently scientific calculation underpinning the headline figure of the volume of fraud is best understood as a series of choices reflecting the best interests of insurers and not the public at large.

My particular interest in the insurance fraud data was piqued by a question asked by a fellow academic member of the U.K.'s Insurance Fraud Taskforce in 2015. Professor Philip Rawlings enquired of the room of industry and legal experts: why detected insurance fraud is always more-or-less £1.2 billion per year.<sup>95</sup> The flatness of the trajectory in

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<sup>92</sup> See *infra*, text accompanying note 105.

<sup>93</sup> Empirical criminologists note the wide range of predictions, and the wide range of methods used to estimate insurance fraud. See Etienne Blais & Jean-Luc Bacher, *Situational Deterrence and Claim Padding: Results from a Randomized Field Experiment*, 3 J. EXPERIMENTAL CRIMINOLOGY 337, 347 n.10 (2007).

<sup>94</sup> FEINMAN, *supra* note 6, ch 10.

<sup>95</sup> This is recorded in the published minutes as: 'discussion about the accuracy of existing statistics on fraud and debate about the existence of certain trends', see Minutes from Insurance Fraud Taskforce, Stakeholder Roundtable

recent years in the ABI insurance fraud data is indeed surprising.<sup>96</sup> Much is made in insurance industry briefings of the wide-ranging and innovative response to fraud, and of the growing role of artificial intelligence in its detection. These might be expected to ‘move the dial’ on the level of detected fraud. The ABI’s latest annual fraud briefing explains the dynamic nature of the system:

- A total of 469,000 insurance frauds were detected by insurers. Of these, 98,000 were fraudulent claims, with 371,000 dishonest insurance applications. The number of fraudulent claims detected fell 6% on 2017, while the number of dishonest applications for cover rose by 5%.
- The value of the 98,000 dishonest claims detected, at £1.2 billion, fell marginally by under 1% on the previous year.
- Motor insurance scams remained the most common and most expensive, with 55,000 dishonest claims worth £629 million detected. The number and value of these claims both fell on the previous year - down 8% and 9% respectively.
- Of the 55,000 motor insurance frauds, 80% involved personal injury fraud. These ranged from staged crash for cash frauds to opportunistic scams. The measures in the Civil Liability Act will help ensure fair compensation for genuine claimants.
- There were 20,000 property frauds detected, down slightly on the previous year. However, the value of these frauds, at £115 million, rose by 11%.<sup>97</sup>

Within all of these moving parts, the element that moved the least was the overall figure of almost £1.2 billion in detected fraud. As the table below shows,<sup>98</sup> this figure has been largely unchanged for a

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Apr. 21, 2015, [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/454535/Insurance\\_fraud\\_taskforce\\_-\\_stakeholder\\_roundtable\\_21\\_April\\_summary\\_note.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/454535/Insurance_fraud_taskforce_-_stakeholder_roundtable_21_April_summary_note.pdf).

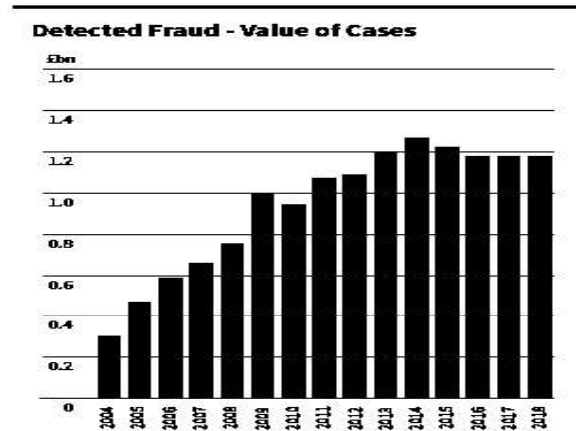
<sup>96</sup> See Association of British Insurers, U.K. *Insurance & Long-Term Savings Key Facts*, 18–19 (2019), <https://www.abi.org.uk/data-and-resources/industry-data/insurance-and-long-term-savings-key-facts/>.

<sup>97</sup> ABI, *Detected Insurance Frauds in 2018*, (Aug. 28, 2019), <https://www.abi.org.uk/news/news-articles/2019/08/detected-insurance-frauds-in-2018/>.

<sup>98</sup> ASS’N OF BRITISH INSURERS, *supra* note 96, at 18.

number of years, despite methodological changes in the capture of insurance fraud data.

*Figure 1: ABI figures on Detected Insurance Fraud, 2004-2018*



What follows is an attempt to unpick the headline statistics within insurance fraud. This is based on the U.K. figures, but similar methodological “sleights of hand” are very likely at play in the U.S. market.

#### B. UNPICKING THE INSURANCE FRAUD DATA

Access to the underlying data on which the ABI calculates its annual figures is heavily restricted. Members of the trade body can get the data for internal use for £500, but those wishing to use it for “external” purposes (such as independent academic analysis) would be required to pay £2,600 for access.<sup>99</sup> These fees would have to be paid every time the data was updated. Whilst this may reflect the cost of collating the data, the fees effectively remove the data from public scrutiny. Similar charges are imposed for other ABI datasets.

The ABI has improved the transparency of the process in recent years by publicising the methodology by which it collects data and giving practical examples of what would (not) be recorded as fraud. This methodology is now provided as an extensive footnote on its press

<sup>99</sup> Ass’n of Brit. Insurers, *Industry Data and Subscriptions*, ABI, <https://www.abi.org.uk/data-and-resources/industry-data/industry-data-and-subscriptions/> (last visited Sept. 7, 2020).

releases and reports.<sup>100</sup> But this is not enough. Distinguish two distinct elements in the fraud data at this point: frequency and magnitude. The first measures the number of incidents of insurance fraud. These figures were given in annual reports produced by the ABI and showed considerable variation year-on-year.<sup>101</sup> The second measures what appears to be the level of fraud, this is our £1.2 billion per annum.

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<sup>100</sup> The ABI seeks information from its members which fall into the following description, which has been based around the Fraud Act 2006, and reflects the definition adopted in relation to the Insurance Fraud Register:

Any party seeking to obtain a benefit under the terms of any insurance-related product, service or activity can be shown, on a balance of probabilities, through its actions, to have made or attempted to make a gain or induced or attempted to induce a loss by intentionally and dishonestly:

- making a false representation; and/or
- failing to disclose information; and/or
- having abused the relevant party's position

And one or more of the following outcomes has taken place which relates to the fraudulent act:

- an insurance policy application has been refused;
- an insurance policy or contract has been voided, terminated or cancelled;
- a claim under an insurance policy has been repudiated;
- a successful prosecution for fraud, the tort of deceit or contempt of court has been brought;
- The relevant party has formally accepted his/her guilt in relation to the fraudulent act in question including, but not limited to, accepting a police caution;
- an insurer has terminated a contract or a non-contracted relationship / recognition with a supplier or provider;
- an insurer has attempted to stop/recover or refused a payment(s) made in relation to a transaction;
- an insurer has challenged or demonstrated that a change to standing policy data was made without the relevant customer's authority;

Provided that the relevant party has been notified that its claim has been repudiated, or relevant policy or contract voided, terminated, or cancelled, for reasons of fraud and/or it is in breach of the relevant terms and conditions relating to fraud within the relevant policy or contract.

See ASS'N OF BRIT. INSURERS, *supra* note 96.

<sup>101</sup> ASS'N OF BRIT. INSURERS, *supra* note 96.

The revised methodology for estimating the frequency of insurance fraud represents a “best efforts” attempt to capture data that is inherently uncertain. Insurance fraud is not only those cases where successful litigation ensues; it includes the abandoned claim and the low-ball settlement where neither side was entirely sure of success. In an ideal world, we would have an independent body design the method and collate the data, but this is not a high priority for government agencies. I am less critical of this part of the data science.

My focus is the “headline figure” of magnitude, as raised in the “Rawlings question,” and here the method is much less transparent. The analysis is developed by reference to leading U.K. cases, but the circumstances described are routine. The facts of *Gottlieb*,<sup>102</sup> considered above in the development of the “forfeiture rule” illustrate the issue. A routine household claim generated several heads of loss. Some were settled quickly; others were ongoing. Towards the end of the claims process, the insured padded the genuine claim (valued at around £72,400) by adding two fraudulent invoices. These sought to evidence credible expenses: the rental of alternative accommodation whilst work was carried out (for £16,250) and a forged invoice for £1,200 (claiming to be work carried out by an electrician). This was a claim exaggerated by around 24 percent of the true value.

The response of English law is settled. The whole claim is forfeit. But what do we report as the level of insurance fraud? There are two possibilities: the dishonest part (£17,450) and the total claim avoided (honest and dishonest parts combined) at £89,950. These are not only substantially different in size, but represent different things being measured and reported. The detailed description of how insurers estimate fraud does not give us the answer on what elements are reported—only what circumstances are treated as fraud.

The static nature of the overall fraud figure suggests that what is reported is the overall figure, the size of the claim avoided. But this is not the actual level of fraud, rising and falling each year; that would be the lesser figure. What the insurance industry is most likely reporting in these reports is the amount of insurance business tainted by fraud. This will not vary according to the precise level of fraud in each claim but will capture the extent to which insurance fraud is distributed through the system. That is much more likely to be stable.

There are obvious reasons for reporting these figures separately if we wish to create an accurate impression. If we use the higher figure to report the prevalence of insurance fraud, then a \$1,000 fraud on a \$100,000 total claim would make the figures look worse than a \$25,000 fraud with no underlying honest claim. That cannot be right. One

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<sup>102</sup>*Axa Gen. Ins. LTD V. Gottlieb*, [2005] EWCA (Civ) 112, [2005] Lloyd’s Rep IR 369.

immediate suggestion might be to run two sets of data, but this is a limited solution. It does not help us where the entire claim is supported by a dishonest statement. The classic example is a situation where the dishonesty is found in forged documents to support an otherwise honest claim. We cannot then separate the honest part from the dishonest. As before, a recent case provides a useful exemplar.

In the commercial insurance case of *Sharon's Bakery*,<sup>103</sup> two separate businessmen came together to set up a bakery. The new business was created by the input of some capital and some equipment as a benefit in kind. When the business was destroyed in an accidental fire, the owners submitted a forged document claiming to be an invoice for the machinery. The precise reason why this forgery was created is not apparent on the facts, but there seems to have been some concern that the insurer would seek to pay only a limited sum for the second-hand machinery used in the business. The insurance policy contained an express fraudulent claims clause on the standard English terms that: "If any claim upon this Policy shall be in any respect fraudulent or if fraudulent means or devices be used by or on behalf of the insured to obtain any benefit under the Policy . . . all benefit under this Policy shall be forfeited."

On the basis of the express clause, the claim was forfeit. The judgment was explicit in stating that the claim was only dishonest due to the forged invoice, and the level of indemnity sought was justifiable:

[T]his is not... a case in which the insured is dishonestly advancing a claim under the insurance policy to which it knows it is not entitled . . . [T]here was valuable equipment in the premises, which were used as an operational wholesale bakery business. There was a fire on 8 June 2008, which caused extensive damage and no evidence of arson. On its face, the claimant's claim is a perfectly legitimate one for reinstatement and business interruption indemnity under the policy.<sup>104</sup>

This kind of situation poses a particular difficulty for recording insurance fraud. The claim was for around £400,000, the level of exaggeration is zero. The evidence in support of the claim was dishonestly created, but the claim is otherwise perfectly good. It is not within the spirit of the insurance fraud figures to record the fraudulent element as zero—this claim was avoided for fraud—but neither does it make sense to record the fraud as £400,000. There is no immediately

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<sup>103</sup> *Sharon's Bakery (Europe) Ltd. v AXA Ins. U.K. PLC* [2011] EWHC 210 (Comm), [2009] QB 1120 (Eng.).

<sup>104</sup> *Id.* at [13].

calculable figure that weighs the fraudulent conduct here in monetary terms that is compatible with the figure recorded for a *Gottlieb* loss. They are incommensurate. This creates a break in the data recording system along fault lines not normally used in recording insurance fraud. This is not simply a matter of uncertainty (we do not know how much fraud is in the market), but of pooling data across two very different data sets. The selection of this method favours insurers, as it makes the overall figure for insurance fraud much higher.

### C. HOW MUCH FRAUD IN INSURANCE FRAUD?

The best interests of the insurance industry lie in reporting insurance fraud in one of two ways: the cumulative figure or the personal. The first figure—the £1.2 billion per year for U.K. markets—is for government consumption. The second one is for consumers, and part of the storytelling that insurers do to present an image of the trusted counterparty, protecting honest policyholders from the bad people in society.<sup>105</sup> It is well-established that our reaction to data is not purely rational, and that the framing of information influences our perception of it.<sup>106</sup>

Just as insurance fraud is not one thing, but many, the way in which insurance fraud data must be presented needs to change according to the context in which it is used. The data are packaged for political and marketing purposes. The standards to which we hold parties engaged in politics and advertising are low. The NAIC, United Policyholders<sup>107</sup> (and in the U.K., the Financial Conduct Authority) should present competing accounts of the fraud data in the wider public interest.

More troubling is the use of this data within the judicial system. It is evident from a review of the judgments in U.K. insurance litigation that judges have been persuaded that the headline figure (the £1.2 billion) represents the sum total of fraud, and not the higher figure of insurance business affected by fraud. This matters because the court is developing rules to counter insurance fraud based on a misleading account of what is being measured. This issue is particularly acute when the figures are used in seeking to persuade the court to impose a custodial sentence for contempt of court or insurance fraud.

The penetration of these statistics into the judicial psyche is near complete. In a case that is frequently cited as setting the appropriate

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<sup>105</sup> See Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1397 (1994).

<sup>106</sup> BEN GOLDACRE, *BAD SCIENCE*, chs 13–14 (Fourth Estate, 2nd ed. 2008)

<sup>107</sup> UNITED POLICYHOLDERS, <https://www.uphelp.org/> (last visited Sept. 5, 2020).

sentencing standard for participation in staging motor accidents, Mr. Justice Thomas stated:

This fraud has occurred in the area of motor insurance. It appears that in 2010 dishonest motor insurance fraud occurred on an extensive scale. There were 40,000 of them. Motor frauds were, of all the frauds, the most costly. They totalled over £466 million. The insurance industry estimates that insurance fraud costs £2 billion a year adding on average an extra £44 per year to the insurance bill for every U.K. policy holder . . . As was said by counsel for the insurers today, that is the tip of the iceberg.<sup>108</sup>

He was initially minded to imprison the defendants for twelve months for contempt of court but reduced the sentence to six weeks in recognition of the guilty plea and cooperation with insurers.

What should be done in response to this? For data used solely within the political arena, the insurance industry should be required to share its method and data with regulators and trusted consumer groups. This is a situation in which the industry has privileged access to information, and it should—at the very least—be vetted by regulators to ensure that the claims made are accurate. It would stretch irony beyond breaking point for this not to take place. When used in the courts, the headline figure should be described for what it actually is: a measure of prevalence of fraud, and not a measure of magnitude.

To provide equality of arms in the judicial arena, judges need to be presented with well-informed counter-narratives. In an ideal world, prosecuting lawyers and counsel for insurers would be exercising professional restraint in introducing to the court headline figures that are potentially misleading. In the absence of that ideal, consumer groups and regulators should provide counter-narratives. A useful first step would be the application of the “frequency/magnitude” distinction developed above.

The final substantive section of this paper moves to administrative change, and the application of behavioural science in the design of counter-fraud initiatives. This has met some resistance from those who favour traditional models of deterrence based on rational choice theory. Recent empirical research suggests that this traditional view is deeply flawed.

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<sup>108</sup> *Liverpool Victoria Ins. Co. v. Bashir* [2012] EWHC 895 (Admin), [2011] QB 2257 (Eng.).



## V. INSURANCE FRAUD, BEHAVIOURAL SCIENCE & DETERRENCE

### A. INSURANCE FRAUD RULES AND “RATIONAL DETERRENCE”

In a Supreme Court decision focused (somewhat unusually) on issues of public policy in commercial law, Lord Sumption gave an insight into the kinds of evidence that informed his design of commercial law rules: “Courts are rarely in a position to assess empirically the wider behavioural consequences of legal rules. The formation of legal policy . . . depends mainly on the vindication of collective moral values and on judicial instincts about the motivation of rational beings, not on the scientific anthropology of fraud or underwriting.”<sup>109</sup>

Lord Sumption’s description of the working of the judicial mind when deciding significant matters of principle—here, the design of rules to combat commercial insurance fraud—was noteworthy not only for its content but for its scarcity. There are relatively few occasions on which U.K. judges have explained the basis by which they derive the outcome of a case in this way.<sup>110</sup> He tells us several things about his approach to resolving problems, and this combines positive and negative elements. He begins by rejecting a form of knowledge offered to the court in the case: empirical evidence casting doubt on the prior policy basis for the rule. At this point it is necessary to declare an interest: although not cited in the judgment, previous work of the author<sup>111</sup> was considered in detailed argument before the Supreme Court in promoting the use of empirical evidence on deterrence effects in private law. It is a reasonable assumption that Lord Sumption referenced the above and the wider literature contained in its footnotes. The wider empirical literature was supplied to the Court at the request of another of the judges on the panel.

The empirical evidence was rejected by Lord Sumption, not because it was uninformative, but because it was not normally available. Instead of relying on external evidence of this type to determine the optimal shape of commercial law rules, he favoured a largely internal process, by reflection on “collective moral values” and on “the motivation of rational beings.” Assuming Lord Sumption is not

<sup>109</sup> *Versloot Dredging BV v. HDI Gerling Industrie Versicherung AG*, The DC Merwestone [2016] UKSC 45 [10], [2017] AC 1 (Lord Sumption SCJ).

<sup>110</sup> For an insightful consideration of values and implicit policy considerations in English law, see R. J. Cahill – O’Callaghan & B. J. Richards, *Policy, Principle, or Values: An Exploration of Judicial Decision-Making*, 79 LA. L. REV. 397 (2018).

<sup>111</sup> James Davey & Katie Richards, *Deterrence, Human Rights & Illegality: The Forfeiture Rule in Insurance Contract Law*, LLOYD’S MAR. & COM. L. Q. 314, 326 (2015).

misspeaking, the inference to be drawn from this is that the court routinely has sufficient evidence before it to assess these matters: that morality and rationality are self-evident to an experienced judge. The function of this part of the paper is to establish that he is wrong on this point.

Lord Sumption's version of forfeiture is a deterrent by which he is seeking to effect a change in the behaviour of a subset of society (those who might commit insurance fraud). As a rule intended to alter behaviour by imposing a sanction, we need to understand how the targeted group would respond to different types of sanction. This we might call the "efficiency" of the rule. It is not the only variable: we would need to consider any change in underwriters' ability to deny genuine claims. There is also the possibility of externalities. If the rule imposes additional burdens on society, that is a relevant consideration. But if the primary benefit of intervention is the deterrence of some behaviour, then it cannot be correct to measure that benefit by ignoring the actual effect it has on the group targeted. This needs empirical support.

#### B. THE INHERENT LIMITS OF RATIONAL DETERRENCE VS. RATIONAL INCENTIVES

Let us assume that judges and other policymakers know and understand that not all parties are perfectly rational. Moreover, that they are—on occasion—not even boundedly rational,<sup>112</sup> and that their conduct may be irrational under certain conditions. We further assume that the extent to which any given party is (ir)rational is not predictable, but that the overall effect across all participants is fairly predictable. We know our market, but not the nature of every participant.

If a rule-maker wishes to encourage a certain form of socially useful behaviour, it might reasonably choose to distribute a benefit such that those who are at least boundedly rational will alter their behaviour and claim the reward. This has two effects. It incentivises parties to change their behaviour in a desirable way, but it also rewards those behaving (boundedly) rationally. Those who behave irrationally would have reduced access to the benefits distributed. This type of incentive structure should "educate" participants to be more rational.<sup>113</sup> This does not always work in practice, but there is at least a certain logic behind it.

Much of the justification for the continued use of neo-classical law and economics in counter-fraud looks like this. If Lord Sumption could be interrogated on the point, he might say something similar. It is

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<sup>112</sup> Herbert A. Simon, *Bounded Rationality*, in *UTILITY AND PROBABILITY* 15 (John Eatwell et al. eds., 1990).

<sup>113</sup> Thomas Russell & Richard Thaler, *The Relevance of Quasi Rationality in Competitive Markets*, 75 AM. ECON. REV. 1071, 1074 (1985).

not that he believes that everyone is rational, but it is the best working approximation for conduct in these kinds of exchanges. There is a fundamental logical flaw in the application of this model to deterrence. The kinds of cases that the Supreme Court has been facing in this and related areas are not about the promotion of conduct through the possibility of reward (“be rational and you get a free cake”) but by the imposition of prescriptive rules designed to disincentivise certain conduct.

Let us repeat the thought experiment using the Sumption methodology but using the proper fact pattern. We imagine that rule-makers wish to discourage a form of socially-harmful conduct. Recognising that not all people are rational, it designs a system of sanctions that bite most effectively on those who are at least boundedly rational. This is what Lord Sumption is proposing. This does not generate a series of rational disincentives as he imagines, it shifts punitive action away from the irrational and towards the rational. The more rational parties are, the more the sanctions are felt. As Thomas Ulen said:

Specifically, people may not respond to the traditional policy correctives in the manner predicted by rational choice theory. Consider, for example, that many potential criminals may be overoptimistic about their ability to avoid detection, arrest, and conviction or to adapt to prison life and, therefore, may not be deterred by criminal sanctions that deter you and me.<sup>114</sup>

Questioning the applicability of rational choice theory as a universal tool is not to say that it is never useful. As with so many models, we have to check that its use is apt. If rational choice theory is not predictive of conduct in the context in which the lawmaker seeks to intervene, then the lawmaker will be falsely overconfident of the accuracy of the judgment.

The counter-veiling argument that law will incentivise increasingly rational conduct is credible<sup>115</sup> but only in circumstances where law provides benefits (for example in certainty of outcome) to those who behave rationally: “namely, that decision makers may learn the value of more rational behavior through experience and, importantly,

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<sup>114</sup> Thomas S. Ulen, *Behavioral Law and Economics: Law, Policy, and Science*, 21 SUP. CT. ECON. REV. 5, 9–10 (2013).

<sup>115</sup> *Id.* at 31.

that the competitive market may be a significant device for inducing more rational behavior.”<sup>116</sup>

It is far less credible where we seek to proscribe conduct by the imposition of sanctions. Why would a market participant behave more rationally so as to fall within a punitive scheme of sanctions? The reverse is more likely. Moreover, recent empirical evidence (reviewed in Section C below) suggest that parties do not “drift towards rationality” when deciding whether to commit soft fraud.

We need to unpick the system-wide effects of the characterisation of Lord Sumption’s refusal to move beyond rational choice theory. He did not refuse to do so because the empirically derived behavioural approach is “bad science,” but because the data that enhances the design of the rule in this specific example are not generally available. He favoured simplicity over accuracy. The behavioural approach to law undoubtedly makes our predictions about human conduct more uncertain. It would have required him to be less dogmatic and less confident. I suspect that his rejection of the behavioural science as “scientific anthropology”<sup>117</sup> is because it required him to draw on external data, rather than his own internal monologue. I would rather have a judge that understands the limits of legal process than one who closes his mind to the possibility that he is wrong. I deliberately do not rephrase this in gender-neutral language.

The crucial argument here is that insurance fraud takes place in a complex and messy ecosystem. The iconic work undertaken by the U.K.’s Financial Conduct Authority<sup>118</sup> and in the U.S. by Baker & Siegelman<sup>119</sup> showed this mixture of rational and irrational at play in insurance purchasing decisions. We should expect a similar mix of models underlying insurance fraud.

To support these claims, I review recent evidence on whether parties involved in soft fraud are engaged in rational decision-making. A complete review of the prior academic literature in this area is beyond

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<sup>116</sup>John A. List, *The Behavioralist Meets the Market: Measuring Social Preferences and Reputation Effects in Actual Transactions*, 114 J. POL. ECON. 1 (2006).

<sup>117</sup> *Versloot Dredging BV v. HDI Gerling Industrie Versicherung* [2016] UKSC 45, [2017] 1 AC 10 (UK).

<sup>118</sup> FIN. CONDUCT AUTH., GEN. INS. ADD-ONS: FINAL REPORT – CONFIRMED FINDINGS OF THE MARKET STUDY (2014), [www.fca.org.uk/publications/market-studies/general-insurance-add-ons-market-study](http://www.fca.org.uk/publications/market-studies/general-insurance-add-ons-market-study).

<sup>119</sup> Tom Baker & Peter Siegelman, “*You Want Insurance with That?*” *Using Behavioral Economics to Protect Consumers from Add-on Insurance Products*, 20 CONN. INS. L.J. 1 (2013).

the scope of this paper, and has been provided in other work.<sup>120</sup> I move instead to recent empirical work in this field, and how it came about.

### C. INSURANCE FRAUD: THE EMPIRICAL TURN

To explain the move towards an empirical picture of insurance fraud, a little historical context is required. The dominant judicial narrative at the start of my career was that judicial enforcement of private law rules were a core (and effective) part of the deterrence of insurance fraud. Much of my work on insurance fraud has been to challenge this simplistic model and provide a richer narrative. Early work showed that considerable sectors of the insurance market were not subject to the strict judicial rule, and received more sympathetic treatment under the Financial Ombudsman Service.<sup>121</sup> Moreover, this work drew on the lack of any equivalent “bad faith” rule in English law to restrain opportunism on the part of insurers. My objection was based in part to the unilateral nature of the rule: an underwriter that claimed an operative defence to liability that it could not evidence suffered no effective sanction, but an insured that over claimed its indemnity was to be treated punitively. This did not win me many friends within the insurance industry. Alongside this work on insurance fraud, I explored the role of behavioural science in explaining other aspects of the insurance relationship, such as the parties’ willingness to negotiate duties and not remedies in claims notification provisions,<sup>122</sup> and in “contracting out” of the default rules on insurance warranties.<sup>123</sup> This placed me in an ideal position to engage with industry at the intersection of these two fields: the behavioural aspects of insurance fraud.

The Insurance Fraud Taskforce<sup>124</sup> was created in 2015 as a joint initiative between the British government (under the Ministry of Justice) and the insurance industry (represented by the Association of British Insurers). It drew on insurance industry, legal, and academic expertise to produce an interim and a final report on the best practical steps to reduce insurance fraud. At the request of the Chair, I provided a specific briefing

<sup>120</sup> See Davey & Richards, *supra* note 47, at 327 n.76–81.

<sup>121</sup> James Davey, *Unpicking the Fraudulent Claims Jurisdiction Insurance Contract Law: Sympathy for the Devil?*, LLOYD’S MAR. & COM. L.Q. 223 (2006).

<sup>122</sup> James Davey, *Claims Notification Clauses and the Design of Default Rules in Insurance Contract Law*, 23 INS. L.J. 245 (2012).

<sup>123</sup> James Davey, *The Reform of Insurance Warranties: A Behavioural Economics Perspective*, J. BUS. L. 118, 119 (2013).

<sup>124</sup> *Insurance Fraud Taskforce*, GOV.UK, <https://www.gov.uk/government/groups/insurance-fraud-taskforce> (last visited Sept. 26, 2020).

on the possibility of using behavioural science to better understand opportunistic fraud. By reflecting on the outcomes from experimental economics in equivalent government processes, such as tax and benefits fraud, a process was developed for modelling key insurance processes. The U.K. government's willingness at this time to engage with behaviourally informed policy provided key strategies that could be tested in the insurance environment:

Insight 1. Make it easy: Make it as straightforward as possible for people to pay tax or debts, for example by pre-populating a form with information already held.

Insight 2. Highlight key messages: Draw people's attention to important information or actions required of them, for example by highlighting them upfront in a letter.

Insight 3. Use personal language: Personalise language so that people understand why a message or process is relevant to them.

Insight 4. Prompt honesty at key moments: Ensure that people are prompted to be honest at key moments when filling in a form or answering questions.

Insight 5. Tell people what others are doing: Highlight the positive behaviour of others, for instance that '9 out of 10 people pay their tax on time.'

Insight 6. Reward desired behaviour: Actively incentivise or reward behaviour that saves time or money.

Insight 7. Highlight the risk and impact of dishonesty: Emphasise the impact of fraud or late payment on public services, as well as the risk of audit and the consequences for those caught.<sup>125</sup>

My work for the Insurance Fraud Taskforce led to specific recommendations for the industry to invest in behavioural research on the topic.<sup>126</sup> Unlike some law and economics models that predict near

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<sup>125</sup>CABINET OFFICE BEHAVIOURAL INSIGHTS TEAM, *APPLYING BEHAVIOURAL INSIGHTS TO REDUCE FRAUD, ERROR AND DEBT* 4 (2012), [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/60539/BIT\\_FraudErrorDebt\\_accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/60539/BIT_FraudErrorDebt_accessible.pdf).

<sup>126</sup>INSURANCE FRAUD TASKFORCE, INSURANCE FRAUD TASKFORCE: FINAL REPORT 57 (Jan. 2016), [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/494105/PU1817\\_Insurance\\_Fraud\\_Taskforce.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/494105/PU1817_Insurance_Fraud_Taskforce.pdf) ("The ABI and CII should commission research on behavioural economics. The

universality, there is no assumption that these principles would be effective in insurance because of positive results in similar processes. The insights above provided a series of hypotheses to be tested empirically. These tests can be undertaken through a variety of different methods.

In important work in 2007, Blais and Bacher<sup>127</sup> carried out field work in the Canadian insurance market.<sup>128</sup> The work ran for six months and involved four large Canadian insurance companies. Claimants (outside of the control group) were provided with a copy of a letter, which arrived at the point at which they had to commit to their claim. It provided three salient types of information:

- (1) to inform the claimant that the insurance company was concerned about claim padding and was prepared to prosecute claimants that had exaggerated their claims;
- (2) to remind claimants of the sanctions associated with claim padding;
- (3) to encourage social conformity, by pointing out that most people consider claim exaggeration to be dishonest.<sup>129</sup>

The findings from the survey are open to interpretation. The effect on claims across the impacted groups was noticeable, a reduction of around \$300 per claim, but this was ‘only 1% of the variance, which indicates a very weak relationship between the stimulus and the outcomes.’<sup>130</sup> The difficulty is that the study had no benchmark for the existing level of fraud within the control group by which to assess the effect. It could be that this reflected substantially lowered claims from those who would otherwise have padded their claim. It is also possible that this lowered the claims of honest claimants, below the honest level of recovery, as the letter made them overly cautious. It could be a combination of both.<sup>131</sup>

The behavioural research commissioned by the United Kingdom’s Insurance Fraud Bureau (which represents the industry on

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research should be available to all and the ABI should encourage take up of the conclusions through its voluntary best practice guidance.”).

<sup>127</sup> Etienne Blais & Jean-Luc Bacher, *Situational Deterrence and Claim Padding: Results from a Randomized Field Experiment*, 3 J. EXPERIMENTAL CRIMINOLOGY 337 (2007).

<sup>128</sup> As described by Blais and Bacher, this built on earlier studies in experimental criminology. Blais & Bacher, *supra* note 127, at 340.

<sup>129</sup> Blais & Bacher, *supra* note 127, at 342.

<sup>130</sup> *Id.* at 347.

<sup>131</sup> See *id.* at 347–48 (the authors of the Blais and Bacher study recognise this as a limiting factor).

these matters) sought to control for the limitations in the earlier work. Rather than running a field experiment, requiring the cooperation of third-parties, it was run as an experimental economics laboratory test. The research was undertaken by a behavioural science consultancy, Decision Technology,<sup>132</sup> rather than by an academic unit. The report was embargoed until September 2019, although the author was provided with a copy.<sup>133</sup> It can now be discussed in print and the principal researchers have done so.<sup>134</sup> As the method and findings of this research are central to my claims for the development of English Law, I review each in some depth.

1. “Reducing Opportunistic Insurance Fraud with the Use of Behavioural Interventions”: Method

The use of experimental economics to generate empirical evidence of consumer decision-making to test hypotheses is well-established. In academic papers, this is often limited to observing volunteer undergraduates.<sup>135</sup> The Decision Technology method adopted a more professional approach to sampling, and produces a reasonably representative group of auto (motor) insurance customers.<sup>136</sup> This group was then run through a series of mock insurance decisions, including an online application for insurance and a claims process. A total of around 12,000 processes were completed, with subtle differences each time. In addition to the control group, where the website mirrored standard procedures, “a total of 19 nudges were tested as behavioural interventions in a simulated online experiment. These interventions took the form of pop up messages placed immediately before a contentious question i.e. where the customer could lie or exaggerate in order to get a better deal.”<sup>137</sup>

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<sup>132</sup> See generally DECTECH, <https://www.dectech.co.uk> (last visited Sept. 12, 2020).

<sup>133</sup> DECISION TECH. LTD., REDUCING OPPORTUNISTIC INSURANCE FRAUD WITH THE USE OF BEHAVIOURAL INTERVENTIONS: INSIGHTS REPORT (2018) (on file with author).

<sup>134</sup> Tim Mitchell & Benny Cheung, *Using Behavioural Science to Reduce Opportunistic Insurance Fraud*, 5 APPLIED MKTG. ANALYTICS 294 (2020). Pre-print available at:

[https://www.dectech.co.uk/studies/200129\\_AMA\\_Reducing\\_Opportunistic\\_Insurance\\_Fraud.pdf](https://www.dectech.co.uk/studies/200129_AMA_Reducing_Opportunistic_Insurance_Fraud.pdf).

<sup>135</sup> The work of Russell Korobkin is a good example of this. *E.g.*, Russell Korobkin, *The Endowment Effect and Legal Analysis*, 97 NW. U. L. REV. 1227 (2002).

<sup>136</sup> Aged 18 or over, based in the U.K., and motor insurance customers. The data set controlled for age and other expected variables. DECISION TECH. LTD., *supra* note 133, at 27.

<sup>137</sup> DECISION TECH. LTD., *supra* note 133, at 4.



The nudges were designed to test a number of distinct hypotheses as to “soft” fraud in consumer insurance, broadly themed around “norming”; “self-consistency”; “priming”; “framing”; and “reciprocation.” The interventions are displayed in detail in the results section below.

Alongside this empirical evidence on decision-making, Decision Technology sought to measure two other key elements: propensity to commit insurance fraud and effect on the “consumer journey.”

The baseline propensity data looks to establish the likelihood of the experimental group to commit insurance fraud at the application stage and the claims stage. This was acknowledged in previous work (including Blais & Bacher) as a limiting factor in assessing the effectiveness of interventions. The data for this study was obtained by means of an “unmatched count technique” analysis.<sup>138</sup> This method is useful where direct questioning will not give completely truthful answers. Assume that we wish to know how many people would admit to having been caught speeding by the police. In one survey (to Group A), we ask directly and record the answer. That comes out at twenty-one percent. In a second, we compare the answers of two groups of people with similar profiles to Group A:

*Table A: Unmatched Count Technique*

Group B: How many of the following are true?	Group C: How many of the following are true?
I ate a packet of crisps in the past 24 hours	I ate a packet of crisps in the past 24 hours
I have played a team sport in the last week	I have played a team sport in the last week

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<sup>138</sup> The technique can be traced to D. Raghavarao & W. T. Federer, *Block Total Response as an Alternative to the Randomized Response Method in Surveys*, 41 J. ROYAL STAT. SOC’Y B. 40 (1979).

I have read a novel cover to cover in the past six months	I have read a novel cover to cover in the past six months
I have been to Spain	I have been to Spain
	I have been caught speeding before
Average: 1.83	Average: 2.22

The difference between the answers between Group B and C are those who will disclose a speeding offence when it is bundled together with other non-culpable information. This is likely to be closer to the real figure. On this basis, whilst twenty-one percent of people would disclose when questioned directly, thirty-nine percent disclose when the moral costs of disclosing are removed. That gives us a baseline of fifty-four percent honesty; forty-six percent dishonesty in relation to that question: *Honest* =  $(21/39 * 100)\%$ ; *Dishonest* =  $(18/39 * 100)\%$ .

This baseline serves two functions, and these must be distinguished. The primary use is as a comparator for this experiment. It does not matter for this purpose if this figure is accurate, as we will test for relative frequency of insurance fraud under variable conditions. In other words, which of the interventions trialled are most effective? The ancillary purpose is more controversial. If we assume these findings describe real-world behaviour, then it suggests that a high percentage of insurance applications and claims are fraudulent. This inference is not justifiable. In the real world, there would be sanctions for a failure to disclose, and no such sanctioning threat was present in the unmatched answers test. This, if anything, only answers the extent to which moral force alone limits the propensity to commit fraud.

The Decision Technology research also sought to measure the effect of behavioural interventions on customer perceptions of the process. This represents the real likely cost to insurers. The direct monetary cost of changing websites and claims forms is low, as the ability to spread the cost across multiple business streams and over time is considerable. Insurers were more concerned that these interventions might be seen as intrusive, unfair or manipulative. The existing

sociological evidence<sup>139</sup> points towards consumers feeling untrusted by insurance professionals and the industry was alert to the risk of exacerbating that feeling. Those working through the dummy websites were therefore asked to respond on the standard 7-point Likert scale<sup>140</sup> about their experience of the process, and changes in attitude towards the insurer.

## 2. “Reducing Opportunistic Insurance Fraud with the Use of Behavioural Interventions”: Results

The benchmark figures from above predicted that thirty-nine percent of people have been stopped for speeding, and that only fifty-four percent of those in that position would disclose this information voluntarily. This is the benchmark for honesty with no interventions. As consumers are processed through the dummy websites, a series of messages appeared on the screen at key moments, when honest disclosure was required. In this model, this is when the insured is asked whether (s)he has been stopped for speeding. The eighteen different types of message are shown in the table below, and the accompanying figures show the estimated effect on those who would have improperly withheld the requested information. Almost all interventions had a positive effect, in that a greater level of disclosure occurred. The percentage figure shown is the amount of expected fraud that was converted to an honest disclosure. The effect on those making an application for insurance varied considerably from those making a claim.

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<sup>139</sup> ERICSON ET AL., *supra* note 2.

<sup>140</sup> A Joshi, S Kale, S Chandel & D. K. Pal, *Likert Scale: Explored and Explained*, 7 BRIT. J. APPLIED SCI. & TECH. 396, 397 (2015).

Dishonesty Swayed			
Domain	Intervention	Application	Claim
Norming	Statistics on others' honesty	55%	74%
	Case study of being caught	47%	71%
	Fraud is a crime / how to avoid	53%	54%
	Agency investigating fraud	44%	50%
	Techniques investigating fraud	44%	50%
	Example of how fraud is a crime	45%	33%
Self-consistency	Telling people they will be honest	30%	63%
	Honesty declaration at the top	44%	41%
Priming	Direct appeal to honesty	38%	48%
	Authority logos (Police)	33%	43%
	Honesty words	46%	25%
Framing	Negative consequences	48%	53%
	Human / friendly tone	-2%	27%
Reciprocation	Someone affected by fraud	36%	44%
	Statistics on claims paid out	48%	15%
	Fraud causing higher premium	22%	20%
	Lemonade charity approach	14%	16%
	Insurer honesty pledge	15%	5%
Average intervention		36%	37%

Table 3: Operational Communications Experiment Dishonesty Swayed Results

On average, the use of a “nudge” of the type tested reduced the propensity to lie about a pre-existing motor conviction by thirty-six percent. Some of this will undoubtedly be boundedly rational, with useful information provided costlessly to the claimant.<sup>142</sup> But other pieces of information are less obviously rational in their effect, and in particular, the “herd effect” information about how others act. This was one of the most significant factors in changing behaviour, with the display of statistics on the honesty of most claimants reducing the level of expected fraud by seventy-four percent. This is crucial for the future

<sup>141</sup> DECISION TECH. LTD, *supra* note 133, at 15.

<sup>142</sup> Oren Bar-Gill & Omri Ben-Shahar, *Rethinking Nudge: An Information-Costs Theory of Default Rules*, (Univ. Chi., Pub. L. Working Paper, Paper No. 744, 2020), [http://www.law.harvard.edu/programs/olin\\_center/papers/pdf/Bar-Gill\\_1031.pdf](http://www.law.harvard.edu/programs/olin_center/papers/pdf/Bar-Gill_1031.pdf).

design of insurance interventions. The threat of increasingly severe sanctions might reduce the tendency that insureds have to fraudulently withhold information, but this research suggests that it is less effective than making clear that most people are honest. The routine use of statistics informing consumers how much insurance fraud costs them (a routine tactic used by the insurance industry) is effective, but again less effective than a direct appeal to honesty. The measured effect on the “customer journey” of these positive messages was also negligible, which means that they present an achievable mechanism for reducing the levels of insurance fraud without demonising the average policyholder and without over-stating the effects of fraud.<sup>143</sup>

Insurers have been harming their own best interests by operating the political message that fraud is rife and that the costs are vast. More effective messages can be phrased in positive terms. For those who follow behavioural science in insurance, it is notable that the “Lemonade” model, by which premiums not used to pay claims are donated to charity, was one of the least effective interventions. This may reflect a lack of familiarity with this model in the U.K., but does not support its wider adoption, at least on the counter-fraud agenda.

In response to this research the U.K. insurance industry designed an implementation blueprint for insurers wishing to adopt these techniques. Much of what will be done by the industry from this point will be commercially confidential and provide an opportunity for insurers to compete on the best implementation of this technique. Part of the savings from those interventions can be reinvested to refine and retest the messages used. Behavioural science favours empirically driven iterative approaches, and does not rely on the assumption that immediate, simple answers will arise from a single test.

#### D. CHOICE ARCHITECTURE AND REFLEXIVE OPPORTUNISM: THE GOLDEN TICKET?

Let us assume that as a society we would wish to achieve a ten percent reduction in the level of “soft” (opportunistic) fraud. Assume that this could be achieved by either of two means. First, the removal of any judicial or State regulation on the enforcement of “false swearing” and related provisions. Policies would be void on the occurrence of any fraudulent misrepresentation, irrespective of proven materiality, reliance or proportionality of outcome. Alternatively, by the widespread introduction of “pop-ups” at key moments when information which is commonly misrepresented is submitted online, during applications for

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<sup>143</sup> DECISION TECH. LTD, *supra* note 133, at 3 (“Historically, there has been some reluctance amongst insurers to over-play counter fraud during the customer journey, not least for fear of alienating customers.”).

insurance and submission of claims. The empirical evidence generated by Decision Technology suggests that these pop-ups will operate as behavioural cues that have the population wide effect of reducing the incidences of dishonesty. It is not a complete solution. But it carries with it significantly reduced costs—both monetary and social—compared to the deterrence by sanction model routinely proposed.

The use of behavioural science to nudge insureds away from soft fraud is beneficial in three distinct ways. First, it maintains customers within the market as honest participants. Here, prevention is better than cure. Second, it is almost costless to implement. Not only do these consumers continue to participate in insurance markets, but the industry avoids the enforcement costs, both financial and reputational, associated with the denial of a claim. Thirdly, it carries a much lower risk that the intervention will be operated to limit the recovery of honest claims.

The reminder that most insureds are honest at the key moments of contracting and claim were tested to see if the customer's experience of the process was affected. Against a control group, insureds left with a slightly *more* positive view of the process, and not less. I suggest that a comparable increase in the severity of the sanction would not produce the same result. Indeed, the sense that insureds are “under suspicion” when submitting claims runs strongly through the sociological studies in this field.<sup>144</sup> My claim is that there are credible reasons to suppose that the behavioural insights tested would not have the chilling effect on honest claims that increased monitoring, enforcement and criminalisation often bring. This is an important benefit.

To this proposal to adopt behavioural insights, I add two caveats. First, this is a single empirical study, and the generality of these finding will need to be tested. There will be cultural differences within the U.S., let alone between the U.K. and the U.S. Home insurance may not work in the same way as motor insurance. And so on. The “replication” crisis is real.<sup>145</sup> But the use of these techniques is not instead of a legal response to fraudulent claims, but as a primary filter. We should look to prevent where possible.

Second, I do not hold a naïve assumption that behavioural science could not be repurposed to create a chilling effect on honest claims. The potential misuse of behavioural science is a real, but distinct, regulatory imperative. There is bureaucratic “sludge”<sup>146</sup> as well as

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<sup>144</sup> ERICSON ET AL., *supra* note 2.

<sup>145</sup> Donald A. Hantula, *Editorial: Replication and Reliability in Behavior Science and Behavior Analysis: A Call for a Conversation*, 42 PERSP. ON BEHAV. SCI. 1 (Mar. 11, 2019), <https://doi.org/10.1007/s40614-019-00194-2>.

<sup>146</sup> Cass R. Sunstein, *Sludge Audits*, BEHAV. PUB. POL'Y 1, 3 (Jan. 6, 2020), <https://doi.org/10.1017/bpp.2019.32> (“*sludge*: ‘a viscous mixture’, in the form

“nudge for good.”<sup>147</sup> The regulation of those interventions is for a later paper. The insurance industry has a blueprint here for effective, cost efficient interventions that have a less stringent effect on honest customers than draconian legal remedies. Unwillingness to adopt the smart solution can, in time, be judged as a preference for the selfish desire to lower claims payable overall under the guise of the socially desirable reduction of fraud. “Therefore by their fruits you will know them.”<sup>148</sup>

## VI. CONCLUSION

Insurance fraud is entirely undesirable. But some of the actions taken to reduce it create further undesirable effects. Part of the difficulty is that we do not know how much fraud exists in insurance markets. One of the ways in which insurers use insurance fraud to their advantage is by persuading legislators, regulators and courts that insurance is rife, and that insurers need protection. This produces sub-optimal outcomes in the design of private law rules in civil justice and within insurance contract law. This regulatory dilemma is best viewed through the lens of “reflexive opportunism” but this in many ways simply labels a phenomenon known for many years.

The search is for practices that can lower the incidence of fraud without carrying the chilling effect produced by stricter formal legal rules. English law has moved in this direction by a series of changes across the tiers of insurance law and practice. The judiciary has sought to develop a more proportionate response, with particular focus on the materiality component within “false swearing” cases, and a more nuanced remedial response. Academics have sought to demonstrate the power-games within the presentation of insurance fraud data. Administrative action has sought “best practice” ideas from a range of stakeholders and moved the industry towards behaviourally informed policy.

The change is gradual. Insurers still seek the implementation of restrictions on personal injury claims,<sup>149</sup> a rate reduction in the tax

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of excessive or unjustified frictions that make it difficult for consumers, employees, employers, students, patients, clients, small businesses and many others to get what they want or to do as they wish . . . .” (internal citation omitted).

<sup>147</sup> Leonhard K. Lades & Liam Delaney, *Nudge FORGOOD*, BEHAV. PUB. POL’Y 1 (JAN. 27, 2020), <https://doi.org/10.1017/bpp.2019.53>.

<sup>148</sup> *Matthew* 7:19 (New King James).

<sup>149</sup> Ass’n of Brit. Insurers, *Whiplash Claims*, ABI, <https://www.abi.org.uk/products-and-issues/topics-and-issues/personal-injury-claims/whiplash-claims/> (last visited Sept. 6, 2020).

imposed on the industry<sup>150</sup> and to vilify claimant lawyers.<sup>151</sup> But within this is the hope that change in the design of insurance process—chiefly electronic proposal and claims forms—that reduce the incidences of insurance fraud without reducing the recovery of honest claims. The behavioural turn in countering insurance fraud does not mean abandoning past practices, but it does provide us with a mechanism for checking the relative efficacy of each. There will be those who argue that this is simply a more advanced form of utility maximisation, or an example of highly bounded conduct. I do not agree, but that is also irrelevant. The rule-maker conception of rational choice theory is often as simplistic as that of Lord Sumption's. That is what I am seeking to dismantle. If it takes a behavioural approach to shift from the use of simplistic models to empirically informed policy making, then that is a price worth paying.

The future of insurance law cannot be left to partisan attempts to shift the legal and political football slightly towards either insurers' goals or those of insureds. We can do better than that. There are some developments that benefit both sides of the aisle. A more sophisticated regime of remedies is within the control of the lawyers. Regulators can work to narrow the gap between how each side measures and describes the incidences of fraud. A single agreed figure is unlikely ever to be reached, but at least let us recognise the contested nature of the process. The development of low-cost measures to nudge insureds towards honesty at key moments improves the outcomes for all concerned. The outcome of a single empirical test is of course not the basis for immediate policy change. Behavioural science should be based on thoughtful trial and error. It supplements formal legal measures and need not replace them. The interventions can be trialled in different States and different markets, and nuanced positions will emerge. They need only to have minimal effect to be justified on a cost/benefit basis. The insights derived

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<sup>150</sup> Ass'n of Brit. Insurers, *As Motor Premiums Continue to Rise, Time for Insurance Premium Tax to Fall*, ABI, <https://www.abi.org.uk/news/news-articles/2020/01/as-motor-premiums-continue-to-rise-time-for-insurance-premium-tax-to-fall/>.

<sup>151</sup> Neil Rose, *ABI Lashes Out at MPs Over Small Claims Report as Claimant Lawyers Urge Government to Act on It*, LEGAL FUTURES (May 18, 2018), <https://www.legalfutures.co.uk/latest-news/abi-lashes-out-at-mps-over-small-claims-report-as-claimant-lawyers-urge-government-to-act-on-it> ("James Dalton, the ABI's director of general insurance policy, said: 'If accepted, these recommendations would achieve absolutely nothing in terms of reducing the number and cost of whiplash-style claims, would allow lawyers to continue to line their pockets and honest motorists would continue to pay higher car insurance premiums as a result.'").



from those further studies can be applied more widely. We might consider how forms completed within litigation might be amended to reduce fraud in litigation. The lessons from English law's thoughtful study of the causes of insurance fraud deserve to be repeated in all major insurance markets.

# WHAT IS A PROTECTION GAP? HOMEOWNERS INSURANCE AS A CASE STUDY

JAY M. FEINMAN\*

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In the past few years, the insurance community has paid increasing attention to the “protection gap”—the extent to which significant losses are not covered by insurance. The Geneva Association, the insurers’ global think tank, has pioneered the concept, and it has become widely adopted.

Insurance always presents gaps in coverage; not all risks are insured or indeed insurable. The protection gap concept necessarily embodies a normative component—that insureds with limited coverage, potential insureds who lack insurance, and society as a whole suffer when certain gaps in insurance exists. It is this normative component of the protection gap concept that has not been fully developed and is the subject of this article.

Part I of the article explains the commonly used definitions of the protection gap. The most commonly used definition—the “risk protection gap”—is purely empirical, measuring the difference between total losses and insured losses. Analytically superior but harder to operationalize is the “insurance protection gap,” which is the difference between the amount of

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insurance that is economically beneficial and the amount of insurance in place. The insurance protection gap properly introduces a normative element to the concept, but it does not capture all of the considerations at stake. Part I offers a different definition: In a particular context, the protection gap is the difference between the amount of insurance that is in place and the amount of insurance that should be in place.

Part II of the article expands on the definition and discusses how much insurance “should be” in place. The method begins by defining a particular insurance context and then constructs policyholder expectations in that context. To define a baseline against which a protection gap should be measured, however, policyholder expectations must be reasonable. Therefore, the risks at issue must be insurable, the insurance must not be undermined by other effectiveness issues, and the social effects of coverage or its absence must be taken into account.

Part III illustrates how the article’s definition of the protection gap can be applied by analyzing several issues in homeowners insurance. A major problem, and a clear instance of the protection gap, is the extent to which homeowners frequently are underinsured for their losses. The most frequently discussed protection gap involves disaster losses, so this part applies the analysis to flood losses. The part concludes by considering whether several more mundane issues constitute protection gaps, damage caused by rain runoff, and matching of damaged and undamaged property.

## I. DEFINITIONS OF THE PROTECTION GAP

The Geneva Association offers two definitions of a protection gap. Both are useful, but neither entirely captures the issues involved in thinking about protection gaps. Its definitions are:

- *The risk protection gap*—The difference between total losses and insured losses.
- *The insurance protection gap*—The difference between the amount of insurance that is economically beneficial and the amount of insurance actually purchased.<sup>1</sup>

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<sup>1</sup> The Geneva Association, *The Global Insurance Protection Gap: Assessment and Recommendations* 7 (2014), [https://www.genevaassociation.org/sites/default/files/research-topics-document-type/pdf\\_public/ga2014-the\\_global\\_insurance\\_protection\\_gap\\_1.pdf](https://www.genevaassociation.org/sites/default/files/research-topics-document-type/pdf_public/ga2014-the_global_insurance_protection_gap_1.pdf).

The risk protection gap definition identifies the extent to which insurance is not providing protection for potentially insured losses. The definition's principal advantage is that it is relatively easy to calculate, at both the individual and the societal levels. After a natural disaster, for example, government and private entities can readily estimate the losses caused and the amount of insurance paid; the difference between the two is the risk protection gap.

The insurance protection gap definition introduces an important normative element, focusing attention on the kind of insurance that should be provided and not just the kind of insurance that is in place. Losses derive from risks, but insurance is only one way of addressing risk, and often not the only way or the best way. For some risks, control, mitigation, or retention may be superior to insurance.<sup>2</sup> For other risks, insurance may be unavailable at a price that potential insureds are willing or able to pay. The insurance protection gap definition forces attention to the process of evaluating particular types of insurance or insurance coverage decisions, because it takes account of the beneficial role of insurance in some circumstances and its limited role in other circumstances.

But the insurance protection gap definition is incomplete in two respects. First, the definition most often is used to assess the adequacy of amounts of insurance in place for a region after a natural disaster or otherwise for a class of actual or potential insureds. This macro level obviously is important, but the concept of a protection gap also can be used more narrowly, to determine whether a particular policyholder suffers from a protection gap or whether one insurance policy creates a greater protection gap relative to another policy of the same type.

Second, the insurance protection gap definition suggests that for a defined type of risk, there exists an optimal level of insurance that is "economically beneficial." That is not necessarily true, either for individual

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On the protection gap in general, *see id.*; The Geneva Association, *Understanding and Addressing Global Insurance Protection Gaps* (2018),

[https://www.genevaassociation.org/sites/default/files/research-topics-document-type/pdf\\_public/understanding\\_and\\_addressing\\_global\\_insurance\\_protection\\_gaps.pdf](https://www.genevaassociation.org/sites/default/files/research-topics-document-type/pdf_public/understanding_and_addressing_global_insurance_protection_gaps.pdf); Bermuda:Re+ILS, *The Protection Gap* (2017), [https://axaxl.com/-/media/axaxl/files/pdfs/fff/2017/xlcatlin\\_protection\\_gap\\_2017.pdf](https://axaxl.com/-/media/axaxl/files/pdfs/fff/2017/xlcatlin_protection_gap_2017.pdf); Lloyd's, *A World at Risk: Closing the Insurance Gap* (2018). The concept of a protection gap is widely used, often in less precise ways. *See, e.g.,* ROB GALBRAITH, *THE END OF INSURANCE AS WE KNOW IT* 60–61 (2018).

<sup>2</sup> GEORGE E. REJDA, *PRINCIPLES OF RISK MANAGEMENT AND INSURANCE* 12–15 (11th ed. 2011).

policyholders or for society as a whole. The purchase of insurance is a response to risk aversion;<sup>3</sup> a person or firm incurs a small, certain loss—the insurance premium—to protect against an uncertain but potentially larger loss. The insurance transaction is economically beneficial because the purchaser protects against a loss that it might otherwise be unable to bear at all, or only by using funds that would be more advantageously spent elsewhere. Individuals and entities have different levels of risk aversion and different underlying financial conditions, however, that enable, prevent, or dispose them in the decision of whether to purchase insurance and, if so, how much of what kind. Therefore, it is impossible to determine, in the abstract, what level of insurance is economically beneficial.

Moreover, insurance provides social benefits and costs that are not effectively captured in the assessment of how much insurance is socially beneficial. The social benefits of insurance include the aggregation of individual economic benefits, capital accumulation that becomes a source of investment funds, the production of knowledge about risks and the use of that knowledge to reduce losses, other loss reduction through the regulatory function of insurance, and forms of redistribution and social responsibility.<sup>4</sup> Insurance also has social costs, notably the transaction costs of conducting the insurance enterprise and potential discriminatory effects of the availability and cost of insurance. Measuring and weighing the costs and benefits in order to determine the economically beneficial level of insurance is a Herculean task at best.

Even more important, focusing only on the economic benefits of insurance misses a large part of the nature of insurance, particularly when the focus shifts from the societal level to the situation of individual policyholders. The idea of insurance that is economically beneficial focuses on insurance as a financial transaction of risk transfer entered into by an economically rational policyholder. That does not fully capture the nature of insurance for many policyholders, as a socially constructed relationship of security, taking into account factors other than a stylized account of economic rationality. The relationship between insurer and policyholder is a relational contract, constituted in part by the written policy and in part by broader understandings and expectations created by insurance company advertising, consumer expectations, and social norms, and the relationship is situated in a system of relationships among insurers, policyholders, financial

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<sup>3</sup> TOM BAKER & KYLE D. LOGUE, *INSURANCE LAW AND POLICY* 3–4 (3rd ed. 2013).

<sup>4</sup> *Id.* at 14–24.

institutions, tort victims, and society at large. For the individual policyholder, the relationship yields a sense of security that is not captured in the economic effects of the transfer of financial risk. Therefore, the insurance relationship has value and meaning beyond its portrayal as an economic transaction.<sup>5</sup>

A full definition of the protection gap accordingly needs to be context-sensitive and useful in assessing protection gaps at the macro and micro level, and it needs to take into account economic and noneconomic understandings of the insurance relationship:

In a particular context, the protection gap is the difference between the amount of insurance that is in place and the amount of insurance that should be in place.

The key term in this definition, to define the baseline of how much insurance “should be” in place, is of course vague in the extreme.<sup>6</sup> By contrast, the easy step is to determine how much insurance is in place, either prospectively or relative to a loss that has occurred. Here are the steps to filling out the determination of how much insurance “should be” in place:

First, the insurance must relate to a defined class of potential insureds and the context in which they are situated.

Second, in a developed insurance market, the insurance should accord with policyholders’ reasonable expectations about the type of insurance at issue. Policyholders have general expectations, often indistinct, about the protection and security their insurance provides. Actual expectations are not the whole point; expectations must be reasonable as

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<sup>5</sup> REJDA, *supra* note 2, at 30–31; see Jay M. Feinman, *Contract and Claim in Insurance Law*, 25 CONN. INS. L.J. 153, 161–66 (2018); 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, 556–59 (2009).

<sup>6</sup> In a recent article in this journal, Kenneth Abraham rejects the concept of a protection gap. Kenneth S. Abraham, *“Incomplete” Insurance Coverage*, 26 CONN. INS. L.J. 116. “[T]he notions of a ‘gap’ in coverage and ‘incomplete’ coverage tend not to be helpful.” As to the definition of a protection gap, Abraham concludes:

Finally, a very different baseline for determining whether a policy contains a gap in coverage could be the optimal set of coverages that a policy of that type would contain. Unfortunately, however, although this baseline is superior in principle to the other possible baselines, it is impractical in the extreme, for a number of reasons.

well, which involves many of the other factors about what insurance should be provided.

Third, the risks must be insurable: calculable, non-correlated, and offered at a price that covers all costs and produces adequate demand.<sup>7</sup>

Fourth, the insurance must avoid problems that would undermine the viability of the insurance pool: moral hazard, adverse selection, improper risk segmentation, and high transaction costs.

Fifth, the insurance must provide positive social effects. In the case of a natural disaster, for example, whether homeowners in a community have adequate insurance to rebuild has important consequences for local businesses and the community as a whole. Similarly, whether their insurance has been priced to provide incentives for risk mitigation before the disaster occurs will influence the level of economic consequences for the community.

## II. DEFINING THE BASELINE

The concept of a protection gap is complicated. There are easy examples. The paradigm case of a protection gap at the individual level arises when a typical potential insured does not have insurance that is readily available, reasonably priced, easily understood, economically rational given their level of risk preference, and socially beneficial; at the societal level, the paradigm cases involves many such potential insureds. Low take-up rates for federal flood insurance in high-risk areas and the purchase of inadequate policy limits under replacement cost homeowners insurance policies are common examples.<sup>8</sup> But beyond those examples, the application of the definition to a particular issue can be contestable. Moreover, the definition of the baseline against which a protection gap is measured cannot easily be separated from the causes and consequences of protection gaps, and those causes and consequences need to be considered in describing instances of protection gaps and cures for them.<sup>9</sup>

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<sup>7</sup> The third and fourth elements, and to an extent the fifth element, are discussed in REJDA, *supra* note 2, at 22–24, 30–33; BAKER & LOGUE, *supra* note 3, at 4–13; Mark Geistfeld, *Interpreting the Rules of Insurance Contract Interpretation*, 68 RUTGERS U.L. REV. 371 (2015).

<sup>8</sup> See *infra* text accompanying notes 54, 58.

<sup>9</sup> The Geneva Ass'n, *Managing Physical Climate Risk: Leveraging Innovations in Catastrophe Risk Modelling* (2018), at 25–31; The Geneva Ass'n, *The Global Insurance Protection Gap: Assessment and Recommendations* 7 (2014), at 33–38;

The first step in defining the baseline is to describe the particular insurance context in which the gap is to be measured, such as typical homeowners insurance, life insurance for middle-income wage earners, or general liability insurance for small- to medium-sized businesses. Within each context, policyholders have expectations of coverage, and those expectations are the starting point to determine how much insurance should be provided in the context. But policyholder expectations are only the beginning. Policyholders may expect maximal coverage, but their expectations may be unreasonable because of factors that limit the insurability of risks or that would undermine the operation of the insurance mechanism.<sup>10</sup> Insurability issues are the extent to which the risks are calculable, noncorrelated, and capable of being priced at a level that policyholders will pay. Effectiveness issues are moral hazard, adverse selection, risk segmentation, and transaction costs. Finally, the social effects of the insurance, positive and negative need to be considered. The process involves balancing, of course.

#### A. THE TYPE AND CONTEXT OF INSURANCE

In the abstract, many potential insureds are subject to protection gaps because they lack insurance coverage for losses that occur. But the economics of risk spreading, the social construction of an insurable risk, and the path-dependence of types of insurance that ordinarily are available limit the potential contexts in which a protection gap usefully can be analyzed. A protection gap is always defined with reference to a particular context and a

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Jay M. Feinman, *The Protection Gap in Homeowners Insurance: An Introduction* 8–9.

<sup>10</sup> A dramatic recent example involves the disputes over business interruption insurance claims by businesses in the COVID-19 pandemic. Many business owners professed an expectation of coverage for lost business income when their businesses were forced to close. As expressed by President Trump, “You have people that have never asked for business-interruption insurance and they have been paying a lot of money for a lot of years for the privilege of having it and then when they finally need it, the insurance company says ‘We’re not going to give it,’” *Trump Tells Insurers to Pay Virus Claims If Pandemics Not Excluded*, INS. J. (Apr. 14, 2020), <https://www.insurancejournal.com/news/national/2020/04/14/564744.htm>.

Insurers, on the other hand, argued that the policyholders’ expectation of coverage was unreasonable for two reasons: as a matter of application of policy language, which sometimes contained a virus exclusion and generally required loss of or damage to property as a triggering event and, more generally, because losses in a pandemic were the most extreme example of an uninsurable risk.



particular type of insurance that now exists. The Geneva Association definitions, for example are pragmatic in measuring protection gaps against baselines of types of insurance that currently are widely available, such as different types of disaster insurance;<sup>11</sup> filling the gap would involve providing more insurance, not different insurance.<sup>12</sup>

The first step in considering context is to define the concept of an insurable loss. What constitutes an insurable loss is a constructed concept, of course. When a fire destroys a home, for example, the owner may incur a variety of losses, including:

1. the cost of rebuilding the dwelling,
2. the cost of replacing personal property such as clothes and furniture,
3. additional living expense while the home is being rebuilt,
4. time lost to work,
5. time lost to family, community, or social activities that now must be spent on the insurance claim and rebuilding process,
6. the loss of irreplaceable personal items such as family photographs, and emotional distress.
7. In addition, there are what might be thought of as secondary losses suffered by persons or groups other than the homeowner:
8. If the homeowner ordinarily would have a weekly house cleaner, the cleaner suffers a loss of income while the house is under repair.
9. If the homeowner usually coaches a Little League team but lacks the time to do so due to the demands of repair, the organization and its participants suffer a real if immeasurable loss.

Items 1–4 are measurable economic losses, but items 5–9 are also real losses. Item 8 conceivably could be covered by contingent business interruption insurance but in the overwhelming majority of cases it will not

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<sup>11</sup> The Geneva Ass'n, *Managing Physical Climate Risk: Leveraging Innovations in Catastrophe Risk Modelling* (2018), at 5, 14–15.

<sup>12</sup> The Geneva Ass'n, *The Global Insurance Protection Gap: Assessment and Recommendations* 7 (2014) at 7, 13.

be. But only 1, 2, and 3 are generally regarded as insurable losses that would figure into most definitions of a protection gap. This is for practical reasons; in measuring the protection gap, the baseline is limited to losses that could be covered by the kind of insurance that is readily available or, by modest extension of existing types of coverage, could be available.<sup>13</sup> The kind of insurance that is or could be available is partly a product of history and partly a product of the nature of insurable risks.<sup>14</sup> Many risks covered by the modern homeowners policy result from a process of accretion, as more and more perils were added to policies that originally covered only losses by fire.<sup>15</sup> The reasons that some type of losses are not covered by homeowners insurance—time lost to community activities or emotional distress, for example—rest in the limits of insurance discussed in later sections, such as not being readily calculable.

To begin to define the baseline, we could think of the homeowner as an instance of the class of homeowners facing property losses and their cleaning person as a potential insured under a contingent business interruption policy. However, there is no available insurance for the Little League that loses the time of a coach, so that is not relevant to the definition of a protection gap.

Depending on the level at which the analysis is aimed and the purpose for which the definition is employed, the context may need to be more narrowly defined. “Homeowner” and “business potentially subject to loss of income” are categories that are sufficient for some purposes but not others. For example, if the goal is to determine the extent to which homeowners are protected against disaster or businesses against shutdowns due to a pandemic, the broad contexts may be useful. In other situations, these contexts need to be narrowed. The means of narrowing the category are related to the concept of the policyholder’s reasonable expectations discussed in the next section, but as a start, consider the ways in which a group of insureds or potential insureds seems to cohere and to be distinguished from other groups. Thus, middle-class homeowners insured under typical replacement cost policies belong to a different group than owners of luxury vacation homes insured under specially procured policies

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<sup>13</sup> This is measuring from the top down—insurance that could be but is not provided—rather than from the bottom up—losses that could be insured. Thanks to Steve Figlin for the insight.

<sup>14</sup> Abraham, *supra* note 6, at 118.

<sup>15</sup> Harold Weston, *À la Carte Coverage: Unbundling Causes of Losses and Coverage Grants to Allow Consumer-Insured Selection*, 11 RUTGERS J. L. & PUB. POL’Y 38, 42–51 (2013).

with numerous endorsements, or homeowners with more limited dwelling fire policies ordinarily used to insure rental houses. An individual house cleaner who may be entirely uninsured is different than a franchised housecleaning service that might have business interruption insurance. The protection gap concept applies to any context once it is defined; the examples in this article are drawn from the typical homeowners policy context.

#### B. POLICYHOLDERS' REASONABLE EXPECTATIONS

In insurance law, the reasonable expectations doctrine arises most often in disputes about the meaning and operation of policy language.<sup>16</sup> A claim potentially covered by the policy arises; the insurer asserts that the language of the policy denies coverage, while the policyholder asserts that the language should be understood, supplemented, or even overcome by the policyholder's own reasonable understanding of the language. Once regarded as a potential challenger to traditional interpretation rules, reasonable expectations as a doctrine today is not regarded as particularly robust.

The importance of reasonable expectations in defining protection gaps is different. The issue is not interpreting the language of an insurance policy but determining reasonable expectations as a basis for a normative consideration in finding the level of insurance that should be in force.<sup>17</sup> In that sense, reasonable expectations may be regarded not as a doctrine but as a principle that animates rules of insurance law and of contract law more generally. According to Corbin's magisterial contracts treatise, the "main purpose of contract law [is] the protection of reasonable expectations."<sup>18</sup> In insurance law, this is further development of an idea first suggested by Kenneth Abraham, building on work by Robert Keeton, twenty years ago:

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<sup>16</sup> ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 142–51 (5th ed. 2012).

<sup>17</sup> Abraham, *supra* note 6, at 139 (rejecting the concept of reasonable expectations in contexts because "the scope of coverage that is optimal for one policyholder is not necessarily optimal for others.").

<sup>18</sup> ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS § 1, at 2 (one vol. ed. 1952). For Corbin the principle was "the realization of reasonable expectations that have been *induced by the making of a promise*" *Id.* (emphasis added). The latter phrase does not capture all of my analysis. See Jay M. Feinman, *Good Faith and Reasonable Expectations*, 67 ARK. L. REV. 525 (2014).

As a regulative ideal, the expectations principle reflects an elegantly simple notion, which is why the principle serves so powerful an ideal. This is the notion that people should be able to buy the insurance that they reasonably want. Accompanying this notion is a corollary: people should not be led to believe that they have the insurance they reasonably want, when in fact they do not have that insurance. Since both the principle and the corollary refer to *reasonable* expectations of coverage, these are for the most part statements about the expectations of the vast majority of policyholders, not of isolated individuals. An expectation of coverage is most likely to be reasonable, after all, if a large number of people hold it in common. Indeed, most expectations of coverage held by the vast majority of policyholders are reasonable, and most expectations that are not held by the vast majority of policyholders are not reasonable.

Thus, taken together, the expectations principle and its corollary constitute a normative statement about the proper relation between the supply side of the insurance market and the demand side of the market.<sup>19</sup>

In the context used as an example in this article, the reasonable expectations principle reflects a particular conception of the insurance relationship appropriate to the context of the homeowners insurance. For the prototypical member of the class of policyholders under a replacement cost homeowners insurance policy, the relationship between the insurer and its policyholder is not fully described by the terms of the policy. The insurance policy involves minimal planning and choice 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. The policyholder, rather than agreeing to the detailed terms, invests in a relationship of security, a relationship that is formally created by the policy but that is socially constructed and promoted by insurers as a group.<sup>20</sup> For the policyholder the insurance policy has value prior to loss because it

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<sup>19</sup> Kenneth S. Abraham, *The Expectations Principle as a Regulative Ideal*, 5 CONN. INS. L.J. 60, 63–64 (1998). Abraham built on Robert Keeton's earlier identification of reasonable expectations as a doctrine and principle. *Id.* at 65.

<sup>20</sup> Feinman, *Contract and Claim in Insurance Law*, 25 CONN. INS. L.J. 153, 162–66 (2018)

provides this expectation of security. The reasonable policyholder understands that relationship does not guarantee coverage for every conceivable loss, but the policyholder has a legitimate expectation of broad coverage.<sup>21</sup>

Reasonable expectations begin with actual expectations, which Abraham defines as the “expectations of the vast majority of policyholders.”<sup>22</sup> Individual policyholders also may have unique expectations about coverage, but reasonable expectations focus on the general expectations of the class, not those unique expectations.<sup>23</sup>

Surprisingly little research exists on policyholders’ actual expectations about coverage. The studies that do exist show that homeowners understand some of the basics of homeowners insurance coverage, but they have significant gaps in knowledge, and they often believe they have more coverage than policies actually provide. For example, an Insurance Information Institute survey found that ninety-one percent of homeowners knew they were protected for fire damage and seventy-nine percent for theft from the house.<sup>24</sup> But homeowners often believe that homeowners insurance covers catastrophic losses that in fact are uniformly excluded. A survey by Allstate concluded that sixty-one percent of homeowners believed that flood damage was covered,<sup>25</sup> as did fifty-six percent of respondents in a survey for insuranceQuotes.com,<sup>26</sup> an NAIC survey found that fifty-one percent either believed that flood damage was covered or were not sure, and a survey by Zogby International concluded

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<sup>21</sup> Cf. Abraham, *supra* note 6, at 120 (“[S]ome omissions from coverage under certain kinds of policies would be surprising, based on the kind of policy involved.”).

<sup>22</sup> Abraham, *supra* note 19, at 63.

<sup>23</sup> Millar v. State Farm Fire & Cas. Co., 804 P.2d 822, 826 (Ariz. Ct. App. 1990) (“[T]he reasonable expectation concept must be limited by something more than the fervent hope usually engendered by loss. (citation omitted) Thus, a plaintiff’s expectation of coverage must be objectively reasonable.”).

<sup>24</sup> Ins. Info. Inst., *2016 Consumer Insurance Survey Homeowners Insurance: Understanding, Attitudes and Shopping Practices* (Feb. 2017), <https://www.iii.org/sites/default/files/docs/pdf/pulse-wp-020217-final.pdf>.

<sup>25</sup> *Do You Know What Your Insurance Covers?*, Allstate (Nov. 2015), <https://www.allstate.com/tr/insurance-basics/what-insurance-covers-infographic.aspx>.

<sup>26</sup> *Survey: Majority of Americans Mistakenly Believe That a Standard Home Insurance Policy Covers Flood Damage*, Ins. Quotes (Apr. 6, 2017), <https://www.insurancequotes.com/press-room/home-renters-insurance-misconceptions>.

that twenty-eight percent incorrectly believed they were covered for earthquake damage and an equal amount weren't sure.<sup>27</sup>

Therefore, in the absence of more reliable data, policyholders' expectations about coverage can first be described as a diffuse expectation of broad coverage. That expectation reflects the social understanding of the role of insurance as protector of financial security and is powerfully shaped by insurance company advertising. The iconic slogans of insurance company advertising have expressed that understanding, and they continue to do so: "Like a good neighbor, State Farm is there" and, more recently, "Here to make life go right." "You're in good hands with Allstate" and now, "Better protected from mayhem."

More specifically, here are a set of propositions about policyholders' expectations of homeowners insurance coverage. More research would be needed to validate the propositions empirically, and they may be subject to qualification, but they are at base inarguable.

- Coverage is provided for common causes of significant accidental loss.
- Coverage is particularly important to protect against large financial losses (the large-loss principle).
- Broad coverage is provided for covered losses, subject to the stated general deductible, without obscure limitations or exclusions.
- In interpreting terms of coverage and resolving claims, insurers will act consistently with the relation of security and in the insureds' interests, as long as it is reasonable to do so consistent with insurers' obligation to the pool of insureds.

Further, because of the prevalence of mortgage lender requirements and the limitation of the class to replacement cost policies in the homeowners insurance marketplace, there are additional features:

- Insurance that is required by lenders or mortgage guarantors is adequate to meet those parties' requirements.

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<sup>27</sup> *Homeowners Coverage Knowledge Gap Wide*  
*Among Consumers, INS. J. (Aug. 24, 2010),*  
<https://www.insurancejournal.com/news/national/2010/08/24/112704.htm>.

- In a replacement cost policy, coverage is provided for complete repair of damage or restoration of property, subject to the general deductible.

Finally, because of the ways policies are advertised and represented in the insurance marketplace:

- Coverage is related to price and description of policies. In comparing policies, higher-priced policies and policies with names such as “Gold Star Special Deluxe Form” provide much better coverage than cheaper or “Special” policies.<sup>28</sup>

Policyholder expectations of coverage are the starting point to determine how much insurance should be provided in the context. But as noted, actual expectations are only the beginning. Only reasonable expectations are relevant, constructed as what insurance the reasonable policyholder would purchase, or, put another way, what the reasonable policyholder in the relevant class believes they have purchased. Factors that limit the insurability of risks or that otherwise affect the operation of the insurance mechanism need to be considered as well.

### C. INSURABLE RISKS

Some risks or losses are less insurable on economic terms than others, and some may even be uninsurable. At its best, insurance embodies an economic logic based on the law of large numbers that permits the transfer and pooling of risk and therefore the potential for coverage.<sup>29</sup> In defining the

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<sup>28</sup> See *Homeowners Policies*, MO. DEPT. OF INSURANCE, [https://insurance.mo.gov/consumers/home/homeowners\\_policies.php](https://insurance.mo.gov/consumers/home/homeowners_policies.php) (last visited Feb. 23, 2021).

<sup>29</sup> The insurance and society literature demonstrates that insurance often does not operate in this way, so that insurers’ decisions sometimes move, “beyond the domain of risk (where uncertain individual losses become predictable in the aggregate) into the domain of uncertainty (where losses are not predictable even in the aggregate).” Tom Baker, *Uncertainty > Risk: Lessons for Legal Thought from the Insurance Runoff Market* (Sept. 20, 2020), <https://ssrn.com/abstract=3532449>. See also Sean M. Fitzpatrick, *Fear is the Key: A Behavioral Guide to Underwriting Cycles*, 10 CONN. INS. L.J. 255, at n.29 (2004). For present purposes, the ideal type

amount of insurance that should be in force as a baseline for measuring the protection gap, the extent to which a risk is insurable needs to be evaluated. Three factors are relevant: The risk should be calculable and non-correlated, and it should link cost, price, and demand.<sup>30</sup> Typically the question is not whether a risk is insurable or uninsurable, but the extent to which these factors need to be balanced against other considerations in defining the baseline against which the protection gap is measured.

First, the probability and magnitude of loss must be calculable. For an insurer to calculate the cost of coverage, it must be able to predict with reasonable accuracy how likely it is that a risk will cause a loss and how large that loss is likely to be.<sup>31</sup> Most of the risks addressed by a typical homeowners policy are calculable, whether they are covered or excluded.<sup>32</sup> There are a large number of similar exposures (single-family dwellings), losses are determinable and measurable (the cost to repair), and the chance of loss is predictable (the proportion of dwellings likely to suffer losses of specified kinds within a year).

Second, the risk of loss for each policyholder must be substantially independent of the risk for other policyholders.<sup>33</sup> The law of large numbers works only when relatively few policyholders in a large pool suffer similar losses in given period. If instead many policyholders are likely to suffer similar losses at the same time, then the pool and the insurer can less effectively distribute the risk. The risk that a home will be destroyed by an accidental electrical fire is independent of the risk of similar losses to other homes, and so is readily insurable. Destruction by wildfire in risk-prone areas of California presents a much greater correlated risk, which is why some insurers have ceased offering such coverage.

Third, and often related, premiums must be economically feasible.<sup>34</sup> Insurers need to price their products at a level that will produce premiums sufficient to pay for the losses and for the other expenses of operating the

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of insurance is sufficient, in that it is harder to argue the existence of a protection gap in the absence of a relatively determinate risk calculation.

<sup>30</sup> The discussion focuses on the economics of insurance in general. In particular cases, business or regulatory considerations also may render a risk uninsurable. See GALBRAITH, *supra* note 1, at 127.

<sup>31</sup> REJDA, *supra* note 2 at 22–25.

<sup>32</sup> Only some of the exclusions suggest less calculable risks, such as loss caused by “[s]moke from agricultural smudging or industrial operations.” ISO, HOMEOWNERS 3 – SPECIAL FORM, HO 00 03 10 00 (1999) —Perils Insured Against, A.2.c.(6)(d).

<sup>33</sup> REJDA, *supra* note 2, at 23–24.

<sup>34</sup> REJDA, *supra* note 2, at 24.



enterprise and to produce a profit, but the premiums also must be low enough so that many potential policyholders are able and willing to pay them.<sup>35</sup>

#### D. OTHER EFFECTIVENESS ISSUES

Even risks that are economically insurable cannot always be effectively insured. Four other factors should be considered in determining the effective provision of coverage: moral hazard, adverse selection, risk segmentation, and transaction costs. In particular contexts, the application of the factors might suggest that the baseline against which the protection gap is measured should not include some elements of insurance.

*Moral hazard* arises when the presence of insurance decreases an insured's incentive to protect against a loss or to reduce the cost of a loss.<sup>36</sup> The failure of an insured to make a cost-effective expenditure to avoid or reduce the cost of a risk imposes higher costs on the pool of insureds. Insurance is less effective when it creates a significant moral hazard.

In many instances in homeowners insurance, the insured's tendency toward moral hazard *ex ante* is mitigated by the consequences of loss despite the presence of insurance; a homeowner who is fully insured against loss still is not likely to be indifferent to the possibility of fire and so less inclined to take precautions. Insurers employ a number of measures to control moral hazard; in terms of coverage, these efforts may include deductibles, coinsurance terms, policy limits, and specific limitations and exclusions. The specific limitations and exclusions require distinct justification. For example, the common exclusion for wear and tear aims to prevent the moral hazard of failing to protect against a loss caused by ordinary deterioration. The post-loss requirement that an insured act reasonably to prevent further damage is justified as an attempt to prevent the moral hazard of failing to reduce the cost of a loss *ex post*.

*Adverse selection* refers to the potential for higher-risk policyholders to seek more coverage than lower-risk policyholders.<sup>37</sup> Because premiums are not finely tuned to the risk profile of each policyholder, lower-risk

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<sup>35</sup> *Id.*

<sup>36</sup> BAKER & LOGUE, *supra* note 3, at 6. Sometimes "moral hazard" is distinguished from "morale hazard," with the former referring to dishonesty and the latter carelessness that each can increase the frequency or severity of a loss, but there is little meaningful difference in effect in most contexts. *See also* REJDA, *supra* note 2, at 5–6.

<sup>37</sup> BAKER & LOGUE, *supra* note 3, at 12; REJDA, *supra* note 2, at 26, 111.

policyholders subsidize the losses of higher-risk policyholders and, in extreme cases, the increase in premiums may even cause the lower-risk policyholders to drop out of the insurance pool.

At least in the homeowners insurance context, adverse selection as a general problem may be more theoretical than real; practically all homeowners are required to purchase insurance, and the more common phenomenon may be propitious selection—better risks are likely to purchase more and better insurance.<sup>38</sup> But at the extreme and with respect to certain coverage provisions, adverse selection can be a problem. Flood insurance presents the problem of large, correlated losses, but also adverse selection; property owners at higher flood risk are more likely to insure than those at lower risk. How large a problem adverse selection is depends on insurers' ability to engage in accurate underwriting and pricing of policies; risk classification and pricing are justified in part by the desire to charge prices that limit adverse selection.

*Risk segmentation* is the process of assigning different risks to different forms of insurance.<sup>39</sup> Risk segmentation sometimes simply reflects the history of the way that policies have been constructed and reconstructed over time.<sup>40</sup> In other circumstances it may reflect an attempt to address adverse selection; segmenting risks avoids the need and expense of engaging in more extensive underwriting with respect to a risk carved out of one policy and covered in another, such as the exclusion of earthquake coverage in the basic homeowners policy.<sup>41</sup> Or it may make the provision of a general type of insurance more economically feasible by excluding coverage not needed by a typical insured.<sup>42</sup>

In the realm of homeowners insurance, risks are segmented by the type of property insured (e.g., car vs. home, property used for business vs. domestic property) and the type of risk (e.g., fire vs. flood). Where coverage commonly is available and purchased under other policies, there is less need to include the risk under a homeowners policy. Where coverage is otherwise unavailable or hard to procure and the risk is substantial and should be covered, there is more reason to include coverage under the homeowners

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<sup>38</sup> BAKER & LOGUE, *supra* note 3, at 13.

<sup>39</sup> BAKER & LOGUE, *supra* note 3, at 440 (“market segmentation”); Adam F. Scales, *A Nation of Policyholders: Governmental and Market Failure in Flood Insurance*, 26 MISS. COLL. L. REV. 3, 22 (2006).

<sup>40</sup> Abraham, *supra* note 6, at 118–121 (discussing bundling and fragmenting coverage).

<sup>41</sup> Abraham, *supra* note 6, at 122, 123 nn. 20–21.

<sup>42</sup> REJDA, *supra* note 2, at 196.

policy. Similarly, segmentation also can occur through the offer of endorsements to a standard policy, such as endorsements that provide coverage for property loss or liability arising out of substantial business use of the premises. Endorsements should not be a substitute for basic elements of coverage under a standard policy, but where an endorsement is broadly available, reasonably priced, commonly offered, and well understood, it can reduce the need for coverage under the basic policy.

*Transaction costs* arise in the underwriting process or in the process of determining whether a loss is covered—investigating the underlying facts and applying the policy language to the facts. Ordinarily the scale of the transaction costs relative to the amount of loss is acceptable even if not minimal. However, there may be some cases in which a particular coverage term generates such high transaction costs in a large number of cases that render the term so expensive as to be unworkable.

#### E. SOCIAL EFFECTS

Homeowners insurance is a private market transaction, but one that is constituted and regulated by public authority and endowed with a significant public interest. Therefore, social effects merit consideration in the determination of how much insurance should be provided.

Insurance as an institution has broad social effects, from the generation of knowledge about risk and means of reducing it to capital accumulation, but the inquiry here is narrower. Many of the desirable social effects of coverage terms are built into the earlier elements of the analysis. Policy terms that reduce moral hazard, for example, can lead to socially efficient risk reduction as homeowners invest in risk prevention measures. But there are at least three related social impacts of insurance that are particularly important in determining a baseline for the protection gap.

First, homeowners insurance provides security to the policyholder against significant losses, and it also provides a safety net for communities against the economic and social dislocation that follows from property losses. This is most apparent in large-scale disasters, when insurance provides funds for rebuilding areas that otherwise would be devastated economically and socially. But even when a single homeowner suffers a major property loss, the effects can ripple throughout a community.

Second, fostering homeownership is a public policy goal in the United States,<sup>43</sup> and insurance supports that goal. Loan guarantee programs, tax incentives, and other government measures support the goal of homeownership, and insurance protects the private and public investment in a home.

Third, insurance potentially is an expression of community and solidarity as well as an economic form of risk transfer. To the extent that premiums are not individualized, insurance embodies a sense of collective responsibility for the losses of all members of an insurance pool. Beyond the economics of the transaction, homeowners insurance can be understood as a coming-together of members of a community to pool their resources for the protection of all.

These social effects do not suggest that maximal coverage always is desirable. In assessing the desirability of terms of coverage, however, social effects do factor into the construction of terms that cover large losses which otherwise could have broad social impacts and could undermine the goals of homeownership and solidarity.

### III. EXAMPLES OF PROTECTION GAPS

The definition of a protection gap developed here addresses the difference between the amount of insurance that is in place and the amount of insurance that should be in place, in individual cases or in a group, relating to a defined insurance context. The amount of insurance that “should” be in place accords with policyholders’ reasonable expectations. The reasonableness of those expectations requires that the risks covered must be insurable and the coverage must be economically feasible, that problems that would undermine the viability of the insurance be controlled, and that the social effects of the insurance be taken into account.

Once the baseline in a particular context is established against which a protection gap can be measured, it becomes possible to identify significant protection gaps, in individual cases and as a class. Protection gaps take several forms:

- Entirely uninsured. A property owner lacks insurance for all risks, or all property owners are uninsured with respect to a risk.

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<sup>43</sup> See, e.g., U.S. DEP’T OF HOUS. & URBAN DEV., HOMEOWNERSHIP: PROGRESS AND WORK REMAINING 1 (2000) (“Making homeownership more attainable has always been a goal . . .”).

- Underinsured. A policyholder has coverage against relevant risks, or the class of policyholders generally have coverage, but in an amount that is less than the extent of actual or potential losses (the underinsurance gap).
- A policyholder is insured for some risks, or the class of policyholders generally have coverage, but certain other significant risks are not covered (the risk protection gap).
- A policyholder is insured for some risks, or the class of policyholders generally is insured, and the risk resulting in loss generally is covered, but coverage is subject to other limitations. That is, limitations or restrictions in the insurance policy other than the exclusion of property or risks prevent full coverage for actual or potential losses (the coverage gap).
- The insurance in place potentially covers risks and losses, but factors in the claim process result in a failure to pay fully for an individual policyholder or for the class of policyholders (the claiming gap).

To illustrate the application of the baseline, this section briefly discusses examples of the underinsurance gap, the risk protection gap, and the coverage gap in the context of the prototypical residential homeowner. The protection gap created where policyholders are entirely uninsured or by the claiming gap needs only brief mention.

Much of the protection gap literature addresses the problem in developing economies, where a large portion of the gap may arise because of the unavailability of insurance.<sup>44</sup> The situation in developed economies with mature insurance markets is different, so only about five percent of U.S. homes are entirely uninsured.<sup>45</sup> In part this is driven by the requirements of mortgage lenders and the federal mortgage programs, which require

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<sup>44</sup> See, e.g., THE GENEVA ASS'N, *Managing Physical Climate Risk: Leveraging Innovations in Catastrophe Risk Modelling*, at 6, 10 (2018).

<sup>45</sup> Ins. Info. Inst., *How Many Homes are Insured? How Many are Uninsured?*, THE TRIPLE-I BLOG (Jan. 29, 2016), <https://www.iii.org/insuranceindustryblog/how-many-homes-are-insured-how-many-are-uninsured/>.

insurance.<sup>46</sup> In some cases, however, insurance may be unavailable for some property owners. Risk factors such as a history of recurring high-value claims or unusual hazards, for example, may make an individual home uninsurable.<sup>47</sup> More commonly, when special factors make insurance generally unavailable in an area, regulatory or legislative action typically follows. In many cases, a property that is uninsurable in the ordinary private market may be eligible for insurance under a state's residual market mechanism, such as a FAIR plan, or in the surplus lines market. After the California wildfires of 2015–2017, insurers have been less willing to write new policies or offer renewals in areas prone to wildfire,<sup>48</sup> but proposals to expand the market soon followed.<sup>49</sup>

Under any of the definitions of the protection gap, the assumption is that the amount of insured losses is relatively fixed, and that coverage under a policy equates to payment if there is a loss. But even where coverage is in place, there are factors in the claim process that can result in the failure to pay and therefore in a claiming gap type of protection gap.

On the policyholder side, the factors are captured in the well-known concept of the dispute pyramid.<sup>50</sup> Of all covered losses (the base of the pyramid), only some are actually paid, due to filters that cause the pyramid to narrow as losses proceed through the process to eventual payment of a smaller number of claims at the top of the pyramid. Policyholders first must recognize they have a covered claim. If they contact their insurer and the insurer incorrectly responds that the claim is not covered, or if the insurer offers an amount in settlement lower than the amount to which the

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<sup>46</sup> Fannie Mae, *Selling Guide*, at B7-3-02 (Sept. 2, 2020), <https://selling-guide.fanniemae.com/Selling-Guide/Origination-thru-Closing/#Coverage.20Requirements>.

<sup>47</sup> *What if I Can't Get Coverage?*, INSURANCE INFORMATION INSTITUTE, <https://www.iii.org/article/what-if-i-cant-get-coverage> (last visited Sept. 11, 2020); *What to Do if You Get Turned Down for Homeowner Insurance*, ALLSTATE (June 2020), <https://www.allstate.com/tr/home-insurance/high-risk-homeowners-insurance.aspx>.

<sup>48</sup> CAL. DEP'T OF INS., *THE AVAILABILITY AND AFFORDABILITY OF COVERAGE FOR WILDFIRE LOSS IN RESIDENTIAL PROPERTY INSURANCE IN THE WILDLAND-URBAN INTERFACE AND OTHER HIGH-RISK AREAS OF CALIFORNIA* 1 (2018).

<sup>49</sup> Don Jergler, *Backers of Controversial California Homeowners Insurance Bill Like Its Momentum, Timing*, INS. J. (June 17, 2020), <https://www.insurancejournal.com/news/west/2020/06/17/572626.htm>.

<sup>50</sup> William L.F. Felstiner, Richard L. Abel & Austin Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming . . .*, 15 L. & SOC'Y REV. 631, 631 (1980).

policyholder is entitled, they may defer to the insurer's expertise. If they are dissatisfied with the insurer's action, policyholders may not seek professional help. They may find the transaction costs of doing so are unjustified in small claims, or they may be willing to resolve claims for less than full value because of the financial and emotional toll of delay.

On the company side, failure to pay claims at less than full value may be due to bureaucracy, claims personnel's lack of knowledge of the terms of policies, or worse. The "worse" is the potential mismatch of incentives in an organization; customer service that aids reputation and retention are important, but so is the need to limit claim costs. If the claim process is perceived as a profit center, claims can be underpaid in ways large and small, incidental and institutional.<sup>51</sup>

#### A. THE UNDERINSURANCE GAP

Often policyholders have coverage but in dollar amounts that are less than the extent of actual or potential losses. Until the 1990s, guaranteed replacement cost coverage was the norm, ensuring that coverage would be available for the entire cost of rebuilding even in the case of a total loss.<sup>52</sup> Now it is the exception. As a result, most homes are insured for less than the cost to rebuild in the event of a total loss, because even replacement cost coverage is subject to policy limits that are likely to be too low. Three of every five homes in America are underinsured by an average of twenty percent less than full value, according to analytics firm CoreLogic, whose software is a widely used tool for estimating replacement cost.<sup>53</sup> Following the 2007 wildfires, the California Department of Insurance found that even though many homeowners bought coverage higher than the policy limit recommended by their insurer, more than half still were underinsured.<sup>54</sup> A

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<sup>51</sup> See generally JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 56–120 (2010).

<sup>52</sup> 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, 363 (2011).

<sup>53</sup> Ron Hurtibise, *Do you have enough homeowner insurance? Here's how to find out*, S. FLA. SUN SENTINEL (July 13, 2018), <https://www.sun-sentinel.com/business/fl-bz-do-you-have-enough-property-insurance-20180711-story.html>; Kenneth S. Klein, *Minding the Protection Gap: Resolving Unintended, Pervasive, Profound Homeowner Underinsurance*, 25 CONN. INS. L.J. 35, 42–43 (2018).

<sup>54</sup> Klein, *supra* note 53, at 40–41.

decade later the underinsurance gap was still substantial; a year after the North Bay wildfires in California, “66% of survey respondents . . . [knew] if they had enough insurance to cover the cost of repairing, replacing or rebuilding their home, reported being underinsured,” according to a United Policyholders survey.<sup>55</sup>

The underinsurance gap arises from a mix of information problems, underwriting issues, and mixed incentives. Although the homeowner nominally is responsible for arriving at a proper estimate of replacement cost and choosing appropriate policy limits, homeowners almost always rely on insurers’ own estimates.<sup>56</sup> Because of inadequacies in the software used to estimate costs, underinsurance often occurs.<sup>57</sup> The problem is complicated because homeowners, insurers, and insurance agents have one incentive to arrive at a proper estimate of value, so that there are sufficient funds to rebuild in case of loss. But they also have a contrary incentive to keep the premium low by undervaluing the property. In the price-dominated market for homeowners insurance, insurers and insurance producers have an incentive to understate the replacement cost and so offer a less expensive product, particularly because the error will never be revealed, as few policyholders ever suffer a total loss where the estimate is relevant.<sup>58</sup> Properties are even more likely to be undervalued if the loss occurs in a widespread disaster such as a wildfire, when the cost of repair or rebuilding usually rises dramatically because of demand surge—increased demand for a limited supply of labor and materials.

With respect to an individual homeowner and the class of homeowners, the failure to insure for full replacement cost almost always constitutes a true protection gap. First, a homeowner who purchases a policy that is described as “replacement cost” likely and reasonably expects that the insurance for a covered loss will be adequate to provide for complete repair of damage or restoration of property, subject only to the general deductible. Under the large-loss principle, coverage is particularly important to protect against large losses, and the shortfall from underinsurance is likely to be substantial, as the CoreLogic study found.<sup>59</sup>

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<sup>55</sup> *North Bay Fires – 12 Month Survey Results*, UNITED POLICYHOLDERS, [https://www.uphelp.org/sites/default/files/attachments/north\\_bay\\_fires\\_12\\_month\\_survey\\_report\\_v1.pdf](https://www.uphelp.org/sites/default/files/attachments/north_bay_fires_12_month_survey_report_v1.pdf) (last visited Sept. 5, 2020); Klein, *supra* note 53, at 48.

<sup>56</sup> Klein, *supra* note 53, at 56.

<sup>57</sup> See Klein, *supra* note 53, at 60–80.

<sup>58</sup> Klein, *supra* note 53, at 100.

<sup>59</sup> Sources cited at note 51.



Second, replacement cost is an insurable risk. The replacement cost is calculable. With basic information provided by the homeowner in the application process, the insurer can draw on a variety of sources of information to arrive at an accurate estimate of rebuilding.<sup>60</sup> The estimate may be marginally inaccurate in individual cases, but in insuring a large number of homes the insurer has the benefit of the law of large numbers tending toward accuracy over the entire run of losses. Even demand surge after a disaster can largely be accounted for, based on past experience, so correlated risk is not a problem. To the extent that the difference between an accurate estimate and a lower, inaccurate estimate, has an effect on the premium, the insurance is still economically feasible since a policyholder informed about the consequences of under-insurance is likely to accept a modest additional premium in exchange for the risk of being substantially underinsured.

Third, there are no effectiveness issues—policyholder-side moral hazard, adverse selection, or risk segmentation. Transaction costs in arriving at an accurate estimate may be modestly higher, but not significantly so.

Finally, there is a significant social effect in providing true replacement cost. Full replacement cost promotes prompt recovery for an individual homeowner, and in large-scale disasters, for communities, against the economic and social dislocation that otherwise might result. The failure to provide full replacement cost delays rebuilding and prevents full economic recovery.

Therefore, the underinsurance gap in homeowners insurance is an excellent example of a true protection gap. Replacement cost coverage should be provided in an amount that accurately reflects the cost of rebuilding, and the failure to do so constitutes a protection gap.

#### B. THE RISK PROTECTION GAP: WATER DAMAGE

A risk protection gap arises when a policyholder is insured for some risks, or the class of policyholders generally have coverage for relevant risks, but certain other significant risks are not covered. An example is the exclusion from homeowners insurance of coverage for many types of water damage. Under the standard ISO HO-3 insurance policy, Section I—Exclusions, the exclusion is as follows:

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<sup>60</sup> Klein, *supra* note 53, at 58–64.

We do not insure for loss caused directly or indirectly by...

### 3. Water Damage

Water Damage means:

a. Flood, surface water, waves, [including tidal wave and tsunami, tides,] tidal water, overflow of any body of water, or spray from any of these, whether or not driven by wind, [including storm surge];

b. Water ... which[:]

[(1) B]acks up through sewers or drains[:]

or

[(2) O]verflows or is discharged from a sump, sump pump or related equipment; or

c. Water ... below the surface of the ground, including water which exerts pressure on or seeps[,] leaks [or flows] through a building, sidewalk, driveway, [patio,] foundation, swimming pool or other structure; [or

d. Waterborne material carried or otherwise moved by any of the water referred to in A.3.a. through A.3.c. of this exclusion.

...

This Exclusion A.3. applies regardless of whether any of the above, in A.3.a. through A.3.d., is caused by an act of nature or is otherwise caused.

This Exclusion A.3. applies to, but is not limited to, escape, overflow or discharge, for any reason, of water or waterborne material from a dam, levee, seawall or any other boundary or containment system.]

Provisions such as these exclude many types of damage caused by water from coverage—flooding caused by a hurricane, rain-gorged streams, sewer backup off premises, sump pump failure on premises, and more. Other terms of the policy may provide coverage for some water damage, such as accidental discharge of water from a plumbing system.<sup>61</sup> Each type of loss excluded from coverage requires separate analysis as a potential protection gap. To illustrate how the analysis applies, contrast two situations: flooding caused by a hurricane and water that flows into a basement as heavy rain accumulates in the street.

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<sup>61</sup> ISO, HOMEOWNERS 3 – SPECIAL FORM, Section I – Perils Insured Against, A., Exception to.c.6 (HO 00 03 10 00), at 12 (1999).

Flood coverage, or the lack thereof, often is used as an example of a protection gap. As the ISO form illustrates, homeowners insurance policies exclude flood damage from coverage. Coverage is available through the National Flood Insurance Program (NFIP), but many homeowners fail to purchase flood insurance. In hurricane-prone south Florida, for example, penetration of NFIP flood insurance is only thirty-four percent in Miami-Dade County, twenty-six percent in Broward County, and twenty-two percent in Palm Beach County.<sup>62</sup> In areas most affected by recent Category 4 hurricanes Harvey, Irma and Maria, as many as eighty percent of homeowners in Texas, sixty percent in Florida, and ninety-nine percent in Puerto Rico lacked flood insurance.<sup>63</sup>

As noted earlier, policyholder expectations about flood coverage under homeowners insurance are mixed and often mistaken.<sup>64</sup> Despite substantial advertising campaigns by the federal government, state regulators, and insurance companies, many homeowners hold the mistaken belief that homeowners insurance includes flood coverage.<sup>65</sup> The confusion is not surprising. Two of the basic elements of policyholders expectations are that coverage is provided for common causes of significant accidental loss, and coverage is particularly important for risks that result in large financial losses. But the studies tend to be general. It is likely that policyholders in flood-prone areas are more knowledgeable about the absence of flood insurance from homeowners policies. The increase in the rate of purchase of federal flood insurance in an area after it has suffered catastrophic flooding, for example, suggests a higher level of awareness.

Despite potential policyholder expectations of coverage, the exclusion of flooding from homeowners insurance has been justified because of several related reasons. Flood damage may be hard to calculate,<sup>66</sup> or at

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<sup>62</sup> *Facts + Statistics: Flood Insurance*, INS. INFO. INST., <https://www.iii.org/fact-statistic/facts-statistics-flood-insurance>; see generally Michael K. McShane & Juita-Elena (Wie) Yusuf, *Toward Better Management of Flood Losses: Flood Insurance in a Wetter World*, 24 PUB. WORKS MGT. & POL'Y 88, 93 (2019).

<sup>63</sup> Erwann Michel-Kerjan & Giambattista Taglioni, *Insuring Hurricanes: Perspectives, Gaps, and Opportunities After 2017*, MCKINSEY & CO. (Dec. 20, 2017), <https://www.mckinsey.com/industries/financial-services/our-insights/insuring-hurricanes-perspectives-gaps-and-opportunities-after-2017>.

<sup>64</sup> *Id.* at 11.

<sup>65</sup> *Id.* ("Research shows that many people underestimate the risk and think accidents will not happen to them, or they believe their homeowners insurance covers all hazards.").

<sup>66</sup> Scales, *supra* note 39, at 8, 15, 46.

least it was hard to calculate at the time it was generally excluded from homeowners policies (although that may not be the case any longer<sup>67</sup>). Floods damage large numbers of properties all at once, so there is a substantial problem of correlated risk. Correlated risk in itself may render a risk uninsurable, or it may raise the price at which insurance can be sold to high and therefore unsaleable levels. It requires a higher premium because of the higher expected loss rate and, due to capital requirements, insurers often need to charge a premium that actually is higher than the expected loss.<sup>68</sup> The cost problem also can be exacerbated by adverse selection; property owners more at risk are more likely to buy insurance, including even those who have suffered repeated losses, which can drive prices higher. These factors caused private insurers to stop selling flood insurance and arguably still justify the general exclusion of flood from homeowners policies. Recently private insurers have reentered the market in a more substantial way, although by selling stand-alone products rather than removing the flood exclusion.<sup>69</sup>

In response, of course, the federal government stepped in and created the National Flood Insurance Program (NFIP). The NFIP has its own problems; as relevant to the protection gap, a key issue is that prices are not actuarially sound. A study of NFIP pricing in Texas, for example, found that in some areas, the NFIP charges prices that are more than fifteen times the pure premium, while other areas are charged up to three times less than the pure premium.<sup>70</sup> The subsidies in general and especially the egregious example of repetitive loss properties, where recurring losses and constant risk should prevent an economically rational homeowner from purchasing insurance and, as a consequence, building or rebuilding in a high-risk area,

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<sup>67</sup> Erwann Michel-Kerjan, Jeffrey Czajkowski & Howard Kunreuther, *Could Flood Insurance be Privatized in the United States? A Primer*, 40 THE GENEVA PAPERS ON RISK AND INS. - ISSUES AND PRAC. 2 (2015).

<sup>68</sup> Carolyn Kousky & Roger Cooke, *Explaining the Failure to Insure Catastrophic Risks*, 37 THE GENEVA PAPERS ON RISK AND INS. - ISSUES AND PRAC. 2, 207 (2012).

<sup>69</sup> See e.g., Nancy Watkins & David D. Evans, *U.S. Private Flood Insurance: The Journey to Build a New Market*, INS. J. (Sept. 27, 2019), <https://www.insurancejournal.com/news/national/2019/09/27/541314.htm>; see also, *Spotlight on: Flood Insurance*, INS. INFO. INST. (Aug. 11, 2020), <https://www.iii.org/article/spotlight-on-floodinsurance#Private%20Flood%20Insurance> (according to the National Association of Insurance Commissioners, there were 116 private companies writing flood insurance in 2018).

<sup>70</sup> Michel-Kerjan et al., *supra* note 67, at 1.

encourage moral hazard and provide an unjustified public subsidy of private homeownership.

All of these issues coalesce around price. For many homeowners, insurance against flood damage will be an expensive product. Many will fail to purchase it even if it is economically rational to do so; cognitive biases often lead homeowners to fail to protect against low-probability, high-consequence losses.<sup>71</sup> And for some homeowners, the combination of high premiums and their limited financial resources lead to the failure to purchase flood insurance.<sup>72</sup> The result is a significant protection gap, made more significant because of the social effect of the failure of insurance to be available or to be purchased when it is available. For individuals and communities, the effect of substantial flood losses can be catastrophic. For the individual and the community, therefore, the true protection gaps are exacerbated in the situations in which insurance is or should be available. Insurance against flood loss in those settings not only is calculable and effective, but its absence presents a real and significant social loss. Much of the protection gap literature appropriately uses the lack of insurance against disasters such as flooding as the paradigmatic example of a protection gap.

The difficulty, of course, is defining a vehicle that will effectively fill the protection gap. The gap arises not because flood damage is excluded from the basic homeowners policy but because flood damage is not covered at all in many cases. Widespread dissatisfaction with the usual absence of coverage through homeowners insurance policies and the ineffectiveness of the NFIP have produced a variety of suggestions. Reform of the NFIP to remove some of the problems was attempted in the Biggert-Waters Flood Insurance Reform Act of 2012, but was thwarted by the Homeowner Flood Insurance Affordability Act of 2014, and has since been stalled in Congress as the program repeatedly has been reauthorized without change.<sup>73</sup> In some areas, private insurers are entering the market, although their participation has yet to reach the critical mass needed to fill the protection gap. And

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<sup>71</sup> Howard Kunreuther, *Improving the National Flood Insurance Program*, BEHAVIOURAL PUB. POL'Y, Apr. 2018, at 1, [https://marketing.wharton.upenn.edu/wp-content/uploads/2018/08/improving\\_the\\_national\\_flood\\_insurance\\_program.-Behavioral-Public-Policy-2018.pdf](https://marketing.wharton.upenn.edu/wp-content/uploads/2018/08/improving_the_national_flood_insurance_program.-Behavioral-Public-Policy-2018.pdf).

<sup>72</sup> Kousky & Cooke, *supra* note 68, at 206.

<sup>73</sup> James Jarvis, *Congress Extends Flood Insurance Program for 14th Time Since 2017*, THE HILL: BLOG BRIEFING ROOM (Nov. 21, 2019, 1:35 PM), <https://thehill.com/blogs/blog-briefing-room/471522-congress-extends-flood-insurance-program-for-14th-time-since-2017>.

broader proposals have been offered, such as incorporating a variety of catastrophic losses in the standard homeowners policy—windstorm and earthquake in addition to flood, for example.<sup>74</sup> Until adequate vehicles are found, the failure to insure against flood losses presents a large risk protection gap.

Now consider a more mundane element of the exclusion for water loss—the exclusion of damage caused by “surface water.” Assume heavy rain accumulates, causing a rush of water in the street that flows into a basement and causes major damage to a house. Under the standard homeowners policy, the damage is excluded as surface water, which ordinarily is defined as “water that is on the surface of the ground, generally derived from falling rain or melted snow, and that does not have a permanent existence, has no banks, and follows no defined course or channel.”<sup>75</sup>

Sometimes the loss will be covered by flood insurance, because the definition of flood includes “[a] general and temporary condition of partial or complete inundation of two or more acres of normally dry land area or of two or more properties (one of which is your property) from . . . Unusual and rapid accumulation or runoff of surface waters from any source.”<sup>76</sup> But often there are problems. Many homeowners, particularly in low-risk areas, will not have flood insurance. The losses covered by flood insurance also are limited; additional living expense is not covered, and finished walls, floors, ceilings, and personal property in the basement are not covered except for elements of the structure such as electrical work and heating and air conditioning equipment.<sup>77</sup>

The lack of coverage for runoff losses is problematic. This is a potentially significant loss. The policyholder’s expectation is that this type of loss would not be excluded as flood damage. It’s much less of a correlated risk, because it sometimes happens over large areas but more often is confined to a smaller area. There is no moral hazard and likely no adverse selection. If a property is in a low-risk flood zone, no one reasonably would purchase flood insurance just to guard against this risk, so there is not a segmentation problem.

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<sup>74</sup> Christopher C. French, *America on Fire: Climate Change, Wildfires & Insuring Natural Catastrophes* (54 U.C. DAVIS L. REV., Research Paper No. 12-2020, forthcoming 2020), [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=3579734](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3579734).

<sup>75</sup> Wayne D. Taylor, Arthur J. Park, Sean O’Brien, *Unique Coverage Issues in Flood Losses*, 48 TORT TRIAL & INS. PRAC. L.J. 619, 631 (2013).

<sup>76</sup> FEMA, *NFIP Dwelling Form F-122*, 1 § II.A.1.b (Oct. 2015).

<sup>77</sup> *Id.* at § III (A) (8).

The best argument in support of the exclusion is that it addresses a transaction cost problem. Surface water cases can involve damage to only one or a few properties, or to a much larger number. The exclusion is needed to forestall complex factual disputes and possible error in decision in covering losses that should be excluded as “true” flood losses, which should be excluded because of correlated risk. This is at base an empirical question, but it is likely that many of the cases are smaller cases that should be covered. Some involve more widespread surface water losses that clearly are excluded as flood losses, and only a small number are in between. If so the transaction cost issue is not significant and the runoff exclusion typically constitutes a risk protection gap and is unjustifiable.

C. THE COVERAGE GAP: MATCHING

The coverage gap form of the protection gap arises when a policyholder is insured for some risks, or the class of policyholders generally is insured, and the risk resulting in loss generally is covered, but coverage is subject to other limitations. That is, limitations or restrictions in the insurance policy other than the exclusion of property or risks prevent full coverage for actual or potential losses. Not every limitation or restriction on coverage presents a true protection gap, of course. The typical homeowners policy limits the amount payable for a loss by theft of watches or jewelry. This is not a coverage gap, either because most policyholders do not expect that very expensive items of jewelry are covered or because such a belief would be unreasonable, given the rarity of such items among the pool of homeowners and the availability of additional coverage if such items are owned. To illustrate a true coverage gap, consider the issue of “matching.”<sup>78</sup>

If property is partially damaged under a replacement cost policy, the insurer may assert that it is only required to pay for repair or replacement of the limited portion of the property that is damaged, while the policyholder claims that more is needed to replace the property to the condition it was in

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<sup>78</sup> For summaries of the relevant law, *see* Jay Feinman et al., “Matching” In Replacement Cost Homeowners Insurance Policies (Rutgers Law School, Apr. 2016) [https://www.uphelp.org/sites/default/files/publications/matching\\_memo\\_4-2016\\_to\\_post.pdf](https://www.uphelp.org/sites/default/files/publications/matching_memo_4-2016_to_post.pdf); MATTHIESEN, WICKERT, & LEHRER, “Matching Regulations” and Laws Affecting Homeowners’ Property Claims in all 50 States (Oct. 2019) (unpublished report) <https://www.mwl-law.com/wp-content/uploads/2019/02/MATCHING-REGS-AND-LAWS-AFFECTING-HOMEOWNERS-PROPERTY-CLAIMS-CHART.pdf>.

prior to loss. This is the issue of matching—matching the damaged part of the property to the undamaged part to restore the property to the condition prior to loss, such as a roof with a uniform appearance. For example, if a portion of a roof is damaged, replacing only the damaged shingles restores the functionality of the roof to its pre-loss condition but does not restore its appearance because the new shingles do not match the existing shingles. On the one hand, the homeowner has suffered a significant loss, because prior to the loss the roof had a uniform appearance, and uniformity may have an effect on economic value or simply may have aesthetic value to the homeowner. On the other hand, if the entire roof must be replaced, the cost may be very high and if the roof is replaced, the policyholder would be in a better economic position before the loss, having been provided an entirely new roof, which violates the principle of indemnity.

Traditional policy language requires the insurer to pay “the replacement cost of that part of the building damaged with material of like kind and quality and for like use.”<sup>79</sup> Some more recent policies limit matching by, for example, requiring only “common construction materials and methods,”<sup>80</sup> or using limiting language or proportional coverage for roof damage.<sup>81</sup> The NAIC Unfair Property/Casualty Claims Settlement Practices Model Regulation states, “[w]hen a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the area so as to conform to a reasonably uniform appearance.”<sup>82</sup>

A policyholder’s ordinary expectation is that replacement cost coverage provides for complete repair of damage and restoration of property. That reflects the difference between a replacement cost policy and an actual cash value policy.

Replacement cost coverage was devised to remedy the shortfall in coverage which results under a property insurance policy compensating the insured for actual cash value alone. That is, while a standard policy compensating an insured for the actual cash value of damaged or destroyed property makes the insured responsible for bearing the cash difference necessary to replace old property with new

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<sup>79</sup> Insurance Services Office Inc.’s Homeowners Form. HO 00 03 10 00 (1999).

<sup>80</sup> Insurance Services Office Inc.’s Definitions and Loss Settlement. HO DP 05 30 07 14 (2014).

<sup>81</sup> *E.g.*, ISO HO 06 46 04 16 (2015).

<sup>82</sup> NAIC Model Laws, Regulations and Guidelines, 902-7 § 9.A2 (1997).



property, replacement cost insurance allows recovery for the actual value of property at the time of loss, without deduction for deterioration, obsolescence, and similar depreciation of the property's value.<sup>83</sup>

This expectation applies where the loss is substantial in economic terms or otherwise is of significant value to the policyholder. Residential property is commonly understood to be more than an economic asset, and the insurance relation is constructed on that understanding. Some of the property has the characteristics of and is held partly as an economic asset—the structure of a home. Some of the property is not—furniture, which is purchased for use and, once used, has little or no economic value on the market. Here there is applied a functional conception of indemnity, not an economic conception, where “the purpose of a measure of recovery could be to return the insured to roughly the same style of life as he or she occupied before loss.”<sup>84</sup> In this conception, payment of replacement cost does not violate the indemnity principle:

A homeowner whose twenty-year old garage is destroyed by fire needs a new garage. If recovers only the market value of the garage, he has the same net worth before and after loss, be he is worse off nevertheless—because he either has no garage, or must take money out of his pocket in order to build a new one.<sup>85</sup>

However, the expectation of complete repair may be qualified in two ways. The policyholder's reasonable expectation may differ depending on the size of the loss; the large-loss principle states that full coverage is important for large financial losses, but less so for smaller losses, so matching is important for large losses but less so for small losses. A fundamental expectation also is that insurance provides indemnity against economic losses. “Replacement cost coverage, therefore, in contravention of the general rule that an insured cannot profit through insurance, results in the insured being better off than he or she was prior to the loss, since the insured

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<sup>83</sup> 12A COUCH ON INS. § 176:56 (3d ed. 2020).

<sup>84</sup> KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 262 (6th ed. 2015).

<sup>85</sup> *Id.*

ends up with a more valuable property.”<sup>86</sup> Where matching does not result in an economic loss, or where matching would put the policyholder in a better position than before the loss occurred, matching may be unjustified. The competing factors suggest that there are three types of cases.

First, the failure to match would have a significant economic effect; for example, where some kitchen cabinets are destroyed, the failure to replace all cabinets in order to match would reduce the value of the house to a prospective buyer by thousands of dollars.

Second, the failure to match would not have a significant negative economic effect but would disappoint ordinary expectations, and matching could put the policyholder in a better position than prior to the loss. The appearance of the mismatched roof would be unsightly but the economic value of an older roof which has damage to some shingles is not materially reduced by adding non-matching shingles; although the value of the house to a potential buyer is decreased by the mismatched shingles, the diminution in value may not be great. If the entire roof is replaced, in turn, the value of the home is substantially increased by the substitution of new for old.

Third, neither the economic value nor the noneconomic value to the homeowner would be affected materially by the failure to match; only a few nonmatching shingles on a roof likely would have this effect.

The balance of expectations in the first and third cases are relatively clear—matching in the first<sup>87</sup> but not the third. The second case is more difficult and requires consideration of the reasonableness of a policyholder’s expectation of matching.

The need to match is an insurable risk. It is readily calculable in both individual cases and in the aggregate. Insurers have access to vast amounts of information about repair and reconstruction costs in general. In individual cases, information about the property such as the age of the roof can and usually is factored into the premium. Matching losses are not correlated and do not present moral hazard, adverse selection, or risk segmentation problems. The social effect of the failure to match arguably is not substantial.

The keys to deciding difficult cases are expectation, which is larger in the case of large losses, and the economic feasibility of providing full matching and transaction costs. If providing matching in situations like the second case would substantially raise the premium, to the point at which many policyholders would prefer not to pay it, matching is less justified. This requires calculation of the number of such cases and the additional cost if

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<sup>86</sup> 3 INS. CLAIMS & DISP. § 11:35 (6th ed.) (citations omitted).

<sup>87</sup> See, e.g., *Alessi v. Mid-Century Ins. Co., Inc.*, 464 S.W.3d 529, 530 (Mo. Ct. App. 2015) (citations omitted).

matching is required. And distinguishing among the three cases is not costless; if disputes are likely to arise in a large number of cases as to whether matching has a significant economic effect or is cost-justified, then matching also is less justified. In short, coverage should be provided for matching except in a class of cases in which coverage could not be provided at a reasonable premium. If it is too hard to construct that category, then matching generally is less attractive.

A related issue is cosmetic damage. Cosmetic damage involves dents, scratches, or other minor imperfections in appearance that do not affect functionality.<sup>88</sup> Because cosmetic damage does not involve a functional impairment of the property and rarely involves a significant economic effect, under the large-loss principle it may not be included in an ordinary expectation of coverage. In addition, cosmetic damage creates moral hazard problems, and the cost of coverage for cosmetic damage may be much more than a reasonable policyholder would pay. Therefore, cosmetic damage is not a key term of coverage that presents a protection gap, and coverage should be available only as an option. Of course, there is a transaction cost issue presented by a line-drawing problem. Some cases will require fact-finding and may lead to disputes; dents in a metal roof may be purely cosmetic or they may affect the roof's functional operation. But as with water runoff losses, the number of cases in which there are significant transaction cost issues likely is small enough that it does not undermine the primary conclusion of lack of coverage.

#### IV. CONCLUSION

Insurance plays an important economic and social role in protecting individuals and firms from financial disaster, permitting the efficient transfer, pooling, and distribution of losses, and benefiting society as a whole. To serve those roles effectively, the right amount and kind of insurance needs to be in force. Where insurance is inadequate, protection gaps result. This article offers a definition of the protection gap concept that enables the determination of how much insurance of what kind should be in place to avoid protection gaps.

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<sup>88</sup> The Florida "chipped tile" cases are the most notorious. See *Ergas v. Universal Prop. & Cas. Ins. Co.*, 114 So. 3d 286 (Fla. Dist. Ct. App. 2013); Chip Merlin, *Framing the Chipped Tile Claim*, MERLIN LAW GROUP (Apr. 29, 2013), <https://www.propertyinsurancecoveragelaw.com/2013/04/articles/insurance-claim/framing-the-chipped-tile-claim/>.

# THE AMERICAN LAW INSTITUTE’S RESTATEMENT OF THE LAW, LIABILITY INSURANCE: SCHOLARSHIP AND CONTROVERSY

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## I. INTRODUCTION

The Restatement of the Law, Liability Insurance (Restatement or RLLI), carries on the traditions of the American Law Institute (ALI) in presenting rigorous scholarship and a synthesis of the views of the law from leaders across the legal profession. Begun in 2010,<sup>1</sup> the Restatement represents eight years of work by reporters Tom Baker and Kyle Logue,<sup>2</sup> and the Restatement’s advisers, members consultative group (MCG), council, and (later) the ALI general membership. As a result of the ALI’s dialectical process, the Restatement reflects the diverse perspectives of lawyers and advocates for both insurers and insureds, judges, professors, scholars, insurance brokers, and others.

Despite this rigorous work, the insurance industry has mounted a coordinated campaign to discredit not only the Restatement but also the ALI, first in motions made in the ALI to delay the Restatement’s adoption or to revise numerous sections of the Proposed Final Draft and later in other venues, including the press and state legislatures, as well. Since the RLLI was adopted in May 2018 (and even before the final version was completed), insurers and insurance-industry organizations, with insurance defense and coverage counsel whose practices derive from insurance companies, have pursued an organized effort to oppose the RLLI by publishing articles in insurance industry, legal, and other publications; speaking at seminars organized by bar associations and similar legal organizations; and developing proposed legislation stating a “public policy” against the RLLI or otherwise seeking to direct how or whether courts may cite or even consult it.<sup>3</sup> A working group of insurance industry organizations, insurers, and their counsel have

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<sup>1</sup> See Tom Baker & Kyle D. Logue, *In Defense of the Restatement of Liability Insurance*, 24 Geo. Mason L. Rev. 767, 771 (2017) [hereinafter Baker and Logue]. The Council of the ALI in 2014 voted to convert the project, begun as a Principles project, to a Restatement. See *infra* 40. See also AM. L. INST., THE VOICE OF THE AMERICAN LAW INSTITUTE: A HANDBOOK FOR ALI REPORTERS AND THOSE WHO REVIEW THEIR WORK, at 13 (rev. 2015), [https://www.ali.org/media/filer\\_public/08/f2/08f2f7c7-29c7-4de1-8c02-d66f5b05a6bb/ali-style-manual.pdf](https://www.ali.org/media/filer_public/08/f2/08f2f7c7-29c7-4de1-8c02-d66f5b05a6bb/ali-style-manual.pdf) (last visited Feb. 20, 2021) [hereinafter ALI HANDBOOK AND STYLE MANUAL].

<sup>2</sup> Professor Tom Baker of the University of Pennsylvania Law School and Professor Kyle D. Logue of the University of Michigan Law School served as Reporter and Associate Reporter, respectively, throughout the project.

<sup>3</sup> See discussion of legislation *infra* § IV.B.

coordinated, working to “fund opposition to ALI’s representation of minority positions as established law”<sup>4</sup> and otherwise oppose the Restatement, even when it states (as it does in most instances) the majority rule.

This effort has extended to the legislative arena. The National Association of Mutual Insurance Companies (NAMIC) and the National Council of Insurance Legislators (NCOIL) have published statements, press releases, and reports attacking the Restatement.<sup>5</sup> Other groups and individual counsel, some as retained counsel for the industry, have also published such pieces.<sup>6</sup> Many of the articles, seminars, and hearings held on the RLLI have included little or no input from policyholder representatives, consumers, or the ALI. In some cases, these discussions have included little analysis of the 100-plus principles of law stated (in 50 sections) in the RLLI or made little attempt to separate positions favored by and sought by insurers and their representatives from those they deplore. Proposed legislation, discussed below, often makes little effort to distinguish between rules insurers favor and those they do not, or to compare provisions of the Restatement to the law of the state. As pointed out in a letter submitted to the Arizona state legislature by former Chief Justices of the Arizona Supreme Court,<sup>7</sup> legislation adopted and proposed in many states may increase, and not—as proponents tend to argue—reduce uncertainty. Those statutes clearly would distort the process used to develop the common law—that body of law that courts have developed when faced with specific controversies and disputed facts, and with regard to which courts around the country have consulted Restatements, and many other secondary sources, for decades.

A faithful recounting of the eight years of work that created the *Restatement* and the various drafts of the project over the years confirms the participation throughout the process by insurance company representatives (from insurance

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<sup>4</sup> *Our Positions American Law Institute (ALI)*, NAMIC, <https://www.namic.org/Issues/american-law-institute> (last visited Feb. 20, 2021).

<sup>5</sup> *Id.* (“The end result of this ALI project could seriously harm all property casualty insurance companies. NAMIC and AIA have enlisted a working group of insurance companies to coordinate and fund the opposition to ALI’s improper representation of minority positions as established law.”). *See also infra* notes 71–72 and associated text.

<sup>6</sup> *See infra* notes 74–80 and associated text.

<sup>7</sup> Letter from former Arizona Supreme Court Chief Justices, Hon. Ruth V. McGregor (ret.), Hon. Rebecca White Berch (ret.) & Hon. Scott Bales (ret.), Opposing House Bill 2644 [hereinafter *Letter of Former Arizona Supreme Court Chief Justices*] (copy on file with author), *see discussion infra* § IV.B.(2).

companies and from insurance industry defense firms) and an insurance industry “liaison” from the American Insurance Association (AIA). While policyholder lawyers and United Policyholders, a small, nonprofit dedicated to serving consumers, participated in the process, they do not (and throughout the process did not) have the power or size to counter positions taken by insurance industry trade groups or counsel who obtain a stream of business from insurance companies.<sup>8</sup> There really is no comparable “industry group” that represents policyholders in the way industry trade groups represent the insurance industry.

The Restatement throughout its drafting sought to state “the efficient and fair rules that should govern the insurer/insured relationship.”<sup>9</sup> Of course, debates among the Restatement’s advisers, MCG, and others were often intense, reflecting the viewpoints of the many constituencies interested in the development of the law governing liability insurance, and it continues to be a subject of intense interest and controversy. This article surveys the background of the ALI and ALI process, the development of the RLLI, insurance industry commentary on the RLLI, legislation promoted by insurers, and cases citing the RLLI. It discusses the organized effort by the insurance industry to undermine not just the Restatement but also the ALI itself. Finally, this article discusses issues in the RLLI that remain the subject of controversy<sup>10</sup> and seeks to provide context and counter-balance to commentaries provided to date (mostly by insurers).

## II. BACKGROUND OF THE ALI

To understand the full story of the Restatement, it is necessary to have an understanding of both the ALI history and process, developed over the almost 100 years of the ALI’s existence<sup>11</sup> and the eight-year history of the Restatement. To quote the Bard, “past is prologue.”<sup>12</sup> This section gives a thumbnail sketch of ALI history, its process, and the development of the Restatement from 2010 to 2018. It also outlines the topics addressed in the Restatement, to show that general attacks stating that the RLLI “got the law wrong” present a gross oversimplification.

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<sup>8</sup> At some point, a representative from the Risk & Insurance Management Society (RIMS) was involved but was never active.

<sup>9</sup> RESTATEMENT OF THE L. OF LIAB. INS. (AM. L. INST. Draft Jul. 2014) (quoted in Masters, Bach, & Wade, *infra* note 41, at 2).

<sup>10</sup> With some exceptions like nuclear insurance and terrorism insurance, insurance is regulated, of course, at the state level, and on many issues is determined as a matter of judge-made or common law.

<sup>11</sup> Founded in 1923, the ALI will celebrate its centennial in 2023.

<sup>12</sup> WILLIAM SHAKESPEARE, *THE TEMPEST*, act 2, sc. 1, l. 217.



Lawyerly analysis and good public policy depend on fact and an informed understanding of the nuances of complex topics. This article submits that critique and proposed legislation addressing the Restatement should be based on a reading of the Restatement, its 50 sections, 100-plus principles of law, and comments, not based on past grievances about the drafting process as seems to be the focus in at least some insurer commentaries.<sup>13</sup>

A. A SHORT HISTORY OF THE ALI

Prominent American judges, lawyers, and legal scholars came together in the early 1920s to create a “Committee on the Establishment of a Permanent Organization for the Improvement of the Law” (the “Committee”), led by icons of the American legal profession, Elihu Root, George Wickersham, and William Draper Lewis.<sup>14</sup> The Committee convened to consider ways to address a “general dissatisfaction with the administration of justice,” in part arising from the belief that “the law is unnecessarily uncertain and complex.”<sup>15</sup> Based on the Committee’s recommendations, the ALI was incorporated in 1923, and work that year began on

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<sup>13</sup> See, e.g., point-counterpoint discussion: George L. Priest, *A Principled Approach Toward Insurance Law: The Economics of Insurance Law and the Current Restatement Project*, 24 GEO. MASON L. REV. 635 (2017); and Tom Baker & Kyle D. Logue, *In Defense of the Restatement of Liability Insurance Law*, 24 GEO. MASON L. REV. 767 (2017). See also Kim V. Markkand, *How a Broken Process, Broken Promises, and Reimagined Rules Justify the Bench and Bar’s Skepticism Regarding the Reliability of the Restatement of the Law, Liability Insurance*, 50 THE BRIEF, No. 1 (Journal of American Bar Association Tort Trial and Insurance Law Section, Fall 2020) (insurer side counsel). This issue of THE BRIEF includes other articles on the RLLI. For other perspectives that will be beneficial, in the authors’ views, and bring balance to consideration of the topic, see Elizabeth C. Sackett & Jeffrey Thomas, *Perspectives on the Restatement of the Law, Liability Insurance: What’s all the Hoopla About?* (at 9) (editor of THE BRIEF); Jeffrey W. Stempel, *From Quiet to Confrontational to (Potentially) Quiescent: The Path of the ALI Liability Insurance Restatement* (at 10) (Professor of Law, UNLV); Laura A. Foggan & Rachel Padgett, *Rules of Policy Interpretation Reflect Lingered Policyholder Bias in the ALI’s Restatement of the Law, Liability Insurance* (at 26) (insurer side counsel); Lorelie S. Masters, *“Plain Meaning” and the Meaning of “Plain”: Section 3 of the Restatement of the Law, Liability Insurance* (at 36) (policyholder side counsel).

<sup>14</sup> *The Story of ALI*, ALI, <https://www.ali.org/about-ali/story-line/> (1923: *Founding of the American Law Institute*) (last visited Feb. 20, 2021).

<sup>15</sup> See *id.* for a discussion, decade by decade, of the history of the ALI, its leaders, projects, and contributions since the Institute’s founding in 1923.

its first Restatements, on the law of agency, conflict of laws, contracts, and torts.<sup>16</sup> Since then, the ALI has grown to include more than 4,000 members from all disciplines in the legal profession—judges from all corners of the judiciary; scholars from law schools; think-tanks and non-profits; practicing lawyers; and others, largely from the United States but also from abroad.<sup>17</sup>

Reading about the founders of the ALI is a humbling experience. Secretary Root, for example, was an American lawyer and statesman who served as Secretary of State under President Theodore Roosevelt and Secretary of War under Presidents Theodore Roosevelt and William McKinley. He served one term as a United States Senator from the State of New York. For his work in international arbitration, he won the Nobel Peace Prize in 1912. He led the Carnegie Endowment for International Peace, the Carnegie Institution of Washington, and the Carnegie Corporation of New York. He is credited with modernizing the United States Department of War and “transforming the army into a military machine comparable to the best in Europe.”<sup>18</sup> Other early leaders included President and Chief Justice William Howard Taft, Justice Charles Evan Hughes, Judge Learned Hand, and Judge Benjamin Cardozo.<sup>19</sup>

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<sup>16</sup> *Id.*

<sup>17</sup> The ALI elects lawyers to membership through a confidential nomination process. *Election*, ALI, <https://www.ali.org/members/membership-proposal-process/election/> (last visited Feb. 20, 2021), [United States Supreme Court Justices, Chief Judges of the United States Courts of Appeals, and Chief Justices and Chief Judges of the highest courts in each state and U.S. jurisdiction, deans of law schools in the Association of American Law Schools (AALS), and Presidents of the ABA, National Bar Association, and Federal Bar Association among others, are ex officio members of the ALI. *Membership*, ALI, <https://www.ali.org/members/> (last visited Feb 20, 2021). One commentary posits: “Absent the implied imprimatur of the ex officio members, one can fairly ask if a Restatement would be treated any differently than any other law review quality article.” Kim Marrkand, *Why Ohio Nixed the New Liability Insurance Law Restatement*, LAW360 n. 8 (Aug. 10, 2018), <https://www.law360.com/articles/1071830>. These comments appear to misapprehend the in-depth work and thinking from across the legal profession that is apparent from a review of ALI Restatements and other projects and is contrary to author Lorelie Masters’ experience in attending and participating in discussions of ALI projects at the ALI annual and other meetings.

<sup>18</sup> *Supra* note 14 (click “Elihu Root” hyperlink within the “Founding of the American Law Institute” section).

<sup>19</sup> *Id.*

Restatements “are primarily addressed to Courts,”<sup>20</sup> and typically address the common law, “the law developed and articulated by judges in the course of specific cases.”<sup>21</sup> In addition to Restatements, the ALI has played a key role in the creation of other significant contributions to the law, including the Uniform Commercial Code (UCC) and the Model Penal Code, and through its “Principles” projects.<sup>22</sup> As defined in the *ALI Handbook and Style Manual*, Principles “are primarily addressed to legislatures, administrative agencies, or private actors.”<sup>23</sup>

In one of its very significant contributions, during World War II, the ALI helped organize a committee that researched the constitutions of different countries in the world and other foundational documents relating to individual rights.<sup>24</sup> This work, conducted over the years of the War, resulted in the ALI’s Statement of Essential Human Rights, one of the texts used to create the Universal Declaration of Human Rights.<sup>25</sup> Adopted by the United Nations in 1948, the Declaration has become the best-known and most-cited document on human rights in the world. It

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<sup>20</sup> ALI, *Frequently Asked Questions*, <https://www.ali.org/publications/frequently-asked-questions/#differ> (last visited Feb. 20, 2021).

<sup>21</sup> AM. LAW INST., CAPTURING THE VOICE OF THE AMERICAN LAW INSTITUTE: A HANDBOOK FOR ALI REPORTERS AND THOSE WHO REVIEW THEIR WORK 4 (rev. 2015), [www.ali.org/publications/style-manual/](http://www.ali.org/publications/style-manual/) (last visited Feb. 20, 2021).

<sup>22</sup> *Supra* note 14.

<sup>23</sup> *Supra* note 20. Principles can “be addressed to Courts when the area is so new that there is little established law. Principles may suggest best practices for these institutions.” ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 13. The ALI’s concept of the Principles projects has evolved over time since the ALI first tackled such a project (with the ALI’s Corporate Governance Project). The concept of Principles has been refined over the years as discussed in the *ALI Handbook. Id.* at 13–15.

<sup>24</sup> See, e.g., ALI, *The Statement of Essential Human Rights* (Dec. 10, 2018) <https://www.ali.org/news/articles/statement-essential-human-rights>; JOHN P. HUMPHREY, HUMAN RIGHTS AND THE UNITED NATIONS: A GREAT ADVENTURE (1984). Mr. Humphrey was the first Director of Human Rights of the U.S., in 1946. These comments appear to refer to First Lady and world-renowned humanitarian Eleanor Roosevelt who led this effort and fought for its adoption. The ABA celebrated the 70th Anniversary of the Declaration in 2018. UNITED NATIONS, UNIVERSAL DECLARATION OF HUMAN RIGHTS iii (rev. 2015).

<sup>25</sup> *Id.*

has been translated into more than 500 languages and, showing the power of an idea and vision, incorporated into the constitutions of many countries.<sup>26</sup>

B. THE ALI GUIDELINES AND PROCESS

**ALI Guidelines.** First set forth in 1923 in the ALI's Certificate of Incorporation, the Institute's goals and purposes set forth below have remained consistent throughout its history: "[To] promote the clarification and simplification of the law and its better adaptation to social needs, to secure the better administration of justice, and to encourage and carry on scholarly and scientific legal work."<sup>27</sup>

As provided in the ALI's Bylaws, "[p]ublication of any work as representing the Institute's position requires approval by both the membership and the Council."<sup>28</sup> As known by the Council members identified in every ALI publication, the Council includes jurists, professors, and other recognized leaders from across the legal profession.

**Restatements and Principles Include Black-Letter Statements of Law, Comments and Reporters' Notes.** As the *ALI Handbook and Style Manual* explains:

Each [ALI project] addresses a particular area of the law and seeks to clarify and synthesize it in such a way as to contribute to the "better administration of justice." Each consists of a series of concise "black-letter" legal formulations, elucidated by extended commentary and illustrations, and supported by scholarly annotation of the sources considered.<sup>29</sup>

The black-letter statements of law and Comments are considered the official position of the ALI.<sup>30</sup> The Reporters' Notes are that—notes on the authorities the Reporters reviewed in creating the black-letter comments. They are not the official position of the ALI.<sup>31</sup>

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<sup>26</sup> *About the Universal Declaration of Human Rights Translation Project*, UNITED NATIONS HUM. RTS. OFF. OF THE HIGH COMM'R, <https://www.ohchr.org/EN/UDHR/Pages/Introduction.aspx> (last visited Feb. 20, 2021).

<sup>27</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 1.

<sup>28</sup> *Id.* (quoting the ALI Bylaws).

<sup>29</sup> *Id.* at 3.

<sup>30</sup> *How the Institute Works*, ALI, <https://www.ali.org/about-ali/how-institute-works/> (last visited Feb. 20, 2021).

<sup>31</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 35–36; 45 (Ch. II.B.); and extended discussion at 33–46 (Ch. II.B.).

The *ALI Handbook and Style Manual*<sup>32</sup> describes how a project is selected and begun:

The nature, content, and scope of each Institute project are initially developed by its Reporter in consultation with the Institute's Director, generally on the basis of a prospectus or memorandum prepared by the Reporter at the invitation of the Director and subsequently reviewed by the Projects Committee and either by the Council as a whole or its Executive Committee. The Director's Recommendations that particular projects be undertaken and designations of specific Reporters are subject to the approval of the Council or Executive Committee. Once a project begins, its character and scope maybe further refined in the course of the drafting process.<sup>33</sup>

Recognizing that case law could be and “had become obscured by the ever-growing mass of decisions in the many jurisdictions”<sup>34</sup> in the United States, founders of the ALI in creating Restatements sought to “assume [] the perspective of a common-law court, attentive to and respectful of precedent, but not bound by precedent that is inappropriate or inconsistent with law as a whole.”<sup>35</sup>

As noted by one commentator decades ago, a Restatement is “a product of highly competent group scholarship subjected to a searching criticism of learned and experienced members of the bench and bar.”<sup>36</sup> As stated in the *ALI Handbook and Style Manual*, Restatements provide “clear formulations of common law and its statutory elements or variations and reflect the law as it presently stands or might appropriately be stated by a court.”<sup>37</sup> While a Restatement aims to “recapitulate the law as it presently exists,” it also reflects an “impulse to reformulate it, thereby rendering it clearer and more coherent while subtly transforming it in the process.”<sup>38</sup>

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<sup>32</sup> See *id.*, *supra* note 1.

<sup>33</sup> *Id.* at 3 (Ch. I.B.).

<sup>34</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 4.

<sup>35</sup> *Id.* at 4, 5 (Ch. I.B.1.a.).

<sup>36</sup> Herbert F. Goodrich, *The Story of the American Law Institute*, 1951 WASH. L.Q. 283, 285 (1951).

<sup>37</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 1 (Ch. I. A.).

<sup>38</sup> *Id.* (Ch. I. A.).

Commentaries that decry the RLLI in articles or at conferences, which often are from people with little background in the ALI, have argued that the ALI somehow has lost its way. Ah, for the good ol' days when Restatements stated only majority rules! These critiques, however, ignore history. In creating Restatements, the ALI has focused on majority rules, but has always focused on the larger body of law. It has always sought, as shown in its Certificate of Incorporation, among other things, the "better adaptation [of the law] to social needs"; and, as shown in the *ALI Handbook and Style Manual*, to ascertain trends in the law.<sup>39</sup> ALI Restatements on more than one occasion have stated legal principles that were not majority rules when the Restatement first was published but since have become the majority rule.<sup>40</sup>

**The ALI Process:** The ALI follows a rigorous, dialectical process in creating any of its projects, whether a Restatement, Principles of the Law, or a Model Act.<sup>41</sup> The process includes as participants active practitioners on all sides of the issues in the practice area in question: judges, professors, and other interested parties. Reporters, usually law school professors, are appointed to write the drafts and manage the process of reviewing and revising the text under the supervision of the ALI's Council and Officers.

The following description of the Restatement process from the *ALI Handbook and Style Manual* provides additional context:

The Restatement process contains four principal elements. The first is to ascertain the nature of the majority rule. If most courts faced with an issue have resolved it in a particular way that is obviously important to the inquiry. The second step is to ascertain trends in the law. If 30 jurisdictions have gone one way but the 20 jurisdictions to look at the issue most recently went the other way, or refined their prior adherence to the majority rule, that is obviously important as well. Perhaps the majority rule is now widely regarded as outmoded or undesirable. If *Restatements* were

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<sup>39</sup> *Certificate of Incorporation*, ALI, [https://www.ali.org/media/filer\\_public/10/62/106284da-ddfe-4ff4-a698-0a47f268ee4c/certificate-of-incorporation.pdf](https://www.ali.org/media/filer_public/10/62/106284da-ddfe-4ff4-a698-0a47f268ee4c/certificate-of-incorporation.pdf) (last visited Feb. 20, 2021).

<sup>40</sup> The best-known example of course is § 402A of the Restatement (Second) of the Law, Torts, which set forth a then-minority rule on strict liability in tort. Strict liability in tort is now the widely accepted majority rule.

<sup>41</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 1–20; *see also* Lorelie S. Masters, Amy R. Bach, & Daniel R. Wade, *The American Law Institute Principles/Restatement of the Law of Liability Insurance: Part III-Selected Comments from a Policyholder Perspective*, NEW APPLEMAN ON INS.: CURRENT CRITICAL ISSUES IN INS. L. (Summer 2015) at 1–5, [hereinafter MASTERS ET AL.].

not to pay attention to trends, the ALI would be a roadblock to change, rather than a “law reform” organization. A third step is to determine what specific rule fits best with the broader body of law and therefore leads to more coherence in the law. And the fourth step is to ascertain the relative desirability of competing rules. Here social-science evidence and empirical analysis can be helpful.<sup>42</sup>

The Reporters outline the project at the outset and revise that outline often through the drafting and revision process.<sup>43</sup> The drafts of the black-letter Comments, and Reporters’ Notes are circulated for input by both advisers appointed by the ALI Council and ALI members of a MCG. As with any significant work, the drafts are revised and honed over a course of time (in this case, years) based on the many rounds of comments from the advisers and MCG at meetings held to debate the current draft. Throughout, the Reporters also typically accept written comments from interested parties outside the advisers, MCG, and ALI. When a significant part or parts of the project are completed, the draft is submitted for comment by both the ALI Council, and the ALI general membership at ALI Annual Meetings.

### III. CREATING THE RESTATEMENT

#### A. DRAFTING THE RLLI

As far as the authors are aware, no one involved in the Restatement has questioned whether the ALI and Reporters followed the ALI’s usual, rigorous dialectical process, incorporating input from a wide variety of sources. Indeed, they did follow that process from author Lorelie Masters’ view as an adviser active throughout the eight years of the project.<sup>44</sup>

Constituencies commenting on the drafts of this Restatement included:

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<sup>42</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at 5.

<sup>43</sup> *How the Institute Works*, ALI, <https://www.ali.org/about-ali/how-institute-works/> (last visited Feb. 20 2021).

<sup>44</sup> The ALI Reporter, *Restatement of the Law, Liability Insurance: Practitioners’ Perspectives* (Oct. 10, 2019) (<https://thealiadviser.org/liability-insurance/restatement-of-the-law-liability-insurance-practitioners-perspectives/> (last visited Feb. 20, 2021)) [hereafter *The ALI Reporter*].

- Advisers, appointed by the ALI's Council. The advisers included practicing lawyers from both sides of the aisle (insurer and policyholder), in-house counsel and executives from insurance companies, an in-house counsel from a policyholder company, judges, academics, an insurance broker, and others with an interest in the subject area. Advisers need not be members of the ALI (although most were).
- Members of the MCG for the Restatement. Consistent with the ALI's standard process, the MCG included ALI members who (like the advisers) volunteered their time to the project. Like the advisers, the MCG here included practicing lawyers from outside law firms on both sides of the aisle, in-house counsel from insurance companies and other companies, judges, academics, and others with an interest in liability insurance.
- A liaison from the American Insurance Association.
- The ALI's Council.
- The ALI's membership.

Thus, a wide range of interested constituencies, including parties not members of the ALI, submitted comments and attended the annual meetings (on invitation) at which the RLLI was debated. From observation and experience, the Reporters considered, and responded to, all comments.<sup>45</sup> In directing the process, the Reporters, in the authors' view, sought to encourage efficiency and fairness to both insurers and policyholders, as well as to serve the interests of the public, including individual consumers and small businesses.

As with all Restatements, the Reporters' drafts for this Restatement were discussed at meetings of the advisers, the MCG, and the ALI Council that took place over eight years and involved 30 different drafts. Drafts also were presented to the ALI general membership at seven Annual Meetings of the ALI (which are held once a year).<sup>46</sup>

It is also important to note, especially in the face of insurance-industry opposition to the Restatement, that policyholder representatives objected to, commented on, and made motions at ALI Annual Meetings opposing many provisions during the drafting (although many fewer than were presented by insurer representatives).<sup>47</sup> A fair reporting on the RLLI should note that the Restatement,

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<sup>45</sup> ALI HANDBOOK AND STYLE MANUAL, *supra* note 1, at IX.

<sup>46</sup> RESTATEMENT OF THE L. OF LIAB. INS., FOREWORD at XIV (AM. LAW. INST. 2019).

<sup>47</sup> A collection of such motions is available from the authors; at the 2017 ALI meeting, insurer representatives made at least 35 motions. Seven of those motions were to the entirety



throughout its drafting and in the final book, includes provisions that policyholder counsel do not like and that do not state the typical policyholder position.<sup>48</sup> However, in part because policyholders lack the unified mindset and industry trade groups dedicated to advancing interests of the insurance industry, policyholders have no organized effort to undercut (or bolster) the Restatement.<sup>49</sup>

#### B. THE PROCESS AND GOALS FOR THE RESTATEMENT

The entire project was approved at the May 2017 Annual Meeting.<sup>50</sup> However, after significant insurer opposition, comment on many provisions and numerous motions to recommit (extend—or derail—the process) the ALI membership, on the recommendation of leadership, voted to extend the RLLI

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of the RLLI. Other motions targeted at 23 of the separate sections of the Restatement. *See also The ALI Reporter*, *supra* note 44, at 7 (discussing author Lorelie Masters' views of controversies about the RLLI in ALI interview); *see also, generally*, Baker and Logue, *supra* note 1, 24 GEO. MASON L. REV. 767. The controversy about the standard applicable to the issue of allocation of long-tail liability ("all sums" vs. "pro rata") is discussed in the ALI interview, ALI Practitioners' Perspectives, *supra* note 44, at 7; and at length in Lorelie S. Masters, "The 'A-C-P's' of Liability Insurance: Allocation, Contribution, and Proration in the Restatement of the Law, Liability Insurance," NEW APPLEMAN ON INSURANCE: CURRENT CRITICAL ISSUES IN INSURANCE LAW (Lexis-Nexis 2015) [hereafter Masters A-C-P's].

<sup>48</sup> Examples include the policy interpretation sections, which did not adopt doctrines like reasonable expectations. The most prominent example is § 41, titled "Allocation in Long-Tail Claims Covered by Occurrence-Based Policies," adopting pro-rata allocation of long-tail liabilities. *See The ALI Reporter Fall 2019*, *supra* note 44, at 7; *see generally* Masters A-C-P's, *supra* note 47.

<sup>49</sup> At one point in early 2018, before final approval of the RLLI, a group of general counsel from major U.S. policyholder companies submitted a letter to the ALI supporting the insurance industry's anti-RLLI position. Letter of General Counsels of Tamko Building, Brunswick Corp., Eli Lilly, Novartis, RPM, Shell, Glaxo Smith Kline, Johnson & Johnson, submitted to ALI as comments to RLLI Proposed Final Draft No. 1 (Mar. 28, 2017) (copy on file with authors). The submission of that letter was mystifying to policyholder advocates involved in the RLLI, and we assumed it was solicited by and submitted at the behest of the insurance industry. There has been no further similar, organized push-back on the RLLI from policyholder companies since then, perhaps because further reflection and knowledge of the RLLI has caused a rethinking of the wisdom of such an effort.

<sup>50</sup> RESTATEMENT OF THE L. OF LIAB. INS., FOREWORD at XIV (AM. LAW. INST. 2019) ("After the sixth of [the ALI Annual Meetings at which the Restatement was considered], in May 2017, all of the Sections had been approved.").

process for another year, to allow for additional revision and debate. As ALI Director Revesz recounts in his Foreword to the published Restatement, “the Reporters took another year to consider feedback, particularly from stakeholders, before submitting a final draft for [final] approval in May 2018.”<sup>51</sup> During that additional year, the advisers, MCG, Council, and others held additional meetings and made further comments, and the Reporters “made large numbers of changes, most importantly in Sections dealing with policy interpretation [§§ 2–4], liability of insurers for the conduct of the defense [§ 12], consequences of the breach of the duty to defend [§ 19], and remedies [§§ 47, 50].”<sup>52</sup>

Throughout the drafting process, the goals of the project were stated throughout to be uniformity, predictability, and reduction of disputes and litigation of disputes. These are laudable goals upon which, we assume, all involved can agree. Because homeowners’ liability, automobile liability, and commercial general liability (CGL) insurance policies are standardized and many forms of liability insurance use standard-form policy language, drafted by insurance industry groups and approved by state insurance commissions, it is also reasonable to support the Restatement’s objectives of seeking to promote consistency and predictability in the rules applicable to all policyholders and insureds on the one hand, and insurers on the other, under similar standardized policy terms. This, of course, promotes not just fairness but the ability of the insurance industry to mass-market insurance by allowing for an “apples to apples” actuarial analysis.<sup>53</sup> These objectives also promote confidence in the public and by the millions of insurance consumers who want to know what they are buying<sup>54</sup> in these boilerplate contracts and that the insurance purchased will provide the protection promised. We see very little discussion of the interests of consumers who buy insurance—which of course includes almost all of us—in the industry commentaries about the RLLI.

The Restatement was adopted on May 21, 2018, by the General Membership of the ALI in accordance with ALI rules, subject to conformance pursuant to the “Boskey Motion” made at the meeting.<sup>55</sup> The final Restatement was published in 2019.

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<sup>51</sup> RESTATEMENT OF THE L. OF LIAB. INS., FOREWORD at X (AM. LAW. INST. 2002).

<sup>52</sup> *Id.*

<sup>53</sup> MASTERS, ET AL., *supra* note 41, at §§ 1.02-1.03.

<sup>54</sup> INSURANCE SERVICES OFFICE (ISO), [www.verisk.com/insurance/brands](http://www.verisk.com/insurance/brands) (last visited Jan. 25, 2021).

<sup>55</sup> Under ALI rules, a Boskey Motion, named after long-time ALI Council member Bennett Boskey, allows for approval of a Proposed Final Draft subject to revisions by the

## C. PUBLIC DISCUSSION OF THE RESTATEMENT

The project that ultimately became the Restatement was discussed for years in insurance circles. As one prominent insurer-side commentator put it, “[t]he ALI Insurance Restatement has been the Kardashians of insurance coverage.”<sup>56</sup> At one point, the AIA pulled its liaison from the project; later, the AIA returned with another liaison.<sup>57</sup> In the two years before it was finally approved and was nearing completion, insurance industry focus intensified.

In publicizing a May 15, 2017 conference on the RLLI, the NAMIC stated that it “has spent years and vast resources to correct this injustice,” characterizing the Restatement as having “errantly and purposely adopted numerous minority rules . . . .”<sup>58</sup> By agreement with the ALI, the AIA’s liaison attended the meetings discussing the RLLI, and the advisers since 2010 including then-current or former general counsels and in-house counsel of State Farm, ACE, and Allstate Insurance Company. Outside counsel to insurers participated as advisers and members of the RLLI MCG. NAMIC actively monitored the project (at least in its final years), and insurers AIG and Liberty Mutual, among others, submitted comments.

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Reporters that capture comments made at the last Council and ALI general membership meetings and “subject to the usual editorial prerogatives.” See video found at <https://www.ali.org/about-ali/how-institute-works/> featuring U.S. District Judge and ALI Council member, Lee Rosenthal (accessed Jan. 20, 2020). That video quotes Mr. Boskey in defining the ALI as “the solid alliance of a wisely selected group of practicing lawyers, judges, and academics working together to produce major reforms that will facilitate adjusting the law to the changing needs of Society as one generation gives way to the next.”

American Law Institute, *Bennet Boskey and the Boskey Motion*, <https://www.ali.org/about-ali/how-institute-works/>.

<sup>56</sup> Randy Maniloff, *A Curious Letter Is Sent to the ALI About Its Liability Insurance Restatement*, COVERAGE OPINIONS (May 17, 2017), <http://coverageopinions.info/Vol6Issue5/ACuriousLetter.html>.

<sup>57</sup> See, e.g., Preliminary Draft No. 6, PRINCIPLES OF THE L. OF LIAB. INS. (Mar. 10, 2014) (listing Craig A. Berrington as Liaison for the American Insurance Association (AIA)); Preliminary Draft No. 7, PRINCIPLES OF THE LAW, LIABILITY INSURANCE (Aug. 15, 2014) (showing no liaison); Discussion Draft No. 1, RESTATEMENT OF THE L. OF LIAB. INS. (Mar. 2, 2015) (listing Laura A. Foggan as liaison for the AIA) (copies on file with authors).

<sup>58</sup> NAT’L ASS’N OF MUTUAL INSURANCE COMPANIES, <https://www.namic.org/Home/DisplayContentById/11866ddc-402c-412a-bb54-5cacf238c549#about> (last visited Jan. 25, 2021).

The Restatement was discussed at seven ALI Annual Meetings, and the reporters, advisers, and MCG members began speaking in public about the RLLI starting no later than June 2011, when a public presentation was made to none other than the Law and Regulation Committee of the AIA. Author Lorelie Masters first spoke about the RLLI on a panel at the December 2012 Annual Insurance Coverage and CLE Conference of the Defense Research Institute (DRI) in New York City.

The Restatement received substantial coverage in legal and insurance press and publications over the years since 2010.<sup>59</sup> In 2014, Rutgers Law School held a nationally publicized symposium on the RLLI and, in 2015, devoted an issue of its Law Review to the RLLI, publishing articles from both policyholder and insurer-side lawyers.<sup>60</sup> The American College of Coverage Counsel (ACCC) discussed the Restatement at its annual meetings beginning around 2015.<sup>61</sup> Publications read regularly by insurance practitioners have addressed the Principles/Restatement including Law 360: Insurance. The ALI quarterly newsletter, *The ALI Reporter*, published commentaries about the Restatement beginning no later than mid-2016.<sup>62</sup> Lexis Nexis in 2015 published point-counterpoint analyses of key issues in the RLLI by insurer-side lawyer William Barker on the one hand; and by Ms. Masters and her co-authors on the other.<sup>63</sup> Statements that the project was unknown are belied by these public discussions of its progress.

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<sup>59</sup> The RLLI was analyzed at many seminars, including annual meetings of the American College of Coverage Counsel, the ABA TIPS Insurance Coverage Litigation Committee (ICLC), the ABA Section of Litigation ICLC, DRI's Annual Insurance Coverage and CLE Seminar (in addition to the first one in 2012). NAMIC, Rutgers Law School, and George Mason Law School also sponsored webinars and presentations on the RLLI. [Remove italics on RLLI.]

<sup>60</sup> Symposium, *The Restatement of the Law of Liability Insurance as a Restatement: An Introduction to the Issue*, 68 RUTGERS U.L. REV 1 (Fall 2015).

<sup>61</sup> The ACCC is dedicated to advancing collegiality and professionalism in the national insurance-coverage bar and includes members representing both policyholders and insurers. The Presidency alternates between an insurer representative and a policyholder representative. The author was a co-founder and the second President of the College. See [www.americancollegecoverage.org](http://www.americancollegecoverage.org).

<sup>62</sup> *The ALI Reporter Fall 2019*, AM. L. INST., (Oct. 9, 2019).

<sup>63</sup> Masters, Bach, & Wade, NEW APPLEMAN ON INSURANCE: CURRENT CRITICAL ISSUES IN INSURANCE LAW, *supra* note 41; William T. Barker, "The American Law Institute Principles of the Law of Liability Insurance Part II: Selected Comments from an Insurer Perspective," NEW APPLEMAN ON INSURANCE: CURRENT CRITICAL ISSUES IN INSURANCE LAW (Lexis Nexis Spring 2015) (hereinafter Barker). The Masters, Bach, & Wade article has been posted on the publicly available website of United Policyholders since

## D. STRUCTURE OF THE RESTATEMENT AND AREAS OF CONTROVERSY

## 1. Structure

The Restatement contains the following four chapters, which contain 50 sections of black-letter principles and by rough count 110 points of law.<sup>64</sup>

## Chapter 1, Basic Liability Insurance Contract Rules:

- § 1—Definitions,
- §§ 2-4—Topic 1: Interpretation,
- §§ 5-6—Topic 2: Waiver and Estoppel, and
- §§ 7-9—Topic 3: Misrepresentation.

## Chapter 2, Management of Potentially Insured Liability Claims:

- §§ 10-23—Topic 1: Defense,
- §§ 24-28—Topic 2: Settlement, and
- §§ 29-30—Topic 3: Cooperation.

## Chapter 3, General Principles Regarding the Risks Insured:

- §§ 31-33—Topic 1: Coverage,
- §§ 34-36—Topic 2: Conditions, and
- §§ 37-43—Topic 3: Application of Limits, Retentions, and Deductibles.

## Chapter 4, Enforceability and Remedies:

- §§ 44-46—Topic 1: Enforceability, and

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the Fall of 2015 ([www.uphelp.org](http://www.uphelp.org)). *See also* Masters, A-C-P's NEW APPLEMAN ON INSURANCE: CURRENT CRITICAL ISSUES IN INSURANCE LAW.

This article was noted in the Fall 2015 edition of *The ALI Reporter* (<https://www.ali.org/news/articles/ali-reporter-fall-2015/>).

<sup>64</sup> The Restatement uses the terms “insured” to refer to any entity or person insured under a liability insurance policy and “policyholder” to refer to the party that purchased the insurance. Restatement §§ 1(4) and (10).

- §§ 47-50—Topic 2: Remedies.<sup>65</sup>

## 2. Controversies

Many sections of the Restatement remain the subject of controversy. This article focuses on several that continue to be the source of significant insurance-industry critique:

- §§ 2-4 on principles of insurance policy interpretation, and specifically on § 3.
- § 8 on the standard for materiality applicable to the defense of misrepresentation in the policy application.
- § 12 on insurer liability for the conduct of lawyers appointed by insurers as defense counsel.

This article also briefly addresses controversy generated by the following RLLI sections:

- § 13(3) on the duty to defend and the Restatement's "one-way rule" (specifically the relevance of facts outside the complaint against the insured to the determination of whether the duty to defend applies).
- § 19 on the consequences for breach of the duty to defend (with references to §§ 15 and 50).
- §§ 24 and 27 on liability insurers' "duty to settle."  
§§ 47 and 50 on damages for breach of the insurance policy and for bad faith.

## IV. REACTIONS TO THE RESTATEMENT

The Restatement has excited many reactions. Most of the commentary since the Restatement was adopted has come from insurance-industry commentators, repeating variations on the themes favored by insurers. Another significant effort has focused on getting legislation enacted to try to limit the ability of courts to consider the Restatement. Although few courts have addressed the Restatement substantively, one court arguably has relied on Restatement provisions while others, following existing state law on this issue at hand, have rejected the Restatement's treatment of the issue.

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<sup>65</sup> See RESTATEMENT OF THE L. OF LIAB. INS. (AM. LAW INST. 2019).

Insurance legislation, of course, plays an important role in the regulation of insurance and setting the standards that apply as a general rule (e.g., on claims-handling and settlement standards). However, legislation is not designed to address and resolve disputes about how a specific insurance policy applies to a specific claim or set of facts. In addition, many of the principles used regularly in insurance-coverage practice have developed (and will continue to develop) in the common law, and not from legislation. Indeed, state legislatures have never addressed or resolved all aspects of insurance law—and given the need to consider the facts of individual cases—they could not and, in the future will not, resolve all disputes over insurance. These differences are not, as many insurer representatives argue, a reason that the ALI should never have set out to create the Restatement. Indeed, given the ALI's mission, those differences are the very reason to do so.<sup>66</sup> To preclude development of law that serves the citizens and businesses of a state through a narrow perception of one secondary source like the Restatement seems misguided at the very least. Limiting courts' ability to consider relevant sources also is inconsistent with the bedrock principles in the United States of judicial independence and separation of powers.

Negative consequences could, over time, result from this organized effort to undermine the ALI and the Restatement. As one example, it is useful to consider the effect these efforts could have on the marketability of insurance. As noted above, insurance is a mass-marketed product that can be sold on a mass basis only because it uses standardized policy terms,<sup>67</sup> and, thus, allows for “apples to apples” comparisons among insureds and actuarial analysis.<sup>68</sup> The insurance-buying public, companies and individuals alike, want to know that it will provide needed protection.

Courts have recognized the public's interest in a well-functioning insurance system as it facilitates commerce by spreading risk; by protecting infrastructure and providing resources for people and businesses to recover from disaster and other loss; and by controlling and preventing loss by encouraging “best practices” on

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<sup>66</sup> Many Restatements, like the RLLI, in truth, address topics involving this same mix of statute and common law, with variations from state to state exist. Examples include the Restatements of Contracts and Torts.

<sup>67</sup> For the Restatement's definition of insurance policy “term,” *see* RESTATEMENT OF THE L. OF LIAB. INS. § 1(14) (AM. LAW. INST. 2019).

<sup>68</sup> *See* MASTERS ET AL., *supra* note 41, at Ch. 1, for further examination of the drafting of standardized policy language and its role in the creation of modern insurance markets, with citations to insurance industry analyses and related sources.

disaster recovery and rebuilding and construction.<sup>69</sup> Consistency in application of liability insurance policies promotes the confidence of insurance purchasers, ordinary consumers and businesses alike, in the purchase of liability insurance. In the long-term, that is a positive for insurance purchasers, insurers, and, given the public purpose of insurance of spreading risk and encouraging innovation, Society as a whole.

#### A. ARTICLES AND PUBLISHED CRITIQUES

Internet searches reveal a plethora of articles from insurer industry groups, insurer spokespeople, and insurer counsel attacking the Restatement,<sup>70</sup> and assailing the ALI's purported efforts to "invade" the prerogative of insurance legislation.<sup>71</sup> Few present or acknowledge countervailing perspectives. Legislators belonging to NCOIL referred to "overreach" by the ALI and asserted the need for legislation that would "accurately state" the law applicable to liability insurance. As reflected in minutes of NCOIL's Property and Casualty Insurance Committee, a NAMIC representative stated at one of the Committee's meetings that assignment of its

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<sup>69</sup> For example, insurance underwriting helps encourage companies to invest in systems that prevent and mitigate loss. Insurance incentivizes purchasers to put in place beneficial processes and systems by offering lower rates to purchasers who meet best practices and construction and security standards. In the context of liability insurance, lower rates are often offered to companies with robust cyber security systems and practices.

<sup>70</sup> E.g., Patricia McHugh Lambert, *How Will States Respond to The Restatement of the Law, Liability Insurance?*, JDSUPRA (July 8, 2019) <https://www.jdsupra.com/legalnews/how-will-states-respond-to-the-96410/>; O'MEARA LEER WAGNER KOHL, SEVERAL MORE STATES RESPOND TO THE ALI'S RESTATEMENT OF LIABILITY INSURANCE (2019) (as shown on the firm website, although not in articles published in other venues, O'Meara Leer Wagner Kohl represents insurance carriers on insurance coverage issues); Alan Smith, *As an Unelected Legal Organization Attempts to Rewrite Insurance Law, Indiana Legislators are Pushing Back*, RSTREET (Apr. 22, 2019), <https://www.rstreet.org/2019/04/22/as-an-unelected-legal-organization-attempts-to-rewrite-insurance-law-indiana-legislators-are-pushing-back/>; Kim Markkand, *ALI Shouldn't 'Teach' Insurance Restatement in a Courthouse*, LAW360 (Feb. 11, 2019, 12:44 PM), <https://www.law360.com/articles/1127838/ali-shouldn-t-teach-insurance-restatement-in-a-courthouse>; *Why Ohio*, *supra* note 17.

<sup>71</sup> See, e.g., Press Release, Thomas B. Considine, Nat'l Council Ins. Legislators, *NCOIL CEO Statement on ALI Restatement of Liability Insurance Law* (May 25, 2018) (opening by stating that NCOIL had "been working with the ALI to ensure that legislative prerogatives were respected," and calling the Restatement the "NEWstatement" and "a drafters' wish list," ignoring the extensive participation by insurance company in-house and outside counsel and an AIA liaison in the Restatement's eight-year drafting process).



proposed legislation to a legislature's Judiciary Committee, rather than the Insurance Committee, would undermine the "intent" of the legislation.<sup>72</sup>

These arguments and efforts ignore that much of the law on insurance is common law, made by courts tasked with resolving disputes over coverage for specific claims. As a Minnesota appellate court explained years before the RLLI began, "Restatements of the Law are persuasive authority only and not binding unless specifically adopted in Minnesota by statute or case law."<sup>73</sup> The court's observation, of course, states a universal truth—courts do not rely on secondary authority when binding law, in court decisions or statutes, exists in the jurisdiction.

Many of the recent critiques of the RLLI published since approval of the RLLI in May 2018 do not acknowledge the many changes made over the years of its drafting, or that many were made at the behest of and based on comments from insurance industry proponents. These critiques sometimes do not disclose the authors' ties to the insurance industry or whether insurance industry clients or groups have paid them for their time in writing such articles.<sup>74</sup> Transparency, of course, is ideal. Further, publications publishing such critiques should insist on disclosure of whether the commentator represents insurers or policyholders, and whether the author is being paid for writing such critiques and by whom. Finally, it is important to note that many criticisms of the RLLI complain about provisions that appeared in Drafts of the RLLI and not the final Restatement. As anyone who has written a brief

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<sup>72</sup> Minutes of NCOIL's Property and Casualty Committee (Mar. 17, 2019), <http://ncoil.org/wp-content/uploads/2019/04/Nashville-PC-Minutes.pdf> (referring to the remarks of Erin Collins, Assistant Vice President, State Affairs, NAMIC).

<sup>73</sup> *Williamson v. Guentzel*, 584 N.W. 2d 20, 24-25 (Minn. Ct. App. 1998) (citing *Mahowald v. Minnesota Gas Co.*, 344 N.W.2d 856, 860 (Minn. 1984)). Other court decisions of course make the same point. *E.g.*, *Cramer v. Starr*, 375 P.3d 69, 74-75 (2016) (highlighting that the court refused to adopt § 475 of RESTATEMENT (SECOND), TORTS, because it was contrary to Arizona statutes and case law).

<sup>74</sup> Some prime movers in the insurance industry have hired law firms to address and make the insurer's or insurance industry's arguments about the RLLI. *See, e.g.*, Mintz Levin Cohn Ferris Glovsky Poppeo, *The Restatement of the Law, Liability Insurance*, <https://www.employmentmattersblog.com/industries-practices/case-studies/restatement-law-liability-insurance> (last accessed Feb. 5, 2020) ("We were retained by Liberty Mutual to respond to the ALI's effort to remake the existing law of liability insurance . . . . We have provided extensive legal authority, published articles, and spoken at the ALI Annual Meeting in 2018 in response to draft provisions of the four chapters of the Restatement.").

can appreciate the final product often bears little resemblance to the early drafts. As Yogi said, “it’s ain’t over ‘til it’s over.”

B. LEGISLATIVE MEASURES RAISED IN REACTION TO THE RESTATEMENT

1. Model Acts or Legislation

Certain insurance industry and legislative groups have focused intently on the RLLI, especially from 2017 to the present.<sup>75</sup> For example, a packet of materials distributed at the March 2019 NCOIL meeting included proposed legislation, drafted by NAMIC, that legislators could introduce in their state legislatures.<sup>76</sup> Interestingly, as shown below, the model legislation evolved and has gone through multiple revisions, in the same way that the RLLI drafts evolved and were revised in response to comments and from further research and work.

*a) First Proposed Model Act on the Restatement*

On March 17, 2019, NCOIL circulated a “Model Act Regarding Interpretation of an Insurance Policy,” patterned after legislation passed in Tennessee in 2018 (before the final *Restatement* was published) to require application of the “plain meaning rule” to interpretation of insurance policies. NCOIL’s Preface to the model language encouraged States to work with “stakeholders and the insurance department to amend the appropriate portion[s] of

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<sup>75</sup> Some motions made by insurer representatives in the Spring of 2017 asked that the ALI recommit or “defer” approval of the RLLI, stating in part that insurers were unaware before early 2017 of the effort to create the RLLI. *See* Letter from Thomas B. Considine, CEO, Nat’l Council Ins. Legislators, to Honorable Thomas V. Balmer, Chief Justice, Oregon Supreme Court (Feb. 27, 2018), <http://ncoil.org/2018/02/28/ncoil-writes-to-state-chief-judges-urging-action-on-alis-proposed-liability-insurance-restatement/>. Another adviser to the RLLI, John G. Buchanan III, submitted a response, identifying the many conferences and articles that had addressed the RLLI before 2017. The argument also ignored the many insurer representatives involved since 2010 in the RLLI (including, as noted above, outside and in-house insurer counsel and the liaison from the AIA). The comments submitted by RLLI adviser John G. Buchanan III on RLLI Proposed Final Draft (Mar. 28, 2017), are on file with the authors.

<sup>76</sup> Letter from Erin Collins, Assistant Vice President of State Affairs, Nat’l Ass’n Mut. Ins. Cos., to Chairman and Members of the Nat’l Council Ins. Legislators (Mar. 14, 2019), <http://ncoil.org/wp-content/uploads/2019/03/NAMIC-ALI-testimony-Nashville-EMC-002.pdf>.

[the] insurance code . . . in order to avoid the ‘*Restatement of the Law, Liability Insurance*’ . . . being construed as the state’s settled law on this issue.”<sup>77</sup>

Most other bills introduced in state legislatures to date are addressed to the RLLI as a whole—all 50 sections and 100-plus individual principles of law. Some of these bills and pieces of legislation state that courts may not consider the RLLI as “an authoritative source.” These and similar bills raise the question of whether the legislation serves a reasonable purpose as a fair reaction to them is that they potentially undermine the independence of the courts and the judicial process that creates common law.

This provision also did not acknowledge the Restatement’s treatment of the contextual rule of contract interpretation in the Restatement (Second) of Contracts. Indeed, the final version of the Restatement specifically declined to follow the modern, contextual approach to contract interpretation on the ground that “a substantial majority of courts in insurance cases have adopted a plain-meaning rule,”<sup>78</sup> a point that insurer advocates had fought to obtain for years in the RLLI process. Thus, the approach adopted in the Restatement uses an approach that harkens back more to the Restatement (First) of Contracts.

The ALI engaged with NCOIL in a dialogue about their concerns. For example, the ALI’s Deputy Director Stephanie Middleton sent a letter to NCOIL’s CEO and General Counsel in early April 2019, asking that the letter be shared with NCOIL’s Property and Casualty Insurance Committee and the entire NCOIL membership. The letter explained that the ALI had posted NCOIL letters commenting on various provisions of the Restatement on the ALI website “so all ALI members could read them,” and brought those comments to the attention of the ALI Council, before the Restatement was approved. The ALI stated that, “in response to many comments, including NCOIL’s, ALI decided in May 2017 to take an extra year to review the entire project.”<sup>79</sup> The letter set forth the ALI’s observation

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<sup>77</sup> MODEL ACT REGARDING INTERPRETATION OF AN INS. POL’Y drafting note (NAT’L COUNCIL INS. LEGISLATORS 2019).

<sup>78</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 3, cmt. a (AM. L. INST. 2019).

<sup>79</sup> Letter from Stephanie A. Middleton, Deputy Director, Am. L. Inst., to Thomas B. Considine, CEO, Nat’l Council Ins. Legislators, and William Melofchik, General Counsel, Nat’l Council Ins. Legislators (Apr. 3, 2019), <http://ncoil.org/wp-content/uploads/2019/04/Ltr-to-NCOIL-Apr2019-1.pdf>. Motions were made in opposition to this delay but were voted down by a clear majority of the membership present. This decision was made not simply as NCOIL documents indicate “because NCOIL requested it.”

that many of the provisions in the final Restatement conformed to changes the insurance industry sought to the Proposed Final Draft of the RLLI, as presented at the 2017 ALI Annual Meeting:

In that final year [after the May 2017 ALI annual meeting] the draft adopted some significant changes that your letters urged: a simple plain-meaning rule; greatly limited insurer liability for negligent selection of counsel; an added catch-all exception to the complaint allegation rules; revised language to make it even clearer that an insurer may discontinue the defense without seeking a declaratory judgment; removal of language that would prevent insurers from asserting coverage defenses in cases of non-bad-faith breach; and removal of language that would require insurers to pay the attorneys' fees of the insured when the insured prevails in a suit against the insurer for non-bad-faith breach.<sup>80</sup>

In addition, as noted above, courts are highly unlikely to consider any secondary source, including a Restatement, authoritative when a state legislature or appellate court (or even trial courts) have spoken on the issue.

*b) Second Proposed Model Act on the Restatement*

These messages evidently were received at NCOIL. On July 25, 2019, NCOIL approved the following text for a "Model Act Concerning Interpretation of [State] Insurance Laws," (hereafter called the NCOIL 2019 Model Statute):

**Section 2. Interpretation of [State] Insurance Laws**

A statement of the law in the American Law Institute's *Restatement of the Law, Liability Insurance* does not constitute the law or public policy of this state if the statement of the law is inconsistent or in conflict with:

1. The constitution of the United States or of this State;
2. A statute of this State;

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<sup>80</sup> *Id.*

3. This State's case law precedent; or
4. Other common law that may have been adopted by this State.<sup>81</sup>

The accompanying Press Release by NCOIL President, Louisiana Senator Dan “Blade” Morrish, stated that NCOIL had been involved with “ALI and their scholars” at multiple NCOIL meetings since May 2017 and thanked ALI for a “consistent and constructive dialogue” over that period of time. The Press Release stated that NCOIL “appreciate[s] the changes made from the initial draft [of the RLLI].”<sup>82</sup> It stressed NCOIL’s concern with protecting “legislative prerogatives” and, in a twist exalting practicing lawyers like me, categorized us with academics and seemed to ascribe to us powers from which legislators fear they need “protection.” Thus, the Press Release stated that NCOIL will “ensure our legislative work is protected from academics that interpret the law into something it is not”<sup>83</sup>; and that “[c]ertain select portions [of the RLLI] remain more of an ALI wish list than a statement of the majority rule of current law.” Especially given the Restatement’s reliance in all but a handful of instances on majority rules, it is fair in the authors’ views to say that the in-depth work of the Restatement is not a “wish list.” Indeed, as noted above, most provisions in the RLLI are majority rules,<sup>84</sup> and

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<sup>81</sup> Press Release, Nat’l Council Ins. Legislation, NCOIL Adopts Model Act Concerning Interpretation of State Insurance Laws 3 (July 25, 2019), <http://ncoil.org/2019/07/25/ncoil-adopts-model-act-concerning-interpretation-of-state-insurance-laws/> (noting that the Property & Casualty Insurance Committee adopted the act in on July 12, 2019 and the Executive Committee on July 13, 2019).

<sup>82</sup> *Id.* See also *supra* Section III (noting that the drafting process took place over eight years and involved thirty different drafts, which involved a wide range of interested constituencies).

<sup>83</sup> See Press Release, Nat’l Council Ins. Legislation, *supra* note 71, at 2.

<sup>84</sup> See, e.g., BAKER AND LOGUE, 24 GEO. MASON L. REV. at 768. As Professors Baker and Logue, the Reporters for the RLLI, state in that article, “All of the rules adopted by the Restatement are grounded in existing case law. In that sense, none of them are new, and certainly none are radical. Most of the rules in the Restatement have in fact been adopted by a majority of the U.S. jurisdictions that have considered them. The Restatement Follows a minority rule in only a few instances and only when the minority rule is better reasoned and will likely lead to better consequences than the alternatives. This is a common practice in ALI Restatement projects.” *Id.*

it includes or did not accept many provisions that policyholder representatives do not like.<sup>85</sup>

## 2. Legislative Efforts in Various States

A number of states as of this writing have adopted legislation, either by statute or resolution, on the Restatement. Governors of some states (Iowa, Maine, Nebraska, South Carolina, Texas, and Utah) in 2018 sent letters of disapproval to the ALI.<sup>86</sup> Numerous bills and resolutions on the Restatement were introduced in legislatures sessions for the period 2018–2020. At least one such measure was introduced in the legislative session which began in January 2021.

**The Tally:** Some of the legislative efforts passed before the RLLI was approved<sup>87</sup> and provided guidelines for legislation introduced in other states. Other states, particularly since approval of the RLLI in May 2018, have taken the July 2019 Model Act drafted by NCOIL as a base. Some are statutes while others are

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<sup>85</sup> See, e.g., RESTATEMENT OF THE L. OF LIAB. INS.: Allocation in Long-Tail Harm Claims Covered by Occurrence-Based Policies § 41 (AM. L. INST. 2019) (ruling that occurrence-based liability insurance policies were subjected to time-on-the-risk pro-rata allocation rather than all sums allocation). Policyholder representatives made motions to revise this Section from “time-on-the-risk pro rata allocation” in 2016 and 2017, and also moved to add the “unavailability exception” to the black letter. Those motions failed. While early drafts of the Restatement set forth “all sums allocation” for long-tail liability, insurers objected vociferously on the ground that pro rata is the majority rule. Policyholders made the point that, in those states that have adopted a rule on allocation in the context of long-tail liability, pro rata has been adopted in a scant majority and then only if one counts all of the different formulations of pro rata. By itself, the form of proration adopted in § 41, time-on-the-risk pro rata allocation, is not a “majority rule.” See Masters A-C-Ps, *supra* note 47. As other examples, policyholders did not favor the insurance-policy interpretation structure set forth in §§ 3–4 of the Restatement, or certain provisions relating to misrepresentation in §§ 7–9 (e.g., regarding innocent misrepresentations (§ 7, cmt. j); objective standard set forth in § 8; rejection of contribute-to-the-loss approach (§ 9, cmt. b)).

<sup>86</sup> Letter from Governors of South Carolina, Iowa, Maine, Nebraska, Texas, and Utah, to Hon. David F. Levi, President, Am. Law. Inst. (Apr. 6, 2018) (on file with author); see also Marrkand, *supra* note 13. It seems fair to assume that these Governors had encouragement from the insurance industry.

<sup>87</sup> Ohio was the first State to adopt provisions on the RLLI, enacting them before the final version of the RLLI was available. Tennessee also adopted a statute addressing standards applicable to insurance-policy interpretation, prompted by the advent of the Restatement, but the statute does not reference the RLLI.

resolutions. Acts of course are binding statutory law, while resolutions express “the sentiment or intent of the legislature” or govern the business of the legislature.<sup>88</sup>

Below is a summary of legislative efforts on the Restatement as of this writing (in early-February 2021).

- The codes in the following states now include provisions regarding the Restatement: Ohio, Michigan, Arkansas, North Dakota, Texas, and Utah.<sup>89</sup>
- The following states have adopted resolutions about the Restatement: Kentucky, Indiana, and Louisiana.<sup>90</sup>
- Legislators introduced legislation similar to the bills and resolutions adopted by the states above. Some measures were not enacted before legislative sessions from 2018–2020 expired.<sup>91</sup> Oklahoma now is entertaining bills introduced in the current (2021) legislative session.

Earlier versions of such legislation sometimes used pejorative or intemperate language in referring to the Restatement and the ALI or use language that reflected ignorance of the history of the ALI and the scholarship that went into the RLLI. “Cooler heads,” in such circumstances, appear sometimes to have prevailed. For

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<sup>88</sup> See e.g., *Glossary of Legislative Terms*, NAT’L CONF. ST. LEGISLATURES, <https://www.ncsl.org/research/about-state-legislatures/glossary-of-legislative-terms.aspx> (last visited Nov. 6, 2020).

<sup>89</sup> OHIO REV. CODE ANN. § 3901.82 (West 2018); TENN. CODE ANN. § 56-7-102 (West 2018); MICH. COMP. L. ANN. § 500.3032 (West 2018); ARK. CODE ANN. § 23-60-112 (West 2019); N.D. CENT. CODE ANN. § 26.1-02-34 (West 2019); TEX. CIV. PRAC. & REM. CODE § 5.001. (West 2019).

<sup>90</sup> H.R. Res. 222 (Ky. 2018) (enacted); H.R. Con. Res. 62, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019) (enacted); H.R. Res. 86 (Ind. 2019) (enacted); S. Res. 149, Reg. Sess. (La. 2019) (enacted); UTAH CODE ANN. § 31A-22-205.

<sup>91</sup> S.B. 260, 123d Gen. Assembly, 1st Reg. Sess. (S.C. 2018) (introduced); S.B. 368, 84th Leg., Reg. Sess. (W. Va. 2019) (introduced); S.B. 1176, 65th Leg., 1st Reg. Sess. (Idaho 2019) (introduced); S.B. 2303 (Tex. 2019); H.R. Con. Res. No. 58 (Tex. 2019) (Comm. Rept.); H.B. 2106 (Mo. 2020) (refer to Comm.); S.B. 939 (Mo. 2020) (refer to Comm.); S.B. 1692 (Okla. 2020) (passed Sen., withdrawn from Comm.); H.B. 4436 (W. Va. 2020) (refer to Comm.); S.B. 772 (W. Va. 2020) (passed Sen., refer to Comm. in house).

example, one resolution proposed in Texas that “condemn[ed]” the Restatement did not pass.<sup>92</sup>

A number of these states adopted this legislation in 2018 and 2019, including Arkansas (by statute),<sup>93</sup> Indiana (by resolution),<sup>94</sup> Louisiana (by resolution),<sup>95</sup> Michigan (by statute),<sup>96</sup> North Dakota (by statute),<sup>97</sup> and Texas (by statute).<sup>98</sup> Kentucky introduced a bill in early 2020 (pre-filed in 2019). A bill on the RLLI introduced in the Idaho legislature in 2019 did not advance.<sup>99</sup> Neither did house and senate bills in Missouri, which expired when the legislature adjourned in Spring 2020.<sup>100</sup> Bills on the RLLI were introduced in ten states in early 2020.<sup>101</sup> Amidst the coronavirus pandemic, many bills introduced in 2020 did not progress and expired at the conclusion of the 2020 legislation session. Oklahoma has reintroduced an identical bill, which pending in the state senate.<sup>102</sup> Other states with prior legislative efforts may follow suit in 2021.

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<sup>92</sup> Tex. Concurrent Res., H.C.R. No.58 (RLLI “is not worth of recognition by the courts as an authoritative source; no, therefore be it RESOLVED That the 86th Legislature of the State of Texas hereby condemn the American Law Institute’s 2018 Restatement of the Law of Liability Insurance and discourage courts from relying on the Restatement as an authoritative reference . . .”).

<sup>93</sup> 2019 Ark. Act 742, S.B. 565, 92nd Gen Assemb., Reg. Sess. (Ark. 2019) (codified as amended at ARK. CODE ANN. § 23-60-112 (West 2019) (effective July 24, 2019)).

<sup>94</sup> H.R. Cong. Res. 62, 121st Gen. Assemb., Reg. Sess. (Ind. 2019); H.R. Res. 86, 121st Gen. Assemb., Reg. Sess. (Ind. 2019) (the text of both being virtually identical).

<sup>95</sup> S. Res. 149, 2019 Reg. Sess. (La. 2019) (adopted May 30, 2019).

<sup>96</sup> MICH. COMP. LAWS ANN. § 500.3032 (West) (passed Dec. 2018; effective Jan. 1, 2020).

<sup>97</sup> H.B. 1142, 66 Leg. Assemb., Reg. Sess. (N.D. 2019) adopted as N.D. CENTURY CODE ANN. § 26.1-02-34 (enacted Mar. 21, 2019).

<sup>98</sup> H.R. Cong. Res. 58, 116th Cong. (2019), adopted as Tex. Cir. Prac. & Rem. Code § 5.001. Texas has entertained other bills relating to the RLLI, including the following bills which did not advance: Tex. S.B. 2303 and Tex. House Con. Res. 2303.

<sup>99</sup> S.B. 1176, 65th Leg., Reg. Sess. (Idaho 2019).

<sup>100</sup> H.B. 2106 98th Gen. Assemb., Reg. Sess. (Mo. 2018); S.B. 939 99th Gen. Assemb., Reg. Sess. (Mo. 2018) (refer. to Comm. Feb. 27, 2020).

<sup>101</sup> H.B. 2644, 2020 44th Leg., 2d Leg. Sess. (Ariz. 2020); H.B. 359, (Fla. 2020); S. Study B. 3014, 88th Gen. Assemb., (Iowa, 2020); Iowa H.B. 513; H.B. 150, Reg. Sess. (Ky. 2020); H. B. 2106, 100th Gen. Assemb., 2nd Reg. Sess. (Mo. 2020) & S.B. 939, 99th Gen. Assemb. 2nd Reg. Sess. (Mo. 2020); Leg. B. 884, 106th Leg., 2d. Sess. (Neb. 2020); S.B. 1692, Reg. Sess. (Okla. 2020); S.B. 1036, 123d Gen. Assemb. (S.C. 2020); H.B. 37, Gen. Assemb. (Utah 2020); H.B. 4436, 116th Cong., (W. Va. 2020); S.B. 772, Reg. Sess. (W.Va. 2020).

<sup>102</sup> S.B. 137 (Okla. 2021) (refer to Comm.).



***The Substance:*** Statutes, resolutions, and bills addressing the Restatement break into the following rough categories<sup>103</sup>:

- *“Early Adopter” Statutes:* One of the first statutes to be passed about the RLLI, a statute in Ohio takes a broad approach, evidently seeking to limit Ohio courts’ consideration of the Restatement on any issue. It does not appear that the legislature engaged in any analysis of the myriad principles of law and comments included in the RLLI; certainly, the one-sentence statute does not address any specific issue. In contrast, a Tennessee statute, also passed in 2018, surgically addresses one issue, policy interpretation, setting the applicable standard on policy interpretation under Tennessee law by statute.
- *Legislation Following the 2019 NCOIL Model Statute:* Statutes, resolutions, and bills following the 2019 NCOIL Model Statute state that the *Restatement* does not comport with the public policy of the state to the extent that the principle is “inconsistent with” or “in conflict with” the law of the state.<sup>104</sup> These statutes seem to state a truism: that Restatements are “not controlling [law],” or that they cannot be applied if there is contrary law (either by statute or common law) in the state.<sup>105</sup>
- *Legislation Expanding on the NCOIL Model Statute, and Potentially Intruding on Judicial Authority or Separation of Powers:* These statutes, resolutions, or bills include several formulations. Some say that courts in the state “shall not apply a principle”<sup>106</sup> from the RLLI; may not take judicial notice of the RLLI; or even seek to ban use of the RLLI as any kind of

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<sup>103</sup> This categorization is based on our reading and consideration of legislation passed or pending as of the date of this writing (early-February 2021). Others may categorize the various proposals differently.

<sup>104</sup> S. Study B. 3014 (Iowa 2019) and Iowa H. Study B. 513; S. Res. 149, Reg. Sess. (La. 2019); Leg. B. 884, 106th Leg., 2nd Sess. (Neb. 2020); OHIO REV. CODE ANN. § 3901.82; S. Res. 149, Reg. Sess. (La. 2019); S.B. 1692, 57th Leg., 2d Sess. (Okla. 2020); S.B. 137 58th Leg., 1st Sess. (Okla. 2021); S.B. 1036, 123rd Sess. Gen. Assemb. (S.C. 2020); H.B. No. 37 (Utah 2020); H.B. 4436, Reg. Sess. (W.Va. 2020) and S.B. 772, Reg. Sess. (W.Va. 2020).

<sup>105</sup> See, e.g., Tex. Civ. Prac. & Rem. Code § 5.001.

<sup>106</sup> MICH. COMP. L. § 500.3032 (eff. Jan. 1, 2020).

“authoritative reference.”<sup>107</sup> In a formulation that this article calls “NCOIL+,” some say that courts may not rely on the RLLI if the principle at issue is “not otherwise addressed” in state law.<sup>108</sup> These formulations likely will retard the development of the common law. They also threaten to intrude on judicial independence and violate separation of powers concepts.

- *Hybrids*: Hybrids that adopt some or all of the above approaches.<sup>109</sup>

Some legislation discussed below falls into more than one category and is cited then in two or more categories.

***The “Early Adopter” Statutes:*** As noted above, the legislation passed in Tennessee in 2018 was very specific<sup>110</sup> and consistent with examples of state legislation adopted on other topics addressed in other Restatements.<sup>111</sup> The Tennessee statute specifically defines how courts are to address insurance policy interpretation under Tennessee law, stating that an insurance policy must be interpreted “fairly and reasonably,” giving the policy language its “ordinary meaning.” It also states that an insurance policy must be construed “reasonably and logically as a whole,” and that rules governing interpretation of insurance policies “are the same as [those applying to] any other contract.” This of course is a principle of not just insurance-policy interpretation but general contract interpretation and is supported in the Restatement.<sup>112</sup>

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<sup>107</sup> H.B. 2106, 100th Gen. Assemb., 2d Reg. Sess. (Mo. 2018) and S.B. 939, 100th Gen. Assemb., 2d Reg. Sess. (Mo. 2018); N.D. CENTURY CODE § 26.1-02-34 (eff. Aug. 1, 2019); H. Res. 222 (Ky. 2018) (passed Mar. 27, 2018).

<sup>108</sup> See, e.g., ARK. CODE ANN. § 23-60-112 (2020).

<sup>109</sup> H.R. Cong. Res. 62, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019); H.R. Res. 86, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019).

<sup>110</sup> TENN. CODE ANN. § 56-7-102 (2020).

<sup>111</sup> As one example where a state legislature has passed legislation in response to a specific Restatement provision unrelated to the RLLI, Arizona passed legislation to confirm the state’s law on four distinct issues of trust law. That legislation was enacted to conform to the principles set forth in the Restatement (Second) of Trusts but not the Restatement (Third) of Trusts with respect to four specific issues (e.g., “The rights and powers of creditors of beneficiaries” and “The duties of trustees to distribute to those to whom a beneficiary owes any duties”). ARIZ. REV. STAT. ANN. § 14-10106 (2020). This “surgical approach” on those issues of trusts law is in contrast to most of the legislation on the RLLI that seeks to reject the entire Restatement without analyzing or addresses any specific issues.

<sup>112</sup> *Id.* For comparison, the text of the RLLI’s “black-letter” principle on this point, however, specifically states that very principle: “Except as this Restatement or applicable

The Ohio statute on the RLLI passed the Ohio legislature and was signed by Ohio Governor Kasich in 2018. It was included as a rider, buried in an 11-page statute discussing political subdivisions and regional councils of government. The pertinent sentence in this otherwise irrelevant and lengthy statute states that the RLLI is not “the public policy” of the state and is not subject to judicial notice: “The ‘Restatement of the Law, Liability Insurance’ that was approved at the 2018 annual meeting of the American Law Institute does not constitute the public policy of this state and is not an appropriate subject of notice.”<sup>113</sup>

It does not attempt to address any single issue in the RLLI or distinguish in any way among those of the 100-plus principles in the Restatement. Indeed, it is possible that some of the provisions in the RLLI do accord with Ohio public policy (or certainly do not contradict it). As with other RLLI legislation discussed in this section of the article, this broad-brush approach could create confusion and intrude on judicial authority to resolve issues that are unsettled or not addressed in Ohio law.

For one insurance defense firm, the Ohio statute “likely does not go far enough.” In what a cynic might consider the insurance-law version of book burning, the firm’s commentary worries that the Ohio statute might “not prevent Ohio’s appellate courts from looking to or adopting rules set forth in the RLLI as the common law of Ohio.”<sup>114</sup>

**Legislation Following the NCOIL 2019 Model Statute:** After Ohio adopted its statute on the RLLI, NCOIL revised its Model Act, and a number of states have adopted or are considering legislation stating that courts may consult the Restatement unless it is contrary to existing law in the state on the issue.<sup>115</sup> Stated affirmatively, under such legislation, courts may consult or cite the Restatement

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law otherwise provides, the *ordinary rules of contract interpretation apply* to the interpretation of liability insurance policies.” RESTATEMENT OF THE L. OF LIAB. INS. § 2(3) (AM. L. INST. 2019) (emphasis added).

<sup>113</sup> OHIO REV. CODE ANN. § 3901.82 (2020).

<sup>114</sup> O’Meara, *supra* note 70. The article also does not disclose the firm’s insurance defense work or who pays for it.

<sup>115</sup> For statutes or resolutions that have passed, see: ARK. CODE ANN. § 23-60-112 (2020); OHIO REV. CODE ANN. § 3901.82 (2020); TEX. CIV. PRAC. & REM. CODE ANN. § 5.001 (2019); H.R. Res. 222, Reg. Sess. (Ky. 2018); S. Res. 149, Reg. Sess. (La. 2019). For pending or previously-introduced legislation following this model, see H.B. 2644, 54th Leg., 2d Reg. Sess. (Ariz. 2020); H.B. 150, Reg. Sess. (Ky. 2020); Legis. B. 884, 106th Leg., 2d Reg. Sess. (Neb. 2020); S.B. 1692, 57th Leg., 2d Reg. Sess. (Okla. 2020); S.B. 137 58th Leg., 1st Sess. (Okla. 2021); S.B. 1036, 123d Gen. Assemb., 2d Reg. Sess. (S.C. 2020).

when the state does have existing law (by constitution, statute, or case law) on the issue. While it does not seem necessary to pass such legislation, it states an otherwise harmless truism, as courts typically do not look to Restatements on an issue when the legislature or the court of last resort in that state has spoken on an issue.<sup>116</sup>

***Legislation Expanding on the NCOIL Model Statute, and Potentially Intruding on Judicial Authority or Separation of Powers:*** In contrast, other legislation states that the RLLI is “not authoritative,” or takes the NCOIL 2019 Model Statute and expands its reach to preclude a court from considering the RLLI not only when the law in the state is “inconsistent” with the RLLI but also when the state has no law on the topic or the state has “not otherwise” addressed the principle in question.<sup>117</sup>

For example, the North Dakota legislation states that the *Restatement* should not be used “as an authoritative reference regarding interpretation of North Dakota laws, rules, and principles of insurance law.”<sup>118</sup> Other states have adopted similar provisions. For example, Michigan’s Code now states:

In an action brought in a court in the state, the court shall not apply a principle from the American Law Institute’s “*Restatement of the Law, Liability Insurance*” in ruling on an issue in the case unless the principle is clearly expressed in a statute of the state, the common law, or case law precedent of the state.<sup>119</sup>

It is unclear what the reference to the “common law” in the Michigan statute means. Does it mean common law generally? Does it mean common law only in Michigan? How does “common law” differ from “case law precedent” in this context? This legislation also raises another interesting question: How does the common law

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<sup>116</sup> For authority or commentary making this point, see *Williamson v. Guentzel*, 584 N.W.2d 20, 24-25 (Minn. Ct. App. 1998); Letter of former Arizona Supreme Court Chief Justices, opposing Ariz. House Bill 2644.

<sup>117</sup> For statutes and resolutions that have passed, see H.R. Cong. Res. 62, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019); H.R. Res. 86, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019) (identical to H.R. Con. Res. 62); H.R. Res. 222, Reg. Sess. (Ky. 2018); MICH. COMP. LAWS § 500.3032 (2020); N.D. CENT. CODE ANN. § 26.1-02-34 (2020). For previously-introduced legislation following this model, see S. Stud. B. 3014, 88th Gen. Assemb., 2020 Sess. (Iowa 2020); H. Stud. B. 513, 88th Gen. Assemb., 2020 Sess. (Iowa 2020); H.B. 2016, 100th Gen. Assemb., 2d Reg. Sess. (Mo. 2020); S.B. 939, 100th Gen. Assemb., 2d Reg. Sess. (Mo. 2020); H.B. 4436, 84th Leg., Reg. Sess. (W. Va. 2020); S.B. 772, 84th Leg., Reg. Sess. (W. Va. 2020).

<sup>118</sup> N.D. CENTURY CODE § 26.1-02-34 (2019).

<sup>119</sup> MICH. COMP. LAWS ANN. § 500.3032 (2020).

advance when the legislature puts this kind of heavy hand on the scale? On the plus side, this statute refers to “an issue in the case” rather than all principles in the RLLI.

The Arkansas statute provides an example of the “NCOIL+ Model,” going beyond the NCOIL 2019 formulation that a court may not cite the RLLI when state law is “inconsistent” with it. The Arkansas statute allows a “statement of the law” in the Restatement to be used if it is consistent with or “otherwise is not addressed by” other Arkansas law (or, interestingly, “the common law and statute law of England as adopted” by an Arkansas statute):

A statement of the law in the American Law Institute’s *Restatement of the Law, Liability Insurance* does not constitute the public policy of this state if the statement of the law is not consistent or in conflict with, or otherwise not addressed by:

- (1) A statute of the State of Arkansas;
- (2) The common law and statute law of England as adopted in Arkansas under § 1-2-119; or
- (3) Arkansas case law precedent.<sup>120</sup>

It seems obvious that these provisions could retard the development of case law and its application to the particular sets of facts that come up in litigated insurance-coverage disputes. These statutes potentially violate separation of powers by prohibiting judges from looking to the RLLI on issues where that state has no law on-point. In such cases, courts typically consult other relevant law, as well as secondary sources. Legislation on the RLLI potentially precludes courts from consulting a respected secondary source, possibly leading to less optimal results in the development of the common law.

These provisions, given their blunderbuss approach, also may create confusion in the courts, causing a potential for delay in resolution of cases. It also must be asked: Does a legislature in proposing such legislation mean to stop the judicial branch from citing a secondary source that supports an established principle of state law just because it is discussed in the Restatement?

***Legislation Referring Not Only Restatements – But Also Other Secondary Authority:*** A bill introduced in early 2020 in Florida states that not only is the

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<sup>120</sup> ARK. CODE ANN. § 23-60-112 (2019).

Restatement off-limits to courts but also any secondary source relating to liability insurance as well:

(10) A secondary legal authority does not constitute the law or public policy of this state if its statement of the law relating to liability insurance is in conflict with: . . . [to be inserted]<sup>121</sup>

Again, this provision states the truism that courts do not adopt a secondary source as law or use it to override the law adopted by the jurisdiction's legislature or, with common law, the jurisdiction's highest or other authoritative courts. However, courts of all levels, up to the United States Supreme Court, routinely consult and cite secondary sources in an area where relevant law, either by case law or statute, does not exist or is unsettled. What lawyer or judge has not cited or consulted secondary authority, including learned treatises, law review articles (often written by law students and not lawyers), and, yes, Restatements, when faced with an issue where the law is not developed?

**Hybrids:** The “hybrids” adopt a variety of the approaches discussed above.<sup>122</sup> A resolution passed by the Indiana House of Representatives in 2019 stated a version of the “public policy prohibition” and also adopted guidance to the courts that they should not consider the RLLI authoritative:

[RESOLVED] that the *Restatement of the Law, Liability Insurance* that was approved that the 2018 annual meeting of the American Law Institute does not reflect the determination of the state of Indiana's public policy, is not a faithful statement of existing law of the state of Indiana, is not an appropriate subject of notice, and should not be afforded recognition by courts as an authoritative reference regarding established rules and principles of insurance law.<sup>123</sup>

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<sup>121</sup> Fla. B. No. PCS for H.B. 359, Amendment No. 2a (offered by Rep. Diamond). *See also* Ky. Res. 150 (pending), as discussed below.

<sup>122</sup> For a “hybrid” legislation that passed, see H.R. Con. Res. 62, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019) and H. Res. 86 (which are identical). For pending “hybrid legislation,” see H.B. 150 (Ky.); H.B. 2106, 100th Gen. Assemb., 2d Reg. Sess. (Mo.), and S.B. 939, 100th Gen. Assemb., 2d Reg. Sess.; H.B. 4436, Reg. Sess. (W. Va. 2020) and S.B. 772, Reg. Sess. (W. Va. 2020).

<sup>123</sup> H. Cong. Res. No. 62 (Ind. 2019). The O’Meara article, published in April 2019, notes that this resolution was introduced by Representative Matt Lehman, a member of NCOIL and its Property and Casualty Insurance Committee “which is currently exploring

The Indiana resolution does not preclude reliance on the RLLI with regard to issues on which Indiana state courts have not spoken. It also does not, however, make any distinction between or among any of the more than 100 legal principles discussed in the RLLI or try to analyze whether the Restatement includes principles that accord with existing Indiana law. In such situations, courts commonly cite secondary authority that further supports existing law or the principle handed down in the instant case. Is it sensible to preclude use of the RLLI in such a situation?

A bill currently pending in Kentucky includes the “not authoritative” language, but after consultation, was amended to allow courts to refer to the RLLI to the extent that it may be “informative” or “persuasive.” As amended and reported out to the House of Representatives, the bill stated: A statement or restatement of the law in any legal treatise, scholarly publication, textbook, or other explanatory text shall not constitute the law or public policy of the Commonwealth of Kentucky. No Kentucky court shall treat any such publication or text as controlling authority.<sup>124</sup>

However, the bill was amended on the floor of the House to state that courts may “use” secondary sources when there is no controlling state authority:

A statement or restatement of the law in any legal treatise, scholarly publication, textbook, or other explanatory text shall not constitute the law or public policy of the Commonwealth of Kentucky. No Kentucky court shall treat any such publication or text as controlling authority, *however a court may use such publication or text as an informative or persuasive source.*<sup>125</sup>

**Commentary:** Policyholders and other stakeholders, either generally or as a group, generally have not been consulted about these legislative efforts. It is not apparent that efforts have been generally made for the legislatures or other government officials to obtain a balanced perspective on the ALI and its process, the Restatement; the effect of such legislation on insurance markets; or judicial independence and separation of powers.

These bills tend to be submitted to the legislatures’ committees overseeing insurance and not to the legislatures’ Judiciary Committees where they might have

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ways to respond to the *RLLI*, including through the development of guidance and model legislation.” O’Meara, *supra* note 70.

<sup>124</sup> H. B. 150 (Ky. 2020) (as reported out of the Judiciary Committee).

<sup>125</sup> H. Res. 150 (Ky. 2020) (as passed by the House) (emphasis added to show addition made during debate).

been vetted by lawyers (as at least one interested and experienced constituency). Indeed, as noted above, NAMIC cautioned that submission of the legislation to the legislature's Judiciary Committee would kill the "intent" of such bills.

As these efforts have come to light and attracted attention outside of legislatures considering the measures, other interested constituencies have expressed concerns and opposition to passage. For example, three former Chief Justices of the Arizona Supreme Court submitted a statement opposing Arizona House Bill 2644, calling it "unnecessary, confusing, and misguided":

- The Justices argue it is unnecessary, pointing out that, consistent with the practice of courts generally, Arizona courts consult Restatements only when "there is no Arizona statute or case law" on the issue at hand. At that point, they "may consult a Restatement to see whether it describes a sound and sensible approach or rule and to see what courts in other states" may have ruled.
- They argue that passage of the proposed legislation risks "causing confusion in litigation because it is unclear whether a court may apply a rule that comports with the Restatement, so long as it does not cite the book."
- They explain that the legislation is misguided because, "[w]here the legislature has not enacted substantive law to address certain matters, in the realm of insurance and other matters, courts of necessity resolve the issues through the common law process."<sup>126</sup>

The letter concludes by stating a point made earlier in this article: that such legislation runs afoul of a key doctrine undergirding our system of government, the separation of powers:

[T]he bill, by singling out one legal resource and directing courts not to refer to it, or to disregard it and not cite it, flouts the separation of powers between the judicial and legislative branches. Where Arizona law has not already settled an issue, we should want our

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<sup>126</sup> *Letter of former Arizona Supreme Court Justices, supra* note 7 (arguing that the proposed legislation is unnecessary and cites to *Cramer v. Starr*, 375 P.3d 69, 75 (Ariz. 2016), in which the Arizona Supreme Court refused to apply a section of the Restatement (Second), Torts finding it to be contrary to Arizona law).



courts to inform themselves by consulting pertinent legal resources.<sup>127</sup>

Can that logic be assailed?

Testimony to the Nebraska legislature during its consideration of legislation about the RLLI argues, in addition to points raised in the letter by the former Arizona Supreme Court Chief Justices, that the legislation sweeps too broadly. That testimony argued that the legislation failed to undertake meaningful analysis of, or make any distinction among, the many principles addressed in the Restatement:

There are some 10–110 different statements of law governing liability insurance in the restatement. Does [Nebraska bill] LB 884 mean that this Legislature has carefully considered each one, compared it to existing Nebraska law, and rejected each of those that are inconsistent? And what of the restatement rules that are not inconsistent or in conflict with current Nebraska law[?] Has the legislature, by implication, adopted all of these as Nebraska law even where Nebraska has not yet addressed the issue?<sup>128</sup>

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<sup>127</sup> *Id.* See Letter from David F. Levi, President, ALI, to Hon. Roger Hanshaw, Speaker, W. Va. House of Delegates, and Hon. John Shott, Chair, Judiciary Committee, W. Va. House of Delegates (Jan. 20, 2020) (“[I]n singling out the work of The American Law Institute—and, most specifically, in prohibiting West Virginia judge from using the *Insurance Restatement* as a resource, even when faced with a legal issue on which there is an absence of West Virginia statute or precedent—House Bill 4436 does a disservice to the judges and people of West Virginia by depriving them of a resource that represents the time and effort of many lawyers, judges, and academics from our membership, which includes West Virginia members.”).

<sup>128</sup> *Hearing on LB 884 Before the Judiciary Committee*, 106th Leg., 2nd Sess. 28 (Neb. 2020) (statement of Harvey S. Perlman, Professor of Law). The Minutes of the December 7, 2018 meeting of NCOIL’s Property & Casualty Insurance Committee do identify certain provisions that NCOIL staff believe “deviate[] from certain statutory law.” Such provisions included the “plain meaning rule” (RLLI § 3), § 12 on insurer liability, and a “provision relat[ing] to interpretations of an insurance policy that involves principles of contract law.” The Minutes refer to “8 remaining issues within the *Restatement* that were problematic,” making a total, by this author’s addition, of 11 that NCOIL found “problematic.” The reference to the plain meaning rule as being a subject of statutory law, at

## C. COURT CASES IN WHICH THE RESTATEMENT HAS BEEN CITED

Few courts to date have cited the Restatement, and fewer can be said to have adopted the position explicated in the RLLI or specifically followed its reasoning. Contrary to the fears expressed by legislators and insurance-industry representatives, the sky is not falling: Courts citing the Restatement have refused to blindly follow the RLLI provisions cited to them, engaging (as frankly one would expect) in an analysis of applicable case law and other authorities in the state. Most decisions thus far citing the Restatement acknowledge its status as a secondary source and not law itself. Some courts cite it as additional support for a principle supported by governing law; or for a general, but not dispositive, point.<sup>129</sup> Thus, a reading of such decisions shows that, thus far at least, the insurance industry's fears that the Restatement will somehow distort the common law, in blind support for policyholders and unfairly to their detriment, are overblown.

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least without more explanation, is odd given that these rules, like general rules of contract interpretation often are common law. They also point out that, using NCOIL's own count on provisions in controversy, 99 provisions in the RLLI did not raise concern for insurers.

<sup>129</sup> See, e.g., *Travelers Indem. Co. v. Mitchell*, 925 F.3d 236, 241 (5th Cir. 2019) (citing RLLI § 33, cmt. b, as one of many sources of support on the concept of harm-based of triggers of coverage); *OTRA, LLC v. Am. Safety Indem. Co.*, No. 3:20-CV-01063-SB, 2020 WL 6828738, at \*1 n.1 (D. Or. Nov. 20, 2020) (citing RLLI § 13, cmt. a); *Stepney, LLC v. Nautilus Ins. Co.*, No. 3:19CV720 (AWT), 2020 WL 7630791, at \*3 (D. Conn. Dec. 22, 2020) (citing RLLI § 1); *Century Sur. Co. v. Andrew*, 432 P.3d 180, 184 n.4, 186 (Nev. 2018) (quoting § 13 cmt. c and citing § 48); *Cannon Elec. v. Ace Prop. & Cas. Co.*, No. BC 290354, slip op. at 17 (Cal. Super. Ct. Jan. 9, 2019) (citing RLLI § 23(1)(a)); *Marcus v. Allied World Ins. Co.*, 384 F. Supp. 3d 115, 122–23, 126 n.22 (D. Me. 2019) (citing § 32, cmt. e and § 21, cmt. a); *Country Mut. Ins. Co. v. Martinez*, No. CV-17-02974-PHX-ROS, 2019 WL 1787313, at \*13 n.15 (D. Ariz. Apr. 24, 2019) (citing § 12); *Akorn, Inc. v. Fresenius Kabi AG*, No. 2018-0300-JTL, 2018 WL 4719347, at \*59 n.619 (Del. Ch. Oct. 1, 2018) (quoting RLLI § 32, cmt. e); *Bedivere Ins. Co. v. Blue Cross and Blue Shield of Kan., Inc.*, No. 18-2371-DDC-JPO, 2020 WL 5819612, at \*8 (D. Kan. Sept. 30, 2020) (citing § 20 & cmt. b); *Montrose Chem. Corp. v. Superior Ct. of L.A. Cty.*, 460 P.3d 1201, 1204 (Cal. 2020) (quoting § 39, cmt. d), *modified*, 2020 Cal. LEXIS 3442 (Cal. 2020). In a series of cases in 2019, one judge cited § 13 on the basic rules on the duty to defend, finding no dispute in the law: *Webcor Constr. LP v. Zurich Am. Ins. Co.*, 372 F. Supp. 3d 1061, 1070 (N.D. Cal. 2019) (Gonzalez Rogers, J.); *Conway v. Northfield Ins. Co.*, 399 F. Supp. 3d 950, 959 (N.D. Cal. 2019) (Gonzalez Rogers, J.); *Mesa Underwriters Spec. Ins. Co. v. Blackboard Ins. Spec. Co.*, 400 F. Supp. 3d 928, 936 (N.D. Cal. 2019) (Gonzalez Rogers, J.) (insurer vs. insurer dispute); *Scottsdale Ins. Co. v. Darke*, No. 19-cv-02225-YGR, 2019 WL 6251241, at \*3 (N.D. Cal. Nov. 22, 2019) (Gonzalez Rogers, J.).

In a twist odd to these lawyers at least, it is generally understood and our experience confirms that a number of major insurers, including AIG and, not surprisingly, Liberty Mutual, have instructed the lawyers they retain not to cite the Restatement—even on issues where the Restatement supports the insurer's position.<sup>130</sup>

***Decisions Relying on or Citing the RLLI with Approval:*** A number of cases decided since the final approval of the RLLI have cited the Restatement as part of a larger analysis of applicable law.

Only one case to this point can be said to have followed the *Restatement* although the decision also analyzes multiple other authorities, cases, and secondary authorities to support the result. In *Sapienza v. Liberty Mutual Insurance Co.*,<sup>131</sup> a federal court in South Dakota reaffirmed the reasoning in an earlier decision which had adopted § 12(2) of the RLLI, the provision stating that a liability insurer “is subject to liability for the harm caused by the negligent act or omission” of counsel hired by the insurer to defend its policyholder.<sup>132</sup>

In the initial suit, the Sapienzas alleged that defense counsel hired by Liberty Mutual had provided an inadequate defense. Finding no South Dakota law on the issue, the federal court considering the issue decided that it had to “attempt to predict” how the Supreme Court of South Dakota would decide that the issue. The court referred to “a draft of the *Restatement*”<sup>133</sup> and concluded:

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<sup>130</sup> For example, insurers in *Sapienza* (discussed below) did not affirmatively cite favorable Restatement provisions. 389 F. Supp. 3d 648 (D.S.D. 2019). In a case pending in the Montana Supreme Court, the insurer brief challenging rulings below did not cite § 41 of the RLLI even though that section supports the position of the insurer, National Indemnity, on allocation. See Appellant/Cross-Appellee National Indemnity Company's Opening Brief, Nat'l Indem. Co. v. Montana, No. DA 19-0533 (Mont. Mar. 2, 2020).

<sup>131</sup> *Sapienza v. Liberty Mut. Fire Ins. Co.*, 389 F. Supp. 3d 648 (D.S.D. 2019); *Sapienza v. Liberty Mut. Fire Ins. Co.*, No. 3:18-CV-03015-RAL, 2019 WL 5206289 (D.S.D. Oct. 16, 2019).

<sup>132</sup> This provision states in full: “An insurer is subject to liability for the harm caused by the negligent act or omission of counsel provided by the insurer to defend a legal action when the insurer directs to the conduct of the counsel with respect to the negligent act or omission in a manner that overrides the duty of the counsel to exercise independent judgment.” RESTATEMENT OF THE L. OF LIAB. INS. § 12(2) (AM. L. INST. Draft Apr. 13, 2018).

<sup>133</sup> RESTATEMENT OF L. LIAB. INS. (AM. L. INST. Proposed Final Draft Apr. 13, 2018) ((this reference is to Proposed Final Draft No. 2 of the RLLI, approved in May 2018, and,

Because the draft *Restatement* follows the well-reasoned majority rule and because the Supreme Court of South Dakota has found the *Restatements* “persuasive in many instances,” this court predicts that the Supreme Court of South Dakota would adopt the *Restatement*’s position on insurer liability for an improper defense.<sup>134</sup>

After quoting § 12 from Proposed Final Draft No. 2 of the RLLI presented at the 2018 ALI Annual Meeting, the court continued to analyze law on the issue.<sup>135</sup> The court noted that the Restatement had rejected “the rule applied by a minority of states that insurers are vicariously liable for all malpractice by defense counsel they hire.”<sup>136</sup> The court surveyed case law in other states, discussing both the majority and the minority rules on the issue and noted that, “to be liable under section 12, then, the insurer itself must have engaged in some misconduct.”<sup>137</sup> The court concluded that Liberty Mutual could be liable for alleged malpractice by the defense counsel it hired to the extent that the insurer had affirmatively directed the defense, overriding the defense counsel’s independent professional judgment.<sup>138</sup>

In applying those principles to the facts at bar, the court specifically rejected the plaintiffs’ argument that the insurer could be vicariously liable for errors by defense counsel. The court noted that, although earlier drafts of the RLLI had accepted this theory, the final version of the Restatement had rejected that minority rule, opting instead to follow the majority rule which would place liability on an insurer only to the extent that it had explicitly directed actions taken by the lawyers

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given passage of a “Boskey Motion,” thus subject to final revisions “of a conforming nature” and to address comments and changes agreed to at the 2018 Annual Meeting).

<sup>134</sup> *Sapienza I*, 389 F. Supp. 3d at 653–54 (citing *Chem-Age Indus., Inc. v. Glover*, 652 N.W.2d 756, 770 (S.D. 2002); *Hendrix v. Schulte*, 736 N.W.2d 845, 848–49 (S.D. 2007) (applying Restatement); *Wildeboer v. S.D. Junior Chamber of Commerce*, 561 N.W.2d 666, 674 n.10 (S.D. 1997) (dissent, stating “This court frequently consults and employs the *Restatements*.”); *Beau Townsend Ford Lincoln, Inc. v. Don Hinds Ford, Inc.*, 759 F. Appx. 348, 353 (6th Cir. 2018) (“we may look to an applicable *Restatement* . . . for guidance when there is no controlling state law on point [and] the state has indicated that it considers the *Restatements* to be persuasive authority.” (brackets in original))).

<sup>135</sup> *Sapienza I*, 389 F. Supp. 3d at 654 (citing Revised Proposed Final Draft No. 2 of *Restatement* (dated Sept. 8, 2018); George M. Cohen, *Liability of Insurers for Defense Counsel Malpractice*, 68 RUTGERS L. REV. 119, 125 n.37 (2015)).

<sup>136</sup> *Sapienza I*, 389 F. Supp. 3d at 655–56.

<sup>137</sup> *Id.* at 654. Some commentators discussing the decisions in *Sapienza* fail to mention the court’s extensive analysis of case law on the issue.

<sup>138</sup> 389 F. Supp. 3d at 654.

it hired. However, the court in *Sapienza I* denied the insurer's motion to dismiss on this issue, giving the plaintiffs leave to amend their complaint to allege additional facts in support of a claim that Liberty Mutual had directed the counsel's actions, in large part because the plaintiffs "may not have contemplated in the absence of settled South Dakota precedent" that the court would apply "the most recent draft of § 12 of the *Restatement* to dismiss their breach of the duty to defend claim."<sup>139</sup>

In *Sapienza II*, addressing Liberty Mutual's opposition to the plaintiffs' motion to amend their complaint, the court noted that the *Restatement* had been finalized. Quoting *Restatement* § 12 in full, given the absence of South Dakota law on the issue, the court concluded that, "[t]o be liable under § 12, then, the insurer itself must have engaged in some misconduct."<sup>140</sup> This was the position that insurers argued for, vigorously, during adviser and MCG meetings, in comments and motions, and on the floor of the ALI at its Annual Meetings.

Perversely it seems, Liberty Mutual in *Sapienza II* argued "that the Supreme Court of South Dakota would not adopt § 12(2) because the American Law Institute created the section 'out of a complete absence of precedent.'"<sup>141</sup> The court, however, concluded "that is simply not true," citing numerous cases from around the country that have applied the principles adopted in the black letter of RLLI § 12.<sup>142</sup> The court therefore predicted, after analyzing the law from other states and secondary

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<sup>139</sup> *Id.* at 656.

<sup>140</sup> 2019 WL 5206289, at \*4. As in *Sapienza I*, the court in *Sapienza II* explained, "§ 12 rejected the rule applied by a minority of states that insurers are vicariously liable for all malpractice by defense counsel they hire." *Id.*

<sup>141</sup> *Id.* (quoting Liberty Mutual's brief). Liberty Mutual made this argument despite the fact that the RLLI supported its position.

<sup>142</sup> 2019 WL 5206289, at \*4. The cases cited include one case decided after the RLLI was adopted, and four that were decided years before its adoption (some resolved before the RLLI was even a "twinkle in anyone's eye"): *Progressive N.W. Ins. Co. v. Gant*, No. 15-9267-JAR-KGG, 2016 WL 4430669, at \*4 (D. Kan. Aug. 22, 2016) ("*Gant I*"); *Hackman v. W. Agric. Ins. Co.*, 275 P.3d 73 (Table), 2012 WL 1524060, at \*16 (Kan. Ct. App. Apr. 27, 2012) (per curiam); *Ingersoll-Rand Equip. Corp. v. Transp. Ins. Co.*, 963 F. Supp. 452, 455 (M.D. Pa. 1997); *Gibson v. Casto*, 504 S.E.2d 705, 708 (Ga. Ct. App. 1998); *Mentor Chiropractic Ctr., Inc. v. State Farm Fire & Cas. Co.*, 744 N.E.2d 207, 211 n.3 (Ohio Ct. App. 2000); *Trau-Med of Am., Inc. v. Allstate Ins. Co.*, 71 S.W.3d 691, 697 (Tenn. 2002). The *Sapienza* court also cited another secondary authority on point: Robert E. Keeton, Alan Widiss & James M. Fischer, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices* § 8.7 (2d ed. 2016) (discussing case law on insurer liability for defense counsel misconduct).

authorities (in addition to the RLLI), that the South Dakota Supreme Court would follow the “majority rule” on this issue, as set forth in § 12:

[RLLI] Section 12(2) follows the majority rule that insurers are not vicariously liable for defense counsel’s errors while at the same time recognizing that insurers can be liable for their own misconduct. Liberty Mutual has not made a convincing argument for why the Supreme Court of South Dakota would protect an insurer from liability in the rare instance when the insurer is able to override counsel’s independent professional judgment and thereby harm the insured.<sup>143</sup>

Applying this standard, the court concluded that the Sapienzas’ amended complaint pleaded facts sufficient to survive a motion to dismiss.<sup>144</sup>

Some courts have cited the RLLI as one of many sources on the issue at bar.<sup>145</sup> For example, a federal court in late 2018 quoted, but did not rely on, § 39 of the RLLI to support its application of a “cause test,” not the “effects test,” on the issue of number of occurrences.<sup>146</sup> Applying Oklahoma law, the court concluded that Oklahoma state courts had adopted the cause test; and cited the RLLI as additional support for the application of the cause test—which of course is the majority rule<sup>147</sup>—on this issue.

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<sup>143</sup> 2019 WL 5206289, at \*4 (citing ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES: REPRESENTATION OF INSURANCE COMPANIES & INSURED § 4.42 (6th ed. rev. Apr. 2019) (“If counsel breaches a duty to the insured, either at the company’s request or with the company’s knowledge and consent, the insurer should be held accountable . . . .” (footnotes omitted))).

<sup>144</sup> 2019 WL 5206289, at \*5. Another federal court opinion, decided in April 2019 and now on appeal, appears to endorse the majority rule in § 12(1) on insurer liability for the acts of defense counsel in those situations where the insurer, not counsel, is directing the defense. *Country Mut. Ins. Co. v. Martinez*, No. CV-17-02794-PHX-ROS, 2019 WL 1787313, at \*13 (D. Ariz. Apr. 24 2019), *appeal docketed*, No. 19-16095 (9th Cir. May 28, 2019).

<sup>145</sup> Some courts have cited the RLLI, noting that it accords with governing law. *See, e.g., Twin City Fire Ins. Co. v. Hartman, Simons & Wood, LLP*, No. 1:13-CV-1608-SCI, 2017 WL 11497779, at \*6 (N.D. Ga. Feb. 28, 2017) (citing RLLI § 25, Tentative Draft No. 1 (2016), noting that the RLLI rule accords with Georgia’s voluntary-payment doctrine).

<sup>146</sup> *Nat’l Cas. Co. v. W. Express Ins.*, 356 F. Supp. 3d 1288, 1299 (W.D. Okla. 2018).

<sup>147</sup> *See, e.g., RESTATEMENT OF THE L. OF LIAB. INS. § 38, cmt. c. (AM. L. INST. 2019); See also* the in-depth discussion of the cause test, and other tests, that courts apply to this highly fact-intensive issue, in *MASTERS ET AL.*, *supra* note 41, § 9.03[A].

Several cases as of this writing in early-February 2021 also have cited the RLLI. The Tenth Circuit in *Progressive Northwestern Insurance Co. v. Gant*<sup>148</sup> cited § 12 on numerous occasions, recognizing the “general rule,” in Kansas and otherwise, that an insurer is not subject to direct vicarious liability for the professional malpractice of defense counsel; and noting that a Kansas appellate court had ruled “consistent with [the] view” in § 12 in declining to impose vicarious liability in this manner.<sup>149</sup> *Port Authority of N.Y. & N.J. v. Brickman Group*<sup>150</sup> cited RLLI § 22(2)(a) as one of a number of sources showing a trend toward applying duty-to-defend rules in order to determine whether an insurer may obtain reimbursement of defense costs. The United States District Court for the District of Hawaii, citing RLLI § 21, acknowledged a split in the relevant case law. After analyzing relevant court opinions, the court concluded that § 21 and decisions addressing the insurer’s right to recoup defense costs “had little bearing on the question before the court.”<sup>151</sup> In ruling for insurers, a California state court noted that their seemingly nonsensical antipathy toward the Restatement (and, it seems, the ALI generally): “[a]lthough Defendant Insurers see fit to denigrate the integrity of the American Law Institute’s modern Restatements, the final draft of the [RLLI] supports Defendant Insurers’ position.”<sup>152</sup> One dissent relied on the Restatement.<sup>153</sup>

***Decisions Refusing to Rely Upon the Restatement:*** Some cases have dismissed citations to the Restatement on the ground that the final version of the Restatement had not been published at the time of decision.<sup>154</sup> Others—consistent with the practice by courts over the course of the authors’ careers—have refused to

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<sup>148</sup> *Progressive Northwestern Ins. Co. v. Gant*, 957 F.3d 1144 (10th Cir. 2020).

<sup>149</sup> *Id.* at 155 (citing *Hackman v. W. Agr. Ins. Co.*, No. 104786, 2012 WL 1524060 (Kan. Ct. App. Apr. 27, 2012)).

<sup>150</sup> *Port Authority of N.Y. & N.J. v. Brickman Group*, Index No. 451213/17, 2019 WL 6749520, at \*21–22 (N.Y. App. Div. Dec. 12, 2019) (citing RLLI § 22(2)(a)); *see also* *Evanston Ins. Co. v. Desert State Life Mgt.*, No. CIV-18-0654 JB/KK, 2020 WL 249023, at \*1098 (D.N.M. Jan. 16, 2020) (citing RLLI §§ 32, 34).

<sup>151</sup> *GGA, Inc. v. Kiewit Infrastructure W. Co.*, No. 18-00110-JMS-WRP, 2020 WL 369643, at \*26 (D. Haw. Jan. 22, 2020).

<sup>152</sup> *City of L.A. v. Certain Underwriters at Lloyds, London*, Case No. BC588876 (Cal. Super. Ct. Jan. 2020) (Kuhl, J.) (citing § 20) (*L.A. v. Lloyds*).

<sup>153</sup> *Nadkos, Inc. v. Preferred Contractors Ins. Co. Risk Retention Group, LLC*, 132 N.E.2d 568, 580, 584 (N.Y. 2019) (Wilson, J. dissenting).

<sup>154</sup> *Progressive Nw. Ins. Co. v. Gant*, No. 15-9267-JAR-KGG, 2018 WL 4600716 (D. Kan. Sept. 24, 2018) (*Gant II*); *Catlin Spec. Ins. Co. v. CBL & Assoc. Prop., Inc.*, No. N16C-07-166 PRW CCLD, 2018 WL 3805868 (Del. Super. Ct. Oct. 17, 2017).

follow the Restatement when governing law is contrary to the principle for which the Restatement is cited.

For example, a decision by a federal court in Kansas refused to follow Restatement provisions on insurer liability for the negligence of insurer defense counsel for both of these reasons.<sup>155</sup> First, the court found, in the fall of 2018 before the Restatement volume was released, that, though approved, the final version of the Restatement had not yet been published.<sup>156</sup> More significantly, the court refused to rely on a substantive Restatement provision that the policyholder cited because Kansas courts had not adopted the principles proposed in that section.<sup>157</sup> More recently, a federal court in Wisconsin cited the RLLI § 21 as evidence of “the controversy” surrounding the question of insurer recoupment of defense costs for uncovered claims.<sup>158</sup> The court ultimately rejected the insurer’s views, however, based on governing Wisconsin law (and federal precedent within the state), notwithstanding the fact that the cited RLLI provision supported the court’s conclusion.<sup>159</sup>

***Decisions Using the Restatement to Support the Insurer Positions:*** Some decisions have used the Restatement to support the positions favored by insurers. A Delaware trial court in *Catlin Specialty Insurance Co. v. CBL Associates Properties, Inc.*,<sup>160</sup> agreed with an earlier federal court’s predictions on how the Tennessee Supreme Court would decide the issue of whether a liability insurer has the right to seek “recoupment” of defense costs paid to insured. Concluding that the Tennessee

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<sup>155</sup> Gant II, 2018 WL 4600716, at \*12.

<sup>156</sup> *Id.* at \*12–13. The Restatement was published in late September 2019.

<sup>157</sup> *Id.* at \*12 (“[T]his Court is not . . . inclined to use a nonbinding *Restatement* as a means to overturn . . . or expand Kansas law.”) (citing RLLI § 12).

<sup>158</sup> *Hayes v. Wisconsin & S. R.R., LLC*, No. 18-CV-923, 2021 WL 199343, at \*3 (E.D. Wis. Jan. 20, 2021) (comparing RLLI § 21 (default rule is not recoupment of defense costs) with RESTATEMENT OF THE L. 3D, RESTITUTION AND UNJUST ENRICHMENT § 35 (favoring reimbursement)).

<sup>159</sup> *Id.* at \*6 (“[T]he court concludes that, if presented with the question, the Wisconsin Supreme Court would likely hold that under Wisconsin law an insurer may not, by way of a claim of unjust enrichment, seek to recover from its insured the costs it expended defending a claim for which the insurance policy did not provide coverage.”); *accord* RLLI § 21 (“Unless otherwise stated in the insurance policy or otherwise agreed to by the insured, an insurer may not obtain recoupment of defense costs from the insured, even when it is subsequently determined that the insurer did not have a duty to defend or pay defense costs.”).

<sup>160</sup> No. N16C-07-166 PRW CCLD, 2018 WL 3805868 (Del. Super. Ct. Aug. 9, 2018) (*Catlin*).



high court would not follow the black-letter rule stated in the RLLI on this issue, the court refused to follow § 21.<sup>161</sup>

As stated above, a California trial court noted the insurers' interesting advocacy tactic in "denigrat[ing]" the RLLI even though the relevant section actually supported their position.<sup>162</sup>

***Decisions Citing but Not Relying Upon the Restatement:*** Most of the decisions citing the Restatement to date have used the Restatement to explain an insurance policy term or concept; or as one of many authorities, but not as the primary authority for the court's ultimate decision.<sup>163</sup> In a case reflecting a concern raised in the testimony in January 2020 to the Nebraska legislature and discussed above, the Nevada Supreme Court adopted a rule stated in the RLLI, citing but relying on the Restatement in reaching that result. The court in *Century Surety Co. v. Andrew*<sup>164</sup> held that an "insured may recover any damages consequential to the insurer's breach of its duty to defend," concluding that the insurer's liability was not capped at the policy limits even in the absence of bad faith.<sup>165</sup>

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<sup>161</sup> *Id.* at \*2–3.

<sup>162</sup> *L.A. v. Lloyds*, slip op. at 23.

<sup>163</sup> See cases cited *supra* note 129. Several decisions cited to drafts of the RLLI in years before it was approved. See, e.g., *Outdoor Venture Corp. v. Phila. Indem. Co.*, No. 6:16-cv-182-KKC, 2018 WL 4656400, at \*18 (E.D. Ky. Sept. 27, 2018) (noting insured's citation of RESTATEMENT OF THE L. OF LIAB. INS. § 16 (AM. L. INST., Tentative Draft No. 1, 2016)); *Selective Ins. Co. of Am. v. Smiley Body Shop, Inc.*, 260 F. Supp. 3d 1023, 1033 (S.D. Ind. 2017) (citing favorably and quoting from RESTATEMENT OF THE L. OF LIAB. INS. § 21 (AM. L. INST., Discussion Draft, 2015)); *Nooter Corp. v. Allianz Underwriters Ins. Co.*, 536 S.W.3d 251, 272 (Mo. Ct. App. 2017) (quoting RESTATEMENT OF THE L. OF LIAB. INS. § 44 cmt. j (AM. L. INST., Tentative Draft No. 1, 2016)); *Mid-Continent Cas. Co. v. Petrol. Sols., Inc.* No. 4:09-0422, 2017 WL 2964933, at \*6 (S.D. Tex. July 12, 2017) (Atlas, J.) (citing and quoting RESTATEMENT OF THE L. OF LIAB. INS. § 29 cmt. b (AM. L. INST., Tentative Draft No. 1, 2016)).

<sup>164</sup> 432 P.3d 180 (Nev. 2018).

<sup>165</sup> *Id.* at 186. This case is also cited in RESTATEMENT OF THE L. OF LIAB. INS. § 48 cmt. d (AM. LAW INST. 2019).

## V. SECTIONS OF THE RESTATEMENT GENERATING CONTROVERSY

## A. OVERVIEW

As with any work of such depth and scholarship, the Restatement was revised extensively during the eight years of drafting. Of course, that is the nature of the ALI's 90+ year-old dialectical process. Many of the changes were made in response to comments from insurance industry advocates. As with any project of this scope, including input from so many different stakeholders, everyone has provisions with which they disagree. This reaction reflects the myriad, complex issues that arise in insurance-coverage disputes. In fact, it would be surprising if there were no controversy with the RLLI. This section discusses issues that generated, and seem now to continue to generate, the most controversy.

In opposing these rules, insurer advocates have argued that the Restatement rules will increase costs that will be passed onto other policyholders in the form of higher premiums.<sup>166</sup> Despite repeated requests for support during the RLLI drafting process, no empirical evidence was introduced to support such assertions. We have seen little evidence of this alleged correlation between liberal interpretation rules and premium costs. Indeed, one could say that ensuring that the insurance protection promised at the point of purchase is available at the point of claim could increase confidence and maintain or improve sales of insurance. Even assuming that such rules increase costs, it is reasonable to presume that insurers factored the effect of those rules—which have been around for decades—into premiums years ago.

## B. MANDATORY VERSUS DEFAULT RULES

Most of the rules in the Restatement are mandatory rules, i.e., rules that cannot be changed by agreement of the parties. Despite the common-sense nature of this distinction and the fact that many kinds of liability insurance (especially homeowners liability, automobile liability, and CGL insurance) are standard-form or boilerplate contracts, typically sold without any review or negotiation of substantive contract terms at the time of purchase, this distinction, as with so much of the Restatement, was met with resistance largely from insurance-industry representatives.

According to the Restatement, designating mandatory rules helps ensure fairness and consistency in interpretation and application of the substantive standard-form policy terms used in modern liability insurance policies. This is a

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<sup>166</sup> See e.g., Barker, *The American Law Institute Principles of the Law of Liability Insurance: Part II—Selected Comments from an Insurer Perspective*, *supra* note 63, at 4.

logical approach because insuring agreements and provisions for liability insurance of necessity must be standardized, use standard concepts and terms, and thus constitute contracts of adhesion.<sup>167</sup> In addition, while the Restatement addresses liability insurance, the rules of policy interpretation have the potential to spill over to disputes about first-party property (also heavily standardized and regulated) and other types of insurance.

Under the Restatement, default rules apply only if the substantive insurance policy term or terms at issue in a dispute have been negotiated jointly by the parties (insurer and policyholder) and are not in regular usage in the insurance markets. This rule is important to ensure uniform rules on policy terms and reduce litigation, stated goals of the Restatement,<sup>168</sup> and a necessary underpinning of the mass-marketing of insurance.

C. SECTION 3, PLAIN MEANING RULE, AND RELATED PRINCIPLES

The initial formulation of this Section, which proposed a “presumption of plain meaning” that could be rebutted with the introduction of extrinsic evidence, generated as much controversy as any of the sections in the Restatement process. Earlier drafts of the Restatement sought to reach a middle ground between a strict approach to interpretation<sup>169</sup> and a highly contextual approach.<sup>170</sup> Preliminary Draft No. 1, for example, stated a rebuttable presumption that the plain meaning should

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<sup>167</sup> See discussion in MASTERS ET AL., *supra* note 41, § 1.01[A]. See also RESTATEMENT OF THE L. OF LIAB. INS. § 2 cmt. d.

<sup>168</sup> E.g., RESTATEMENT OF THE L. OF LIAB. INS. § 2 cmt. d.

<sup>169</sup> E.g., RESTATEMENT (FIRST) OF CONTRACTS (AM. L. INST. 1932).

<sup>170</sup> E.g., RESTATEMENT (SECOND) CONTRACTS. The Comments identify the objectives of insurance-policy interpretation also, as follows:

- “effecting the dominant protective purpose of insurance;
- facilitating the resolution of insurance-coverage disputes and the payment of covered claims;
- encouraging the accurate marketing of insurance policies; and
- providing clear guidance on the meaning of insurance policy terms in order to promote, among other benefits, fair and efficient insurance pricing, underwriting, and claim management.”

RESTATEMENT OF THE L. OF LIAB. INS. § 2, cmt. c. (*Objectives of legal insurance interpretation*).

apply unless “the court determines that a reasonable person would clearly give the term a different meaning in light of the extrinsic evidence.”<sup>171</sup> The presumption could be displaced if a court concluded that extrinsic evidence revealed an alternative meaning that “reasonable persons in the policyholder’s position would give to the term under the circumstances and that the plain meaning is, in this sense, a less reasonable meaning.”<sup>172</sup> Contrary to some of the more “emotional” descriptions of the approach, it focused from the outset, on insurance-policy plain meaning.”<sup>173</sup>

In the end, the Restatement eliminated the “rebuttal presumption” concept and demoted the evidence point from the black-letter to a comment making use of such evidence permissive. This is a sensible approach, and one that courts in the authors’ experience generally employ after review of applicable law.

### 1. Provisions of the Final Restatement

Section 3(2) defines “plain meaning” as the “single meaning to which the language of the term is reasonably susceptible when applied to the fact of the claim at issue in the context of the entire insurance policy.”<sup>174</sup> This Section adopts principles that are widely accepted in both insurance-policy and contract interpretation. For example, this Section brings into play the reasonableness of terms used and makes clear that meaning should be considered as the terms are used in the insurance policy as a whole. The Section further makes clear that provisions that do not have a plain meaning as defined in subsection two are ambiguous and interpreted in as provided in § 4. Although insurers continue to complain about these sections, one could argue that the principles of policy interpretation adopted in the Restatement are less favorable to policyholders than those coming out of a strict adoption of the Restatement (Second), Contract’s contextual approach. This argument could be made in some quarters even though § 2 of the RLLI specifically states that, “[e]xcept as this *Restatement* or other applicable law otherwise provides,

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<sup>171</sup> See, e.g., RESTATEMENT OF THE L. OF LIAB. INS. § 3(2) (Preliminary Draft, No. 1, Mar. 2, 2015).

<sup>172</sup> See, e.g., *id.* at § 3 cmt. c. (*Rebuttable presumption*).

<sup>173</sup> See, e.g., BARRY R. OSTRAGER & THOMAS N. NEWMAN, HANDBOOK OF INSURANCE COVERAGE DISPUTES § 1.01 (Elisa Alcabes & Karen Cestari, eds., 19th ed. 2019); JEFFREY W. STEMPEL, LAW OF INSURANCE CONTRACT DISPUTES § 4.04 (2d ed. 1999 & Supp. 2005); accord MASTERS ET AL., *supra* note 41, at § 2.03.

<sup>174</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 3(2).

the ordinary rules of contract interpretation apply to the interpretation of liability insurance policies.”<sup>175</sup>

Given the substantial revisions to these provisions until the final adoption of the RLLI, it is unclear what is generating the continuing antipathy by the insurance industry to this Section. It may arise from comments that discuss custom, practice, and usage evidence, discussed below.

## 2. Comment c. Custom, Practice, and Usage

Comment c. explains:

Some courts that follow a plain-meaning rule also consider custom, practice, and usage when determining the plain meaning of insurance policies entered into between parties who can reasonably be expected to have transacted with knowledge of the custom, practice, or usage. The plain-meaning rule adopted in this Section follows this approach, which recognizes that informed insurance-market participants conduct their business in light of custom, practice, and usage in the insurance market and in the trade or business being insured.<sup>176</sup>

Consistent with generally accepted contract-interpretation principles, the Comment focuses on the objective meaning of the relevant insurance policy terms in the relevant market as distinguished from the subjective intent of a party. Comment c. defines dictionaries, court decisions, statutes and regulations, and secondary legal authority, such as treatises and law-review articles, as external sources of meaning that courts can always consult when determining the plain meaning of insurance policy terms.<sup>177</sup> In a further nod to insurance-company preferences, as widely expressed particularly throughout the final years of the RLLI drafting, a Comment to § 3 states:

Consideration of custom, practice, and usage at the plain-meaning stage does not, however, open the door to extrinsic evidence of the parties’ specific or subjective intent or

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<sup>175</sup> *Id.* at § 2(3).

<sup>176</sup> *Id.* at § 3 cmt. c. (*Custom, practice, and usage*).

<sup>177</sup> *Id.* at cmt. b. (*Generally accepted sources of plain meaning*).

understanding regarding the insurance policy, such as drafting history, course of dealing, or pre-contractual negotiations. Rather, custom, practice, and usage refer only to aspects of the insurance market or the trade or business being insured that are so widely known as to form a shared backdrop against which an insurance policy is reasonably understood to have been written and executed.<sup>178</sup>

These sources of evidence, under the Restatement's formulation, come into play only if insurance-policy terms are considered ambiguous in the context of the facts of the claim at issue. We have seen no insurance-industry company commentaries that mention that the Restatement does not adopt the reasonable-expectations doctrine, a doctrine that is widely accepted<sup>179</sup> but reviled by insurers, and specifically rejects<sup>180</sup> the "latent ambiguity rule" applied in some states,<sup>181</sup> another doctrine that insurance companies oppose.

The controversy may also arise from the fact that the Restatement adopts the generally accepted rule, applied in most jurisdictions with regard to insurance policies and contracts alike, that a contract term is ambiguous "if there is more than one meaning to which the language of the term is reasonably susceptible when applied to the facts of the claim at issue in the context of the entire insurance policy."<sup>182</sup> In that situation, the term is construed against the party that supplied it.<sup>183</sup> Antipathy to this almost universal rule should not be a ground, expressed or otherwise, for supporting (or opposing) the RLLI (or the ALI).

### 3. Standard-Form Terms and "Sophisticated Policyholders"

Section 1, which defines terms used in the Restatement and is not part of Topic 1 of Chapter 1 addressing policy interpretation, includes a definition crucial to application of the principles of policy interpretation. Section 1(13) defines "standard-form term" as: a . . . term [that] appears in, or is taken from, an insurance

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<sup>178</sup> *Id.* cmt. c. (*Custom, practice, and usage*).

<sup>179</sup> *See, e.g.*, MASTERS ET AL., *supra* note 41, at § 2.05.

<sup>180</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 4, cmt. b. (*Using external sources of meaning to determine whether a term is ambiguous*) (AM. L. INST. 2019).

<sup>181</sup> *See* MASTERS ET AL., *supra* note 41, in Ch. 2 generally, and § 2.05 specifically for a discussion of ambiguity and "latent ambiguity."

<sup>182</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 4(1) (AM. L. INST. 2019).

<sup>183</sup> *Id.* § 4(2).

policy form (including an endorsement) that an insurer makes available for a non-predetermined number of transactions in the insurance market.

The Comments provide further gloss, stating:

any term that is not specifically negotiated by the parties for inclusion in the insurance policy at issue is a standard-form term. A term contained in an insurance policy form approved for use by and insurance regulatory authority for any insurer is a standard-form term, unless the circumstances clearly indicate the contrary.<sup>184</sup>

This provision is key to the application of the “ambiguity rule” in § 4, construing terms that are ambiguous against the party supplying the term. Insurers and the insurance industry largely control the terms that go into a standard-form policy. The Restatement eschews “the mechanical application” of *contra proferentem*,<sup>185</sup> stating that the RLLI formation gives insurers the opportunity to use extrinsic evidence to demonstrate to the court that the coverage-promoting interpretation of an ambiguous term is unreasonable in the circumstances . . . .<sup>186</sup> The § 1(13) definition helps ensure that policyholders are protected from the effects of ambiguous contract language into which they had no input.<sup>187</sup>

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<sup>184</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 1 cmt. i. The fact is that most types of liability insurance use the same concepts and terms from one policy form to another (and from one kind of liability insurance to another). The RLLI acknowledges this feature of liability insurance in provisions that recognize the use of the same or similar concepts and terms from one policy form, and one kind of insurance, to another.

<sup>185</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 4 cmt. f.

<sup>186</sup> *Id.*

<sup>187</sup> *E.g.*, Mark Geistfeld, *Interpreting the Rules of Insurance Contract Interpretation*, 68 RUTGERS U.L. REV. 371 (2015), presented at Rutgers Law School Symposium on the *Restatement* (Feb. 27, 2015) (citing Mark Rahdert, *Reasonable Expectations Reconsidered*, 18 CONN. L. REV. 323, 329 (1986) (Rahdert) (“As numerous commentators beginning with Patterson, Kessler and Llewellyn have noted, *there is no mutual assent to most terms of an insurance policy*. Policy language is standardized and mass produced. It, or language very similar to it, appears in nearly every policy of like kind offered by underwriters. The purchaser of the policy probably has no opportunity to read the policy language before purchase. And even when read, the import of much of the technical language used would, in most circumstances, escape notice. *Beyond that, in the unlikely event that the potential insured could both read and understand the policy before purchase, he or she would be powerless to negotiate any change*. In other words, in most cases the insurance

In another nod to the fact that many key forms of liability insurance are regulated and subject to approval by state insurance commissions, the Restatement rejects a “sophisticated-policyholder exception” to principles of policy interpretation. The Comments in § 4 state that the rejection of this exception places the responsibility for residual ambiguity on the party that provided the policy language, thereby creating an incentive to draft terms that are as clear as possible.<sup>188</sup> In addition, as commentators have noted, it is difficult to define what constitutes a “sophisticated policyholder.”<sup>189</sup>

D. SECTION 8 (AND RELATED SECTIONS, §§ 7–9): MISREPRESENTATION

Controversy surrounded the sections on misrepresentation, §§ 7–9, throughout the drafting process. This controversy is not surprising given the significance of misrepresentation as a defense to coverage. Unlike many other coverage defenses, a successful defense of misrepresentation allows the insurer to avoid coverage, effecting a forfeiture of the insured’s contract rights.<sup>190</sup> In part for this reason, insurers often use misrepresentation as a defense to coverage. Despite significant revisions over the life of the Restatement, and earlier during the years that the project was denominated as a Principles project, insurers and industry groups continue to attack these rules, particularly the materiality requirement defined in § 8. However, contrary to generalized protestation one often hears about the RLLI, the final Restatement includes many provisions insurers support (and supported).

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policy is the classic example of the ‘adhesion’ contract.” (emphasis added))). See also MASTERS ET AL., *supra* note 41, in Ch. 2 generally, and § 2.01 at 2–3 specifically for a discussion of Rahdert and other principles applicable to insurance-policy interpretation.

<sup>188</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 4, cmt. d.

<sup>189</sup> E.g. John K. DeMugno, *The American Law Institute’s Restatement, Law of Liability Insurance: A Final Update*, 30 No. 6 CAL. INS. L. & REG. REP. NL 1 (July 2018). Cf. discussion of “cost-benefit analysis” in RESTATEMENT OF THE L. OF LIAB. INS. § 3 cmt. c, with discussion of “sophisticated policyholder exception” in RESTATEMENT OF THE L. OF LIAB. INS. § 4, cmt. h.

<sup>190</sup> In addition, this inherently fact-based inquiry typically is decided as a jury question, delaying a policyholder’s recovery until the often discovery-intensive litigation over such an issue has concluded and the issue has been tried to the finder of fact. For a discussion of misrepresentation as a coverage defense, see MASTERS ET AL., *supra* note 41, §§ 19.02 and 19.02A.



## 1. The Materiality Standard

Under § 7, a liability insurer may rescind an insurance policy if:

- (a) The misrepresentation was material as defined in § 8; and
- (b) The insurer reasonably relied on the misrepresentation in issuing or renewing the policy . . . .<sup>191</sup>

Section 8 defines a misrepresentation as material “only if, but for the misrepresentation, a reasonable insurer in this insurer’s position would not have issued the policy or would have issued the policy *only under substantially different terms*.”<sup>192</sup> The Restatement states that a claim of misrepresentation does not block the insurer’s duty to defend.<sup>193</sup> The Comments make clear that the insurer bears the burden to prove materiality as defined in § 8.<sup>194</sup>

Insurers complain that the “substantially different” part of this test is not supported either by case law or, in those states that have adopted a statutory standard, by statute. The Restatement, however, recognizes these differences. For example, the Comments explain that “[c]ourts have used a wide variety of verbal formulations to express the requirement encapsulated in this section by the phrase ‘substantially different terms.’”<sup>195</sup> In addition, while not stating a position of the ALI, the Reporters’ Note to this Section shows consideration of the law on this issue, citing and explaining standards adopted in various state statutes and cases.<sup>196</sup> The Comments continue by stating that this formulation helps avoid forfeiture of coverage in situations when “a fact having only an insubstantial effect on policy terms is not of sufficient objective relevance to the risk being insured.”<sup>197</sup>

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<sup>191</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 7(2)(a)–(b).

<sup>192</sup> *Id.* § 8 (emphasis added).

<sup>193</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 7(2). Neither the black letter nor the Comments make clear, however, that misrepresentation and other fact-based defenses to coverage do not obviate the duty to defend under the generally accepted “potential for coverage standard stated,” “four-corner,” and “eight-corner” rules and related law. *See, e.g.,* MASTERS ET AL., *supra* note 41, § 3.12[A].

<sup>194</sup> *See, e.g.,* RESTATEMENT OF THE L. OF LIAB. INS. § 8, cmts. c & e.

<sup>195</sup> *Id.* § 8, cmt. e.

<sup>196</sup> *Id.* § 8, Reporters’ Note.

<sup>197</sup> *Id.* § 8, cmt. e.

Despite insurers' continued attacks on the standard, surely it makes sense to avoid forfeitures of coverage and contract rights over trivial misrepresentations which, as the Restatement says, "a reasonable insurer would regard" as "trivial or inconsequential."<sup>198</sup> In fact, public policy (certainly equity) "abhors forfeiture,"<sup>199</sup> and a common-sense consideration of materiality includes this very concept.<sup>200</sup> At the ALI's 2018 Annual Meeting, the Reporters similarly explained the rationale on this standard as necessary to "prevent insurers from rescinding insurance policies based on trivial misstatements."<sup>201</sup> After debate and this explanation, the ALI membership on a voice vote defeated a motion to delete the "substantially different terms" language from § 8.

## 2. The RLLI's Acknowledgment of Legislation on Misrepresentation

In addition, the Restatement applies a "strict liability" standard. Policyholder representatives fought this, as a point of information. The standard adopted does not distinguish between intentional and "innocent" misrepresentations, although it does note the practical application of this standard in individual cases.<sup>202</sup> In doing so, the RLLI acknowledges the principles set forth in legislation on this issue. The Comments note the "strong fairness and efficiency objections to this

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<sup>198</sup> It also states, in response to policyholder critiques, that, in practice, the unfairness that many observers contend results from the absence of a knowledge requirement does not arise as frequently as might be supposed because legislation sometimes addresses this issue, and because courts sometimes find alternative grounds for reaching the same result. *Id.*

<sup>199</sup> *Maxim*, BLACK'S LAW DICTIONARY (11th ed. 2019).

<sup>200</sup> For example, a dictionary definition of "material" defines the term as "having real importance or great consequences." Merriam-Webster Online Dictionary. 2004. <http://www.merriam-webster.com> (last visited Feb. 15, 2021). Black's Law Dictionary defines "material" as "important; more or less necessary." *What is Material?* BLACK'S LAW DICTIONARY ONLINE <https://thelawdictionary.org/material/> (Last visited Feb. 5, 2021).

<sup>201</sup> Author's notes; *see also* RESTATEMENT OF THE L. OF LIAB. INS. 1 § 8, cmt. e. (AM. L. INST. 2019).

<sup>202</sup> RESTATEMENT OF THE L. OF LIAB. INS. 1 § 7, cmt. j (*The problem of innocent misrepresentations*) (AM L. INST. 2019). As stated in the Restatement, under the rules in most states (whether by common law or legislation) and the rule followed in § 7, "the misrepresentation defense is available to the insurer whenever there is reasonable and detrimental . . . on a material misrepresentation by the policyholder, even if the policyholder's misrepresentation was entirely innocent and unintentional." States may include other rules, not discussed in the RLLI, that may blunt the more Draconian effects of such a rule. *See* MASTERS ET AL., *supra* note 41, § 19.02 on misrepresentation.

strict-liability standard,” but point out that legislatures in most states have adopted that standard, as insurance-industry advocates sought during the RLLI process.<sup>203</sup>

Thus, the discussion of this strict-liability standard shows the deference paid by the *Restatement* to rules made by legislatures on insurance issues and belies criticisms by NCOIL and insurance industry groups that the Restatement somehow sought to usurp the role of legislatures in summarizing and synthesizing rules applicable to insurance. The fact is that some states have legislated on this (and certain other issues of insurance law) addressed in the Restatement but many have not, relying instead on the courts to develop common-law rules. The rules on misrepresentation, like those on so many other issues addressed in the Restatement, are in many cases common-law rules, appropriate for discussion in a Restatement.

While § 8 refers to a “reasonable insurer,” it is important to note that the standard is not strictly an objective one.<sup>204</sup> The RLLI Sections on misrepresentation include “both subjective and objective aspects.”<sup>205</sup> Section 7 requires proof that the insurer “reasonably relied” on the representation, a mixed standard.<sup>206</sup> Section 8 requires proof that “a reasonable insurer in this insurer’s position” (again, a mixed standard) would not have issued the insurance policy or would have issued it with substantially different terms absent the misrepresentation.<sup>207</sup> Section 9, similarly, includes both objective and subjective elements, referring to a “reasonable insurer” “in this insurer’s position.”<sup>208</sup>

A significant focus throughout these Sections is on “reasonableness” but through the lens of what the insurer in question would have done. This emphasis on reasonableness in applying this standard—which, of course, can void all coverage—is carried out in ways other than those just discussed. For example, Comments to § 7 state that the Restatement does not endorse the use of warranties as distinct from representations, as a separate defense to coverage:

Warranties are said to remain strictly enforced with respect to marine insurance, for which the most important coverage is a

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<sup>203</sup> RESTATEMENT OF THE L. OF LIAB. INS. 1 § 7, cmt. j (*The problem of innocent misrepresentations*) (AM. L. INST. 2019).

<sup>204</sup> *Id.* at § 8.

<sup>205</sup> *Id.* at §§ 7–9.

<sup>206</sup> *Id.* at § 8.

<sup>207</sup> *Id.*

<sup>208</sup> *Cf. supra* note 200, with RESTATEMENT OF THE L. OF LIAB. INS. 1 § 9 (*Reasonable-reliance requirement*) (AM. L. INST. 2019).

form of property insurance. When policyholders are relatively unsophisticated (as in the case of consumer policyholders), the strict application of warranty provisions is unduly harsh and unfair to insurance, as the law has increasingly recognized. This section does not follow the few remaining courts that retreat warranties as a separate category, outside the special context of commercial marine—insurance policies.<sup>209</sup>

### 3. Other Noteworthy Provisions Relevant to “Misrepresentation Defenses”

Finally, in a sensible and equitable rule—particularly where the remedy is forfeiture of contractual rights—under § 7(3), an insurer “must return all of the premiums paid for the policy” when “the policy is rescinded under subsection (2).”<sup>210</sup> It is more common than not for insurers to fail to repay premiums when asserting that the policy is “void *ab initio*.” A failure to require a return of premiums encourages such unfortunate conduct by insurers, allowing them to treat misrepresentation as any ordinary policy defense, while at the same time accusing their insureds of fraud. Clearly, insureds then are worse off than if no premium dollars had been paid at all.<sup>211</sup>

The Restatement also rejects the “contribute-to-the-loss rule” or “cause relation approach.” These principles limit an insurer’s ability to assert a misrepresentation defense to situations in which the policyholder’s misrepresentation actually “materialized in (‘contributed to’) the loss that occurred.”<sup>212</sup> The Restatement rejects this reasonable approach for four reasons, which gave substantial deference to insurer concerns, without much nod to those of insurance purchasers. For example, the Comments refer to “the problem of high-risk policyholders intentionally and dishonestly understating their risks in order to get coverage at a price that is subsidized by honest” policyholders.<sup>213</sup> The Comments do

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<sup>209</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 7 (AM. L. INST. 2019). This distinction between marine and other types of insurance, of course, is well-recognized in the law. Statutes include other relevant provisions and use a mixed objective-subjective standard. See N.Y. INS. L. § 3105(C) (“[E]vidence of the practice of the insurer which made such contract with respect to the acceptance or rejection of similar risks shall be admissible”). See also MASTERS ET AL., *supra* note 41, § 19.02[B].

<sup>210</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 7 (AM. L. INST. 2019).

<sup>211</sup> *Id.* at § 9.

<sup>212</sup> *Id.*

<sup>213</sup> *Id.*

not acknowledge the public policy favoring enforcement of contract, especially for boilerplate contracts like insurance policies which are imbued with important public purposes. Other rationales refer to “difficulties” faced by an insurer but fail to give even a nod to the hardship faced by insureds who face the common assertion of this defense when trying to enforce their coverage.”<sup>214</sup>

E. SECTION 12: INSURER LIABILITY FOR THE CONDUCT OF DEFENSE COUNSEL

Section 12, entitled “Liability of insurer for conduct of defense,” generated intense controversy throughout the drafting process which continues, it seems, unabated today. Early drafts of the Section stated that an insurer could be vicariously liable for actions by insurer-retained defense counsel who breach their duty of care to insured clients in the course of the defense.<sup>215</sup> After multiple revisions, the Section was revised to apply traditional tort liability for negligent hiring and supervision to only those situations in which the insurer has undertaken to direct the action of defense counsel appointed by the insurer to defend the insured.

Negligent supervision of counsel retained by the insurers, without more, does not provide a basis for insurer liability under the rule stated in the RLLI. The final version of § 12 imposes liability on an insurer into two situations: first, when the insurer chooses counsel without exercising reasonable care; and, second, when the insurer specifically directs the conduct of the defense:

- (1) If an insurer undertakes to select counsel to defend a legal action against the insured and fails to take reasonable care in doing so, the insurer is subject to liability for the harm caused by any subsequent negligent act or omission of the selected counsel that is within the scope of the risk that made the selection of counsel unreasonable.

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<sup>214</sup> *Id.*

<sup>215</sup> While acknowledging a “dearth of reported case law” on the topic, the Reporters relied on provisions in the Restatement, Third, Agency, as support for this principle. Although case law is split on the issue, a majority of courts treat defense counsel as independent contractors whose conduct cannot then be imputed to the insurer that retained them to defend the insured. *Compare, e.g.,* *Feliberty v. Damon*, 531 N.Y.S.2d 778 (N.Y. 1988), and *Ga. Code § 33-7-12*; *with* *Continental Ins. Co. v. Bayless & Roberts, Inc.*, 608 P.2d 281, 294 (Alaska 1980).

(2) An insurer is subject to liability for the harm caused by the negligent act or omission of counsel provided by the insurer to defend a legal action when the insurer directs the conduct of the counsel with respect to the negligent act or omission in a manner that overrides the duty of the counsel to exercise independent professional judgment.<sup>216</sup>

The principles in § 12(1) parallel the general tort law under which a defendant may be found liable when its negligence proximately causes harm in discussing the shift in approach as set forth in the final Restatement, the Comments explain that, “if liability insurers ensure that their chosen defense counsel have adequate liability insurance to cover the consequences of malpractice, there is no need for that vicarious-liability rule.”<sup>217</sup>

Insurers continue to complain about this Section, despite the significant revisions made to address their many comments and concerns. If a person acting as principal to another acting as agent commits negligent acts causing injury, a claim for liability arises. If an insurer takes action to override a defense lawyer’s duty of care to the insured client, it is reasonable to impose liability on the insurer for any professional malpractice that results.<sup>218</sup> The continuing controversy also is ironic given the insurers’ treatment of this provision in *Sapienza*<sup>219</sup> where, as discussed above, the Section is cited. The court relied ultimately on case law around the country to support the approach followed in § 12 (and to reject the minority rule favored by the insured). In another instance, the court rejected § 12 as contrary to the state law that governed there.<sup>220</sup>

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<sup>216</sup> RESTATEMENT OF THE L. OF LIAB. INS. §§ 12(1), 12(2) (AM. L. INST., Draft Sept. 7, 2018).

<sup>217</sup> *Id.* § 12, cmt. e. (*The vicarious-liability rule rejected*).

<sup>218</sup> See, e.g., RESTATEMENT (THIRD) OF THE L. GOVERNING LAWYERS § 134. Cited in the Restatement § 12, cmt. d. (*Insurer liability when overriding the duty of the defense counsel to exercise independent judgment*).

<sup>219</sup> See discussion of *Sapienza*, *infra* pp. 156–159. Interestingly, the insurer in *Sapienza*, Liberty Mutual Fire Insurance Company, has argued in another venue that the ALI “invented” the rules set forth in § 12. NCOIL, Property & Casualty Insurance Committee, Minutes of Meeting held Dec. 7, 2018, at 2 (comments by Assistant Vice President, made after the Proposed Final Draft No. 2, dated Sept. 28, 2018, issued) (discussed *supra* note 133). In response to the insured’s citation of § 12, the *Sapienza* court conducted its own research on the issues, citing case law that specifically supports the rules set forth in § 12.

<sup>220</sup> See case-law discussion, *infra* pp. 156–159 (discussion of *Sapienza* cases).

In addition, the amicus brief submitted in *Sapienza* by insurance industry groups, the Complex Insurance Claims Litigation Association (CICLA) and NAMIC, did not cite the Restatement. This is consistent with what insurer representatives have confirmed is the practice by the insurance industry to reject affirmative citation to, or reliance on, the Restatement, presumably because the insurance industry is promoting legislation in many states that seeks to discourage, or even forbid, citation to the *Restatement*.

F. OTHER SECTIONS OF THE RLLI SUBJECT TO SIGNIFICANT  
CONTINUING CRITICISM BY THE INSURANCE INDUSTRY

Even committed opponents, such as the NAMIC and the American Property & Casualty Insurance Association (APCIA), acknowledge,<sup>221</sup> as it would seem they must, that many of the 100+ principles of law discussed in the Restatement do not raise concerns for insurance companies. If, as is true in many instances, the Restatement is stating a majority rule, then, surely, having courts, parties in litigation, and others refer to the RLLI's overview of the law, prepared during years of work by some of the best minds in the legal profession, should be considered by fair-minded professionals a positive.

In addition to the issues identified above, the issues below also continue to be identified as concerns by insurer industry proponents.

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<sup>221</sup> NCOIL Committee Minutes state that “NAMIC has joined forces with the [APCIA] to undertake a national project to address the Restatement and both organizations have approached it in such a way as to address it in three ways.” NCOIL, Property & Casualty Insurance Committee, *supra* note 72, at 2. The “three ways” include an effort that (i) “fixes the problems with the Restatement in that state,” acknowledging that “one size” does not fit all States; (ii) ensures that the legislative committee that addresses the industry bill in question is the insurance committee, not the judiciary committee, which “might alter the intent of the bill”; and (iii) “appropriately address[es] separation of powers” and the “state’s constitutional requirements in terms of what a legislature can say to the courts.” These “ways” recognize, contrary to statements captured in some of the Committee Meeting Minutes and in insurance industry criticisms of the RLLI, that many issues addressed in the Restatement have not been addressed in state legislation; and that efforts to undermine the Restatement and preclude courts from even reviewing it may run afoul of separation of powers principles integral to our form of government. *Id.* at 2–3.

## 1. Section 13: Duty to Defend / “One-Way Rule”

The duty to defend is one of the two fundamental duties of a liability insurance company and a primary reason businesses and individuals purchase liability insurance. Under the standard used by the vast majority of courts and endorsed by the Restatement, a liability insurer is obligated to defend if the allegations against the insured raise at least a potential for coverage under the policy. The black letter of the Restatement supports that standard, and the Comments specifically refer to it in those terms.<sup>222</sup>

The Restatement thus supports application of the duty to defend when “the insurer knows of an allegation that, under existing pleading rules, could reasonably be expected to be added as an allegation to the legal action, and that, if so added, would require the insurer to defend the action.”<sup>223</sup> The Restatement uses the “complaint allegation rule,” often called the “four-” or “eight-corners rule,” and limits the standard to “facts known to the insurer.”<sup>224</sup> The insurer “must resolve any factual assertion in favor of the duty to defend.”<sup>225</sup> The RLLI makes clear that, except for the six exceptions identified in §§ 13(3)(a)–(f)<sup>226</sup>—added at the behest of

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<sup>222</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 13, cmt. b. (*The potential for coverage*) (AM. L. INST., Draft Sept. 7, 2018).

<sup>223</sup> *Id.* § 13, cmt. b. (*The potential for coverage*).

<sup>224</sup> *Id.*

<sup>225</sup> *Id.*

<sup>226</sup> *Id.* § 13(3)(a)–(f). The exceptions set forth in § 13 follow:

(3) An insurer that has the duty to defend under subsections (1) and (2) must defend until its duty to defend is terminated under § 18 by declaratory judgment or otherwise, unless facts not at issue in the legal action for which coverage is sought and as to which there is no genuine dispute establish that:

(a) The defendant in the action is not an insured under the insurance policy pursuant to which the duty to defend is asserted;

(b) The vehicle or other property involved in the accident is not covered property under a liability insurance policy pursuant to which the duty to defend is asserted and the defendant is not otherwise entitled to a defense;

(c) The claim was reported late under a claims-made-and-reported policy such that the insurer’s performance is excused under the rule stated in § 35(2);

(d) The action is subject to a prior-and-pending-litigation exclusion or a related-claim exclusion in a claims-made policy;



the insurance industry—this principle applies “in one direction only,” “[e]xcept as provided in subsection (3) and discussed in Comment c, the consideration of facts outside the complaint works in one direction only: facts or circumstance is not alleged in the complaint or comparable document generally may not be used to justify a refusal or failure to defend.”<sup>227</sup>

The Restatement therefore adopts the common law, which has upheld the promise of a defense for the insured as long as the allegations or evidence outside the complaint supports the duty. While insurers have objected to this “one-way rule,” the majority of the courts uphold the use of such “extrinsic evidence” to activate the duty to defend as the Comments note.<sup>228</sup> This is true even if facts outside the complaint conflict with the plaintiff’s allegations but support coverage.

The traditional “four-corners” or “eight-corners rule” was of course designed as a rule of inclusion, not exclusion. The insurance industry sought to change this project from a Principles project, to a Restatement; and fought against any rule in the Restatement drafts that was not a majority rule. Insurers then should not be heard to complain about this rule, as this law specifically derives from contract, the protective nature of insurance, and the “piece of the rock” representations made by insurers to purchasers at the time of purchase.<sup>229</sup>

2. Section 19 (with Reference to §§ 15 and 50):  
Consequences of Breach of the Duty to Defend

Section 19 served as a flashpoint throughout the drafting of the Restatement. Under both the Principles, approved in 2014, and initial drafts of the Restatement, a breach of the duty to defend deprived a liability insurer of its right to assert coverage

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(e) There is no duty to defend because the insurance policy has been properly cancelled; or

(f) There is no duty to defend under a similar, narrowly defined exception to the complaint-allegation rule recognized by the courts in the applicable jurisdiction.

<sup>227</sup> *Id.* § 13, cmt. b. (*The potential for coverage*).

<sup>228</sup> *Id.* § 13, cmt. a. (*The duty to defend and the complaint-allegation rule*).

<sup>229</sup> It is true, however, that insurers representatives did peek in meetings. I attended to reject this “potential for coverage” standard in favor of “actual facts.” That effort lost, as it does not compare with the almost universal rule.

defenses, even if the breach was not in bad faith. Those drafts noted the prophylactic effect of that approach in encouraging insurers to honor their duty to defend.<sup>230</sup>

However, after rounds of comments and revisions, the final Restatement deleted from the black letter of this section any reference to forfeiture of coverage defenses as a remedy for breach of a liability insurer's duty to defend. As now configured, § 19 states a non-controversial position, which the Comments note is the "prevailing legal rule": "An insurer that breaches the duty to defend a legal action forfeits the right to assert any control over the defense or settlement of the action."<sup>231</sup> The Comments note that the remedy set forth in the final RLLI is available only for a "material breach" of the duty to defend, defined as "a refusal to defend when required, a provision of a materially inadequate defense, a failure to provide an independent defense when required, and a withdrawal of a defense when the duty has not terminated."<sup>232</sup>

This provision must be considered in light of other relevant sections in the *Restatement*. For example, as shown in § 15, entitled "*Reserving the right to contest coverage*," liability insurers that fail to "timely reserve their rights to contest coverage lose those rights."<sup>233</sup> These provisions note that the rule is now "well established" that "an insurer that does not raise the ground for contesting coverage should be understood to have waived its right to contest coverage in nearly all cases."<sup>234</sup>

Similarly, Comments to § 50, addressing insurer liability for bad faith, identify a forfeiture of coverage defenses as a potential remedy for insurer bad faith "as justice requires."<sup>235</sup> The Comments to § 50 discuss the basis for this rule which the RLLI says, "reinforces the importance" of the "litigation insurance" policyholders seek to purchase when buying CGL coverage:

The loss-of-coverage-defense remedy is particularly appropriate when an insurer refuses to defend in bad faith. Requiring the insurer to pay for a judgment or settlement entered in such a case reinforces the importance of the defense coverage provided by traditional liability insurance policies, which promise to pay for the defense of any potentially covered claim and, in most cases, also to select the

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<sup>230</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 21 cmt. c (AM. L. INST., Draft Jan. 22, 2016).

<sup>231</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 19 (AM. L. INST. 2019).

<sup>232</sup> *Id.* at § 19, cmt. b.

<sup>233</sup> *Id.* at § 15, cmt. a.

<sup>234</sup> *Id.*

<sup>235</sup> *Id.* § 50, cmt. c.

defense lawyer and manage the defense. An insurer that could abandon the defense whenever it concluded that the coverage-relevant facts were in its favor, without any risk of having to pay a judgment or settlement of the action, would have an incentive to do so.<sup>236</sup>

This loss-of-coverage-defense remedy also draws support from two places:

- (i) the rule followed in the minority of states, under which an insurer that breaches its duty to defend loses its coverage defenses, without regard to whether it acted in bad faith or whether available compensatory damages provide sufficient deterrence; and
- (ii) the rule in § 15, pursuant to which an insurer that defends without a reservation of rights loses its coverage defenses.<sup>237</sup>

In some quarters, § 15 has generated more controversy than might be expected.<sup>238</sup> However, the provisions in this Section come right out of insurance claim-handling and settlement statutes adopted around the country. For example, the Model Unfair Claims Settlement Practices Act (UCSPA) was promulgated by the National Association of Insurance Commissioners (NAIC) to promote fair practices and protect the public from unfair practices. The Model UCSPA defines, for example, the following as unfair practices: knowingly misrepresenting relevant facts or policy provisions relating to coverages at issue and “failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising

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<sup>236</sup> *Id.*

<sup>237</sup> See *id.* § 15, cmt. a. (*The basis for the reservation-of-rights requirement*). The rule arises, in part, from estoppel. The comments also note the difficulty insureds may face “to demonstrate detrimental reliance, particularly in the consumer context.” *Id.* These comments also differentiate between the “full-coverage case,” and others where conflicts of interest may arise between the insured and the insurer. *Id.*

<sup>238</sup> See, e.g., Patricia McHugh Lambert, *A Primer on Controversy: Restatement of the Law, Liability Insurance*, JD SUPRA (June 12, 2019), <https://www.jdsupra.com/legalnews/a-primer-on-controversy-restatement-of-78757/>.

under its policies.”<sup>239</sup> It also provides for cease-and-desist orders, fines, and suspension or revocation of licenses as statutory remedies.

### 3. Sections 24 and 27: The Duty to Make Reasonable Settlement Decisions

Section 24, entitled “The Insurer’s Duty to Make Reasonable Settlement Decisions,” addresses what is, of course, another key protection that policyholders seek when they buy liability insurance: Coverage for settlements. Most insureds would prefer, when possible and consistent with their interests, to settle an action rather than to continue to fight it in court. As noted in the Comments, this Section seeks to clarify various strands found in the law, including the law on the duty of good faith and fair dealing and that on insurer bad faith.<sup>240</sup> As the Comments note, “the ultimate test of liability is whether the insurer’s conduct was reasonable under the circumstances.”<sup>241</sup>

This duty, often called generically “the duty to settle,” arises when the insurer has authority to settle the case against the insured, the policyholder faces a potential for a judgment in excess of policy limits. The Restatement defines the duty as follows:

#### **§ 24. The Insurer’s Duty to Make Reasonable Settlement Decisions**

(1) When an insurer has the authority to settle a legal action brought against the insured, or the insurer’s prior consent is required for any settlement by the insured to be payable by the insurer, and there is a potential for a judgment in excess of the applicable policy limit, the insurer has a duty to the insured to make reasonable settlement decisions.

(2) A reasonable settlement decision is one that would be made by a reasonable insurer that bears the sole financial responsibility for the full amount of the potential judgment.

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<sup>239</sup> UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4 (NAIC 1997). The Act provides no private cause of action but shows applicable standards of conduct. *Id.* § 1. Its applicability is limited because it requires proof that the conduct constitutes a “general business practice.” *Id.* § 3.

<sup>240</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 24, cmt. a (AM. L. INST., Discussion Draft Mar. 2, 2015).

<sup>241</sup> *Id.*

(3) An insurer's duty to make reasonable settlement decisions includes the duty to make its policy limits available to the insured for the settlement of a covered legal action that exceeds those policy limits if a reasonable insurer would do so in the circumstances.<sup>242</sup>

As noted above, § 24 defines the duty as "one that would be accepted or made by a reasonable person who bears the sole financial responsibility for the full amount of the potential judgment."<sup>243</sup> The RLLI defines "the ultimate test of liability" as "whether the insurer's conduct was reasonable under the circumstances."<sup>244</sup>

Section 27 defines the remedies recoverable for breach of this duty, using the time-honored *Hadley v. Baxendale*<sup>245</sup> standard of foreseeability:

#### **§ 27. Remedies for Breach of the Duty to Make Reasonable Settlement Decisions**

(1) An insurer that breaches the duty to make reasonable settlement decisions is subject to liability for any foreseeable harm caused by the breach, including the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits.<sup>246</sup>

The Comments explain that, if the insurer breaches this duty, the insured is entitled to recover the policy limit and any "excess judgment," which is "the paradigmatic measure of damages in a breach-of-settlement-duty lawsuit against an insurer."<sup>247</sup> The Section sets forth an objective, "reasonable insurer" standard.

Some commentators have considered this "a broad duty" (meaning too broad a duty). In truth, again, it comes out of principles provided in insurance claims-

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<sup>242</sup> *Id.* § 24(1)–(3).

<sup>243</sup> *Id.* § 24(2); *see also id.*, cmt. b. Comments c.–l. discussing what constitutes "reasonableness," causation, and proof. Comment c says that, like the "general duty of good faith and fair dealing, this settlement duty requires "the insurer to give equal consideration to the interests of the insured, "as to its own." *Id.*

<sup>244</sup> *Id.* § 24, cmt. a. (*Relationship to the duty of good faith and fair dealing*).

<sup>245</sup> *Hadley v. Baxendale* [1854] EWHC J70 (156 ER 145, 9 Ex. Ch 341 (1854)).

<sup>246</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 27(1). (AM. L. INST. 2019).

<sup>247</sup> *Id.* § 27, cmt. a. (*Liability for excess judgment*).

handling and settlement statutes around the country which seek to enforce reasonable claims-handling and settlement practices, and, thus, is not a fundamental reworking of insurer obligations or the law (statutory or common law) governing them. Again, if a State has established statutory or common-law on these issues, that law governs.

#### 4. Sections 47–50: Remedies

These provisions continue to generate controversy, but, as with other sections, were revised significantly throughout the process in response to insurer (and other) comments. Insurers considered particularly controversial one “innovation” in the proposed black letter, stating that insureds should be able to recover attorneys’ fees when they succeed in lawsuits to enforce coverage. While certain States allow recovery of such fees either by statute or common law,<sup>248</sup> the American Rule, providing that each party pays its own fees, prevails in many other states.

Other provisions state rules that are commonly accepted. For example, § 48 states that an insured seeking a determination of rights under its liability insurance policy is entitled to a variety of remedies that are commonplace in contract actions, and ones that lawyers take for granted. For example, can it be controversial that a policyholder is entitled to the following remedies identified in subsection (1)-(8)?

#### § 47. Remedies Potentially Available

An action seeking determination of the rights of the parties to a liability insurance policy may be brought by either the insurer or the insured. In such an action, the remedies that may be available include:

- (1) A declaration of the rights of the parties;
- (2) An award of damages under § 48;

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<sup>248</sup> *E.g.*, FLA. STAT. § 627.428(1) (2020); N.J. CT. R. 4:42-9; *Travelers Indem. Co. v. Rosedale Passenger Lines Inc.*, 55 F.R.D. 494 (D. Md. 1972) (applying Maryland common law to award attorney fees to policyholder who had to sue to enforce coverage). *See also* MASTERS ET AL., *supra* note 41 § 11.13[B]. Even insurers have sometimes argued for the right to recover attorney fees for a policyholder. *Liberty Mut. Ins. Co. v. Continental Cas. Co.*, 771 F.2d 579 (1st Cir. 1985) (insurer vs. insurer case) (Br. of Plaintiff-Appellee Liberty Mut. Ins. Co. (filed Mar. 1, 1985)).

- (3) Court costs or attorneys' fees to a prevailing party when provided by state law or the policy;
- (4) If so provided in the liability insurance policy or otherwise agreed by the parties, an award of a sum of money due to the insurer as recoupment of the costs of defense or settlement;
- (5) Collection and disbursement of interpleaded policy proceeds;
- (6) Payment or return of premiums;
- (7) Indemnification of the insurer by the insured when state law permits recovery from highly culpable insureds; and
- (8) Prejudgment interest.<sup>249</sup>

Under § 48, in reliance on § 27, insureds harmed by their insurers' failure to make reasonable settlement decisions may recover "for any foreseeable harm caused by the breach, including the full amount of damages assessed against the insured in the underlying legal action, without regard to the policy limits."<sup>250</sup> Section 48 also provides that, in addition to the cost of the defense, and indemnification for amounts required to indemnify the insured, an insured may also recover the following for breach of a liability insurance policy:

Any other loss, including incidental or consequential loss, caused by the breach, provided that the loss was foreseeable by the insurer at the time of contracting as a probable result of a breach, which sums are not subject to any limit of the policy.<sup>251</sup>

While insurers continue to complain about this provision, it is a venerable, first-year contracts principle that the party breaching a contract is responsible for the consequential damages from this breach that were foreseeable at the time of contracting.<sup>252</sup>

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<sup>249</sup> RESTATEMENT OF THE L. OF LIAB. INS. § 47(1)–(8). (AM. L. INST. 2019).

<sup>250</sup> *Id.* § 27, cmt. c. (*Other foreseeable loss*); see also *id.* § 48(3).

<sup>251</sup> *Id.* § 48(4).

<sup>252</sup> *E.g.*, *Hadley v. Baxendale*, [1854] EWHC J70.

## VI. CONCLUSION

The Restatement presents cause for satisfaction and cause for unhappiness—by both policyholders and insureds, on the one hand, and insurers, on the other. There is, as shown in the discussion of commentaries and legislation above, however, an “inequality of arms” and approach in how the two sides have addressed these concerns. This of course reflects the institutional advantages enjoyed by insurers. As shown by insurer directives to their counsel not to cite the Restatement—even when it supports their position—this approach seems perverse. Regardless, consistent with rules of good process and ethical standards that call for full disclosure, those who endeavor to critique the ALI process should engage in good and fair process themselves, consistently disclosing their affiliations and whether they are being paid for their time in writing and speaking on the topic; and seek to include contrasting viewpoints.

We look forward to using the Restatement as support and as a foil as we represent clients and we hope to contribute to our practice area in years to come.



# INFECTED JUDGMENT: PROBLEMATIC RUSH TO CONVENTIONAL WISDOM AND INSURANCE COVERAGE DENIAL IN A PANDEMIC

ERIK S. KNUTSEN AND JEFFREY W. STEMPEL \*©

## *Abstract*

*The COVID-19 pandemic created not only a public health crisis but also an insurance coverage imbroglio, prompting near-immediate business interruption claims by policyholders impacted by government restrictions ordered in response to the pandemic. Insurers and their representatives “presponded” to the looming coverage claims by quickly moving to denigrate arguments for coverage, engaging in a pre-emptive strike that has largely worked to date, inducing too many courts to rush to judgment by declaring—as a matter of law—that policy terms such as “direct physical loss or damage” do not even arguably encompass the business shutdowns resulting from COVID-19. Our closer examination of the term and of other key coverage questions suggests that policyholders have a much stronger case than suggested by the initial—and often superficial and conclusory—conventional wisdom flowing from the first wave of judicial decisions. Only a few courts have analyzed the COVID coverage debate with the type of reflective care, judicial humility, and respect for the trial process one would hope to see. The “early returns” in these coverage wars have been analytically disappointing, creating risk of an unfortunate path dependency or cascade of cases excessively narrowing the meaning of key terms such as “loss” and “damage,” and diminishing the quality of future coverage decisions.*

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## I. INTRODUCTION

### A. COVID-19 AND COVERAGE CONTROVERSY

As the world now knows, a variant of the SARS coronavirus emerged in Asia in late 2019<sup>1</sup> creating a severe concentration of infections in Wuhan, China that spread rapidly throughout the world reaching the United States perhaps as early as December 2019.<sup>2</sup> By February 2020, the new virus named COVID-19<sup>3</sup> was a

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<sup>1</sup> “SARS” (Severe Acute Respiratory Syndrome) is the name given to a class of particularly dangerous virus that causes respiratory problems but often adversely affect other organs. Julia Ries, *Here’s How COVID-19 Compares to Past Outbreaks*, HEALTHLINE (Mar. 12, 2020), <https://www.healthline.com/health-news/how-deadly-is-the-coronavirus-compared-to-past-outbreaks>. SARS viruses are common in animals and only occasionally cross over to humans—with dangerous results. *Id.* The SARS-1 virus, which spread rapidly between 2002 and 2004, infected many and caused an estimated 774 deaths worldwide (though none in the United States). *Id.* See generally Center for Disease Control and Prevention, CDC.GOV, <https://www.cdc.gov> (providing range of information regarding the SARS virus and COVID-19 in particular).

<sup>2</sup> See CDC.GOV, *supra* note 1 (noting that as of January 1, 2021, COVID-19 surpassed twenty million cases and 341,199 deaths in the United States). Accord, Johns Hopkins Coronavirus Resource Center, <https://www.coronavirus.jhu.edu>.

<sup>3</sup> COVID-19 is “a mild to severe respiratory illness that is caused by a coronavirus (*Severe acute respiratory syndrome coronavirus 2 of the genus Betacoronavirus*)” transmitted chiefly by contact with infectious material (such as respiratory droplets) or with objects or surfaces contaminated by the causative virus, and is characterized especially by fever cough, and shortness of breath and may progress to pneumonia and respiratory failure.” See *COVID-19*, MERRIAM-WEBSTER DICTIONARY (2020), <https://www.merriam-webster.com/dictionary/COVID-19>.

The term coronavirus derived from the crown-like spikes of the virus that appear when it is viewed by microscope. Kathy Katella, *Our New COVID-19 Vocabulary—What Does it All Mean?*, YALE MEDICINE (Apr. 7, 2020), <https://www.yalemedicine.org/stories/covid-19->

widely acknowledged serious problem<sup>4</sup> that was deemed a “pandemic” by March 11, 2020.<sup>5</sup> Beginning in March 2020, state and local governments began issuing

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glossary/. It is a relative of the SARS-CoV (often referred to as “SARS” or Severe Acute Respiratory Syndrome) that caused substantial injury and death in a 2002-2003 worldwide outbreak. *Id.* Coronaviruses of various types can cause common colds as well as SARS and Middle East respiratory syndrome (MERS). *Id.* The variant emerging in 2019 “is believed to have started in animals and spread to humans. *Id.* Animal-to-person spread was suspected after the initial outbreak in December among people who had a link to a large seafood and live animal market in Wuahn, China.” *Id.*

COVID-19 is thus the name for the disease resulting from infection by the virus with the letters COVI standing for coronavirus, the D for disease, and the number 19 in the name resulting because this particular strain of the virus emerged in Wuhan in November 2019. Because the name is derived from initials, it is frequently abbreviated as “COVID-19” in capital letters.

<sup>4</sup> See Christopher C. French, *COVID-19 Business Interruption Insurance Losses: The Cases for and Against Coverage*, 27 CONN. INS. L.J. 1 (2020) (acknowledging that COVID-19 infections were presenting serious problem). As is not common knowledge, governments exhibited a range of reactions to the COVID-19 problem. Some (e.g., Canada, New Zealand, Hawaii), ordered substantial comprehensive “lockdowns” as a means of retarding the spread of the disease. See, e.g., Lauren Vogel, *COVID-19: A Timeline of Canada’s First-wave Response*, CAN. MED. ASS’N J. NEWS (June 12, 2020), <https://cmajnews.com/2020/06/12/coronavirus-1095847>; Alexis Robert, *Lessons from New Zealand’s COVID-19 Outbreak Response*, THE LANCET (November 1, 2020), [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30237-1/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30237-1/fulltext); Alejandro de la Garza, *Hawaii Is Riding Out the COVID-19 Storm. But Geographic Isolation Isn’t the Blessing it May Seem*, TIME (Nov. 25, 2020 10:07 AM), <https://time.com/5915084/hawaii-covid-coronavirus/>. Others, such as Sweden, adopted a system of modified restrictions that varied among states. Mariam Claeson & Stefan Hanson, *COVID-19 and the Swedish Enigma*, THE LANCET (January 23, 2021), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)32750-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32750-1/fulltext).

<sup>5</sup> The World Health Organization declared COVID-19 a pandemic on March 11, 2020. See *WHO Characterizes COVID-19 as a Pandemic*, WHO (Mar. 11, 2020), <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen> (providing a timeline of COVID-19 developments and quoting WHO Director-General that the organization has “made the assessment that COVID-19 can be characterized as a pandemic” and is “the first pandemic caused by a coronavirus. And we have never before seen a pandemic that can be controlled, at the same time.”). See also Natasha Frost, *Coronavirus, QAnon, Trump: Your Monday Briefing*, N.Y. TIMES (Oct. 11, 2020), <https://www.nytimes.com/2020/10/11/briefing/coronavirus-qanon-trump-your-monday-briefing.html> (“More than six months since the start of the pandemic, European countries such as France, Spain and Britain are reporting daily infection numbers comparable to—and sometimes far beyond—those of their first peaks.”).

closure orders barring access to and operation of many facilities deemed insufficiently essential.<sup>6</sup>

The governmental orders varied, of course. Some demanded a stronger or more comprehensive shutdown than others. But many, if not most, precluded normal operation of “nonessential” business functions, perhaps most prominently indoor dining and entertainment, under pain of punishment for violation.<sup>7</sup> Within days of government recognition (now widely seen as belated) that COVID was highly contagious and dangerous,<sup>8</sup> insurance claims for business interruption were widely anticipated with additional anticipated coverage controversy involving other insurance products. The insurance coverage community was abuzz about the topic throughout Spring 2020, attention that continues only slightly abated today.<sup>9</sup> Lawsuits followed relatively quickly, numbering more than 1,000 by Fall 2020.<sup>10</sup>

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<sup>6</sup> See French, *supra* note 4; Terry Spencer & Teresa Crawford, *US Moves Nearer to Shutdown Amid Coronavirus Fears*, AP (Mar. 16, 2020), [apnews.com/article/1510caddee80ea2d73363fab76d55967](https://apnews.com/article/1510caddee80ea2d73363fab76d55967) (“Officials across the country curtailed many elements of American life to fight the coronavirus outbreak. . . Governors and mayors closed restaurants, bars, and schools as the nation sank deeper into chaos.”).

<sup>7</sup> See *infra* Part I(B) and Part II.

<sup>8</sup> See *Death Rates from Coronavirus (COVID-19) in the United States as of December 22, 2020*, by State, STATISTA (Dec. 22, 2020), <https://www.statista.com/statistics/1109011/coronavirus-covid19-death-rates-by-state> (noting that, as of December 22, 2020, more than 319,000 American deaths were attributed to COVID-19 from a total of more than 20 million infections). Visible case studies of COVID-19 dangers were chronicled in often heart-wrenching news reports, see, e.g., *Those We’ve Lost*, N.Y. TIMES (Nov. 3, 2020), <https://www.nytimes.com/interactive/2020/obituaries/people-died-coronavirus-obituaries.html> (discussing as a regular feature in the Times since the onset of the pandemic), as well as being demonstrated rather dramatically and contemporaneously when President Donald Trump, three US Senators, White House employees, and Secret Service agents were afflicted during late September and early October 2020. The President was treated by a large team of physicians utilizing an array of antibiotics, steroids, and supplemental oxygen during the President’s 3-day hospitalization, with continuing treatment after discharge. See Katie Thomas & Denise Grady, *Trump Returns Home After Downplaying Disease, but Doctor Says He Isn’t ‘Out of the Woods,’* N.Y. TIMES (Oct. 7, 2020, 1:38 AM), <https://www.nytimes.com/live/2020/10/05/world/covid-trump>; Maggie Haberman & Annie Karni, *Trump’s Return Leaves White House in Disarray as Infections Jolt West Wing*, N.Y. TIMES (Oct. 6, 2020), <https://www.nytimes.com/2020/10/06/us/politics/white-house-coronavirus.html>.

<sup>9</sup> See *infra* Part II.

<sup>10</sup> See Tom Baker, *COVID Coverage Litigation Tracker*, [cclt.law.upenn.edu/author/tombaker/](https://cclt.law.upenn.edu/author/tombaker/) (last visited December 31, 2020).

In the early spring days of the pandemic, the insurance industry began a remarkable media campaign to make known its position on the issue of coverage for virus-related losses: there is no coverage. In insurance industry publications, in lawyers' news media, and even in the news media consumed by the general public, the message of "no coverage for pandemic losses" was repeated again and again. This lies in stark contrast to the treatment of coverage for COVID-related losses in other jurisdictions such as Western Europe. But in America, however, the insurance industry repeated the mantra.

Policyholders only had to open a newspaper to see how the industry was advancing their views that claims would be denied, imposing motions to dismiss, at least before presumably favorable tribunals. And insurers began to win. Those wins were reported and highlighted in the media. This anti-coverage public relations media blitz forms a curious backdrop to what actually occurred in courts across the United States deciding COVID-related claims. In short, as this article discusses below, courts often fell short in their analyses in these coverage cases, ignoring time-tested principles of insurance policy interpretation and even of basic civil litigation rules. The spectre of the anti-coverage media blitz may well have primed the judiciary for the results to come.

By January 2021, roughly seventy-five of these cases had some sort of substantive court decision, most commonly the grant or denial of a motion to dismiss for failure to state a claim, particularly the latter, pro-insurer result.<sup>11</sup> Insurers prevailed in sixty-seven of the seventy-five cases, with courts granting Rule 12(b)(6) (or its state equivalent) dismissal on the basis of a lack of sufficiently triggering damage, a virus exclusion that ousts coverage, or both.<sup>12</sup> The speed of these decisions and the success of insurers should be regarded—at least on the triggering damage question—as surprising and erroneous.<sup>13</sup> Although insurers have a significant array of arguments against coverage, we find them considerably less powerful than suggested by insurers and accepted by many judges to date.<sup>14</sup>

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<sup>11</sup> *Id.* In what might be termed the "first wave" of COVID-19 property insurance and business interruption cases, the majority have been brought by policyholders as plaintiffs rather than by insurers seeking a declaratory judgment of no coverage. For clarity, this article will generally use the term "policyholders" to include both named insureds and all other insureds under a policy unless insured status is important to determination of a coverage issue.

<sup>12</sup> See Baker, *supra* note 10.

<sup>13</sup> See *infra* Part IV.

<sup>14</sup> See *infra* Part III. This is not to say that insurers deserve none of these early victories. Where policies contain a sufficiently broad virus exclusion, the facts of many cases will likely make the exclusion applicable and support a finding of no coverage. As Professor Baker has noted:

In our view, each insurance coverage case needs to be decided based upon not only its particular factual context but also according to the specific policy at issue. Some policies contain a virus exclusion (which of course makes a stronger, perhaps even irrefutable, case for no coverage)<sup>15</sup> while many others lack any such limitation on coverage—a factor strongly favoring policyholders.<sup>16</sup> But the “early returns” point toward excessively impulsive and overbroad (in our view) embrace

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Of the seven cases in which a merits-based motion to dismiss has been denied, four involve insurance policies without any virus exclusion, one involves the Hartford’s Endorsement for Limited Fungi, Bacteria, or Virus Coverage (which contains a virus exclusion that could be read to apply only to losses involving defective materials), and two have virus exclusions that apply to sickness or disease.

By contrast, of the eighteen cases in which a court has granted a merits-based motion to dismiss, only two don’t have virus exclusions.

This matters, among other reasons because the presence of a virus exclusion inhibits policyholders from pleading their cases in ways that would help them meet the requirement that their business income losses result from “physical loss of or damage to” the premises in question.

Bottom line [as of Oct. 7, 2020]: insurers are winning, overwhelmingly, when their policies have virus exclusions. But they are losing, at least at the motion to dismiss stage, when their policies do not have virus exclusions.

Baker, *supra* note 10. We are, as discussed in Part IV, nonetheless disturbed by many of these early insurer victory cases because of their superficial and weak reasoning taking an excessively narrow view of what constitutes “physical loss or damage,” which may have negative implications for future coverage disputes.

<sup>15</sup> See *infra* Part V.

<sup>16</sup> If nothing else, the presence of an exclusion implies, sometimes strongly in light of the language of the insuring agreement, that in the absence of an exclusion, a claim or loss is covered. As discussed in Part IV, the virus exclusion was developed to avoid potential coverage pursuant to standard issue policies. If the insuring agreement or other exclusions in those policies had sufficiently precluded coverage, there logically would have been no need for a specific virus exclusion. We appreciate that insurers may want a “belt and suspenders” approach to policy drafting and that exclusions in some cases may be added simply to solidify widely accepted understandings and to foreclose unrepresentative judicial construction of policies. But courts should also appreciate that just as often (or perhaps more frequently), exclusions are added to policies because the policies provide coverage in the absence of such exclusions.

of an insurer-sponsored conventional wisdom that COVID claims are simply not insured.<sup>17</sup>

In particular, we are unimpressed with insurer arguments that COVID and attendant government closure orders do not—as a matter of law—constitute “direct physical loss or damage” to covered property. To date, the majority of judges hearing COVID cases disagree. Although their views are positive law and ours are not, we remain disappointed in the quality of analysis applied in many of the COVID coverage cases, which has often been reductionist, simplistic, crabbed, and overconfident regarding textual analysis, as well as insufficiently sensitive to the value of trial proceedings for resolving these disputes.<sup>18</sup>

Judges granting dismissal motions without any opportunity for discovery, and denying any possibility of coverage at the metaphorical starting gate, have undermined the traditional American commitment to jury trials as well as widely accepted legal principles of insurance policy construction such as interpreting ambiguous terms against the drafter and considering policyholder reasonable expectations.<sup>19</sup> Where the issue is solely whether sufficient “loss” or “damage” has taken place, standard property insurance policy language is simply not as conclusive as purported by these courts. Although other defenses such as a virus exclusion may carry the day for some insurers, insurers have to date gotten much more mileage out of very weak “no-loss/no-damage” arguments than should be the case if trial judges were consistently doing a thorough job.

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<sup>17</sup> Consistent with discussion in Part II of this article regarding the (in our view) successful public relations efforts of insurers to paint COVID-19 business interruption claims as (to use a favorite phrase of the former President Trump) losers, the legal and insurance trade press has tended to under-report policyholder victories while giving significant attention to insurer victories, emphasizing judicial statements labeling policyholder coverage arguments as meritless. Having followed the legal and trade press thoroughly the pandemic, we were surprised upon reading Professor Baker’s COVID Coverage Litigation Tracker to find that policyholders had “prevailed” on as many dismissal motions as they have (which is still a tiny fraction of the total number of motions). Baker, *supra* note 10. We put the term “prevailed” in scare quotes to emphasize that that surviving a motion to dismiss is not the equivalent of obtaining coverage—and certainly does not reflect payments that small business policyholders state they desperately need to survive. By contrast, when an insurer obtains a Rule 12 dismissal, it really has won something. In all eighteen cases where insurers have to date prevailed on dismissal motions, the court has dismissed the entire case with prejudice, leaving the policyholder with the unattractive options of appeal or accepting defeat.

<sup>18</sup> See *infra* Part IV.

<sup>19</sup> See *infra id.*



Potentially aiding and abetting this judicial failure has been substandard briefing and advocacy by policyholder counsel, many of whom are not insurance specialists but tort lawyers prosecuting coverage cases with perhaps relatively little experience or expertise about the nuances of insurance coverage law.<sup>20</sup> In many of the cases with outcomes we criticize, insurers have been served by better advocacy, an important factor in cases where judges also lack insurance expertise. In some other cases, a judge's background formerly representing insurers may also foreshadow pro-insurer rulings.<sup>21</sup> But we also posit that the bench was probably affected by widespread insurer efforts to "poison the well" against COVID-19 coverage claims through an early onslaught of pro-insurer, anti-coverage commentary in the legal press, the insurance trade press, and in mass circulation media.<sup>22</sup>

A more extensive and nuanced analysis of COVID coverage issues suggests to us that policyholders should be winning most of these dismissal motion cases—at least on the loss and damage issues—and proceeding further in the adjudication process. Notwithstanding some shining exceptions,<sup>23</sup> the first wave of decisions in these cases has been largely disappointing and reflects poorly on the legal and hyper-textual analysis of the bench. If this trend continues, the insurance industry will have

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<sup>20</sup> Insurers have taken the rare step of filing memoranda opposing amicus participation in Covid coverage cases, presumably because they wish the court not to have the benefit of analysis by more seasoned coverage counsel. *See, e.g.*, Defendant's Opposition to United Policyholders, National Independent Venue Association, and Washington Hospitality Association's Motion for Leave to Appear as Amici Curiae, *Vita Coffee, LLC v. Fireman's Fund Ins. Co.*, No. 2:20-cv-01079-JCC-DWC (W.D. Wash. 2020) (noted insurer side law firm opposes, *inter alia*, submission of United Policyholders amicus brief authored by Covington & Burling partner David Goodwin, a prominent policyholder coverage attorney).

<sup>21</sup> *See, e.g.*, *Franklin EWC, Inc. v. Hartford Fin. Servs. Grp.*, No. 20-cv-04434 JSC, 2020 U.S. Dist. LEXIS 174010 (S.D. Cal. Sept. 22, 2020) (granting of an insurer's dismissal motion by Magistrate Judge Jacqueline Scott Corley, formerly at DLA Piper, a firm known for representing insurers that has been involved in COVID coverage litigation, sufficiently aggressively that it has opposed judicial consideration of a proffered amicus brief by United Policyholders. *See also infra* Part II).

<sup>22</sup> By legal press, we refer to media directed primarily at lawyers, such as *US Law Week*, *Law 360* and the like. By insurance trade press, we refer to periodicals such as *Insurance Journal*, *Business Insurance*, *National Underwriter*, *Best's Review* and electronic newsletters, bulletins, and blogs (*e.g.*, Randy Maniloff's *Coverage Opinions* or the Hunton & Williams newsletters). General circulation media is aimed primarily at laypersons and runs the gamut from individual blogs or websites to major newspapers of record.

<sup>23</sup> *See infra* Part IV(A) (discussing well-reasoned cases finding sufficient allegations of physical loss or damage for coverage claim to proceed).

obtained an undeserved victory that is inconsistent with the extent of coverage it promised to policyholders, particularly small businesses.

The remainder of this part of the article examines the risk management and insurability issues presented by pandemic claims and identifies the principal types of first-party property insurance that could be implicated. Part II recaps the remarkable public relations campaign of insurers designed to influence both judicial and lay perception of insurance coverage for COVID-related losses. Part III examines the crucial coverage issues of whether there has been direct physical loss or damage sufficient to create coverage, acknowledging that coverage may be taken away by certain virus exclusions or other aspects of the policy or situation. Part IV briefly raises the virus exclusion contained in many policies and some challenges with it.

We conclude with concerns regarding the success of a tightly packaged, insidiously executed, and albeit factually and legally incorrect adversarial position put forth in insurance media may well have affected the initial outcomes of COVID-related coverage litigation. While we of course hope that to be untrue, when one begins to stack together some of the bizarre and frankly un-judicial goings on in these early COVID coverage cases, one has to wonder whether and to what degree concerted insurer-directed media infected the judicial outcomes. If true, that lays a haunting precedent over future coverage litigation for insurance matters both about pandemic-related losses and beyond.

#### B. CONSIDERING COVID COVERAGE DISPUTES IN THE BROADER CONTEXT OF THE INSURABILITY OF PANDEMIC-RELATED LOSSES

A pandemic is a “clash event,”<sup>24</sup> like a war or nuclear accident. Losses flowing from this event are large, uniformly repeated amongst many policyholders, and simultaneously cut across multiple insurance product lines. Insurance is built as a risk-based product, designed to buffer chance happenings of loss-related events by pooling collective risk in a pool while knowing that not all policyholders in that risk pool will experience a loss at exactly the same time.

With a pandemic, “chance” may be frustrated in that the precise manner in which risks become losses may not be fully expected (or rather modelled) by insurers. This makes it difficult for the insurer to spread risk amongst the risk pool or even amongst various lines of insurance products. While some industries in a

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<sup>24</sup> Michelle E. Boardman, *Known Unknowns: The Illusion of Terrorism Insurance*, 93 GEO. L.J. 783, 784 (2004) (dubbing “clash events” those large-scale losses like earthquakes and nuclear disasters that affect many policyholders at once and cut across multiple insurance lines).

pandemic can be severely affected (like the travel and hospitality industries in the current COVID-19 pandemic), and most at least significantly affected (such as retailers and services), there will be some industries that actually thrive in a pandemic (such as online retailers and delivery services). It may be fair to argue that it is the job of insurers to predict and price their insurance products accordingly, as part of building a solvent insurance framework. A failure to incorrectly build and price insurance in the wake of a clash event can leave only two outcomes: financial decimation for either the policyholder or the insurer. The stakes are high.

In a pandemic situation like that with COVID-19, a downturn in commercial activity is also often related to a resulting downturn in the financial markets. This challenges an insurer's ability to capitalize on investment returns for its retained insurance premium funds. The differential between premiums obtained and losses paid out—the spread—becomes tougher to profitably manage, because the financial markets unexpectedly reacted as a result of the very factor causing the losses insured.

But losses realized in a pandemic are not, by nature, impossible to insure. The difficulty is with estimating the correct pricing of the insurance products that tracks the realistic risks of payouts while still maintaining a profitable baseline for the insurer.

Anything that is fortuitous can be insured, in principle. The pandemic is an unexpected event. Whether insurers choose to insure pandemic-related losses as a matter of commercial choice is, of course, itself another matter.

Pandemic-relating losses are insurable in theory because the timing of the pandemic itself is a fortuitous event. We do not know when—or if—one will strike. But even in the wake of a full-blown pandemic, there are still fortuitous aspects making insurance a potentially profitable financial product to sell. Because, as noted above, not all industries will be affected at the same time and to the same degree, insurers may still be able to structure and price insurance profitably, even during a full-blown pandemic. This is because the degree and extent of loss experienced amongst individual policyholders is fortuitous. In fact, some policyholders may profit from the pandemic in their specific industries and may have no loss at all.

An insurer's ability to properly price an insurance product that appropriately accounts for pandemic-related losses based on the underwriting risk involves three factors:

- a) can the insurer properly rate the risk?
- b) is the premium for the risk affordable to policyholders?
- c) will the premium (along with investment income) exceed the loss?

As has probably occurred with COVID, insurance products were likely priced with the foresight of only a slight possibility of a pandemic. The insurer model may not have accounted for the various kinds of losses amongst policyholders (i.e. largely business interruption losses from governmental orders either closing businesses or telling customers to shelter at home to quell the spread of the virus).

Insurers cannot claim that the pandemic was completely unforeseen as an event. The world has seen its share of rising health epidemics in the recent decades, from Ebola to SARS to H1N1, swine flu, Zika, MERS, and HIV/AIDS. In fact, the insurance industry had a virus and bacteria exclusion approved by regulators for inclusion in property insurance policies in 2006, in direct response to the SARS virus (though this exclusion is not featured in all property policies).<sup>25</sup> The insurance industry also marketed specific insurance for pandemic-related losses, a product still available at the start of the COVID-19 pandemic in March 2020.<sup>26</sup>

However, most insurers began the COVID-19 pandemic with blanket coverage denials for policyholders' COVID-related claims. And insurers did this not on the basis of the virus exclusion most logically relevant to the issue, but instead on the argument that the policyholder has suffered no physical loss or damage.

The insurance denials prompted some governments to propose legislation to mandate either government reinsurance for pandemic-related losses,<sup>27</sup> or insist that insurers cover such losses, even despite actual policy coverage wording.<sup>28</sup> In

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<sup>25</sup> INSURANCE SERVICE OFFICE, ISO FORM CP 01 40 07 06 - EXCLUSION OF LOSS DUE TO VIRUS OR BACTERIA (July 6, 2006) [hereinafter ISO VIRUS EXCLUSION], <https://www.propertyinsurancecoveragelaw.com/files/2020/03/ISO-Circular-LI-CF-2006-175-Virus.pdf> (mentioning specifically SARS, avian flu, and influenza, as well as anthrax).

<sup>26</sup> See, e.g., *PathogenRX, An Innovative Solution for Pandemic and Epidemic Risks*, MARSH, <https://www.marsh.com/us/campaigns/pathogenrx.html> (last visited Jan. 24, 2021) (which had almost no take-up prior to COVID-19); Stuart Collins, *Insurers Wary of Meeting Growing Demand for Specialist Pandemic Cover*, COM. RISK ONLINE (Apr. 9, 2020), <https://www.commercialriskonline.com/insurers-wary-meeting-growing-demand-specialist-pandemic-cover/>; see also Robert Hartwig, Greg Niehaus & Joseph Qiu, *Insurance for Economic Losses Caused by Pandemics*, 45 GENEVA RISK & INS. REV. 134, 138 (2020) (discussing the failed PathogenRX market).

<sup>27</sup> See, e.g., Pandemic Risk Insurance Act of 2020, H.R. 6983, 116th Cong. (2020).

<sup>28</sup> Various state governments in New Jersey, New York, Pennsylvania, Louisiana, Ohio, Massachusetts, and South Carolina all proposed bills mandating that insurers cover COVID-19 pandemic-related losses. See, e.g., The Gen. Assemb. of Pa., H.B. 2372, 2020 Sess. (Pa. 2020) ("Business Interruption Insurance Act"); State of N.Y. Assemb., A. 10226-B, 2020 Assemb. (N.Y. 2020) ("An Act in relation to requiring certain perils be covered under business interruption insurance during the coronavirus disease 2019 (COVID-19) pandemic"); State of N.Y. Senate, S. 8178, 2020 S. (N.Y. 2020) ("An Act in relation to

response, the National Association of Insurance Commissioners (NAIC) warned in correspondence to the U.S. House Committee on Small Business that such legislation requiring insurers to cover COVID-19 related losses would financially decimate the insurance industry.<sup>29</sup> The Insurance Commissioners argued that most insurance products were not designed or priced to provide coverage for pandemic-related losses. They also contended that “virtually every policyholder suffers significant losses at the same time.” But pandemic-related losses themselves are not uninsurable in principle. Insurers may just not have properly estimated how the particular losses of this pandemic have played out and may not have priced their products accordingly. Or, perhaps, the insurance products were not designed to cover pandemic-related losses at all.

#### C. INSURANCE IMPLICATED IN A PANDEMIC

A pandemic such as the COVID crisis can result in insurance claims across a variety of insurance product lines, including:

- a) property insurance, especially for contamination losses and business interruption losses, as well as losses arising from civil authority ‘stay at home’ orders or forced business closure orders;
- b) liability insurance, in the event an employee or customer takes legal action against the policyholder for injury suffered as a result of failure to take reasonable health precautions;
- c) workers compensation and employment insurance, for the sickness or quarantining or isolation of employees;
- d) directors and officers insurance, for any liability visited by corporate decisions as a result of the pandemic; and
- e) event cancellation insurance, triggered if a major event is cancelled (such as a sporting event or concert or film production).

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requiring certain perils be covered under business interruption insurance during the coronavirus disease 2019 (COVID-19) pandemic”). These bills are currently winding their way through the legislative processes.

<sup>29</sup> Letter from Nat’l Ass’n of Ins. Comm’rs and the Cntr for Ins. Pol’y & Rsch to The Honorable Nydia M. Velázquez, Chairwoman, U.S. House Committee on Small Business (May 20, 2020), [https://naic.org/documents/government\\_relations\\_200521.pdf](https://naic.org/documents/government_relations_200521.pdf).

### 1. Business Interruption Coverage

The most active area for insurance coverage issues at this stage of the COVID-19 pandemic has been litigation arising from business losses by commercial entities, as a result of policyholder claims for losses under business interruption and civil authority insurance provisions. This has triggered interpretive debates in the courts over the meaning of business interruption and civil authority coverage contained in commercial property policies. These types of insurance products are additional coverages to the standard all-risk commercial property insurance policy.<sup>30</sup>

The standard commercial property policy provides coverage for losses arising from all risks to the policyholder's commercial property, save and except those risks that are specifically excluded in the policy. As a separate add-on, usually as an endorsement and for additional premiums, the policyholder can augment its property policy with various types of insurance coverage for other potential business-related losses.<sup>31</sup>

One such potential business-related loss is the interruption of a business' potential to generate income. This type of coverage is designed to protect the earning stream of the business in the event the business' capacity to earn income is interrupted as a result of a covered cause of loss. The coverage indemnifies the policyholder for income lost while the building restores its operations.<sup>32</sup>

The coverage clause in the standard property policy typically covers "direct physical loss of or damage to" insured property.<sup>33</sup> The business interruption coverage clause typically dictates that the insurer will pay for the loss of business income "due to the necessary suspension or delay of operations caused by direct physical loss of or damage to property." To determine insurance coverage, the policyholder must prove it suffered some "direct physical loss of or damage to property." The archetypal scenario for triggering business interruption insurance is the fire at a commercial establishment. The fire damages the storefront and the

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<sup>30</sup> See French, *supra* note 4, at 17–20; MARK S. DORFMAN & DAVID A. CATHER, INTRODUCTION TO RISK MANAGEMENT AND INSURANCE 346–47 (10th ed. 2013); EMMETT J. VAUGHAN & THERESE M. VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 563–65 (11th ed. 2013).

<sup>31</sup> See French, *supra* note 4, at 21–30; DORFMAN & CATHER, *supra* note 30, at 346–47; VAUGHAN & VAUGHAN, *supra* note 30, at 563–65.

<sup>32</sup> See French, *supra* note 4, at 21–30; DORFMAN & CATHER, *supra* note 30, at 346–47; VAUGHAN & VAUGHAN, *supra* note 30, at 563–65.

<sup>33</sup> See JEFFREY W. STEMPEL & ERIK S. KNUTSEN, STEMPEL & KNUTSEN ON INSURANCE COVERAGE §15.01[D] (4th ed. 2015 & Supp. 2020).

business is unable to earn income until such time as the business can repair the fire-damaged storefront.

In a pandemic situation like COVID, however, the place of business is not physically destroyed but contaminated by virus, making use of the business property unsafe. Alternatively, access to the business' property may be curtailed due to governmental orders designed to curb the spread of the disease. For example, many restaurants have been ordered closed to dine-in customers and could only operate via take-out or delivery for a period of time. The question becomes whether the policyholder has suffered a "direct physical loss of or damage to" its commercial property by either contamination by virus or by a governmental order restricting property access or use.

Insurers will likely stress that commercial property policies are designed to cover physical damage to tangible property—like fire damage. One way of looking at the issue is that any loss of business income should be tied to the necessary interruption of a business' income stream as a result of something that harms the property in a way that would interfere with a policyholder using its property as a place to earn income. If the property itself is not damaged, the coverage should not be triggered.<sup>34</sup>

Policyholders, however, likely believe that they purchased business interruption insurance as an add-on to their property coverage in order to insure a capital asset—the income-earning power of their business (hence the name "business interruption insurance"). If that income stream is interrupted due to an interference with their use of their property—whether by virus contamination or by orders of government—their reasonable expectation would be that the business interruption portion of their policy would cover such losses. The property policy is, after all, "all-risk" property insurance, and the business interruption coverage is tied to that "all-risk" concept. Policyholders who purchased business interruption insurance would expect coverage for an inability to use their property to earn business income.<sup>35</sup>

## 2. Civil Authority Coverage

A common extension to the business interruption coverage in a commercial property policy is civil authority coverage. Under this coverage, a policyholder can insure its lost business income stream if access to its property is impaired or prohibited due to the order of some civil authority (i.e. a government). Some wordings of this coverage specifically require that the civil authority's order is due

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<sup>34</sup> See French, *supra* note 4, at 51.

<sup>35</sup> See French, *supra* note 4, at 68–71.

to the direct physical loss of or damage to property adjacent to the policyholder's insured property as a result of a covered cause. A common coverage clause for civil authority insurance states: “. . . if an order of civil or military authority limits, restricts or prohibits partial or total access . . . provided such order is the direct result of physical damage of the type insured.”<sup>36</sup> The classic example is the burned warehouse that sits next to the policyholder's place of business. To keep people in the adjacent properties safe, a civil authority could ban access to a policyholder's property simply because it is close to another property exhibiting unsafe characteristics (like the unstable structure after a fire).

Business interruption insurance claims due to COVID have arisen under the civil authority coverage provisions, resulting from losses due to state or municipal “shelter in place” orders or the closure of non-essential businesses or the modification of the use of businesses, such as eliminating indoor dining at restaurants. The risk of COVID with its airborne and highly contagious quality prompted many civil authorities to issue various orders in an attempt to contain the disease.

Courts examining civil authority coverage tend to look to causation arguments: was the order the result of directly physical loss of or damage to property? If so, is such a covered cause of loss? Policyholders have argued that they suffered loss of use or loss of functionality of their property due to the civil authority orders, and that constitutes a direct physical loss of property. However, insurers have argued that the language of most coverage grants demands that policyholders must also prove that alleged property damage to some property adjacent to the policyholder's place of business actually led to the civil authority making the order.

### 3. Contingent Business Interruption Coverage

Contingent business interruption coverage is similar to business interruption coverage except that the policyholder's income stream is affected by loss or damage to a related business' property, and not the property of the policyholder. This coverage is commonly implicated in a manufacturer setting, where a supplier suffers a loss and the manufacturer cannot obtain a needed component in a timely fashion and suffers a business interruption.<sup>37</sup>

For example, if a tire manufacturer suffers a fire at the tire plant and is unable to ship its tires to auto makers because of fire damage to the plant, the auto makers will likely have a business interruption loss due to the inability to get tires

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<sup>36</sup> See STEMPEL & KNUTSEN, *supra* note 33, at §28.04.

<sup>37</sup> See French, *supra* note 4, at 21–30; Dorfman & Cather, *supra* note 30, at 346–47; Vaughan & Vaughan, *supra* note 30, at 563–65.



in a timely manner from their supplier. The auto maker can then make a contingent business interruption claim in that, although it did not suffer the loss itself on its own property, its supplier did, and that loss to the supplier affected the policyholder's own business income stream. The key to coverage for contingent business interruption insurance is that, like business interruption insurance, the supplier must have suffered some "direct physical loss of or damage to" property as a result of a cause covered by the policyholder's all-risk insurance.

#### 4. Ingress/Egress Coverage

Ingress/egress coverage is also sub-coverage that may be included in business interruption coverage. It provides coverage for losses arising if access to a policyholder's property is impeded through some reason other than by a civil authority order (i.e. blocked due to construction debris). To date, this coverage has not yet been implicated in any court decisions deciding COVID pandemic-related coverage issues. This makes sense as it was civil authority orders that largely affected property access for policyholders.

## II. INSURER PUBLIC RELATIONS BLITZ: INSURERS PUSH THEIR ANTI-COVERAGE MESSAGE

As previously noted, COVID-19 became recognized as a major public health issue likely to adversely impact commerce in early March 2020. It was fairly clear at the outset, particularly when citizens began to stockpile supplies and stay indoors and when governments issued closure orders, that COVID would have a serious negative impact on many businesses, particularly entertainment, dining, and tourism.<sup>38</sup>

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<sup>38</sup> See French, *supra* note 4, at 1–3; *Why Are Markets Collapsing? How Bad Will COVID-19 Really Be?*, KNOWLEDGE@WHARTON (Mar. 16, 2020), <https://knowledge.wharton.upenn.edu/article/why-are-the-markets-collapsing-how-bad-will-covid-19-really-be/> ("markets are acting as if we are going to encounter the worst-case scenario") (italics removed). The actual downturn in these areas of commerce has perhaps been even worse than anticipated due to the difficulty in containing COVID, resulting in a quilted cycle of closures and declining customer patronage that has perhaps lasted even longer than predicted. See Zoe Wood, *How the Cineworld Closures Could Turn Leisure Parks into a Disaster Movie*, THE GUARDIAN (Oct. 10, 2020 03:00 EDT), <https://www.theguardian.com/business/2020/oct/10/how-the-cineworld-closures-could-turn-leisure-parks-into-a-disaster-movie> (describing massive movie theatre closures and layoffs and ripple effect on bars, restaurants, and shops that benefitted from entertainment traffic). Accord Julian Kozlowski, Laura Veldkamp, & Venky Venkateswaran,

In response to the COVID-19 pandemic, insurers quickly took control of the insurance coverage message in the media: there will be no coverage for COVID-19 related losses.<sup>39</sup> Typical of the industry line were statements by insurance executives that “[p]andemics are not insurable because they are too widespread, severe, and unpredictable to underwrite” and that “[c]ommercial-property insurance policies that include business-interruption coverage generally are not intended to cover disease- or pandemic-related losses.”<sup>40</sup>

Another prominent insurer executive claimed to “see very minimal loss exposure from this” due to the addition of coverage-restricting language in policies

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*Scarring Body and Mind: The Long-Term Belief-Scarring Effects of COVID-19* (Nat’l Bureau of Econ. Rsch., Working Paper No. 27439, June 2020), [https://www.nber.org/system/files/working\\_papers/w27439/w27439.pdf](https://www.nber.org/system/files/working_papers/w27439/w27439.pdf) (finding that “long-run costs for the U.S. economy” from adverse psychological impact of pandemic will be “many times higher than the estimates of the short-run losses in output. This suggests that, even if a vaccine cures everyone in a year, the COVID-19 crisis will leave its mark on the US economic for many years to come.”).

<sup>39</sup> See, e.g., Caroline Glen, *Insurers Are Telling Businesses Their Policies Don’t Cover Coronavirus Shutdown. John Morgan Attorneys Say They’re Wrong*, ORLANDO SENTINEL (May 4, 2020), <https://www.orlandosentinel.com/coronavirus/jobs-economy/os-bz-coronavirus-insurance-denials-morgan-lawsuits-20200504-pbrpq6z7ofbevau67cpgq4nzqi-story.html>; Ellen Ioanes, *Does My Business-Interruption Insurance Cover Closing Because of COVID-19?*, BARRON’S (June 17, 2020 5:30 AM), <https://www.barrons.com/articles/does-my-business-interruption-insurance-cover-closing-because-of-covid-19-51592386201>; Leslie Scism, *Companies Hit by COVID-19 Want Insurance Payouts. Insurers Say No.*, WALL ST. J. (June 30, 2020 10:24 AM), <https://www.wsj.com/articles/companies-hit-by-covid-19-want-insurance-payouts-insurers-say-no-11593527047>. See also INS. INFO. INST., *Insurance Industry Provides Interactive ‘Explainer’ to Help Navigate Business Interruption Insurance*, III (Oct. 16, 2020), <https://www.iii.org/pres-release/insurance-industry-provides-interactive-explainer-to-help-navigate-business-interruption-insurance-101620>. The navigation tends to leave policyholders on the shoals of no coverage as the III Explainer consistently takes a narrow view of the scope of coverage and, in particular, contends that most all COVID-related coverage is not covered. *Accord Business Interruption Insurance: An Interactive Explainer Outlining the Case for a Federal Solution to Pandemic Relief*, FUTURE OF AM. INS. & REINSURANCE, [https://fairinsure.org/business-interruption-insurance/?utm\\_source=Board+of+Directors&utm\\_campaign=5ca10385b4-EMAIL\\_CAMPAIGN\\_2018\\_08\\_15\\_11\\_45\\_COPY\\_01&utm\\_medium=email&utm\\_term=0\\_0934a86008-5ca10385b4-122588685](https://fairinsure.org/business-interruption-insurance/?utm_source=Board+of+Directors&utm_campaign=5ca10385b4-EMAIL_CAMPAIGN_2018_08_15_11_45_COPY_01&utm_medium=email&utm_term=0_0934a86008-5ca10385b4-122588685).

<sup>40</sup> See Ioanes, *supra* note 39 (quoting David Sampson, president and CEO of the American Property Casualty Insurance Association (APCIA)).

because of “past pandemics and/or partial pandemics.”<sup>41</sup> Swinging into attack mode, this industry leader also took the by-now almost obligatory insurer swipe at plaintiff counsel and made it clear that seeking coverage would not be for the faint of heart: “Lawyers and the trial bar will attempt to torture the language on standard industry forms and try to prove something exists that actually doesn't exist . . . .” “The industry will fight this tooth and nail. We will pay what we owe.”<sup>42</sup>

Whether this evolved to be the message over a short period of time, or whether it was a concerted industry effort (likely the latter), we believe it made an impact on the subsequent insurance coverage court decisions about COVID-related claims. It provides an interesting example of insurers seizing the messaging opportunity to potentially affect legal decisions. Making use of extra-legal media messaging to impact the legal sphere is a useful tactic for prospective litigants and insurers seem to be good at it.

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<sup>41</sup> See Leslie Scism, *U.S. Businesses Gear Up for Legal Disputes with Insurers Over Coronavirus Claims*, WALL ST. J. (Mar. 6, 2020 10:00 AM), <https://www.wsj.com/articles/u-s-businesses-gear-up-for-legal-disputes-with-insurers-over-coronavirus-claims-11583465668> (quoting Chubb Ltd. CEO Evan Greenberg, however “Chubb declined to comment further” on the issue when asked by the Journal reporter). See also Maria Sassian, *Triple-I CEO Tells U.S. House—Global Pandemics are Uninsurable*, INS. INFO. INST. (May 21, 2020), <https://www.iii.org/insuranceindustryblog/triple-i-ceo-tells-u-s-house-global-pandemics-are-uninsurable/> (“An event like a global pandemic is uninsurable [said the executive.] Unlike a typical covered catastrophe, which is limited in terms of geography and time, pandemics have the potential to impact everywhere, all at once . . . . As such, this type of magnitude requires government resources to step in and provide support.”).

<sup>42</sup> See Scism, *supra* note 39 (quoting Chubb Ltd. CEO Evan Greenberg).

Media targets included both the legal press,<sup>43</sup> the insurance trade press<sup>44</sup> as well as the business press,<sup>45</sup> and even the mainstream lay press read by the average public<sup>46</sup>

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<sup>43</sup> See, e.g., Larry P. Schiffer, *Does the Novel Coronavirus Cause Direct Physical Loss of or Damage to Property?*, NAT'L L. REV. (July 13, 2020), <https://www.natllawreview.com/article> (concluding that “[b]ased on the case law and the nature of the novel coronavirus, it appears unlikely that courts will conclude that viral contamination causes ‘direct physical loss.’”); *Insurers’ COVID-19 Notepad: What You Need to Know Now*, CROWELL MORING (June 9, 2020), <https://www.crowell.com/NewsEvents/AlertsNewsletters/all/Insurers-COVID-19-Notepad-What-You-Need-to-Know-Now-Week-of-June-8> (suggesting that coverage unlikely for COVID-related claims); Lauraann Wood, *Insurer Says Policy Isn’t Triggered in COVID-19 Coverage Suit*, LAW360 (July 14, 2020 3:56 PM), <https://www.law360.com/articles/1291736/insurer-says-policy-isn-t-triggered-in-covid-19-coverage-suit>.

Even if the virus had been present on the covered businesses’ properties, it wouldn’t constitute direct physical loss or damage because it doesn’t cause ‘a tangible change to the physical characteristics of property,’ [the insurer argued]. COVID-19 isn’t incorporated into their properties’ physical structure, doesn’t require a building’s physical alteration for removal ‘and does not render the building unfit for use,’ it said.

‘Rather, the coronavirus can be removed from surfaces with soap and water and rendered inert with various common household disinfectants, including bleach,’ [said the insurer.] ‘[The insureds’] alleged losses are at most economic losses, not a direct physical loss or damage.’

The businesses also aren’t entitled to coverage under the civil authority provision for additional coverage under their policies, which ‘has a very specific set of terms and conditions that must be met,’ [the insurer represented to the court.]

Wood, *supra*.

<sup>44</sup> See, e.g., Jeff Dunsavage, *COVID-19 Wrap-up: BI Coverage Continues to Make Headlines*, TRIPLE-I BLOG (May 21, 2020), <https://www.iii.org/insuranceindustryblog/covid-19-wrap-upbi-coverage-continues-to-make-headlines> (“The *Post* interviewed Triple-I CEO Sean Kevelighan and Triple-I non-resident scholar Michael Menapace, who explained why the suits are unreasonable and threaten the insurance industry’s solvency. ‘The insurance business works by spreading risk around so the industry isn’t hit all at once with claims,’ Kevelighan says. ‘A pandemic disrupts business far and wide, with no end date in sight.’”); *Focus on Facts, Not Media Misinformation: Berkley*, CARRIER MGMT (June 7, 2020), <https://www.carriermanagement.com/news/2020/06/07/207575.htm?print> (“Arguing that the media has been fed misinformation by

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the plaintiffs bar, the chief executive officer of a property/casualty insurer said facts will win out on debates over business interruption coverage disputes related to COVID-19 shutdowns.”) (referring to W. Robert Berkley, Jr., president and CEO of WR Berkley); Stephan Kahl, *Munich Re to Stop Selling Pandemic Business Coverage*, INS. J. (Sept. 11, 2020), <https://www.insurancejournal.com/news/international/2020/09/11/582141.htm>; *Beazley Hikes Estimate for COVID-19 Related Claims Amid Resurgence in Virus*, SHARES MAG. (Sept. 22, 2020 07:30), <https://www.sharesmagazine.co.uk/news/market/7092096/Beazley-hikes-estimate-for-Covid-19-related-claims-amid-resurgence-in-virus> (estimating range of exposure from \$170 to \$350 million net of reinsurance).

<sup>45</sup> See, e.g., Leslie Scism, *U.S. Businesses Gear Up for Legal Disputes with Insurers Over Coronavirus Claims*, WALL ST. J. (Mar. 6, 2020 10:00 AM), <https://www.wsj.com/articles/u-s-businesses-gear-up-for-legal-disputes-with-insurers-over-coronavirus-claims-11583465668>; Ioanes, *supra* note 39; Katherine Chiglinsky, *Virus Fight Insurers Thought They’d Dodged Is Looming Anyway*, WASH. POST (Mar. 24, 2020 11:20 AM), [https://www.washingtonpost.com/business/on-small-business/virus-fight-insurers-thought-theyd-dodged-is-looming-anyway/2020/03/24/aef84e06-6de1-11ea-a156-0048b62cdb51\\_story.html](https://www.washingtonpost.com/business/on-small-business/virus-fight-insurers-thought-theyd-dodged-is-looming-anyway/2020/03/24/aef84e06-6de1-11ea-a156-0048b62cdb51_story.html); Kate Rogers & Betsy Spring, *On Main Street, Business Owners Push for Greater Protection from Coronavirus-related Lawsuits*, CNBC (June 15, 2020 1:37 PM), <https://www.cnbc.com/2020/06/12/on-main-street-a-push-for-protection-from-coronavirus-related-lawsuits.html> (“‘It turns out that business interruption insurance is not what it sounds like,’ [Robert Cresanti, president and CEO of the International Franchise Association] said. ‘Most of the insurance companies are telling our people that business interruption insurance is actually business destruction insurance. So if your business is burned down or destroyed by a flood, you’re covered. But you’re not [covered] in a crisis like this where your business is truly interrupted.’”); Karen Epper Hoffman, *Business Interruption: Insurers Balk at Paying Claims*, CFO.COM (Sept. 10, 2020), <https://www.cfo.com/risk-management/2020/09/pandemic-losses-out-in-the-cold> (“Robert Gordon, senior vice president for policy, research, and international for the American Property Casualty Insurance Association (APCIA), says that because government emergency orders closed businesses to limit human transmission of COVID-19 and not because there had been direct property loss or damage, business interruption policies are not relevant.”).

<sup>46</sup> See, e.g., Ron Hurtibise, *Sorry, That’s Not Covered: Insurers Fight Businesses Over COVID-19 Shutdowns*, S. FLA. SUN SENTINEL (Sept. 12, 2020 8:55 AM), <https://www.sun-sentinel.com/business/fl-bz-owners-losing-covid-related-business-interruption-suits-20200912-46jlyxsftjenvlyrxg4tfbqyam-story.html> (“the industry has reinforced its message by boasting about nearly every court ruling that has gone its way. ‘Another court agrees: Business Interruption Insurance Does Not Cover Pandemic-Related Losses,’ said the subject line of an email release by the Insurance Information Institute, a trade group created by the industry to educate consumers about insurance-related issues.”); Judith Bachman, *Judges Are Deciding Whether Business Interruption Policies Cover Pandemic-Related Losses*,

as well as scholarly journals.<sup>47</sup> When insurers prevailed in litigation, victory was quickly trumpeted.<sup>48</sup>

A similar public relations campaign by small business policyholders was harder to mount given the disparate number and dispersion of random policyholders with potential claims.<sup>49</sup> Although plaintiff law firms fulfilled some of this function in banging the drum for coverage, their efforts were (in our view) problematic in that many of these lawyers were not insurance coverage specialists from experienced policyholder-side coverage firms. In addition, early pro-coverage efforts were (in our view) too grandiose and not well-targeted.

For example, plaintiff firms sought mass consolidation of claims, including a request for consolidation by the federal Judicial Panel on Multi-District Litigation

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ROCKLAND CNTY. BUS. J. (Oct. 8, 2020), <https://rcbizjournal.com/2020/10/08/judges-are-deciding-whether-business-interruption-policies-cover-pandemic-related-losses>.

<sup>47</sup> See, e.g., Robert Hartwig, Greg Niehaus & Joseph Qiu, *Insurance for Economic Losses Caused by Pandemics*, 45 GENEVA RISK & INS. REV. 134, 134 (2020) (“Private insurance coverage for economic losses caused by pandemics is limited [due in large part] to the high levels of capital that would be required to credibly insure pandemic economic losses with cross-sectional pooling mechanisms.”).

<sup>48</sup> Leslie Scism, *Insurance Firms Gain Early Lead in Coronavirus Legal Fight With Businesses*, WALL ST. J. (Sept. 1, 2020 9:00 AM), <https://www.wsj.com/articles/insurers-gain-early-lead-in-covid-19-legal-fight-with-businesses-11598965200> (“Insurers say the policies are intended to help policyholders as they recover from events, such as fires, that lead to repairs and rebuilding, and were never intended to cover virus-related claims.”); Alison Frankel, *Latest COVID-19 Insurance Coverage Loss Shows Narrowing Path for Policyholders*, REUTERS (Sept. 15, 2020 6:54 PM), <https://www.reuters.com/article/legal-us-otc-insurance-idUSKBN2663HC>; Andrew G. Simpson, *Judges Nix Consolidating COVID Business Interruption Suits Against Big Insurers*, INS. J. (Oct. 4, 2020), <https://www.insurancejournal.com/news/national/2020/10/04/585092.htm>.

<sup>49</sup> This is not to say that the business community did not on occasion make itself heard on the issue. See, e.g., Stephen Gandel, *Companies Say Insurance Companies Are Stiffing Them Over Coronavirus Losses*, CBS NEWS (Sept. 21, 2020 11:16 AM), <https://www.cbsnews.com/news/covid-insurance-business-continuity-interruption-declined-coverage>; Kate Rogers & Betsy Spring, *On Main Street, Business Owners Push for Greater Protection from Coronavirus-related Lawsuits*, CNBC (June 12, 2020), <https://www.cnbc.com/2020/06/12/on-main-street-a-push-for-protection-from-coronavirus-related-lawsuits.html>. See also, Tim Carman, *Restaurants Are Suing Insurance Companies Over Unpaid Claims—And Both Sides Say Their Survival Is at Stake*, WASH. POST (May 19, 2020 1:37 PM), <https://www.washingtonpost.com/news/voraciously/wp/2020/05/19/restaurants-are-suing-insurance-companies-over-unpaid-claims-and-both-sides-say-their-survival-is-at-stake> (reporting both insurers and small businesses taking positions that adverse coverage decisions will be financially ruinous).

(MDL), which almost everyone (including the judges on the Panel) viewed as inapt unless confined to the same policy forms of a single insurer in light of the varying facts and policies of different cases.<sup>50</sup> More extremely, lawyers and legislators sympathetic to business sought to legislatively require coverage by insurers regardless of the policies at issue—a seemingly rather clear attempt to violate the Contract Clause of the U.S. Constitution that gave insurers a rather effortless public relations victory.<sup>51</sup>

As discussed below, we find the insurers’ industry-wide disparagement of coverage as legally misplaced as it may have been rhetorically brilliant. While we cannot help but admire the manner in which insurers moved quickly and uniformly to spin public opinion against coverage, we are dismayed that the tactic seems to have worked on judges. There are real arguments to be made about whether and how policyholders may have coverage for COVID-related losses. In fact, we think the insurance industry’s main contention about coverage—the “physical loss or damage” requirement—can be refuted in most cases. But this requires a more searching analysis of the question and less reflexive recoil than has been displayed in the bulk of court decisions to date.

In several states, legislation was introduced to require insurers to pay for lost policyholder revenue. There was also congressional inquiry pushing for such coverage without regard to the actual insurance policy terms at issue in a particular case. Predictably—and correctly in our view—insurers opposed any such legislative mandates or compulsion as violative of the Contract Clause of the U.S. Constitution.<sup>52</sup> In doing so, they took the doctrinaire position—with which we

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<sup>50</sup> See Andrew G. Simpson, *Judges Nix Consolidating COVID Business Interruption Suits Against Big Insurers*, INS. J. (Oct. 4, 2020), <https://www.insurancejournal.com/news/national/2020/10/04/585092.htm>. However, more limited consolidated treatment has been approved for particularized groupings of policies with the same operative language. See Jacob Rund, *Ski Pass Insurance Row Highlights Complex Route for Virus Suits*, BLOOMBERG L. (Oct. 20, 2020, 6:31 AM), <https://news.bloomberglaw.com/insurance/ski-pass-insurance-row-highlights-complex-route-for-virus-suits> (approving consolidation of 30 actions by policyholders against Society Insurance “for denying business interruption claims of restaurants and other hard-hit shops” as well as skiers’ lawsuits against Arch Insurance Co. and United Specialty Ins. Co. for denials of cancellation insurance purchased in connection with season-long ski passes). Regarding MDL proceedings generally, see DAVID F. HERR, MULTIDISTRICT LITIGATION MANUAL: PRACTICE BEFORE THE JUDICIAL PANEL ON MULTIDISTRICT LITIGATION (2020 ed.).

<sup>51</sup> See *infra* text accompanying notes 51–53.

<sup>52</sup> See Letter from Nat’l Ass’n of Ins. Comm’rs & Ctr. for Ins. Pol’y and Rsch. to Members of Cong. (May 20, 2020) (supporting insurer arguments against legislation forcing

disagree—that business interruption insurance was never intended (apparently under any circumstances) to provide coverage for any losses related to infectious disease like COVID.<sup>53</sup>

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coverage). *See also* H.B. 589, 133d Gen. Assemb., 2019-2020 Sess. (Ohio 2019) introduced by Representatives Crossman and Rogers. The bill would “require insurers offering business interruption insurance to cover losses attributable to viruses and pandemics and to declare an emergency” that presumably would support further orders providing for government-mandated closure of non-essential businesses. *See also* Elizabeth Blossfield, *Despite Insurance Industry Concerns, More States Introduce COVID-19 BI Bills*, INS. J. (Apr. 15, 2020), <https://www.insurancejournal.com/news/east/2020/04/15/564920.htm> (“‘It’s just not constitutional,’ Don Hayden, co-founder and partner of Mark Migdal & Hayden, added. ‘I mean, what you’re essentially doing is creating insurance where there is nothing. You’re essentially throwing out the underwriting and the risk evaluation that insurance companies have done before writing a policy and saying, “You have to cover this. Even though you had expressly said that you would not cover it in your exclusion and in your insurance agreement.”’”). *But see* Mark A. Packman, *Constitutionality Under the Contracts Clause of Proposed Legislation Enabling Policyholders to Obtain Insurance Coverage for Coronavirus Claims*, 55 TORT TRIAL & INS. PRAC. L.J. 509 (2020) (concluding that such legislation is constitutional due to emergency nature of pandemic and economic harm to particular businesses).

<sup>53</sup> Erin Ayers, *Insurers Decline Congress’ Request To Pay All COVID-19 Business Interruption Claims*, ADVISEN FRONT PAGE NEWS (Mar. 23, 2020), [https://www.advisen.com/tools/fpnproc/fpns/articles\\_new\\_1/P/363166470.html?rid=363166470&list\\_id=1](https://www.advisen.com/tools/fpnproc/fpns/articles_new_1/P/363166470.html?rid=363166470&list_id=1) (responding to congressional inquiry re insurer coverage of COVID business loss claims, insurer interest groups state that “[b]usiness interruption policies do not, and were not designed to, provide coverage against communicable diseases such as COVID-19”) (statement from leadership of American Property Casualty Insurance Association, National Association of Mutual Insurance Companies, Council of Insurance Agents and Brokers, and Independent Insurance Agents & Brokers of America) (also taking position that the members of these insurance industry organizations “include many small businesses and employers grappling with the same issues as many businesses.”). *See also id.* (acknowledging that COVID coverage claims will be brought concerning other types of insurance policies); Jeff Sistrunk, *4 Coronavirus Developments Insurance Lawyers Should Know*, LAW360 (Mar. 20, 2020, 5:31 PM), <https://www.law360.com/articles/1255415/4-coronavirus-developments-insurance-lawyers-should-know> (listing the four important topics with subheadings as follows: “Insurers Spurn Call to Expand Business Interruption Coverage”; “NJ Lawmakers Mull Business Interruption Coverage Bill”; “House Lawmakers Press Travel Insurers on Claim Denials”; and “Calif. Regulator Seeks ‘Grace Period’ on Policy Cancellations”).



Insurers also consistently maintained that they would go broke and the insurance industry would be destroyed if carriers were forced to provide COVID coverage.<sup>54</sup> Risk managers and brokers, who are normally viewed as representing policyholder interests, tended to align with insurers, presumably because they feared disruption of the industry more than denial of coverage to policyholder employers or clients, many of which were likely to fail in the absence of prompt payment of insurance coverage.<sup>55</sup> Regulators also sided with insurers,<sup>56</sup> in our view, without sufficient reflection and consciousness of their mission as public servants.<sup>57</sup> These entities also seemed to overlook the likely perception of policyholders who expected (perhaps with sufficient objective reasonableness to obtain coverage) that the premiums they had paid for years for something deemed “business interruption” coverage would provide at least some assistance in the face of the largest business interruption of this type in a century.<sup>58</sup>

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<sup>54</sup> See, e.g., Kate Smith, *Pandemic Partnerships*, BEST’S REV. (Aug. 2020), [news.ambest.com/articlecontent.aspx?refnum=299433&altsrc=43](https://news.ambest.com/articlecontent.aspx?refnum=299433&altsrc=43) (“Even with pandemic excluded from most business interruption policies, COVID-19 is expected to cost the insurance industry more than \$200 billion.”). But see Kate Smith, *The COVID Catastrophe*, BEST’S REV. (June 2020), [http://news.ambest.com/ArticleContent.aspx?pc=1009&altsrc=158&refnum=297254](https://news.ambest.com/ArticleContent.aspx?pc=1009&altsrc=158&refnum=297254) (stating that “The COVID-19 outbreak could dwarf other catastrophe losses insurers have seen. . . .” but also noting that “[e]ven with the economic downturn, the insurance industry, on the whole, is in a strong capital position”). Carman, *supra* note 49. Accord, Andrew G. Simpson, *P/C Insurers Put a Price Tag on Uncovered Coronavirus Business Interruption Losses*, INS. J., (Mar. 30, 2020), <https://www.insurancejournal.com/news/national/2020/03/30/562738.htm>.

“Pandemics are an extraordinary catastrophe that can impact nearly every economy in the world, so it is hard to predict and manage the risk,” Sean Kevelighan, CEO of the Insurance Information Institute, stated. “Pandemic-caused losses are excluded from standard business interruption policies because they impact all business, all at the same time.”

Moreover, he said, the exclusion for pandemic-caused losses have been incorporated into standard business interruption policies for years.

Simpson, *supra*. See also Elizabeth Pineau & Maya Nikolaeva, *Insurer AXA Must Pay Restaurant’s COVID-19 Losses*, French Court Rules, REUTERS (May 22, 2020, 2:08 PM) <https://uk.reuters.com/article/us-health-coronavirus-insurance-axa/french-court-orders-insurer-axa-to-pay-restaurants-covid-19-losses-idUKKBN22Y2LR>. (“AXA reacts to decision by stating that it would appeal.”); Elizabeth Blossfield, *Despite Insurance Industry*

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*Concerns, More States Introduce COVID-19 BI Bills*, INS. J. (Apr. 15, 2020), <https://www.insurancejournal.com/news/east/2020/04/15/564920.htm>.

“I think in layman’s terms, [legislation forcing payment of covid claims] would implode the industry,” Doug Jones, managing director of JAG Insurance Group, told *Insurance Journal* in a March webinar on business interruption and the coronavirus. “At the end of the day, the ripple effect of what that would cause down the road, and I’m talking short-term, not long-term; I’m talking about months from now, not years from now. It would be difficult for anybody to buy any type of insurance.”

Additional concerns among the insurance industry about this type of legislation surround The Contracts Clause in the U.S. Constitution, which places limitations on states’ ability to interfere with private contracts.

“It’s just not constitutional,” Don Hayden, co-founder and partner of Mark Migdal & Hayden, added. “I mean, what you’re essentially doing is creating insurance where there is nothing. You’re essentially throwing out the underwriting and the risk evaluation that insurance companies have done before writing a policy and saying, ‘You have to cover this. Even though you had expressly said that you would not cover it in your exclusion and in your insurance agreement.’”

Blosfield, *supra*.

<sup>55</sup> The tone of reporting appears to suggest that this element of the risk management and insurance community tacitly accepted widespread lack of coverage and economic danger to the insurance industry. As reported in one publication geared toward risk managers and brokers only 14 percent of surveyed risk managers and corporate insurance buyers planning to add new pandemic coverage. Andy Toh, *2020 Property Insurance Survey*, BUS. INS. 31 (June 2020). But 27 percent state that their current policies provide coverage related to diseases and epidemics while 49 percent deny having such coverage. *Id.* 41 percent of policyholders are expecting to make a pandemic claim, with 28 percent not planning such claims. *Id.*

67% of risk professional expect direct business interruption losses due to COVID-19. 77% expect the losses to be over \$1 million, of which 36% estimate losses to be more than \$25 million. 91% support a federal backstop for pandemic risk insurance similar to the Terrorism Risk Insurance Act. 65% of risk professionals would be willing to pay up to 5% more in premium for pandemic risk insurance coverage.

Claire Wilkinson, *Pressure Builds for Pandemic Backstop*, BUS. INS. 4 (May 2020). A draft Pandemic Risk Insurance Act of 2020 then circulating “would establish a federal backstop

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for business interruption losses resulting from a future pandemic and would be triggered when insurance industry losses exceed a \$250 million threshold and capped at \$500 billion . . .” *Id.* “The growing momentum among insurance buyers and others for a government backstop to cover pandemic risks comes as insurers continue to maintain that most commercial property policies do not provide coverage for business interruption losses arising from the COVID-19 pandemic.” *Id.*

The question of whether a potential Pandemic Risk Insurance Act should be retroactive to the COVID-19 pandemic is an issue RIMS is still exploring, she [Mary Roth, RIMS CEO] said

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RIMS doesn’t want to ‘get into the business of’ altering contractual agreements that were ‘legally and freely entered into,’ said Whitney Craig, RIMS government relations director.

‘We would be very wary of supporting legislation that has that. We don’t want to bankrupt an industry that we as risk managers rely on,’ Ms. Craig said.

*Id.*

<sup>56</sup> See Leslie Scism, *Companies Hit by Covid-19 Want Insurance Payouts—Insurers Say No*, WALL ST. J. (June 30, 2020, 10:24 AM), <https://www.wsj.com/articles/companies-hit-by-covid-19-want-insurance-payouts-insurers-say-no-11593527047>. (“Insurers have some conceptual backing for their stance that business-interruption coverage isn’t meant for pandemics. The National Association of Insurance Commissioners, a standards-setting group for state regulators, says pandemics violate a cardinal principle of insurance, which is that large numbers of policyholders pool their risk to fund a few losses at any one time. In a pandemic, almost all policyholders suffer losses, and simultaneously.”).

<sup>57</sup> We appreciate NAIC’s concern that large coverage obligations could imperil the insurance system generally. But we remain more than a little puzzled that a regulatory group charged with protecting the public seems uninterested in supporting policyholders, particularly small business policyholders, in cases where there is arguable coverage. Insurers are in the business of risk transfer and insurance is one of the largest, most profitable industries in the world. Although it may be regrettable if an insurance company (or several or dozens) should fail, we consider it at least equally regrettable if policyholders who paid for coverage fail after wrongfully being denied coverage due to fears of bankrupting the insurance industry. Past insurer claims that their financial sky was falling proved to be exaggerated, something regulators should know and appreciate. See Jeffrey W. Stempel, *Assessing the Coverage Carnage: Asbestos Liability and Insurance After Three Decades of Dispute*, 12 CONN INS. L. J. 349, 353 (2006) (citing asbestos mass torts, despite the massive costs, estimated to have been only a three percent drag on insurer earnings).

In addition, we note that there is more than a little disconnect between NAIC as an entity tending to back the insurer mantra that “everyone knows pandemics are not insured” while

As noted, insurers or their counsel campaigned in earnest to label COVID an uncovered loss in both the general media and what might be termed the insurance trade media.<sup>59</sup> Part of the insurer effort to disparage coverage claims was the continued assertion that nearly all property insurance with business interruption coverage also contained clear virus exclusions precluding coverage.<sup>60</sup> This claim may be overstated. In the COVID coverage decisions to date, more than twenty percent of the policies at issue lacked a virus exclusion.<sup>61</sup> Thus, even if the insurer contention that “most” property policies have such an exclusion, there appear to be

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some individual state commissioners have gone in the opposite direction and attempted to force coverage irrespective of the language, intent, and purpose of particular policies. Our preferred position is between these two extremes.

<sup>58</sup> Matthew Lerner, *Policy Wordings Tested by Interruption Losses*, BUS. INS. 27 (May 2020).

Business interruption claims have fast become one of the principal legal battlefronts between commercial policyholders and insurers since the outbreak of the coronavirus pandemic.

Dozens of businesses, including numerous restaurants, have filed state and federal lawsuits against their insurers seeking declaratory rulings that income lost due to the government-mandated lockdowns is covered by insurance.

Insurers argue that many of the policies include exclusions for virus related losses and most of those that don’t still won’t cover lost income because physical damage to an insured property must occur to trigger claims payments.

*Id.*

<sup>59</sup> See CARRIER MGMT, *supra* note 44. See, e.g., Larry P. Schiffer, *Does the Novel Coronavirus Cause Direct Physical Loss of or Damage to Property?*, X NAT’L L. REV. 114 (Apr. 13, 2020), <https://www.natlawreview.com/article/does-novel-coronavirus-cause-direct-physical-loss-or-damage-to-property> (concluding that “[b]ased on the case law and the nature of the novel coronavirus, it appears unlikely that courts will conclude that viral contamination causes ‘direct physical loss.’”).

<sup>60</sup> Erin Ayers, *Insurers Decline Congress’ Request to Pay All COVID-19 Business Interruption Losses*, ADVISEN FRONT PAGE NEWS (Mar. 23, 2020), [https://www.advisen.com/tools/fpnproc/fpns/articles\\_new\\_1/P/363166470.html?rid=363166470&list\\_id=1](https://www.advisen.com/tools/fpnproc/fpns/articles_new_1/P/363166470.html?rid=363166470&list_id=1) (“The vast majority of commercial property insurance policies contain not only direct physical damage, but also contain exclusions for viral/bacterial contamination due to the unpredictability of the risk.”).

<sup>61</sup> See Baker, *supra*, note 10 (visited Oct. 21, 2020).

a large number of cases where policyholders have a substantially better chance of success than suggested by the insurance industry shibboleth of no coverage.

As part of its aggressive “no coverage” strategy, insurers did more than rest on the virus exclusion (which we agree can be a strong defense to coverage where the policy actually contains such a limitation) even when policies at issue contained the exclusion. Rather, insurers dug in on a remarkable first line of defense: that COVID did not and could not cause *any* direct physical loss or damage to property, which is a prerequisite to most commercial property and business interruption coverage.

[T]he mere **threat** of COVID-19 at the property or the **preemptive closure** of businesses due to the threat of COVID-19 should not be considered “direct physical loss or damage” to property. Additionally, neither **government-ordered closure** of businesses nor a **government’s official statement** regarding COVID-19 damage at properties generally should be sufficient for a court to find “direct physical loss or damage” to a particular property. However, those insured that can prove the actual presence of the virus on the surfaces of or otherwise in covered property may be able to establish “direct physical loss or damage” to property.<sup>62</sup>

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<sup>62</sup> Edward M. Koch & Elizabeth C. Dolce, “Direct Physical Loss or Damage”: *The Gatekeeper to Property Insurance Coverage and COVID-19*, WHITE & WILLIAMS (Mar. 24, 2020), <https://www.whiteandwilliams.com/resources-alerts-Direct-Physical-Loss-or-Damage-The-Gatekeeper-to-Property-Insurance-Coverage-and-COVID-19.html> (emphasis in original). *Accord*, Randy Maniloff, *First Coronavirus Coverage Suit Filed for Business Interruption*, COVERAGE OPS. (Mar. 17, 2020), <https://www.coverageopinions.info/Vol9Issue2/FirstCOVIDcase.html>.

In general, and putting aside any precise policy language that may apply, one critical requirement, for the potential availability of business interruption insurance, is that there has been physical damage to property. This is either to the insured’s own covered premises, or, for purposes of losses on account of the actions of civil authority, another’s premises.

Either way, it will be necessary [for policyholders] to prove that the presence of the coronavirus causes physical loss to the affected premises. Thus, we can expect to see arguments, like the one being made [in the first filed case], that there has been physical loss to a premises because the virus stays on the surface of objects or materials—‘fomites’—for some amount of time.

[A]ny legislative action to compel insurers to pay business interruption claims arising out of the coronavirus [would be] breathtaking. To achieve their result, lawmakers would not only obviate the “virus” exclusion, but, in addition, the fundamental ‘physical damage’ requirement of business interruption coverage.

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Maniloff, *supra*. See Randy J. Maniloff & Margo Meta, *New DJ Takes Different Tack on Business Interruption Coverage for COVID-19*, WHITE & WILLIAMS (Mar. 27, 2020) <https://www.whiteandwilliams.com/resources-alerts-New-DJ-Takes-Different-Tack-on-Business-Interruption-Coverage-for-COVID-19.html> (describing French Laundry Partners, LP v. Hartford Fire Ins. Co. case seeking declaration of coverage and noting that loss of business use was caused primarily by government ordered suspension rather than tangible property destruction. Maniloff & Meta are skeptical of the claim and argue that “in general, to implicate ‘Civil Authority’ coverage, there must be physical damage to property other than the covered premises. But businesses have been closed principally to foster social distancing and not on account of the presence of the virus inside a premises.” Maniloff & Meta also note that French Laundry is represented by the same attorney as policyholder Oceana Grill, a New Orleans restaurant, that filed the nation’s first COVID coverage case).

Policyholders will sometimes be asserting that insurers, that issued immediate denials for [COVID]-19 claims, did so in bad faith on account of an alleged failure to investigate the claim under applicable law[.]

One business interruption coverage theory in particular is getting attention from policyholders [what the author dubs the “public space” theory that the ubiquitous COVID-19 virus has filled the air and attached to tangible property, making it physically damaged—which in turn means that the injury trigger of the typical policy is satisfied].

Another business interruption coverage issue has not received a lot of attention. The biggest push for coverage has been for businesses that have been shut down by order of a civil authority. However, even if owed, such coverage is likely quite limited. Civil authority-based business interruption coverage, per policy language, is usually available for only up to four weeks.

The restaurant industry is beating the loudest drum in the pursuit of business interruption coverage.

Randy Maniloff, *Covid-19 And Coverage: Four Weeks and Four Takeaways*, COVERAGE OPS. (Apr. 5, 2020), <https://www.coverageopinions.info/COVID19ISSUE/COVIDandCoverage.html>. These comments are but from one law firm, albeit a particularly large and prestigious insurer-side firm. Many other lawyers representing insurers wrote in the same vein in various publications and on law firm and other websites.

The New Jersey legislature has premised its actions on the need to take out the “virus” exclusion from business interruption policies. But that’s a tonsillectomy compared to what it is really doing—removing the heart of the policy.<sup>63</sup>

Although there were of course stories highlighting the difficulties faced by businesses and other policyholders due to the COVID pandemic,<sup>64</sup> insurers succeeded in simultaneously pooh-pooing the merits of business interruption claims and painting a scenario of risk management ruin if they were required (either by legislatures or courts) to provide coverage they purportedly never agreed to provide.<sup>65</sup>

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<sup>63</sup> Randy Maniloff & Edward Koch, *COVID-19: The Real Operation of New Jersey’s Proposed Insurance Legislation*, COVERAGE OPS. (Mar. 19, 2020), <https://www.coverageopinions.info/Vol9Issue2/COVIDOperation.html>.

<sup>64</sup> See, e.g., Suzanne Barlyn, *U.S. University Insured Chinese Student Tuition Against Virus. Then COVID-19 Hit*, REUTERS: BUS. NEWS (Aug. 17, 2020, 6:25 AM), <https://in.reuters.com/article/us-health-coronavirus-university-insuran-idINKCN25D15P> (reporting that despite paying annual premium of \$424,000 for coverage, University of Illinois found harder market emerging in early 2020, with only limited coverage and premiums increasing to nearly \$2 million).

<sup>65</sup> See, e.g., Lucca De Paoli & Franz Wild, *Don’t Be Tricky With Virus Clams, Watchdog Warns U.K. Insurers*, BLOOMBERG (Mar. 19, 2020, 10:49 AM), <https://www.bloomberg.com/news/articles/2020-03-19/u-k-fca-requests-coronavirus-contingency-plans-from-insurers> (noting that the U.K. Financial Conduct Authority [FCA] has stated that “insurers must also [like policyholders] be adaptable” in lieu of the problems posed by COVID and must take care to communicate clearly and nondeceptively with policyholder claimants).

The industry has worked to reduce its exposure to pandemics since the 2003 outbreak of SARS in Asia. Over the years, they’ve tightened up their policies, inserting communicable-disease exclusions to prevent potential losses. That means consumers and companies will bear the brunt of the cost for disruptions related to the virus—which has infected more than 217,000 people worldwide and left at least 9,000 dead.

*Id.* Laura Foggan & Michael A. Sabino, *Feeling the Effect*, BEST’S REV. (May 2020), <http://news.ambest.com/articlecontent.aspx?pc=1009&AltSrc=108&refnum=296290> (predicting claims across various lines of insurance, particularly property insurance with business interruption coverage, and stating that “[i]t is essential that legislators—and the courts—recognize the limits of insurance in accordance with policy terms and exclusions.”); Cheri Trites-Versluis, *Renewal Language Scrutiny: COVID-19 Litigation is Generating a*

Policyholder counsel noted and criticized the perceived insurer public relations campaign.<sup>66</sup> And some in the industry had reservations about the industry's aggressive and rather blanket opposition to coverage.<sup>67</sup> Some observers also

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*Resurrection of Arguments Asserted at the Height of Asbestos and Silica Coverage Litigation*, NAT'L UNDERWRITER 1, 42–43 (Sep. 2020), [https://www.sapiens.com/wp-content/uploads/2020/09/NUP\\_0920-dl.pdf](https://www.sapiens.com/wp-content/uploads/2020/09/NUP_0920-dl.pdf) (citing *Above It All Roofing & Construction, Inc. v. Security Nat'l Insurance Co.* and *RLI Insurance v. Gonzalez*, which found asbestos to be a “pollutant” within policy’s pollution exclusion, and *Garamendi v. Golden Eagle Ins. Co.*, which found silica dust to be a pollutant, implying similar approach apt for COVID cases). Mr. Trites-Versluis is identified in the article as “the director of policy analysis for RiskGenius,” the same company whose CEO is extensively quoted in the media disparaging policyholder claims for business interruption coverage. *Id.*

<sup>66</sup> See, e.g., Andrew G. Simpson, *P/C Insurers Put a Price Tag on Uncovered Coronavirus Business Interruption Losses*, INS. J., (Mar. 30, 2020), <https://www.insurancejournal.com/news/national/2020/03/30/562738.htm> (quoting policyholder attorney John Houghtaling II) (“‘To avoid payments for a civil authority shut down the insurance industry is pushing out deceptive propaganda that the virus does not cause a dangerous condition to property.’ [] ‘This is a lie, it’s untrue factually and legally.’”).

<sup>67</sup> See, e.g., Kate Smith, *Pandemic Partnerships*, BEST’S REV. (Aug. 2020), <http://news.ambest.com/articlecontent.aspx?refnum=299433&altsrc=43>.

Stephen Catlin’s mobile buzzed nonstop. It was early April, and he had just written a thought leadership piece on the need for a swift and coherent insurance industry response to pandemic. Frustrated by the falling reputation of the industry and the “clumsy” comments and defensive posture of some insurers, the Convex CEO called on the insurance community to be proactive in finding a long-term solution to pandemic. His message struck a chord.

*Id.* Mr. Catlin is a 50-year veteran of the insurance industry and founder of an insurer and consulting group as well as a member of the International Insurance Society Insurance Hall of Fame, he elaborated on his views in an Op-Ed piece.

[First,] insurers and brokers should do a much better job when communicating with the public and with governments, especially regarding the true value that insurance provides. Secondly, it’s in the nature of our business to focus on the past, and therefore we often neglect giving adequate thought about the future. Finally, I regret that—when an event occurs that causes extreme human suffering—the insurance industry often views the event primarily in terms of dollars and cents.



wondered whether the more receptive negotiable attitude of some European insurers might be more productive.<sup>68</sup> But in the main, American insurers were on the

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Over the years, we have identified a list of potential ‘Big Ones,’ events that could cause severe financial stress for insurers and reinsurers. These events range from a Category 5 hurricane that strikes at the heart of Miami to a powerful earthquake devastating Los Angeles or Tokyo. Over the past two decades, an extreme act of terrorism was added to the list.

However, until recently, relatively few insurers would have guessed that a pandemic could be the costliest event the industry could face. I believe that neither governments nor insurers had truly contemplated the economic consequences of a pandemic, in part because the financial impact of such an event is extremely difficult to model.

Unfortunately, the coronavirus has amplified some of the things that I believe the industry often does poorly.

It is not my place to comment on whether individual policies provide coverage for potential claims arising from COVID-19. However, I can say that I was dismayed at the defensive nature of some insurers’ statements as the crisis began to expand. There always has been widespread public distrust—if not disdain—for the insurance industry, and the comments uttered by some insurers did not help our relationships with governments and our customers.

As I often have said, it’s not what you say, but how you say it.

Now that it appears that COVID-19 may be the costliest event in the industry’s history, we must begin to think ahead. Will society face pandemics of a similar magnitude in years to come? While I hope we will not, I suspect that we will. If so, what should be the role of the insurance industry? Should we simply adopt policy wording that make it crystal clear that insurance coverage will be of little benefit to policyholders for future losses arising from a pandemic? Or should we think about how insurers can play a meaningful role in economic recovery while still protecting the industry’s capital base?

Stephen Catlin, *Setting the Right Tone: Insurers Must Clarify the Role Insurances Can Play in Recovering from Future Pandemics*, BEST’S REV. (Aug. 2020), <http://news.ambest.com/articlecontent.aspx?refnum=299423&altsrc=43>.

<sup>68</sup> See, e.g., Sergio F. Oehninger & Daniel Hentschel, *Will European Insurers’ Positive Response to COVID-19 Claims Influence US Insurers?*, HUNTON INS. RECOVERY BLOG (July 13, 2020), <https://www.huntoninsurancerecoveryblog.com/2020/07/articles/business-interruption/will-european-insurers-positive-response-to-covid-19-claims-influence-us-insurers/>.

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The positive response in Europe is in stark contrast with the insurance industry's preliminary positions in the United States. The headlines on this side of the hemisphere demonstrate certain insurers' attempts to avoid liability for COVID-19 related losses, despite accepting billions in premiums from policyholders in exchange for broad coverage promises.

In addition, the regulatory structure abroad may make for more collaborative attack on coverage problems. Describing the role of the Financial Conduct Authority [FCA] in England regarding COVID coverage, one article noted:

Business interruption insurance generally only covers losses where a company is forced to close temporarily from property damage, like a fire. The FCA said those types of policies did not offer protection from pandemics, but it was interested in the minority that have so-called nondamage extensions.

Those extensions can protect against the closure of a property either from the outbreak of an infectious disease or by the denial of access by a public authority.

The FCA said it had examined more than 500 policies from 40 insurers and narrowed down its selection to just 17 policy wordings it felt were both the most contentious and representative.

*Id.* Martin Croucher, *FCA Picks 8 Insurers for Pandemic Coverage Test Case*, LAW360 (June 1, 2020), <https://www.law360.com/articles/127811> ("Colin Edelman QC of Devereux Chambers, Leigh-Ann Mulcahy QC and Richard Coleman QC of Fountain Court Chambers will represent the FCA in the case, instructed by Herbert Smith Freehills LLP."). For additional background on the Financial Conduct Authority, see Daniel Schwarcz, *Redesigning Consumer Dispute Resolution: A Case Study of the British and American Approaches to Insurance Claims Conflict*, 83 TUL. L. REV. 735 (2009).

In the test case litigation in the U.K., policyholders largely prevailed, but upon somewhat different issues and policy language than has to date been litigated in the United States. See *The Fin. Conduct Auth. v. Arch In. (UK)* [2020] EWHC 2448 (Comm) (UK).

In addition, continental insurers may have been nudged toward a less confrontational style due to judicial decisions supporting policyholders. See, e.g., Oehninger, *supra* (noting that after initially stating it would appeal trial court ruling requiring it to provide business interruption coverage to policyholder with lost revenue due to COVID-19, AXA has relented and agreed to provide coverage; "AXA reportedly has already agreed to pay over 200 COVID-19 related claims."). See also *id.* ("Despite initially denying liability, Swiss insurance company, Helvetia Insurance, announced that most of its policyholders in the hospitality industry have accepted settlements following coverage disputes for COVID-19 related business interruption losses. The settlements reportedly included policyholders from Switzerland, Austria, and Germany.").

defensive. COVID business interruption claims were to be strongly resisted, even where policies lacked a virus exclusion, on the ground that these claims failed to satisfy the “physical loss or damage” trigger for coverage. And, to perhaps state the obvious, insurers were denying COVID claims.<sup>69</sup> Unsurprisingly, this produced litigation by upset policyholders on the brink of financial ruin.<sup>70</sup>

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<sup>69</sup> For an example of rather brusque insurer denial of coverage, see Letter from Susan Sabouni, Property Claims Supervisor, Philadelphia Indemnity Insurance Company, to Steve Powell, Chief Officer of Policyholder, The Goddard School (May 7, 2020) (on file with author). The Letter repeats portions of the policy verbatim for nine pages and then simply states that the insurer “considers the issues outlined above to be dispositive of coverage” and that the insurer’s “Policy does not provide coverage to the Goddard School for the Claim” and thus “respectfully [?] declines coverage for the Claim” in connection with the school’s forced closure due to government order because of the COVID pandemic, even though the policy also contained a “Communicable Disease Endorsement.” See *id.* at 10. The insurer stated that the policyholder’s loss was “not ‘due to an outbreak of a ‘communicable disease’ . . . that caused[d] an actual illness” at the School. The insurer did, however, agree to “reimburse the Goddard School for the cost of disinfecting the insured premises due to reported symptoms of COVID-19 within the premises.” *Id.* at 10.

<sup>70</sup> See Randy Ellis, *Coronavirus in Oklahoma: Tribes Sue Insurance Companies Over Business Interruption Coverage*, THE OKLAHOMAN (Mar. 25, 2020 1:22 AM), <https://oklahoman.com/article/5658477/coronavirus-in-oklahoma> (describing Chickasaw and Choctaw nations suits involving various insurers); *Coronavirus Coverage Issues Loom: Policy Details Crucial to Determine Success of Commercial Claims*, BUS. INS. 4 (April 2020) (surveying possible COVID-related claims implicating Property Business Interruption insurance, Directors and Officers Liability insurance, Cyber Risk insurance, Medical Malpractice insurance, and Workers Compensation insurance); Joseph P. Monteleone, *COVID-19’s Management Liability Concerns*, INS. EXCH. AGENCY (Sept. 14, 2020), <https://www.ieagency.com/post/covid-19s-management-liability-insurance-concerns> (noting that COVID-related losses will prompt substantial coverage claims involving D&O Insurance, Transactional Risk, and EPL insurance as well as Property Insurance); Patricia Vowinkel, *An Insurance Journey: Significant Coronavirus-Related Losses and Legal Battles Over Coverage May Force Some Insurers to Rethink Their Strategic Game Plans*, BEST’S REV., 1 (May 2020); Bob Reville, *Making Waves: COVID-19 Reveals a Possible Future Upwell of Liabilities for Insurers*, BEST’S REV., 16 (Aug. 2020); Celeste Bott, *Coronavirus Litigation: The Week in Review*, LAW360 (Oct. 8, 2020 7:15 PM), <https://www.law360.com/articles/1318126/coronavirus-litigation-the-week-in-review> (summarizing recent legal developments, including several insurer wins; also noting that the “Judicial Panel on Multidistrict Litigation has centralized in Illinois over 30 lawsuits accusing Society Insurance Co. of wrongfully denying coverage for business losses during the COVID-19 pandemic, but declined to create MDLs to group similar cases against The Hartford, Travelers, Cincinnati Insurance Co., and Lloyd’s of London underwriters.”); Lauren Berg, *In-N-Out Sues Zurich To Cover COVID-19 Shutdown*, LAW360 (May 29, 2020

To be sure, policyholder counsel were not silent during the time of insurer pleas of poverty and assertion of absolute defenses to coverage. But they seemed to have reduced prominence in both insurance trade and lay media.<sup>71</sup>

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10:56 PM), <https://www.law360.com/articles/1278397>; See also Hannah Smith, *A Closer Look: Coronavirus Insurance Lawsuit Trends*, PROPERTY CASUALTY 360 (Sept. 4, 2020 12:00 AM), <https://www.propertycasualty360.com/2020/09/04/a-closer-look-coronavirus-insurance-lawsuit-trends/?slreturn=20210107191656> (“The main issue that courts must decide in addressing these claims is whether businesses whose operations were shut down during the crisis can demonstrate ‘direct physical loss or damage.’”) (describing several lawsuits where insurers had prevailed in motions to dismiss, including *French Laundry Partners, LP v. Hartford Fire Ins. Co.*, *In-N-Out Burgers v. Zurich American Ins. Co.*, and several claims where insurers had prevailed in motions to dismiss including *Plastic Surgeons of Lexington, PLLC v. Liberty Mut. Ins. and Ohio Sec. Ins. Co.* and noting that in *Gavrilides Management Co. v. Michigan Ins. Co.*, the “plaintiff alleged that the physical requirement of the policy was met because customers could not physically use the dine-in services. The judge denied this allegation, determining that in order to meet the requirement, the insured must show a physical alteration of the premises.”). See also *id.* (“So far, courts have ruled in favor of insurers in cases of business interruption coverage vs. COVID-19. But the vast majority of these cases are still yet to be seen.”). For additional examples of COVID coverage complaints, see Complaint and Demand for Jury Trial, Prime Time Sports Grill, Inc. v. DTW1991 Underwriting Ltd, No. 8:20-cv-00771-CEH-JSS (M.D. Fla. May 4, 2020); see also, Motion to Dismiss Pursuant to Rule 12(b)(6), *supra* (contending that plaintiff restaurant was not “ordered to close” by Florida Gov. Ron DeSantis Order of March 17, 2020 but was permitted to continue operating restaurant at fifty percent occupancy).

Insurers of course approve of the *Gavrilides Management* decision and were undoubtedly pleased that the insurance trade press has given prominent display to the case even though it is a “mere” state trial court case, albeit one of the first decisions in the area. See Wilson Elser, *Michigan Judge Rules Direct Physical Loss Required to Trigger Business Interruption Coverage*, LEXOLOGY (Jul. 23, 2020), <https://www.lexology.com/library/detail.aspx?g=a9de8e82-e549-44f9-83df-7b66cfd10009> (noting that “Judge [Joyce Draganchuk] stated that direct physical loss [of or damage to the property] must be something ‘with material existence . . . that alters the physical integrity of the property.’”).

<sup>71</sup> See, e.g., Christine Spinella Davis, *Business Interruption Coverage for COVID-19 Losses: You Can Satisfy the “Physical Loss or Damage” Requirement in Your Commercial Property Policy*, BRADLEY (Apr. 24, 2020), <https://www.itpaystobecovered.com/2020/04/business-interruption-coverage-for-covid-19-losses-you-can-satisfy-the-physical-loss-or-damage-requirement-in-your-commercial-property-policy/> (“Temporary loss of use and loss of functionality alone may satisfy the physical loss or damage requirement in a property policy.”); Mark Packman & Jason Rubinstein, *COVID-19 Claims May Survive Insurers’ Physical Loss Defense*, LAW360 (Sept. 1, 2020), <https://www.law360.com/articles/1306134>

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Because COVID-19 does not destroy or tangibly alter the structure of property, the insurers have asserted there is no coverage for claims arising from the pandemic. Initial decisions on this issue broke the insurance industry's way. But the litigation of disputes has barely begun. There is significant evidence to suggest there are many legal paths available to plaintiffs as they struggle with losses related to COVID-19. We explore the findings and implications to date.

Policyholder counsel, for example, argued:

In most property insurance policies, business interruption coverage is triggered when the property at issue suffers "direct physical loss or damage." Structural damage to the property, however, is not a requirement for coverage; proof that contamination or other relatively intangible conditions like bacteria, gases, and fumes that "rendered the insured property temporarily or permanently unusable or uninhabitable may support a finding that the loss was a physical loss to the insure property."

Additionally, many insurance policies include civil authority coverage, which covers losses that occur when government authorities restrict access to the area where a business is located or that the business depends on for its operations.

Many property insurance policies also provide contingent business interruption coverage, triggered by damage to or disruption of a business's suppliers, customers, or other key partners. While the policyholder itself need not be physically damaged, it does need to have coverage for the type of damage that affected its suppliers, business partners, or customers.

Packman & Rubinstein, *supra*. Pamela D. Hans & Marshall Gilinsky, *Insurance Coverage for Losses Stemming from the Coronavirus*, INS. J. (Feb. 26, 2020), <https://www.insurancejournal.com/news/national/2020/02/26/559383.htm> (citing *Mellin v. Northern Sec. Ins. Co.*, 115 A.3d 799, 805 (N.H. 2015) and also citing *Gregory Packaging, Inc. v. Travelers Prop. Cas. Co. of Am.*, 2014 U.S. Dist. LEXIS 165232, \*15-17 (D.N.J. Nov. 25, 2014) "[C]ourts considering non-structural property damage claims have found that buildings rendered uninhabitable by dangerous gases or bacteria suffered direct physical loss or damage.").

Business owners are submitting claims for business interruption insurance losses, but many insurance companies' knee-jerk reaction is to deny. This has led to a proliferation of lawsuits. While the viability of these suits depends on each business's unique circumstances and policy language, the prospects look very good for many Pennsylvania business owners.

There has also been, in our view, something of a race-to-the-courthouse problem in that a number of the initial policyholder claims appear to be brought by counsel without substantial experience in insurance coverage litigation, something that more seasoned coverage lawyers noted with some dismay (along with voicing concerns that the efforts of some plaintiff counsel to consolidate proceedings was hurtful to the COVID coverage cause).<sup>72</sup>

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Many Pennsylvania businesses bought all-risk commercial property insurance policies that contain business interruption coverage. The coverage provisions are broad . . .

Many insurance companies will dispute that COVID-19 losses satisfy the direct physical loss or damage requirement. . . . Courts have rejected this view on numerous occasions in numerous contexts.

Patrick Campbell, Charles Casper & Brett Waldron, *Pa. Insureds' Path to Pandemic Biz Interruption Coverage*, LAW360 (May 19, 2020 5:50 PM), <https://www.law360.com/appellate/articles/1274214/pa-insureds-path-to-pandemic-biz-interruption-coverage> (also arguing that there should be coverage even if policy has virus exclusion due to rule that exclusions are construed narrowly and government shutdown orders rather than the virus itself are the cause of business interruption).

<sup>72</sup> See, e.g., Chip Merlin, *What is Multidistrict Litigation (MDL) and Will It Impact Virus Business Income Claims?*, PROP. INS. COVERAGE L. BLOG (May 10, 2020), <https://www.propertyinsurancecoveragelaw.com/2020/05/articles/commercial-insurance-claims/what-is-multidistrict-litigation-mdl-and-will-it-impact> (writing by noted policyholder coverage attorney expresses some doubt about efficacy of consolidation). A large and prominent policyholder firm was less tentative and more critical of consolidation.

Savvy policyholders and experienced counsel may also find consolidated and class action proceedings ill-suited to the resolution of insurance coverage disputes. That is because claim-specific differences are likely to predominate over common issues in three fundamental respects: (1) the specific facts of any particular insurance claim, and how that claim is best presented and substantiated, often vary greatly from claim to claim, place to place, and industry to industry; (2) the specific language of any given insurance policy is critical, and there can be enormous variation in policy language on the material issues implicated by COVID-19; and (3) insurance coverage is a matter of state law, which varies widely across jurisdictions on issues of importance for many policyholders.

For these reasons, sophisticated insureds should carefully review their own insurance policies, claims, and circumstances before signing on to any

As discussed in the next section, we take issue with the insurance industry's rush to judgment opposing COVID-related coverage across the board. We also are concerned that insurers are exaggerating both their potential financial responsibility if COVID coverage claims succeed and the industry's purported inability to absorb such claims.

First, the estimated costs. Insurers have suggested that if covered, the costs of business interruption claims would range as high as \$800 billion per month.<sup>73</sup> But

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of the current efforts to aggregate coronavirus-related insurance cases into MDL or class action proceedings.

David Goodwin, Allan B. Moore & Rani Gupta, *Policyholders Beware: The Risks of Multi-District and Class Action Treatment of COVID-19 Insurance Claims*, COVINGTON, 1–2 (May 4, 2020), <https://www.cov.com/-/media/files/corporate/publications/2020/05/policyholders-beware-the-risks-of-multidistrict-and-class-action-treatment-of-covid-19-insurance-claims.pdf>.

Strong claims should be timely noticed and pursued aggressively by experienced insurance coverage counsel, particularly if insurers do not meet their obligations to pay promptly. Decisions to pursue coverage litigation must take into account the most favorable jurisdictions, procedures, and timing to maximize recovery for policyholders affected by COVID-19. In knowledgeable counsel is able to litigate the strongest claims first, those cases will set appropriate precedents that will establish insureds' rights to recover COVID-19 losses and benefit other policyholders.

*Id.* at 5.

In addition, despite being defendants, insurers have considerable power to shape early case outcomes by making motions to dismiss when presented with favorable facts, policy language, or courts while simply answering the complaint when faced with unfavorable facts, policy language or tribunals, thereby delaying any legal rulings from these less favorable forums until the industry could accumulated the momentum of early Rule 12 victories.

<sup>73</sup> As reported in one prominent industry periodical:

It's hard to quantify the full financial impact COVID-19 will have on the industry. But one thing is certain, this pandemic is on track to become the largest event in insurance history.

"It is truly a catastrophic event the proportion of which we have not seen before," Stefan Holzberger, chief rating officer for AM Best, said. "The breadth and depth of the event, how it is affecting multiple

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geographics and multiple segments of the insurance market—this is really something that dwarfs the other major events in recent history.”

...

And yet, the insurance industry has been prepared to handle this event.

...

There is a caveat to this, however. The industry’s ability to absorb the impact of COVID-19 hinges on business interruption. As of early May, seven states had introduced legislation requiring insurers to provide retroactive business interruption coverage, in some cases regardless of whether policies included a virus exclusion, as most do.

If forced to pay retroactive BI, the insurance industry could be facing losses of \$150 billion to \$200 billion per month, according to the Best’s Commentary, *Legislation to Nullify BI Exclusions Poses Existential Threat to P/C Insurers*. The Insurance Information Institute’s estimates are even higher. The III [Insurance Information Institute] forecasts costs of up to \$380 billion per month, which it said would “break” the insurance industry within months. That scenario, however, is unlikely [because of lack of coverage.]

If you take business interruption out of the equation, the industry as a whole is on solid financial footing.

Kate Smith, *The COVID Catastrophe: The Global Pandemic is on Track to be the Costliest Event in Insurance History. It’s also a Defining Moment for the Industry Special Risk Section Sponsored by Lexington Insurance*, BEST’S REV. (Jun. 2020), <http://news.ambest.com/articlecontent.aspx?refnum=297254&altsrc=123>. See also Robert Hartwig, Greg Niehaus & Joseph Qui, *Insurance for Economic Losses Caused by Pandemics*, 45 Geneva Risk and Ins. Rev. 134, 135 (2020) (estimating losses at one trillion dollars per month for business interruption alone).

We like hyperbole as well as the next authors, but we think it is a bit much to suggest that possible business interruption coverage would “dwarf” the financial consequences of major insurance events such as the asbestos mass tort or pollution claims. We are not dismissive of the potential magnitude of COVID claims but remain concerned that the insurance industry has been a bit cavalier in suggesting such large losses and generally wailing gloom and doom in the event of coverage. It may be a good public relations strategy that will gain sympathy from the courts but strikes us as overblown. And, as discussed later in the article, there is something concerning about attempts to convince courts and policymakers that insurers are too vulnerable to be saddled with COVID losses when the alternative is saddling much more vulnerable small businesses with these losses. If that is the fate decreed by contractual agreement, perhaps there is no escape (save for invocation of reasonable expectations, unconscionability, and public policy canons for construing those



at this juncture, we have not seen any detailing of this estimate or the methodology behind it. We remain skeptical, particularly so in light of the commonly found sublimits (either temporable or monetary) on coverage for business interruption occasioned by government order that insurers contend is contained in most policies and which appears popular in policy forms. One article provides a flavor of the industry's tone.

The Insurance Information Institute and American Property Casualty Insurance Association place the estimates much higher: The APCIA forecast losses of up to \$668 billion per month, while the III estimated retroactive BI could cost the industry up to \$380 billion per month. "That's an industry-breaking event," James Lynch, chief actuary for the II, said. "That would break the industry in two directions. One, the financial load it would place on companies to have to pay claims they had priced the business for, and had specifically excluded, would create financial ruin. Moreover, that intervention into clear policy language would call into question the entire insurance business model."

....

"They're trying to make the case that they're shutting down because of physical loss and damage from the virus," said RiskGenius CEO Chris Cheatham, whose company uses software to help insurers evaluate policy language. "That's not an accident. That's not how people talk."

Bob Hartwig, director of the Risk and Uncertainty Management Center at the University of South Carolina's Darla Moore School of Business, said politicians were fed such language from plaintiffs' attorney groups who are "looking at this as a potentially huge payday."

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"The State of New York cannot alter the laws of physics to satisfy its trial lawyer masters," Hartwig said. "That's essentially what happened. They developed this language in an attempt to overrule the virus exclusion."

"All legal scholars agree this will fail a Constitutional test. There's no question about it."

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contracts) from this bothersome result. But, as discussed later, the insurance industry's extreme anti-coverage position is incorrect.

The battle over business interruption will, without doubt, make its way into the courts. And most agree the courts will side with insurance companies.

“The exclusion for viruses is not an ambiguous one,” Lynch said. “It’s an exclusion of loss due to virus or bacteria. When it was filed, the filing specifically mentioned the potential for a pandemic similar to SARS CoV-1. And the current pandemic is SARS CoV-2. So I don’t think there’s a lot of ambiguity here about what the exclusion was meant to exclude.

Stefan Holzberger, chief rating officer of AM Best, agreed.

“Those well-defined, long-instituted, regulator-approved exclusions for pandemics or viruses should hold,” Holzberger said. “The business interruption policies that have that exclusion, which is the vast majority in the U.S., should not have to honor claims associated with a loss of revenue related to COVID-19.

[Holzberger further predicted that if legislation negating virus exclusions was enacted and upheld in court] we would see widespread insolvency because the magnitude of lost revenue in relation to the capital surplus is so great. The insurance industry could not bear those losses. Which is why they weren’t covered in the first place.”<sup>74</sup>

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<sup>74</sup> Smith, *supra* note 73. Best’s Review loved the inflammatory quote about trial lawyers so much, it was emphasized in a pull-quote from the sidebar in large print, complete with a 20-year-old picture of Professor Hartwig, a former insurer lobbyist before entering academia.

The property/casualty industry estimates that business interruption losses from the coronavirus just for small businesses in the U.S. could be between \$220-\$383 billion per month—or a quarter to half of total industry surplus available to pay all P/C claims.

David A. Sampson, president and CEO of the American Property Casualty Insurance Association, said the \$200-383 billion per month loss estimate assumes there could be as many as 30 million claims from small business that suffered coronavirus-related losses. According to APCIA, that is 10 times the most claims ever handled by the industry in one year. The industry processed more than three million from the 2005 hurricane season that included Hurricanes Katrina, Rita, Wilma and several other storms, the trade group said.

Second, as to insurer ability to pay: if the insurance industry were a sovereign nation, it would have the third largest economy in the world.<sup>75</sup> Insurers receive hundreds of billions of dollars in premium income alone each year,<sup>76</sup> which in turn has usually been invested for some time before the funds are required to be paid in claims. Insurance is generally a more consistently profitable business than most, advantaged by its ability to amass large sums that can be invested, perhaps for years (or decades in the case of liability insurance) before payment. This “float,” as Warren Buffett calls it, enables even insurers with weak underwriting to survive and even thrive. Insurers with sound underwriting and investment do particularly well.<sup>77</sup>

So, what of the effect of the insurance industry’s initial media messaging? We are not in a position to pinpoint entirely the impact of the industry’s anti-coverage messaging on legal developments to date. We cannot count the claims that

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Sampson said the combined capital of the top business insurance underwriters represents only a fraction of the amount that might be expected in coronavirus losses from just small businesses.

“Insurance stability is especially important in a time of increased natural catastrophes. Spring flood season is underway, hurricane season is around the corner, and wildfires pose a threat year-round,” he said.

Simpson, *supra* note 66.

<sup>75</sup> See Richard V. Ericson, Aaron Doyle & Dean Barry, Insurance as Governance, 1, 4 (2003) (noting the degree to which insurance shapes behavior by setting contours of coverage and conduct in order to obtain insurance).

<sup>76</sup> Ranked by 2019 net premiums written, the smallest of the Top 200 (HCI Ins. Group) collects \$228,488,000 in annual premiums; 82 insurers have \$1 billion or more in annual premium income. See *Top 200 U.S. Property/Casualty Writers*, BEST’S REV. (July 2020), [http://www.ambest.com/review/displaychart.aspx?Record\\_Code=274586&src=43&\\_ga=2.171650912.1123988532.1612739172-73892297.1612560642](http://www.ambest.com/review/displaychart.aspx?Record_Code=274586&src=43&_ga=2.171650912.1123988532.1612739172-73892297.1612560642). Some household name insurers have astounding volumes of premium income, e.g.: State Farm (\$65.1 billion); Berkshire Hathaway (\$53.75 billion); Progressive (\$37.6 billion); Allstate (\$34 billion); Liberty Mutual (\$32.3 billion); Travelers (\$27.2 billion); USAA (\$23 billion); Chubb INA (\$18.2 billion); Nationwide (\$18 billion); AIG (\$14.8 billion); Farmers (\$14.5 billion); Harford (\$11.9 billion); American Family (\$11.8 billion); Auto-Owners (\$8.6 billion); Fairfax (\$7.6 billion); Erie (\$7.5 billion). *Id.* Cincinnati Insurance, a defendant in several prominent COVID coverage actions, received almost \$5.4 billion in premiums in 2019. *Id.*

<sup>77</sup> See Jeffrey W. Stempel, Erik S. Knutsen & Peter N. Swisher, Principles of Insurance Law § 1.06 (5<sup>th</sup> ed. 2020) (“A Note on Insurer Operations”); Stempel & Knutsen, *supra* note 33, at § 1.01 (describing insurer operations, using in part description provided by Buffett (who is typically ranked as one of the world’s ten richest people) in his annual letter to Berkshire Hathaway shareholders; Berkshire’s success, according to Buffett, is due in large part to investment funds generated by its insurance and reinsurance operations).

were not filed because a business or a business' lawyer read in the newspaper that "COVID claims are not covered." Nor can we precisely discern the effect on judges as the majority of COVID-related claims were dismissed in favor of insurers at the pleadings stage (though we find that result quizzical). We have yet to learn the effect of the messaging on lay juries, as these cases have not yet made it far enough in litigation (because most are bounced out on the pleadings alone).

But we are able to say that perhaps it is more influential to get out in front of a story and control the narrative than to be correct. If nearly every insurance trade publication, lawyers' publication and popular news press sees the same message, surely there must be some even subliminal effect on how one approaches the insurance coverage question for COVID cases. Moreover, and most concerning to us, there appear to be absolutely no ramifications if the message proffered in the media is actually incorrect! Are we entering a new phase of insurer public relations tactics that are, at least in part, designed with a motive to affect coverage results in legal cases?

In Part III below, we explain how the main coverage question of "direct physical loss or damage" is counter to the main thrust of the insurance industry's message in the media to date. We conclude with our thoughts as to where the issues will resolve in the end.

### III. THE KEY COVERAGE ISSUE: DISCERNING THE (REASONABLE) MEANING(S) OF "DIRECT PHYSICAL LOSS OR DAMAGE"<sup>78</sup>

#### A. THE INSURER ARGUMENT FOR REQUIRING TANGIBLE DESTRUCTION TO TRIGGER COVERAGE

Insurer efforts to dismiss business interruption claims as strained have resonated with most in the industry, including respected authorities who should in our view be less dismissive of claims of loss or damage. A prominent editor of the Fidelity, Casualty & Surety (FC&S) organization has, for example, approached the question as follows.

When policies don't define a term, courts generally refer to a standard dictionary. Merriam-Webster defines damage as "loss or harm resulting from injury to person, property or reputation." This

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<sup>78</sup> In this article, we focus almost exclusively on coverage issues concerning first-party property insurance and its business interruption component as these policies have been those at issue in the first wave of coverage litigation. We expect significant coverage litigation concerning liability insurance to emerge in the future.

is not definitive, so we look at the definitions of loss and harm. Loss is defined as “destruction, ruin,” and harm is defined as “physical or mental damage.”

The virus does not harm physical property. The virus may be cleaned off like other germs or bacteria. The property does not need to be replaced or repaired, just sanitized as advised by public health authorities.<sup>79</sup>

Continuing in this vein, and seeking a trifecta of sorts of no coverage pursuant to government order provisions plus the prevalent pollution exclusion, she wrote:

ISO has a mandatory virus and bacteria exclusion, but what about carriers not using ISO forms? What about carriers that have adopted parts of ISO forms, such as the business interruption language, but have not adopted the rest and did not adopt the mandatory endorsement?

....

The issue at hand with the virus is business interruption and action of civil authority. Is there coverage when local authorities require bars, restaurants, gyms and other establishments to close because of the chances of spreading the virus? For this, we need to look at an endorsement; for the sake of discussion, we are looking at the Business Income (and Extra Expense) Coverage Form CP 00 30. Coverage is provided for the actual loss of business income due to the necessary suspension of business operations during the period of restoration. The period of restoration must be due to direct physical loss of or damage to coverage property. Also covered is loss triggered by a civil authority prohibiting access to the insured property because of damage to other property, but two conditions must apply. That other property must be within one mile of the insured property, and the action of the civil authority is taken in response to dangerous physical conditions resulting from the loss, continuation of the covered cause of loss that caused the damage, or to allow the authority unimpeded access to the property.

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<sup>79</sup> Christine G. Barlow, *Does COVID-19 Cause Physical Loss?*, NAT’L UNDERWRITER 1, 10 (May 2020), <https://www.property-casualtydigital.com/propertycasualty/202005?pg=12#pg12>.

So herein lies the rub. Coverage is provided only when a property has been physically damaged. COVI-19 does not cause physical damage to property. Even if it is considered physical damage, then you have the pollution exclusion to deal with, and the virus is a pollutant. Pollutants are excluded when they are dispersed, discharged, seep, migrate or otherwise escape. So it comes down to whether an individual can be considered to be dispersing, discharging, or otherwise releasing the virus, action that would trigger the pollution exclusion.

Recently a physician from San Francisco attended a conference with hundreds of other physicians in New York. Upon returning home, he felt ill and was tested for the virus, which came back with positive results. Those people attending the conference were possibly exposed to the virus. Does this count as dispersing the virus, even though unintentionally? It seems so.

This is different from closing businesses, because the threat of the threat of exposure or spread of the virus, a threat is not physical damage, and therefore there is no coverage.<sup>80</sup>

B. THE FLAWS OF THE INSURER-ADVANCED CONVENTIONAL WISDOM

1. Dictionary Fetishism: Improperly Collapsing “Loss” and “Damage”

Notwithstanding our respect for this author and the FC&S organization,<sup>81</sup> we are constrained to disagree. Although the “Order of Civil Authority” coverage provided in many policies is limited to four weeks of lost income<sup>82</sup> and the presence of the basic ISO virus exclusion may typically preclude coverage,<sup>83</sup> the FC&S

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<sup>80</sup> *Id.* at 10–11.

<sup>81</sup> And Ms. Barlow’s dismissiveness toward COVID claims may be mild compared to what is coming from another prominent coverage expert. *See* Bill Wilson, WHY INSURANCE DOESN’T COVER THE COVID-19 PANDEMIC (2020) (e-book format released Oct. 29, 2020). Mr. Wilson is the author of the widely celebrated coverage analysis WHEN WORDS COLLIDE: RESOLVING INSURANCE COVERAGE AND CLAIMS DISPUTES (2018).

<sup>82</sup> *See supra* notes 30–35 and accompanying text discussing order of civil authority coverage.

<sup>83</sup> *See infra* notes 180–202 and accompanying text discussing virus exclusion.

analysis is severely deficient regarding the question of physical loss or damage and utterly absurd regarding application of the pollution exclusion.<sup>84</sup>

Property insurance policies can vary significantly. While many do not include business interruption or “business income” coverage (a plus for insurers in light of the lost business revenue caused by COVID), many also lack a virus exclusion (a plus for policyholders). But almost all make a finding of “direct physical loss or damage” an initial requirement for coverage.<sup>85</sup> As discussed below, in decades of coverage litigation preceding COVID claims, courts have divided over the meaning of these terms. But prior to examining case law, courts might profitably examine the facial clarity of these terms, neither of which is usually defined in the insurance policy despite its separate “Definitions” section that normally contains specifically defined terms.

FC&S’s analysis tends not to look to case law but to focus on policy text. This is historically a typical insurer response, as a contextless reading of insurance policy terms most often favors the insurer. This is so because the policyholder litigating the claim probably suffered a loss within the grey areas of coverage (otherwise, why litigate?). The potential pitfalls of the standard insurer textual approach are reflected in its analysis above: seek out the plain meaning of policy terms so as to have the interpretive analysis stop at the plain meaning stage of determining policy coverage—and thus avoid any interpretive ambiguity in the meaning of those terms (otherwise, the policyholder-favoring tools of *contra proferentem* or reasonable expectations are visited upon the entire analysis).

First, the insurer COVID coverage language assessment tends to collapse the terms “loss” and “damage” into one—a rhetorical move that is both unwarranted

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<sup>84</sup> Due to space limitations, we will not present a full examination of the pollution exclusion in the context of COVID-19 in this article. But for reasons we have set forth at length elsewhere, it is absurdist textual literalism to argue that infection of premises by a virus (or bacteria, fungus or the like) is “pollution” as the term is ordinarily understood. It is similarly laughable to suggest that a conference attendee is “dispersing” “pollutants” when sneezing. What, pray-tell, is next, insurers asserting that an attendee’s nausea at the office cocktail party is a pollution event? Such broad construction of an exclusion—part of the insurance policy upon which the insurer bears the burden of persuasion must be narrowly and strictly construed against the insurer who—would operate to undermine the basic purpose of property insurance or liability insurance. See STEMPEL & KNUTSEN, *supra* note 33, at § 14.11; Jeffrey W. Stempel, *Reason and Pollution: Construing the “Absolute” Pollution Exclusion in Context and in Light of its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1 (1998); Jeffrey W. Stempel, *Unreason in Action: A Case Study in the Wrong Approach to Construing the Liability Insurance Pollution Exclusion*, 50 FLA. L. REV. 463 (1998).

<sup>85</sup> See French, *supra* note 4, at n. 21–22 and accompanying text.

(we think the two words are distinct) and misleading in its use of “the dictionary.” As the fetishism of textualism in American judicial interpretation of insurance policy terms rages on, we think that taking the insurer-led textual charge head-on leads to the opposite result that the insurers advocate. Indeed, this is doubly bizarre because historically, insurers have favored a textualist and literalist approach to policy language—probably because historically they have benefitted from such application. But here, in determining coverage for “direct physical loss or damage,” the use of one of the key textualist interpretive tools—the use of dictionary definitions to discern the ordinary lay meaning of policy terms—actually spins counter to insurer interests, when deployed properly.

Regarding the distinction between the words “loss” and “damage”, it should be noted that courts typically subscribe to the “surplusage” canon of construction, which posits that each word in a document (statute, contract, regulation) should be given its own meaning and not treated as a mere repetition by synonym.<sup>86</sup> Although it is in some ways a problematic canon,<sup>87</sup> it is nonetheless one of the “rules” of interpretation. And insurers, when it suits their purpose, embrace the surplusage canon.

For example, when litigating the application of the pollution exclusion, insurers routinely argue that each of the seventeen words in the exclusion (e.g., irritant, contaminant, chemical, waste) deserves independent meaning rather than reinforcing a core concept of pollution,<sup>88</sup> with courts frequently agreeing and giving

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<sup>86</sup> The “surplusage” canon of construction posits that “[i]f possible every word and every provision should be given effect (*verba cum effectu sunt accipienda*). None should needlessly be given an interpretation that causes it to duplicate another provision or to have no consequence. ‘These words cannot be meaningless, else they would not have been used.’ ANTONIN SCALIA & BRYAN GARNER, *READING LAW: THE INTERPRETATION OF LEGAL TEXTS* 174 (2012) (citing *U.S. v. Butler*, 297 U.S. 1, 65 (1936) (Roberts, J.)).

<sup>87</sup> See Laurence Solan & Jeffrey W. Stempel, *Rethinking Redundancy: The False Premises and Practices of the Surplusage Canon* (Jan. 2020) (manuscript on file with author) (describing drawbacks of surplusage and tendency for drafters to use redundancy as a means of attempting to achieve clarity). Accord, Ethan J. Leib & James Brudney, *The Belt-and-Suspenders Canon*, 105 IOWA L. REV. 735 (2020) (suggesting that in practice many courts treat drafting repetition as clarifying a particular intent rather than using each word to convey its own concept).

<sup>88</sup> The typical definition of “pollutants” in a standard form general liability, which has been widely used for thirty years or more, includes “any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste” with wasted “include[ing] materials to be recycled, reconditioned or reclaimed.” See, e.g., Commercial General Liability Policy Form CG 00 01 01 96, in DONALD S. MALECKI & ARTHUR L. FLITNER, *COMMERCIAL GENERAL LIABILITY* 271 (6th ed. 1998).



the words literal application even though they are contained in an exclusion that is, according to contract construction rules, supposed to be strictly and narrowly construed against the insurer with the insurer bearing the burden of persuasion to demonstrate the applicability of the exclusion.<sup>89</sup> If the insurers are to be consistent in their interpretative arguments, the word “loss” should be viewed as meaning something different than “damage.”

Perhaps more important, if one is “making a fortress” out of the dictionary (something cautioned against by the great Second Circuit Judge Learned Hand),<sup>90</sup> that fortress provides quite a lot of protection to policyholders—and this should be conceded by insurer advocates, who have to date disappointingly taken a self-serving view of the terms “loss” and “damage,” with too much acquiescence from courts. Even if one is not ready to concede that dictionary definitions favor policyholders more than insurers, it seems to us undeniable that there are many dictionary entries supporting the policyholder perspective. This in turn means that policyholder textual arguments are reasonable. And this further means that the term

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<sup>89</sup> See, e.g., *Quadrant Corp. v. Am. States Ins. Co.*, 110 P.3d 733 (Wash. 2005) (taking broad view of pollution exclusion as precluding coverage for policyholder negligence in application of sealant exposing apartment resident to noxious fumes). See William P. Shelley & Richard C. Mason, *Application of the Absolute Pollution Exclusion to Toxic Tort Claims: Will Courts Choose Policy Construction or Deconstruction?*, 33 TORT & INS. L.J. 749 (1998) (detailing a prominent insurer counsel advocate’s broad application of the exclusion to cover claims of policyholder negligent injury with any involvement of chemicals).

<sup>90</sup> See *Cabnell v. Markham*, 148 F.2d 737, 739 (2d Cir. 1945) (“But it is one of the surest indexes of a mature and developed jurisprudence not to make a fortress out of the dictionary; but to remember that statutes always have some purpose or object to accomplish, whose sympathetic and imaginative discovery is the surest guide to their meaning.”) By this, Judge Hand sensibly meant that words should be construed in accord with party intent and overall purpose rather than through textual assessment alone. We agree and also note that there may well be extrinsic evidence supporting the insurance industry’s view that when drafting property policies, it intended to provide coverage only for the sort of tangible structural injury that comes from external forces such as fire, windstorm, a sudden flooding, vandalism or other actions that wreak palpable destruction on property. But to date, insurers have not done so, preferring to fight on the metaphorical “hill” of ahistorical, acontextual textualism. In COVID decisions to date, they have been holding that hill. Should they start to die on the hill (e.g., if courts begin in greater degree to recognize that “physical loss or damage” does not inexorably mean tangible destruction), one would expect them to proffer supporting extrinsic evidence that this is what was meant or intended or required by sound risk management practice. If they cannot provide such evidence, policyholders deserve to win on the “physical loss or damage” question, even in jurisdictions with a weak application of the *contra proferentem* principle.

“physical loss or damage” is sufficiently ambiguous that policyholders should enjoy the benefit of the *contra proferentem* principle and avoid dismissal of their claims on this basis unless insurers can proffer sufficient extrinsic evidence to support their preferred meaning of the term—something insurers have not done to date.

## 2. Dictionary Definitions Support Policyholders as Least as Much as Insurers

In arguing that coverage requires tangible destruction that can not be easily rectified, FC&S refers to the Merriam-Webster dictionary, editions of which are on our respective desks, but selects and presents the definitions in a pronouncedly anti-policyholder fashion. The more complete excerpt of key terms presented below provides an alternative meaning of “loss” that distinguishes it from “damage.”

**damage** [means] **1** : loss or harm resulting from injury to person, property, or reputation . . .

**loss** [means] **1** : DESTRUCTION, RUIN **2 a** : the act of losing possession **b** : the harm or privation resulting from loss or separation **c** : an instance of losing . . . **4 a** : failure to gain, win, obtain, or utilize . . . **5** : decrease in amount, magnitude, or degree. . .

**lose** [means] **1 a** : to bring to destruction . . . **3** : to suffer deprivation of: part with esp. in an unforeseen or accidental manner . . . *vi* **1**: to undergo deprivation of something of value . . .

**physical** [means] **1 a** : having material existence : perceptible esp. through the senses and subject to the laws of nature . . . **b** : of or relating to material things . . .<sup>91</sup>

Applying this mix of Merriam-Webster definitions suggests that one might reasonably find a “physical loss” when a policyholder is deprived of something material—such as use of one’s business, especially if the loss takes place in an unanticipated manner through something like a pandemic that spurs government-ordered use of the business property.

Similarly, it is perfectly reasonable to state that one’s physical property has been lost or harmed or injured by a virus on surfaces or in the air on the property. Insurers argue that because the virus can be “wiped off,” there has been no loss or

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<sup>91</sup> MERRIAM-WEBSTER’S COLLEGIATE DICTIONARY 291, 689, 689, 877 (10<sup>th</sup> ed. 1996).

damage. The “virus damages lungs, not property”<sup>92</sup> has become an insurance industry aphorism akin to “the CGL [commercial general liability] policy is not a performance bond,” a cliché invoked by CGL insurers seeking to avoid coverage for damage inflicted by defective construction.<sup>93</sup> Actually, the damages-lungs-not-property mantra is more misleading.

The not-a-performance-bond trope is true as a general rule. But, as courts have come to recognize almost uniformly, this general rule is not applicable where a CGL policyholder’s negligence inflicts damage (defined as “physical injury to tangible property”) upon other property and the CGL coverage is not based on merely correcting substandard work but compensating victims for damage done to other property by the substandard work.<sup>94</sup>

The damages-lungs-not-property trope is not true—period—or is only true if one excises the word “loss” from the trigger term “physical loss or damage.” Even under the view that a cleaning will make infected property “as good as new” (which may not be the case), the property has nonetheless been lost to its owner for at least some period of time, perhaps a significant period of time depending upon the cleaning and public health requirements to which the property is subject (let alone serious public relations issues with regard to perceived safety of the premises).

Further, a facility in which COVID has been found is, at least temporarily, “damaged” goods. The susceptibility of COVID to cleaning is relevant to questions of the degree of injury and the period of restoration required for a COVID-infected business. COVID infection is not the same as a fire or explosion, and in many cases is more easily rectified than water damage from a burst pipe. But there nonetheless is at least some physical damage and considerable physical loss of property if the cleaning and disinfecting is time-consuming or if government authorities restrict operation of the facility.

In addition, remediation of COVID damage to property is likely to be fleeting in many situations. COVID-inflicted injury may be susceptible to

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<sup>92</sup> Transcript of Teleconference Order to Show Cause at 5:3–4, *Soc. Life Magazine, Inc. v. Sentinel Ins. Co.*, No. 20 Civ. 3311 (S.D.N.Y. May 14, 2020).

<sup>93</sup> See Jeffrey W. Stempel, *Rediscovering the Sawyer Solution: Bundling Risk for Protection and Profit*, 11 RUTGERS J. OF L. & PUB. POL’Y 170, 210, n. 89 (2013) (noting the prevalence of this argument by liability insurers in defective construction cases). See, e.g., *Nationwide Mut. Ins. Co. v. Wenger*, 278 S.E.2d 874 (Va. 1981) (exemplifying a general liability insurer arguing to receptive court that coverage for construction defects, absent injury to non-policyholder property, would improperly convert the liability policy into a performance bond).

<sup>94</sup> See STEMPEL & KNUTSEN, *supra* note 33, at § 14.13; STEMPEL, SWISHER, & KNUTSEN, *supra* note 77, 657–61. See, e.g., *Am. Family Mut. Ins. Co. v. Am. Girl*, 673 N.W.2d 65 (Wis. 2004).

disinfection but may be repeated within hours as customers or employees return to a restaurant, bar, retail outlet, or factory. COVID damage may even be re-imposed almost as quickly as it first struck if members of the cleaning crew are COVID-positive, which may be the case even if the workers show no detectable symptoms of infection.

A brief survey of other dictionaries reveals a nesting of definitions of the key words of COVID coverage disputes that is more consistent with our broader view of the meaning of the terms “physical loss or damage” than the seemingly cherry-picked FC&S emphasis on irreversible tangibility as a prerequisite to finding such loss or damage. Consider the following entries, all from mainstream sources.

**damage** [means] [i]mpairment of the usefulness or value of person or property . . .

**loss** [means] **b.** The condition of being deprived or bereaved of something or someone . . .

**lose** [means] **2.a.** To come to be deprived of the ownership, care, control of (something one has had) . . . <sup>95</sup>

or

**damage** [means] **1.** Harm or injury to property or a person, resulting in loss of value or the impairment of usefulness.

**loss** [means] **1.** The act or an instance of losing . . . **b.** The condition of being deprived or bereaved of something or someone.

**lose** [means] **2a.** To be deprived of (something one has had).

**physical** [means] **2.** Of or relating to materials things . . . <sup>96</sup>

or

**damage** . . . See breakage, harm [as a noun]. See injure [as a verb].

**loss** [means] The act or an instance of losing something : losing, misplacement. . . . See also deprivation.

**deprivation** [means] The condition of being deprived for what one once had or ought to have : deprival, dispossession, divestiture, loss, privation.

**lose** [means] To be unable to find : mislay, misplace.

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<sup>95</sup> THE AMERICAN HERITAGE COLLEGE DICTIONARY 350, 801, 1031 (3rd ed. 1993).

<sup>96</sup> THE AMERICAN HERITAGE COLLEGE DICTIONARY 357, 817, 818, 1050 (4th ed. 2004).

**physical** [means] **1.** Composed of or relating to things that occupy space and can be perceived by the senses: concrete, corporeal, material, objective, phenomenal, sensible, substantial, tangible.<sup>97</sup>

or

**damage** [means] **1.** Impairment of the worth or usefulness of person or property: harm.

**loss** [means] **1.** The damage or suffering that is caused by losing.  
**2.** One that is lost.

**lose** [means] **3.** To be deprived of . . .

**physical** [means] **1.** Of or relating to the body rather than the emotions or mind. **2.** Material rather than imaginary. **3. a.** Of, pertaining to, or produced by nonliving matter and energy.<sup>98</sup>

Perhaps most surprising is that many standard-fare dictionaries actually use the term “damage” in defining the term “loss” to indicate that “loss” can mean “loss of use” or deprivation of property.

### 3. Apt Use of Dictionaries in COVID Coverage Controversies Often Supports Coverage

This is perhaps the time to note that in most every dictionary, the order of definitions does not proceed from most popular to least used, as many people (including lawyers) often mistakenly think. Rather, the presentation proceeds from earliest usage to most recent usage.<sup>99</sup> The first definition presented is simply the oldest and not the primary or best or most widely used or accepted definition. In many cases, the oldest definition may be considerably less popular or representative or “correct” than definitions listed later in the dictionary entry. As a result, we believe it is inappropriate for courts or commentators to argue that a term is clear and unambiguous based on presentation order in the dictionary. For example, a lawyer’s argument that definition number one is what was meant because it is the first definition seems to us quite misplaced.

Insurers might seize upon this to suggest that a definition of “loss” that includes “destruction” or “ruin” is *the* clearly correct definition because it emerged

<sup>97</sup> ROGET’S II: THE NEW THESAURUS 105, 265, 117, 265, 314 (3d ed 1995).

<sup>98</sup> WEBSTER’S II NEW RIVERSIDE DICTIONARY 177, 407, 406, 515 (rev. ed. 1996).

<sup>99</sup> WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 19 (9th ed. 1984) (the “[o]rder of senses [in the dictionary] is historical.”).

relatively later in the usage. But that is too ambitious a claim. Rather, each of the different definitions in a dictionary entry would appear to us to be per se reasonable constructions of the word, at least in the absence of context. Contextual material may make it clear that Definition X should prevail rather than Definition Y. But to claim that the words of the definitions themselves admit of clear choice strikes us as simply incorrect.

In examining dictionary definitions, it is also important to remember the dangers of motivated reasoning. As noted D.C. Circuit Judge Harold Leventhal apparently observed when discussing court use of legislative history, it can be a bit like “looking out over a crowd and spotting your friends.”<sup>100</sup> But the same, of course, is true regarding selection of a preferred dictionary definition. Insurers (and, of course, policyholders as well) know what they want to be the answer and will naturally be drawn, at least subconsciously, to the definition that best meets their coverage dispute and litigation needs. In addition, dictionary use may mislead through simple happenstance when a judge (or law clerk or counsel writing a brief that influences the judge) reaches for the dictionary that just happens to be on the closest desk or shelf or reads only the first dictionary entry resulting from a browser search. To the extent that there are differences in dictionaries, this human foible of taking the path of least resistance may mislead. In addition, it has been our experience that many dictionary users operate under the false impression that the first definitional entry in a dictionary is the primary or main meaning of a term when, as noted above, it is merely the earliest use of the term.

Thus, decision by dictionary is more than a little problematic. Notwithstanding this human tendency, we think the above excerpts (and we could have listed another dozen or two of similar definitions or associations) establishes that the words “physical loss or damage” admit of construction quite favorable to policyholders.<sup>101</sup> FC&S and others supporting insurers in the COVID coverage

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<sup>100</sup> See, e.g. Patricia M. Wald, *Some Observations on the Use of Legislative History in the 1981 Supreme Court Term*, 68 IOWA L. REV. 195, 214 (1983) (citing a conversation with Judge Leventhal), *quoted in* Exxon Mobil Corp. v. Allapattah Servs., Inc., 545 U.S. 546, 568 (2005); Conroy v. Aniskoff, 507 U.S. 511, 519 (1993) (Scalia, J., concurring) (paraphrasing Leventhal); Abner J. Mikva, *Statutory Interpretation: Getting the Law to Be Less Common*, 50 OHIO ST. L.J. 979, 981–82 (1989); Adam M. Samaha, *Looking Over a Crowd—Do More Interpretive Sources Mean More Discretion?*, 92 N.Y.U. L. REV. 554 (2017) (discussing the genealogy and meaning of the quote attributed to Judge Leventhal).

<sup>101</sup> Another possible avenue for assessing the meaning of text is corpus linguistics analysis, which involves assessing the collates and clusters of words as an aid to interpretation. See Lawrence M. Solan & Tammy Gales, *Corpus Linguistics as a Tool in Legal Interpretation*, 6 B.Y.U. L. REV. 1311, 1315 (2017). Although in our view, it would be a mistake to attach talismanic power to the use of big data in assessing insurance policy

battles are simply not being fair or reasonable in arguing that this key coverage provision “clearly” or “unambiguously” requires some sort of structural change of insured property as a prerequisite to coverage. Too many courts have accepted this unsupportable shibboleth. Even if their decisions finding no coverage are correct (due to the presence of a virus exclusion or other bar to coverage), these courts have done unnecessary “damage” to norms of insurance policy construction that impacts not only COVID coverage claims but construction of insurance policies as a whole.

As discussed below, insurers typically argue that “damage” entails a requirement of structural change in covered property and that “loss” is largely a synonym for “damage.” In our view, the term “loss” connotes something quite different than “damage.” For example, dictionaries commonly define “loss” as deprivation of something (whether as a result of “damage,” or theft or something else). Government shutdown orders (described below) by definition deprive policyholders of the use of their property—property that is physical, corporeal, choate, and tangible. Although alternative definitions of loss are also common in dictionaries, definitions connoting deprivation, lack of access, or the like are sufficiently common that a reasonable interpreter must concede that the concept of “loss” proffered by a policyholder forced to curtail operations is at least a reasonable meaning of the term.

According to well-established ground rules for insurance policy interpretation, if both policyholder and insurer have set forth reasonable constructions of a term, the term is ambiguous and questions of meaning should be resolved against the insurer that drafted the policy and in favor of the policyholder.

When this interpretative debate takes place at the motion to dismiss stage of litigation, *contra proferentem* (which translates as “against the drafter”) logically should have particular force. An early ruling favoring the insurer’s implicit argument (that “loss” or “damage” requires structural change in property) effectively involved the court ruling as a matter of law that a definition of loss drawn from dictionaries is not reasonable—an absurd result. If such a construction of the term “loss” was not reasonable, it presumably would not be in a published dictionary.

#### 4. Prior Insurer Industry Action Contradicts Insurers’ Current Interpretation Angle

In addition to taking an insurer-serving approach to defining “physical loss or injury,” the FC&S assertion that COVID claims fail to involve triggering loss is

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term meaning, this sort of broader based linguistic analysis may be superior to simply “looking it up” in the dictionary at random due to the potential unconscious bias or happenstance of dictionary use.

inconsistent with prior FC&S action. Consider, for example, the following FC&S assessment that predated the COVID pandemic by eight years. An insurance agent made the following inquiry.

Our insured accidentally threw away some digital x-ray sensors in the trash. Now, they want to be compensated for them. The BOP policy, Section 1 Property, Coverage agreement states, “We will pay for direct physical loss . . . .”

I believe the coverage agreement precludes coverage as this is not “direct physical loss.” Nothing happened to them—they were simply thrown away.

Do you believe coverage exists?

Oregon Subscriber<sup>102</sup>

FC&S replied as follows.

There is no exclusion that applies to this loss. There does not need to be any impact on or damage to the items themselves for there to be a direct physical loss—just like when items are stolen. But *there is a loss in that they are no longer available to the insured*.<sup>103</sup>

If FC&S was being consistent with this prior analysis, it would have to acknowledge that businesses forced to close due to either site-specific infection or government mandate have suffered a loss in that the physical business facilities are “no longer available” to them, at least until a government order is lifted or infected property is cleaned and otherwise rehabilitated.

This prior inconsistent statement in the insurance press raises the spectre of how important it is to view all media on an issue in its context and not simply that purpose-built for a particular cause. If insurers wish to flood the current press with commentary, past press on the same and related issues will require defense or acknowledgement, to be fair.

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<sup>102</sup> *Direct Physical Loss Under BOP*, NAT’L UNDERWRITER (June 27, 2011), <https://www.nuco.com/fcs/2011/07/12/direct-physical-loss-under-bop-422-12966>.

<sup>103</sup> *Id.*



5. Prior Judicial Treatment of the “Physical Loss or Damage”  
Clauses Has Been More Favorable to Policyholders than Initial  
COVID Coverage Decisions Suggest

The COVID insurance coverage cases to date have shown that courts prefer some allegations of tangible physical harm to property that alters its essential character and structure in order to trigger business interruption or civil authority coverage for pandemic-related losses. “Direct physical loss of or damage to property” thus seems to require that some external force touches the property and alters it in order for insurance coverage to attach. There is no definition of the coverage clause or its individual composite words in any property insurance policy. In attempting to provide meaning to the coverage clause, courts may have inadvertently hyper-focused on the parsed-out words of the clause as standing alone (i.e. “physical,” “loss” and “damage”). The dictionary sections noted in the prior section underline the problems with doing so, because dictionary definitions are inconsistent, are presented in chronological and not frequency order, and can be cherry-picked to “say” what one wants.

Review of the current batch of COVID coverage cases shows that it is possible in some jurisdictions that a policyholder does not need tangible structural harm to property in order to trigger the coverage clause in the policy. The virus does not need to “wreck” some property; it just has to be present to make the property unusable to the policyholder. This reasoning tracks the better-reasoned decisions of courts interpreting “direct physical loss” in other property insurance contexts.<sup>104</sup> Courts have held that the following causes of loss are covered as “direct physical loss or damage:”

- a) noxious particles post-9/11 World Trade Center disaster;<sup>105</sup>
- b) contamination with radioactive dust and radon gas;<sup>106</sup>

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<sup>104</sup> See Scott G. Johnson, *What Constitutes Physical Loss or Damage in a Property Insurance Policy?*, 54 TORT TRIAL & INS. PRAC. L.J. 95 (2019) (surveying caselaw and finding trend and dominance of better reasoned decisions finding loss or damage without palpable destruction or tangible structural alteration of property); Steven Plitt, *Direct Physical Loss in All-Risk Policies: The Modern Trend Does Not Require Specific Physical Damage, Alternation*, CLAIMS J. (Apr. 15, 2013), <https://www.claimsjournal.com/magazines/idea-exchange/2013/04/15/226666.htm>.

<sup>105</sup> Schlamm, Stone & Dolan, LLP v. Seneca Ins. Co., 800 N.Y.S.2d 356 (Sup. Ct. 2005).

<sup>106</sup> Am. All. Ins. Co. v. Keleket X-Ray Corp., 248 F.2d 920, 925 (6th Cir. 1957).

- c) smoke from wildfires cancelling a theatre performance;<sup>107</sup>
- d) unpleasant odor making premises uninhabitable (i.e. “locker room” smell, cat urine, or meth lab);<sup>108</sup>
- e) drywall releasing poisonous gas rendering home uninhabitable;<sup>109</sup>
- f) asbestos in carpeting impaired building’s function;<sup>110</sup>
- g) asbestos in buildings;<sup>111</sup>
- h) mold spores and bacteria rendering home uninhabitable;<sup>112</sup>
- i) release of unknown substance in sewage treatment plant causing plant shutdown;<sup>113</sup>
- j) hidden building decay due to seawater damage;<sup>114</sup>
- k) e-coli contamination in a well;<sup>115</sup>
- l) carbon monoxide poisoning;<sup>116</sup>
- m) trace amounts of benzene in beverages;<sup>117</sup>
- n) metal parts contaminated with lead;<sup>118</sup>
- o) salad dressing exposed to vaporized agricultural chemicals;<sup>119</sup>

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<sup>107</sup> Or. Shakespeare Festival Ass’n v. Great Am. Ins. Co., No. 1:15-cv-01932-CL, 2016 WL 3267247, at \*5 (D. Or. June 7, 2016).

<sup>108</sup> Essex Ins. Co. v. BloomSouth Flooring Corp., 562 F.3d 399 (1st Cir. 2009) (“locker room” smell); Mellin v. N. Sec. Ins. Co., Inc. 115 A.3d 799 (N.H. 2015) (cat urine odor); Farmers Ins. Co. of Or. v. Trutanich, 858 P.2d 1332 (Or. 1993) (meth lab odor).

<sup>109</sup> TRAVCO Ins. Co. v. Ward, 715 F. Supp. 2d 699, 708 (E.D. Va. 2010).

<sup>110</sup> Sentinel Mgmt. Co. v. Aetna Cas. & Sur. Co., 615 N.W.2d 819, 826 (Minn. 2000).

<sup>111</sup> Yale Univ. v. Cigna Ins. Co., 224 F. Supp. 2d 402, 413 (D. Conn. 2002); Bd. of Educ. of Twp. High School Dist. No. 211 v. Int’l Ins. Co., 720 N.E.2d 622, 625–26 (Ill. App. Ct. 1999).

<sup>112</sup> Sullivan v. Standard Fire Ins. Co., 956 A.2d 643 (Del. 2008); Prudential Prop. & Cas. Ins. Co. v. Lillard-Roberts, No. CV-01-1362-ST, 2002 WL 31495830, at \*8–10 (D. Or. June 18, 2002) (applying Oregon law).

<sup>113</sup> Azalea, Ltd. v. Am. States Ins. Co., 656 So. 2d 600, 602 (Fla. Dist. Ct. App. 1995).

<sup>114</sup> Three Palms Pointe, Inc. v. State Farm Fire & Cas. Co., 250 F. Supp. 2d 1357, 1360–61 (M.D. Fla. 2003).

<sup>115</sup> Motorists Mut. Ins. Co. v. Hardinger, 131 F.App’x 823, 823 (3d Cir. 2005).

<sup>116</sup> Matzner v. Seaco Ins. Co., No. Civ. A. 96-0498-B, 1998 WL 566658 (Mass. Super. Aug. 12, 1998).

<sup>117</sup> National Union Fire Ins. Co. of Pittsburgh v. Terra Indus., 346 F.3d 1160 (8th Cir. 2003).

<sup>118</sup> Stack Metallurgical Servs., Inc. v. Travelers Indem. Co. of Conn., No. 05-1315-JE, 2007 WL 464715, at \*2 (D. Or. Feb. 7, 2007).

<sup>119</sup> Henri’s Food Prods. Co. v. Home Ins. Co., 474 F. Supp. 889, 892 (E.D. Wis. 1979) (applying Wisconsin law).

- p) loss of soil supports due to adjacent landslide, even though home itself not damaged;<sup>120</sup>
- q) buildup of gas beneath church rendering church uninhabitable;<sup>121</sup>
- r) ammonia release;<sup>122</sup>
- s) infestation of brown recluse spiders;<sup>123</sup>
- t) organisms in canned creamed corn;<sup>124</sup> and
- u) cereal oats treated with a non-FDA approved pesticide, even though chemically identical to approved pesticide.<sup>125</sup>

There are also a much smaller group of cases which deny claims for what appear to be very similar or even identical causes of loss like:

- a) mold, which apparently could be removed by cleaning;<sup>126</sup>
- b) odors or bacteria in an HVAC system;<sup>127</sup> and
- c) asbestos contamination which apparently did not alter the structure of the building.<sup>128</sup>

The reasoning featured in the first list of cases finding coverage for more ephemeral physical losses also tracks the better-reasoned decisions in recent cases involving coverage for cyber-losses under property policies. Insurance claims for electronic data losses also went through a similar wave as COVID insurance claims as courts wrestled with whether or not electronic data stored on a computer could experience a “direct physical loss or damage” because it appears to be intangible and

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<sup>120</sup> Hughes v. Potomac Ins. Co. of D.C., 199 Cal. App. 2d 239, 248 (1962).

<sup>121</sup> W. Fire Ins. Co. v. First Presbyterian Church, 437 P.2d 52, 55 (Colo. 1968).

<sup>122</sup> Gregory Packaging, Inc. v. Travelers Prop. & Cas. Co. of Am., No. 2:12-cv-04418, 2014 WL 6675934 at \*5–6 (D.N.J. Nov. 25, 2014) (applying New Jersey and Georgia law).

<sup>123</sup> Cook v. Allstate Ins. Co., No. 48D02-0611-PL-01156, 2007 Ind. Super. LEXIS 32, at \*7–9 (Ind. Super. Ct. Nov. 30, 2007).

<sup>124</sup> Pillsbury Co. v. Underwriters at Lloyd's, 705 F. Supp. 1396, 1401 (D. Minn. 1989).

<sup>125</sup> Gen. Mills, Inc. v. Gold Medal Ins. Co., 622 N.W.2d 147, 152 (Minn. Ct. App. 2001).

<sup>126</sup> Mastellone v. Lightning Rod Mut. Ins. Co., 884 N.E.2d 1130, 1144–45 (Ohio Ct. App. 2008).

<sup>127</sup> Universal Image Prods. v. Chubb Corp., 703 F. Supp. 2d 705, 713 (E.D. Mich. 2010).

<sup>128</sup> Great N. Ins. Co. v. Benjamin Franklin Fed. Sav. & Loan Ass'n, 793 F. Supp. 259 (D. Or. 1990), *aff'd*, 953 F.2d 1387 (9th Cir. 1992).

is unseen by the naked eye, existing as data on a hard drive or in the online cloud.<sup>129</sup> Courts have treated losses relating to electronic data and computer equipment in sometimes strange ways.

The more reasonable and now widely accepted approach has been to find that electronic data losses are capable of being covered as a “direct physical loss” under a property policy when the data is corrupted, lost or damaged. Many courts have found that, although data cannot be seen or touched, it nevertheless exists in some fashion electronically and microscopically as property and can suffer a direct physical loss.<sup>130</sup> Indeed, it would be foolish to have a property policy cover data loss if the data were stored in hard paper copy and destroyed, but then deny coverage for a similar loss if the data exists in electronic form. That would make for perverse record-keeping incentives.

Holding that a virus like COVID-19 can at least potentially damage property makes sense in this regard. The virus does render surfaces unusable to humans for a period of time. It is potentially deadly and spreads quickly, through touched surfaces or the air. One would assume insurers would not want business owners putting employees and customers in infected stores if such would vastly increase the risk of an even larger claim if a person became ill or died (though such a claim would be made under a different insurance product: liability insurance or workers compensation).

The long list of cases that have considered various external forces’ impact on property as a “direct physical loss” demonstrate that courts are willing to find coverage if the force is a disease-causing agent or poison, if it is purely airborne, and if it does not permanently affect or even alter in any way the physical property insured. “Loss” or “damage” can mean “lost to the policyholder” in terms of use, in a variety of ways that do not involve actual physical destruction of the property.

The case law supports a conclusion that physical damage from a virus does not have to be permanent; it can be transient.<sup>131</sup> With a virus like COVID-19, an

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<sup>129</sup> See Stempel & Knutsen, *supra* note 33, at §23; Erik S. Knutsen & Jeffrey W. Stempel, *The Techno-Neutrality Solution to Navigating Insurance Coverage for Cyber Losses*, 122 PA. STATE U. L. REV. 645, 646–47 (2018).

<sup>130</sup> See, e.g., *Ashland Hosp. Corp. v. Affiliated FM Ins. Co.*, No. 11-16-DLB-EBA, 2013 WL 4400516, at \*5 (E.D. Ky. Aug. 14, 2013) (finding disk drive damage due to excessive temperatures is a “direct physical loss” at a microscopic level); *Se. Mental Health Ctr., Inc. v. Pac. Ins. Co.*, 439 F. Supp. 2d 831, 837 (W.D. Tenn. 2006) (finding data corrupted by power loss at pharmacy is a covered “direct physical loss”).

<sup>131</sup> See, e.g., *Phibro Animal Health Corp. v. Nat’l Union Fire Ins. Co. of Pittsburgh*, No. A-5589-13T3, 2016 WL 3884255, at \*9–10 (N.J. Super. Ct. App. Div. July 14, 2016) (finding that medicine given to chickens that stunted their growth constituted

insured property may be impacted, and a loss may ensue in two typical scenarios: immediately after an infected customer or employee becomes ill on the premises or, more broadly, while the virus itself is highly prevalent in the community in question and therefore must be on the premises.

For the first scenario—that of immediate infection of an employee—it would seem that physical loss or damage would be simple to prove. There was virus present on the property. No one can tell where it spread or on what surfaces. It may well be in the air or ventilation system. Entry to the property is thus dangerous until the illness reasonably subsides, decontamination has occurred, and it is again safe to enter.

But for the second scenario—that of virus generally prevalent in the community—can coverage attach simply because the illness is potentially ‘out there?’ In that instance, reasoning such as that featured in the *Studio 417, Inc. v. Cincinnati Insurance Company*<sup>132</sup> case is helpful: where the virus is so highly prevalent such that a large proportion of the population is ill (and sometimes without any knowledge of being ill) to the degree that civil authorities are making orders restricting both use of property and peoples’ movement, then one can probably assume actual presence of virus on the property somehow, especially at a place of business open to the public. At a certain point in time, the harm will of course subside. Those cases holding that physical damage does not have to be permanent to trigger coverage support reasoning that coverage would last as long as the danger is rendering the property unfit for use.

A number of cases have found coverage due to the imminent threat of physical loss or damage:

- a) government shutdown due to impending riots;<sup>133</sup>
- b) evacuation from an imminent building collapse;<sup>134</sup>
- c) an impending hurricane;<sup>135</sup>

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property damage, despite the possibility of the chickens being restored to their original conditions, because property damage need not be permanent).

<sup>132</sup> No. 20-cv-03127-SRB, 2020 WL 4692385 (W.D. Mo. Aug. 12, 2020) (applying Missouri law).

<sup>133</sup> See, e.g., *Sloan v. Phoenix of Hartford Ins. Co.*, 207 N.W.2d 434, 437 (Ct. App. Mich. 1973) (finding loss of use due to government shutdown in response to riots is covered even though there is no direct physical loss to property).

<sup>134</sup> See, e.g., *Hampton Foods, Inc. v. Aetna Cas. & Sur. Co.*, 787 F.2d 349, 352 (8th Cir. 1986).

<sup>135</sup> See, e.g., *Houston Cas. Co. v. Lexington Ins. Co.*, No. H-05-1804, 2006 WL 7348102, at \*6 (S.D. Tex. June 15, 2006) (finding coverage for business interruption due to

- d) imminent landslide;<sup>136</sup>
- e) imminent threat of release of asbestos fibres.<sup>137</sup>

However, other cases have found that fears of future threats did not constitute a covered loss because there was no loss to property.<sup>138</sup>

The threat of something can make property uninhabitable. The threat of COVID-19 is quite serious: the virus is highly contagious, spreads through the air and surfaces, and can be deadly. Those in close indoor quarters to the virus also have a high possibility of contracting the disease. To that end, the COVID-19 situation perhaps differs from those cases that have found that future threats did not equate to a loss in property. The possibility of damage in the COVID-19 situation is relatively high if virus is in the vicinity. It is not like taking a preventative measure after an event out of concern for a follow-up event (like ordering a curfew after a socially disruptive event). Rather, it is a highly likely scenario that putting someone in close indoor proximity to the virus will make that person ill. It is more similar to the impending earthquake and hurricane cases where one knows the event is on its way, than it is to those where losses stemmed from concerns of more vague future events occurring. With COVID-19, a significant number of people sufficiently exposed indoors will get sick.

This highlights one other area of coverage concern: actual physical damage versus loss of use or function of property to the policyholder. There is support in

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evacuation arising from impending Hurricane Floyd, even though policyholder did not suffer physical damage to property from hurricane).

<sup>136</sup> See, e.g., *Murray v. State Farm Fire & Cas. Co.*, 509 S.E.2d 1, 16–17 (W. Va. 1998) (finding threat of imminent landslide enough to satisfy “direct physical loss” for coverage to attach).

<sup>137</sup> *Port Auth. v. Affiliated FM Ins. Co.*, 311 F.3d 226, 236 (3d Cir. 2002).

<sup>138</sup> See, e.g., *United Air Lines v. Ins. Co. State of Pa.*, 439 F.3d 128, 133–35 (2d Cir. 2006) (finding no civil authority coverage where a government halt of airport operations is based on fears of future attacks after Sept. 11, 2001 and no property damage to adjacent property); *Paradies Shops, Inc. v. Hartford Fire Ins. Co.*, No. 1:03-CV-3154-JEC, 2004 WL 5704715, at \*6–8 (N.D. Ga. Dec. 15, 2004) (finding no property damage from air ground stop order after Sept. 11, 2001 as the order did not prohibit access to airports and their businesses); *Syufy Enters. v. Home Ins. Co. of Ind.*, No. 94-0756 FMS, 1995 WL 129229, at \*2 (N.D. Cal. Mar. 21, 1995) (finding curfews imposed to curb looting were not the result of damage to adjacent property); *Two Caesars Corp. v. Jefferson Ins. Co. of N.Y.*, 280 A.2d 305, 307–08 (D.C. Cir. 1971) (finding acts of avoiding civil unrest had no causal relation to damage to property).

case law such as *Gregory Packaging*<sup>139</sup> where loss of use or function of a particular property can equate to direct physical loss without tangible physical harm to the property. While property may not be permanently damaged by COVID-19, a policyholder loses the use of that property in a reasonable fashion if there is an infection on the premises or the virus present in the surroundings. Some courts have held that the disjunctive “or” between “physical loss of or damage to” property must mean that “loss” must mean something different than “damage” (typically it is held to mean an absence of property, as in theft). In that regard, “loss” could mean “loss of use” or “loss of function” such that it renders the property useless to the policyholder (i.e. if you lost the useful use of the property, it is as if you lost it, even though it did not physically go away). In fact, the textualist dictionary analysis as noted above also provides support for “loss” equating to “loss of use.”

There is, however, a line of cases often cited by courts adjudicating this first wave of COVID insurance coverage cases—from *Source Food Technology, Inc. v. United States Fidelity and Guaranty Co.*<sup>140</sup> and *Mama Jo’s, Inc. v. Sparta Insurance Co.*<sup>141</sup>—that would hold that only tangible physical alteration of property would qualify as “direct physical loss or damage.” But unlike in those cases, where the courts held respectively that an import ban did not damage imported beef or construction dust did not damage music speakers, the COVID-19 situation has a dangerous substance actually physically present on the property, either in the air or through employees and customers spreading it. This tracks the reasoning in COVID insurance coverage cases finding for the policyholder like *Studio 417*,<sup>142</sup> *Blue Springs Dental Care v. Owners Ins. Co.*<sup>143</sup> and *Mudpie, Inc. v. Travelers Casualty Ins. Co. of America*,<sup>144</sup> where the courts there held that pleading actual physical presence of the virus made the analytical difference in proving coverage through a “direct physical loss.”<sup>145</sup> Indeed, in many of the past non-COVID cases that found a “direct physical loss” due to the invasion of some harmful substance, the substance

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<sup>139</sup> *Gregory Packaging, Inc. v. Travelers Prop. Cas. Co. of Am.*, No. 2:12-CV-04418 WHW, 2014 WL 6675934, at \*8 (D. N.J. Nov. 25, 2014) (applying New Jersey and Georgia law).

<sup>140</sup> 465 F.3d 834 (8th Cir. 2006) (applying Minnesota law).

<sup>141</sup> 823 Fed. App’x 868 (11th Cir. 2020) (applying Florida law).

<sup>142</sup> 2020 WL 4692385 (W.D. Mo. Aug. 12, 2020) (applying Missouri law).

<sup>143</sup> No. 20-CV-00383-SRB, 2020 U.S. Dist. LEXIS 172639 (W.D. Mo. Sept. 21, 2020).

<sup>144</sup> No. 20-CV-03213-JST, 2020 WL5525171 (N.D. Cal. Sept. 14, 2020) (applying California law).

<sup>145</sup> We discuss these cases, particularly *Studio 417*, *supra* note 142, in more detail in the next section, *infra*, as we find their reasoning quite superior to that of most of the courts dismissing policyholder claims on grounds of no physical loss or damage—as a matter of law.

merely resulted in the property owner not being able to use the property until decontamination occurred. This strongly suggests that dismissing COVID claims merely because property can be disinfected is incorrect.

In some jurisdictions, merely partially restricted access to a property does not equate to a prohibition of access by civil authority.<sup>146</sup> In other instances, a recommendation from a civil authority (as opposed to a direct command) may be not enough to provide coverage because access was not “prohibited.”<sup>147</sup> For COVID-19-related losses, it can be challenging to argue that government ordered alterations in service provision—such as a mandated move from in-person dining to take-out and delivery only—results in lost or restricted access to the property or even use of the property.<sup>148</sup> However, on balance, a restaurant faced with this imposed condition could certainly argue that a large proportion of its property typically used for dine-in customers has been rendered entirely unusable by a civil authority.<sup>149</sup>

As the cases now stand, courts appear to be receptive to finding coverage for direct physical loss or damage if the policyholder alleges some factual aspects of physical presence of the virus on the commercial premises. The courts in *Studio 417* and *Blue Springs Dental Care* found the possibility of coverage for this reason and

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<sup>146</sup> See, e.g., *Ski Shawnee, Inc. v. Commonwealth Ins. Co.*, No. 3:09-CV-02391, 2010 WL 2696782 (M.D. Pa. July 6, 2010) (stating there is no coverage when Department of Transport closed main route to policyholder’s ski resort because customers could travel to the resort via an alternate route); *Abner, Herrman & Brock, Inc. v. Great N. Ins. Co.*, 308 F. Supp. 2d 331 (S.D.N.Y. 2004) (noting that after World Trade Center disaster, civil authority coverage only provided where order completely prohibited access to property and not during periods where traffic restrictions made access merely more difficult); *54th St. Ltd. Partners v. Fid. & Guar. Ins. Co.*, 306 A.D.2d 67 (asserting that although traffic to property was diverted, the public was not denied access).

<sup>147</sup> See, e.g., *Kean Miller LLP v. Nat’l Fire Ins. Co. of Hartford*, No. 06-770-C, 2007 WL 2489711, at \*6 (M.D. La. Aug. 29, 2007) (holding that an advisory to stay off streets during Hurricane Katrina did not prohibit access; no civil authority coverage).

<sup>148</sup> See, e.g., *Phila. Parking Auth. v. Fed. Ins. Co.*, 385 F. Supp. 2d 280 (S.D.N.Y. 2005) (finding that government order eliminated need for policyholder’s parking services but did not prohibit access to its garage).

<sup>149</sup> Although this line of argument was unsuccessful in *Henry’s La. Grill, Inc. v. Allied Ins. Co. of Am.*, No. 1:20-cv-2939-TWT, 2020 WL 5938755 (N.D. Ga. Oct. 6, 2020) (applying Georgia law), where the policyholder restaurant argued that a physical change to the property had occurred because the restaurant had to reconfigure its premises for take-out, not dine-in, as a result of governmental orders. The court held that “loss” means “total destruction” and simply moving things around was not a “loss” or “damage.” See also *Hajer v. Ohio Sec. Ins. Co.*, No. 6:20-cv-00283, 2020 WL 7211636 (E.D. Tex. Dec. 7, 2020) (applying Texas law) (finding no damage and dismissing case after policyholder argued it had to physically alter its rug business to follow governmental safety order).



the court in *Mudpie* notes it would have, had the policyholder alleged the presence of the virus.

At its heart, this logic follows the case law stemming from *Gregory Packaging* as opposed to the *Source Foods/Mama Jo's* line of reasoning. Whether or not there needs to be tangible physical damage to property in order for coverage to be triggered, there must be some invasion of the virus physically on the premises in question for coverage to attach.

#### IV. THE DISAPPOINTING EARLY CASELAW CONCERNING COVID-19 BUSINESS INTERRUPTION CLAIMS

##### A. THE PREVAILING ANALYSIS

Cases testing the extent of business interruption insurance coverage for COVID-19 pandemic-related losses are still winding their way through the legal system. To date, court decisions have been made largely in the context of motions to dismiss a policyholder's claim on the pleadings, with no factual record except the pleadings taken by the court as true. Thus, the emerging caselaw is currently limited in its predictive ability as a fulsome canvassing of the issues.

Two distinct lines of reasoning and factual trends have emerged thus far in the case law. Courts are split as to whether the main coverage clause which requires "direct physical loss of or damage to" covered property is even triggered as a result of COVID-19 business interruption losses.

The majority of decisions to date have held that, for "direct physical loss of or damage to" property to have occurred, the property in question must have been physically altered in some tangible fashion. As COVID-19 does not permanently alter the physical characteristics of property, but rather makes people ill by infecting through the air or on touchable surfaces, most courts have found that there is thus no coverage for business interruption losses unless the policyholder specifically alleges the actual physical presence of the virus was on its premises (i.e. on surfaces, in the air, or through infected customers or employees).

If a policyholder alleges physical presence of the virus, some courts to date have found that the covered property was requisitely affected directly and physically by the alleged presence of the virus, even though the virus is microscopic and the property itself appears to be capable of decontamination. The loss of use of the property either through necessary decontamination or as a result of virus presence was enough for those courts to hold that business interruption coverage was triggered as a result of "direct physical loss of or damage to" property.

When determining coverage for losses resulting from civil authority orders, courts have split along the same line. If a policyholder can allege the actual physical presence of the virus on adjacent property that resulted in the order being made, the claim is not dismissed. However, if there are no allegations of the physical presence of the virus on other or adjacent property that prompted governmental authorities to restrict property access, governmental orders to quell the spread of the virus are not enough to trigger loss of use of the property to a degree that it is “direct” and “physical.” These courts denying coverage rest their reasoning on a causation analysis: the virus, not the orders, caused the loss and the virus does not cause direct physical loss unless actual tangible property damage is alleged.

If a property policy has an exclusion for losses caused by viruses or bacteria, courts appear to be ready to deny coverage to policyholders on the face of the exclusionary language, without much more than a cursory analysis. Courts appear to link the cause of any governmental orders restricting property access to the reason for those orders: the virus, an excluded cause of loss. If the virus exclusion has an anti-concurrent cause clause, courts appear even more ready to deny coverage for business interruption or civil authority claims without much substantive analysis.

The cases wrestling with coverage for pandemic-related losses due to COVID-19 commonly engage with lines of reasoning from three prior precedents: the 11th Circuit 2020 decision in *Mama Jo’s, Inc. v. Sparta Insurance Co.*<sup>150</sup> (applying Florida law), the 2014 U.S. District Court for the District of New Jersey case of *Gregory Packaging, Inc. v. Travelers Property and Casualty Co. of America*<sup>151</sup> (applying New Jersey and Georgia law), and the 8th Circuit 2006 decision in *Source Food Technology, Inc. v. United States Fidelity and Guaranty Co.*<sup>152</sup> (applying Minnesota law). These cases highlight the tension between two possible approaches to pandemic-related insurance coverage issues: a strict requirement that the insured property suffer tangible physical alteration to property as a result of some external force (the *Mama Jo’s* and *Source Food* approach) versus the notion of loss of “use” of the property equating to physical loss or damage to property, even though the physical property itself is not permanently altered by some external force (the *Gregory Packaging* approach).

In *Mama Jo’s*, the policyholder restaurant was denied its business interruption and remediation claims when the restaurant’s lighting and audio equipment was coated with dust from outside road construction. Under Florida law, the court held that surfaces that can be cleaned have not suffered a direct physical

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<sup>150</sup> 823 Fed. App’x 868 (11th Cir. 2020) (applying Florida law).

<sup>151</sup> No. 2:12-CV-04418, 2014 WL 6675934 (D. N.J. Nov. 25, 2014) (applying New Jersey and Georgia law).

<sup>152</sup> 465 F.3d 834 (8th Cir. 2006)(applying Minnesota law).

loss: the damage must be tangible and physical, resulting in an actual change in the property. Although dust in the accumulations involved in that case is a tangible contaminant, the court regarded the property as undamaged because it could be wiped away, even though cleaning on this scale exceeded that required for normal business operations.

In *Source Food Technology*, a beef wholesaler brought a claim for business interruption insurance due to lost revenue resulting from an embargo of Canadian beef after reports of “mad cow” disease. Source Food’s sole supplier of beef was located in Ontario, Canada. The beef was not contaminated by mad cow disease. The claim for losses was as a result of the inability to ship the beef across the border. The court held that there was no direct physical loss or damage to the beef—it simply could not be shipped across the border. Thus, there was no coverage for the loss. The court specifically refused to adopt the position that “direct physical loss or damage is established whenever property cannot be used for its intended purpose.”<sup>153</sup>

A different approach was taken by the court in *Gregory Packaging*.<sup>154</sup> In that case, the accidental release of ammonia in a juice box manufacturing plant required that the facility be decontaminated and evacuated. According to the court, the ammonia release physically transformed the air within the manufacturer’s facility to make it unsafe. Because the facility was unusable for a period of time, the court held that the property suffered a direct physical loss. Even though, under Georgia law, coverage requires an actual physical change in property, the court held that that requirement was satisfied because the ammonia release physically changed the facility’s condition to such a state that it needed repair.

#### B. MISAPPLYING TRADITIONAL CONTRACT AND INSURANCE LAW

Our own preference is for the *Gregory Packaging* approach rather than the *Mama Jo’s* or *Source Foods* approach. But we find the early cases dismissing policyholder COVID claims disturbing not only because of their doctrinal choices but also because they in our view reflect a reductionist view and absence of judicial humility. In particular, the courts finding no “direct physical loss or damage” have been insufficiently appreciative of the range of meanings for these words that in turn makes it inappropriate for courts to declare a lack of triggering loss or damage as a matter of law.

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<sup>153</sup> *Id.* at 838 (citing *Marshall Produce Co. v. St. Paul Fire & Marine Ins. Co.*, 98 N.W.2d 280 (Minn. 1959)).

<sup>154</sup> 2014 WL 6675934 (applying New Jersey Law).

### 1. Glib Tautology and False Consensus Bias

Particularly troubling examples are *Social Life Magazine, Inc. v. Sentinel Insurance Company*,<sup>155</sup> (in which the court blithely declared that there was no loss or damage to covered property because COVID “damages lungs. It doesn’t damage printing presses”), *Sandy Point Dental, PC v. Cincinnati Insurance Company*,<sup>156</sup> *Gavrilides Management Company. v. Michigan Insurance Company*,<sup>157</sup> and *Rose’s I, LLC v. Erie Insurance Exchange*.<sup>158</sup>

The *Social Life Magazine* statement may make for a clever punchline but it is not even particularly accurate as a medical statement, let alone as an analysis of potential insurance coverage.<sup>159</sup> COVID’s impact is not confined to lungs but includes many other organs such as kidneys and the brain as well as senses of hearing and smell.<sup>160</sup> More to the point for insurance purposes, viral infestation of a printing

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<sup>155</sup> No. 1:20-cv-03311-VEC (S.D.N.Y. Apr. 29, 2020).

<sup>156</sup> No. 20 CV 2160, U.S. Dist. LEXIS 171979 (N.D. Ill. Sept. 21, 2020).

<sup>157</sup> No. 20-000258-CB (Mich. Cir. Ct., Ingham Cty. July 1, 2020) (explaining that direct physical loss to property requires tangible alteration or damage that impacts the integrity of the property, and dismissing the case because plaintiff failed to allege that the coronavirus had any impact to the premises).

<sup>158</sup> No. 2020 CA 002424 B, 2020 WL 4589206, at \*5 (D.C. Super. Aug. 6, 2020) (granting summary judgment for insurer on restaurant’s claims of lost business caused by coronavirus closure orders because there was no direct physical loss to property).

<sup>159</sup> A similar sort of reasoning featured in *Plan Check Downtown III, LLC v. Amguard Ins. Co.*, No. cv 20-6954-GW-Skx, 2020 WL 5742712 (C.D. Cal. Sept. 10, 2020) (applying California law), where a restaurant’s claim was dismissed because the court anchored its finding that “loss” requires tangible alteration to property because otherwise any regulatory change from any governmental order that affected any business in any fashion would trigger business interruption insurance. It went further to opine that even a snowstorm interferes with “use” of premises for the business by customers and employees and surely covering losses from snowstorms would make business interruption coverage far too broad.

<sup>160</sup> The same concept was picked up by the court in *Uncork & Create LLC, v. Cincinnati Ins. Co.*, No. 2:20-cv-00401, 2020 WL 6436948 (S.D.W. Va.) (applying West Virginia law) which denied coverage and went so far as to state that it would deny coverage even if there was physical presence of the virus. The court held that COVID-19 does not harm inanimate structures, can be eliminated with disinfectant and routine cleaning. *Id.* at 5. The court went so far as to state that even the actual presence of the virus on the property is not enough to trigger the coverage clause “physical damage or physical loss to the property.” *Id.* at 6. *See also* *Promotional Headwear Int’l v. Cincinnati Ins. Co.*, No. 20-cv-2211-JAR-GEB, 2020 WL 7078735 (D. Kan. Dec. 3, 2020) (applying Kansas law) where the court (on a motion to dismiss on the pleadings!) does not accept the policyholder’s allegations that the virus contaminated its property, citing both *Source Food Technology, Inc.* and *Mama Jo’s, Inc.*;

facility does, for the reasons discussed above, damage the facility's air quality and its equipment. Although the "fix" may be relatively straight-forward cleaning, it is damage nonetheless and renders the facility unusable until cleaned—a process that may become so repetitive due to re-infection as to constitute long-term damage and loss of use. More important, if this and other pandemic injury result in government-ordered limitations on operation of the policyholder's property, this produces rather direct physical loss to the policyholder.

*Sandy Point Dental* makes a similarly breezy and overly restrictive reading of the direct physical loss or damage trigger. Although the court recognizes that Illinois law is applicable, it cites no Illinois cases regarding loss or damage<sup>161</sup> even though there are important state law decisions finding that adulterated air or surfaces can constitute physical damage to property.<sup>162</sup> If *Sandy Point Dental* had merely

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Terry Black's Barbecue, LLC v. State Auto. Mut. Ins. Co., No. 1:20-cv-665-RP, 2020 WL 7351246 (W.D. Tex. Dec. 14, 2020) (applying Texas law) (citing Uncork & Create, LLC and holding that, even assuming the virus is present, the court held it can be cleaned).

<sup>161</sup> The *Sandy Point Dental* court's citation of Illinois law is limited to general pronouncements, including the axiom that a court construing an insurance policy should be "giving effect to every provision, if possible, because it must be assumed that every provision was intended to serve a purpose." No. 20-cv-2160, 2020 U.S. Dist. LEXIS 171979, at \*3-4 (quoting *Valley Forge Ins. Co. v. Swiderski Elecs., Inc.*, 860 N.E. 307, 314 (Ill. 2006)). But this "surplusage" canon of construction (discussed *supra* text accompanying notes 85-86) augers in favor of giving "loss" a sufficiently distinct meaning from "damage." But instead of doing this, the *Sandy Point Dental* court treats the words as synonyms but then focuses only on the term "damage," which connotes more tangibility than "loss." The court also notes that Illinois requires words in a policy to be giving their "plain, ordinary, and popular meaning." See U.S. Dist. LEXIS 171979 at \*4 (citing *Central Ill. Light Co. v. Homes Ins. Co.*, 821 N.E.2d 206, 213 (Ill. 2004)). As previously discussed, (see *supra* text accompanying notes 90-99), there is ample evidence in dictionaries and thesauruses suggesting the plain and ordinary meaning approach augers in favor of finding loss when a policyholder's use of property is restricted by viral infection or government order.

<sup>162</sup> Illinois has had more than its share of asbestos coverage cases, the bulk of which have concluded that the presence of asbestos materials in a structure or in the interior air of a building constitutes physical damage. See, e.g., *J.R. French Auto. Castings, Inc. v. Factory Mut. Ins. Co.*, No. 02-c-9479, 2003 U.S. Dist. LEXIS 13060 (N.D. Ill. July 23, 2003) (noting that the presence of human remains in a press machine constituted contamination that was physical damage even though equipment not tangibly structurally altered but no coverage because of exclusionary language in policy); *Affiliated FM Ins. Co. v. Board of Educ.*, No. 90-c-6040, 1992 U.S. Dist. LEXIS 15151 (N.D. Ill. Oct. 5, 1992) (noting that contaminated air is physical damage and the inability to use because of contamination is physical loss); *Lapham-Hickey Steel Corp. v. Prot. Mut. Ins. Co.*, 655 N.E.2d 842 (Ill. 1995) (finding no duty to defend because a formal lawsuit was not filed but suggesting that contamination can

followed this applicable law, it would have reached a correct decision on the motion to dismiss. But the court simply failed to locate (whether due to deficient advocacy or something else) or examine these precedents.

In addition, the *Sandy Point Dental* court seems to have forgotten that even in a world of heightened pleading requirements, the court faced with a Rule 12(b)(6) motion to dismiss must (absent extreme circumstances) treat the allegations of the plaintiff's complaint as true.<sup>163</sup> Instead, the court in essence second-guessed those allegations, with the judge refusing to accept them at face value.

And in perhaps its lowest moment of judicial craft, *Sandy Point Dental* sought to distinguish an important decision favoring the policyholder.

Plaintiff heavily relies on *Studio 417 Inc. v. The Cincinnati Insurance Company*, 20 C 3127-SRB, 2020 U.S. Dist. LEXIS 147600 (S.D. Mo. Aug. 12, 2020), a Missouri case that found that the coronavirus caused a physical loss to property warranting insurance coverage. That court rested its decision on that policy's expansive language, language very different from the policy in the instant case. The unambiguous language in the instant policy warrants a different conclusion—physical damage that demonstrably alters the property is necessary for coverage, and the coronavirus does not cause physical damage.<sup>164</sup>

Unfortunately, *Sandy Point*'s characterization is simply not true. The Cincinnati policy form at issue in *Studio 417* (and the *KC Hopps* and *Blue Springs Dental* cases also decided in the Western District of Missouri) is the same (at least regarding the direct physical loss requirement and the absence of a virus exclusion) as the Cincinnati policy at issue in *Sandy Point*.

In an opinion read from the bench, *Gavrilides Management*,<sup>165</sup> like *Sandy Point*, conflates the term “loss” and the term “damage,” robbing them of their respectively different connotations and emphases. Worse yet, it engrafts on the term

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be physical damage and lack of access can be physical loss of property); *Universal Underwriters Ins. Co. v. LKQ Smart Parts, Inc.*, 963 N.E.2d 930 (Ill. Ct. App. 2011) (noting that the deprivation of use of a vehicle is physical loss) (but there was also tangible physical damage to vehicle); *Board of Educ. v. Int'l Ins. Co.*, 720 N.E.2d 622 (Ill. Ct. App. 1999) (finding that the presence of asbestos fibers in air constituted physical damage to property).

<sup>163</sup> See *Ashcroft v. Iqbal*, 556 U.S. 662 (2009); BROOKE D. COLEMAN, ET AL., *LEARNING CIVIL PROCEDURE* 285–302 (3d ed. 2018).

<sup>164</sup> No. 20-cv-2160, 2020 U.S. Dist. LEXIS 171979, at \*7 n. 2.

<sup>165</sup> No. 20-000258-CB (Mich. Cir. Ct., Ingham Cty. July 1, 2020).

(having collapsed loss and damage into one) a requirement that property must have been permanently, structurally altered to be considered sufficiently “damaged” to merit coverage from the property insurer that, in return for premium dollars (sometimes years of premium dollars), promised to indemnify the policyholder from property loss and attendant business revenue loss.

Although one can argue that this was a correct reading of Michigan law, we are not convinced in that there appears to be no controlling Michigan precedent requiring this approach, which essentially denies coverage unless property is crushed.<sup>166</sup> Consequently, although not compelled to take a more nuanced view of the loss-or-damage requirement, the *Gavrilides Management* judge could (and in our view should) have done so.

*Rose’s I, LLC v. Erie Insurance Exchange*,<sup>167</sup> is disturbing in that, as that court acknowledges, the policyholder proffered definitions of the terms “loss” and “damage” that supported its position. But the court essentially ignored these definitions and adopted definitions it prepared—refusing to recognize that reasonable alternative constructions of a term or provision create ambiguity requiring resolution against the insurer. This is certainly true at the pleading stage. Although *Rose’s I* was a summary judgment decision, we think the same caution in terminating a case in the face of reasonable conflicting constructions of a policy should govern.

It appears that despite the summary judgment posture of the case, the record before the court did not include any extrinsic or discovery-unearthed evidence illuminating the meaning of policy language. Rather, the parties appear to have briefed the case based on textual argument alone, making the posture of the case akin to a 12(b)(6) motion. But instead of deferring to the facts as alleged and resolving any reasonable doubts against the nonmovant, the *Rose’s I* court granted summary judgment after it concluded—based on nothing we can discern—that “loss” requires “a direct physical intrusion on to the insured property.”<sup>168</sup> As we

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<sup>166</sup> Although there are federal trial court cases requiring structural change to property to constitute sufficient physical loss or damage, there does not appear to be state court precedent binding on the *Gavrilades* court. *But see* *Universal Image Prod. v. Chubb Corp.*, 703 F. Supp. 2d 705 (E.D. Mich. 2010) (finding that intangible harms such as odor or mold contamination insufficient to constitute physical loss or damage even though property was rendered unusable).

<sup>167</sup> No. 2020-CA-002424-B, 2020 WL 4589206 (D.C. Super. Ct. Aug. 6, 2020) (granting summary judgment for insurer on restaurant’s claims of lost business caused by coronavirus closure orders because there was no direct physical loss to property).

<sup>168</sup> *Id.* at \*7.

hope we have demonstrated, government orders limiting or forbidding use of physical facilities constitute a physical loss to the owner.

*Diesel Barbershop, LLC v. State Farm Lloyds*<sup>169</sup> displays a similarly disturbing approach to textual analysis. The court, like others finding for insurers, collapses what should be the distinct terms “loss” and “damage” and despite the many dictionary and thesaurus entries supporting a reading of the policy favorable to policyholders, selects the entries most favorable to the insurer contention requiring tangible and rather substantial, long-lasting, structural and character altering injury before there can be coverage. Likewise, the real loss of a physical facility due to COVID-spurred government restriction is given short shrift. To be fair, the *Diesel Barbershop* court recognizes cases that “some courts have found physical loss even without tangible destruction to the covered property.”<sup>170</sup> However, “[e]ven so,” *Diesel Barbershop* found “that the line of cases requiring tangible injury to property are more persuasive here.”<sup>171</sup> That was in essence the scope and depth of the court’s “analysis.”

The problem with the court’s conclusion is that it was to a large degree not the court’s decision to make if it was following the rules of insurance policy construction. Because ambiguities are to be resolved in favor of the policyholder that did not draft the language at issue, a policyholder that proffers a reasonable construction of disputed language (such as “loss” or “damage”) is entitled to the benefit of the doubt—at least regarding a Rule 12(b)(6) motion where another well-established “rule” is that the allegations of plaintiff policyholder’s complaint must be accepted as true. Discovery may later provide information refuting those allegations and supporting the defendant insurer. But until such time as such discovery takes place, the factual universe upon which the court decides is supposed to be limited to the complaint.

Although research (such as reading dictionaries or cases) may bring extrinsic material into the inquiry, the policyholder need not shoulder the ultimate burden of persuasion at this stage of the litigation. It need only set forth a reasonable construction of the policy language that supports its claim for coverage. Policyholders seeking COVID coverage have done that. They may ultimately lose

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<sup>169</sup> No. 5:20-CV-461-DAE, 2020 WL 4724305, at \*5 (W.D. Tex. Aug. 13, 2020) (granting a motion to dismiss because the coronavirus did not cause a direct physical loss, and “the loss needs to have been a ‘distinct, demonstrable physical alteration of the property.’”) (citing *Hartford Ins. Co. of Midwest v. Mississippi Valley Gas Co.*, 181 F.App’x 465, 470 (5th Cir. May 25, 2006)).

<sup>170</sup> *Id.* at \*14–15.

<sup>171</sup> *Id.* at \*15–16 (concluding that “the other cases [finding loss or damage] are distinguishable.”).



due to further factual development establishing lack of loss or damage or due to application of a virus exclusion or other factors. But they should not lose on the loss/damage issue at this stage of litigation.

These and other decisions<sup>172</sup> in which courts are willing to declare as a matter of law that the words “direct physical loss or damage” require structural

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<sup>172</sup> See, e.g., *Mark’s Engine Co. No. 28 Rest., LLC v. Travelers Indem. Co. of Conn.*, No. 2:20-cv-04423-AB-SK, 2020 WL 5938689 (C.D. Cal. Oct. 2, 2020) (applying California law) (involving a restaurant that claimed losses due to orders requiring take-out or delivery service only); *Promotional Headwear Int’l v. Cincinnati Ins. Co.*, No. 20-cv-2211-JAR-GEB, 2020 WL 7078735 (D. Kan. Dec. 3, 2020) (applying Kansas law) (citing both *Source Food* and *Mama Jo’s* to hold that physical alteration of property required for coverage to attach); *Infinity Exhibits, Inc. v. Certain Underwriters at Lloyd’s London*, No. 8:20-cv-1605-T-30AEP, 2020 WL 5791583 (M.D. Fla. Sept. 28, 2020) (applying Florida law); *Hillcrest Optical, Inc. v. Cont’l Cas. Co.*, No. 1:20-CV-275-JB-B, 2020 WL 6163142 (S.D. Ala. Oct. 21, 2020) (applying Alabama law); *Raymond H Nahmad DDS PA v. Hartford Cas. Ins. Co.*, No. 1:20-cv-22833-BLOOM/Louis, 2020 WL 6392841 (S.D. Fla. Nov. 2, 2020) (applying Florida law); *Palmer Holdings & Invs., Inc. v. Integrity Ins. Co.*, No. 4:20-cv-154-JAJ, 2020 WL 7258857 (S.D. Iowa) (applying Iowa law); *T&E Chicago LLC v. Cincinnati Ins. Co.*, No. 20 C 4001, 2020 WL 6801845 (N.D. Ill. Nov. 19, 2020) (applying Illinois law); *Whiskey River on Vintage, Inc., v. Ill. Cas. Co.*, No. 4:20-cv-185-JAJ, 2020 WL 7258575 (S.D. Iowa Nov. 30, 2020) (applying Iowa law); *Zwillo V, Corp. v. Lexington Ins. Co.*, No. 4:20-00339-CV-RK, 2020 WL 7137110 (W.D. Mo. Dec. 2, 2020) (applying Missouri law); *Water Sports Kauai, Inc. v. Fireman’s Fund Ins. Co.*, No. 20-cv-03750-WHO, 2020 WL 6562332 (N.D. Cal. Nov. 9, 2020) (applying Hawai’ian law); *Long Affair Carpet & Rug, Inc. v. Liberty Mut. Ins. Co.*, No.: SACV 20-01713-CJC(JDEx), 2020 WL 6865774 (C.D. Cal. Nov. 12, 2020) (applying California law); *Michael Cette, Inc. v. Admiral Indem. Co.*, 20 Civ. 4612 (JPC), 2020 WL 7321405 (S.D.N.Y. Dec. 11, 2020) (applying New York law); *Real Hosp., LLC v. Travelers Cas. Ins. Co. of Am.*, No. 2:20-cv-00087-KS-MTP, 2020 WL 6503405 (S.D. Miss. Nov. 4, 2020) (applying Mississippi law); *Henry’s Louisiana Grill, Inc. v. Allied Ins. Co. of Am.*, No. 1:20-CV-2939-TWT, 2020 WL 5938755 (N.D. Ga. Oct. 6, 2020) (applying Georgia law); *Newchops Rest. Comcast LLC v. Admiral Indem. Co.*, No. CV 20-1869, 2020 WL 7395153 (E.D. Pa. Dec. 17, 2020) (applying Pennsylvania law); *Brian Handel DMD, PC v. Allstate Ins. Co.*, No. 20-3198, 2020 WL 6545893 (E.D. Pa. Nov. 6, 2020) (applying Pennsylvania law); *Hajer v. Ohio Security Ins. Co.*, No. 6:20-cv-00283, 2020 WL 7211636 (E.D. Texas Dec. 7, 2020) (applying Texas law); *Terry Black’s Barbecue, LLC v. State Auto. Mut. Ins. Co.*, No. 1:20-CV-665-RP, 2020 WL 7351246 (W.D. Tex. Dec. 14, 2020) (applying Texas law); *Santo’s Italian Café LLC v. Acuity Ins. Co.*, No. 1:20-cv-01192, 2020 WL 7490095 (N.D. Ohio) (applying Ohio law); *Graspa Consulting, Inc. v. United Nat’l Ins. Co.*, No. 20-23245-CIV-WILLIAMS, 2021 WL 199980 (S.D. Fla. Jan. 20, 2021) (applying Florida law); *S. Fla. ENT Assocs, Inc. v. Hartford Fire Ins. Co.*, No. 20-23677-Civ-WILLIAMS/TORRES, 2020 WL 6864560 (S.D. Fla. Nov. 13, 2020) (applying Florida law); *Plan Check Downtown III, LLC v. AmGUARD Ins. Co.*, No. Cv 20-6954-GW-SKx, 2020

alteration of the property only reflect judges succumbing to false consensus bias—the tendency of humans to be overconfident that others see things as they do. Significant research suggests this is a particular problem in the interpretation of contracts and other writings. For example, in one study, respondents were given contract language to read and construe. They then were asked whether they thought other readers could reach a different interpretation.<sup>173</sup>

Overwhelmingly, they expressed confidence that others would agree with their reading of the words and that there was no significant interpretive issue as to the document's meaning. Overwhelmingly, they were wrong. The same contract language was being read by other respondents who were reaching a different conclusion as to the meaning of the words.

This tendency, which also accords with cognitive traits such as self-serving bias (the tendency for people to think they are better at things than is actually the case),<sup>174</sup> can be particularly pernicious in judges who by job description need to be decisive (and move on to the next case), and are consistently the object of deference or even adulation (e.g., more likely to be invited to be graduation speakers or faculty in residence than all but a few celebrity lawyers), and who by definition in an adversary system have half the disputants praising each decision.

The net result can often be a brusque, reductionist, insufficiently reflective approach to reading documentary text, including but not limited to statutes, regulations, rules, exhibits, and contracts in addition to insurance policies. The judge, despite frequently reading the text in a vacuum without background contextual information, the aid of a linguist, or more than the closest dictionary or those cited by counsel, quickly determines that she “knows” what the disputed language means. More troublingly, the judge “knows” this so well that she dispenses with further inquiry and dismisses the case.

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WL 5742712 (C.D. Cal. Sept. 10, 2020) (applying California law); *Kirsch v. Aspen Am. Ins. Co.*, No. 20-11930, 2020 WL 7338570 (E.D. Mich. Dec. 14, 2020) (applying Michigan law); *Mortar & Pestle Corp. v. Atain Specialty Ins. Co.*, No. 20-cv-03461-MMC, 2020 WL 7495180 (N.D. Cal. Dec. 21, 2020) (applying California law). *But see, e.g.*, *Seifert v. IMT Ins. Co.*, No. 20-1102 (JRT/DTS), 2020 WL 6120002 (D. Minn. Oct. 16, 2020) (applying Minnesota law) (holding that Minnesota law does not require a showing of structural damage to qualify for coverage).

<sup>173</sup> See Lawrence Solan, et al., *False Consensus Bias in Contract Interpretation*, 108 COLUM. L. REV. 1268 (2008).

<sup>174</sup> See Linda Babcock & George Loewenstein, *Explaining Bargaining Impasse: The Role of Self-Serving Biases*, 11 J. ECON. PERSPECTIVES 109 (1997) (describing phenomenon and its impact in prompting disputants or negotiating parties to overvalue their own skills, conduct, and position in transactions or litigation).

Although this is troubling to us in any case, it is particularly troubling in the insurance context, where the ground rules of adjudication discussed below, if properly followed, are essentially designed to give policyholders the benefit of the doubt. To borrow a baseball term, “ties” are supposed to “go to the runner.” But like the umpire whose right thumb jerks upward if the ball is in the vicinity of first base before the runner has clearly planted a foot, courts taking an aggressively self-reverential view about the meaning of policy language bend the rules in the opposite direction.

In a world where reasonable people may debate the meaning of “direct physical loss or damage” in various contexts, courts should be reluctant to declare meaning as a matter of law. In view of the differing dictionary definitions and case outcomes, such an approach ordinarily amounts to error in COVID claims.

We realize of course that where controlling law provides a clear precedent, it must be followed. If, for example, the Supreme Court of State X has declared in no uncertain terms that both “loss” and “damage” in the property insurance setting always requires tangible, permanent (unless repaired by more than cleaning) injury to the structure or character of property, that precedent must be followed by trial courts no matter how much a trial judge thinks it incorrect. But where case law is mixed, unclear, or absent, trial courts should be taking the more modest approach to perceived certainty of textual meaning.

To be fair, many, perhaps even most, of the courts dismissing policyholder COVID claims have at least considered caselaw taking the broader view of “direct physical loss or damage.” But they have then quickly pivoted to the narrower view certainty unwarranted in light of the dictionary definitions favoring the broader view. Couple this with the established insurance policy interpretation principles favoring policyholders that have been given short shrift by courts dismissing COVID coverage claims and the result is error—at least on the questions of whether loss or damage has occurred (and most certainly at the motion to dismiss stage of litigation).

Depending on the specifics of each case, insurers may prevail on any number of other defenses to coverage such as the virus exclusion or non-COVID defenses such as misrepresentation or intentional destruction or insurers may limit their liability based on calculation of lost business income as well as policy limits or sub-limits. But they generally should not be prevailing on the loss/damage question to the extent reflected in opinions to date. A brief review of a few important insurance concepts underscores this assessment.

## 2. Reasonable Policyholder Expectations of Coverage for Pandemic-related Losses

Consider policyholder and insurer expectations of coverage for pandemic-related losses. If there is rampant confusion as to the scope of coverage such that litigation is arriving at mixed results, perhaps there is a more insidious problem with what is driving that litigation. The reasonable policyholder likely expected that a product marketed and labelled as “business interruption insurance” or “civil authority coverage” would extend coverage to the policyholder’s income stream in the event the policyholder was unable to access or reasonably use its business premises. The reasonable policyholder purchasing an “all risk” policy likely would not have thought that such coverage would hang on how the damage—if any—to the property occurred. Rather, their focus would likely be on their income loss due to either virus contamination or prevention of use of their property due to governmental orders.

Particularly in the case of civil authority coverage, few policyholders would likely expect that, in many instances in order to trigger coverage, there would have to be some physical damage to adjacent property that would prompt a civil authority to restrict access to the policyholder’s property. Policyholders may ironically be better off if their property or adjacent property had burned down, rather than operations ceased by a virus, strange though it may seem. By the mere label of the product alone—“business interruption insurance”—there are likely many policyholders who simply believe that the insurance insures their profit stream. The impetus for that belief may well, in the end, rest with issues of misleading nomenclature by insurers and misleading sales by brokers and agents.

From an insurer’s standpoint, the reasonable insurer may well not have meant nor expected to cover losses relating to a pandemic like COVID-19 in the contexts of business interruption insurance included in commercial property policies. By its nature, a pandemic is a clash event that has the potential to seriously strain insurer resources. Yet surely the industry had modelled a pandemic because it has already seen the effects of SARS, MERS, Ebola, H1N1, swine flu, and HIV/AIDs. And there were products on the market specifically designed to cover pandemic-related losses. The existence of related products like event cancellation insurance makes the generalized insurer contention of “whoever would have predicted COVID-19?” a bit strained.

The more compelling insurer response to pandemic-related losses is perhaps to assert that the business interruption product was never meant to be “guaranteed

profit insurance.”<sup>175</sup> It is an insurance add-on coverage to property insurance. There surely must be some risks in commerce that are not covered by a property policy. For example, no one would expect business interruption coverage for profit losses in a nuclear war (though of course there are exclusions for nuclear causes of loss). But what of, say, a zombie apocalypse or alien invasion, that required governments to issue “stay at home” orders or risk being eaten by green beings? Would the standard business interruption coverage tied to commercial property policies kick in then? Is there then a direct physical loss of or damage to property? Likely not. There are zombies or aliens running about. The property is likely just fine. But again, property owners may have difficulty accessing their property or even be barred from it due to civil authority orders or otherwise.

Some insurers included a virus exclusion in their policy wording before the pandemic struck. Does that mean that those insurers without a virus exclusion did not mean to exclude such losses? Is the virus exclusion itself a rock-solid denial of coverage, under all loss scenarios?

Perhaps instead the business interruption (and by corollary, the civil authority) insurance product needs to be retooled and re-messaged to communicate precisely what is and what is not meant to be covered. Otherwise, in the insurance world, if coverage is unclear, ties go to the policyholder—or at least they should. The insurer must provide coverage until new policy language is drafted in new versions of insurance policies.

### 3. Causation, Civil Authority Coverage and the Virus Exclusion

The trigger of coverage for civil authority business interruption losses rests largely on arguments of insurance causation. Policyholders continue to allege that a civil authority order caused their pandemic-related business interruption losses by restricting their access to their property. To date, courts have perhaps incorrectly declined coverage because they have held that the cause of the policyholder’s losses is not the order and that no physical loss or damage occurred to prompt the order in the first place.

It is important to keep in mind how causation works in the insurance law context and how it is different than principles of tort causation. In assessing insurance causation in a property loss context, one should work backward from the

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<sup>175</sup> A notion picked up by the court in *Real Hosp., LLC v. Travelers Cas. Ins. Co. of Am.*, No. 2:20-cv-00087-KS-MTP, 2020 WL 6503405, at \*8 (S.D. Miss. Nov. 4, 2020) (emphasis omitted) (applying Mississippi law), which held that “this is a commercial property policy, not a stand-alone business interruption policy—Plaintiff’s operations are not what is insured—the building and the personal property in or on the building are.”

loss claimed (here, the loss of profit) and ask what external force affected the property to result in the loss and thus potentially trigger the coverage claimed? The analysis is not a temporal one (i.e. last in time) but rather one of effect: what “hurt” the policyholder such that it suffered the loss claimed? For property claims, the answer to insurance causation questions is usually straightforward: what external force damaged the property? The insurance causation analysis does not involve analyzing chains of causation, as one might do in a tort analysis. Fault, blame, or responsibility play no part in insurance causation. Instead, a court is to determine what external force “hurt” the policyholder such that it triggered the particular loss claimed. The inquiry is decidedly contractual.

The loss to the policyholder is the lost profit from an inability to operate the business. The “hurt,” so to speak, in the civil authority coverage case, is actually arising from the order of the civil authority restricting access to the property (whether employee or customer access). The virus did not need to touch any of the policyholder’s property to result in the economic loss that affected the policyholder. Even the threat of the virus is not necessary. The cause of the loss is thus the civil authority order which restricted access to the policyholder’s property.

In a jurisdiction that adheres to the proximate cause doctrine of insurance causation, the proximate cause of the loss in this scenario—for civil authority coverage insurance purposes—is the governmental order. It is analytically incorrect to chase down what made the governmental authority issue the order in the first place—unless the coverage provisions specifically require such a causal inquiry.

In some cases, such an inquiry is necessary if—and only if—the coverage grant requires a finding that the loss must flow from a covered cause which results in direct physical loss or damage to adjacent property. Only if the coverage granting language specifically asks for such an analysis should a court attempt to ask “why” a governmental order was issued. And even then, it should only ask the simple question: was the order issued due to a covered cause which resulted in direct physical loss or damage to property adjacent to the policyholder?

In the case of a civil authority coverage case where there is a virus exclusion in the policy, the causation analysis is a bit more nuanced. If the coverage grant for civil authority insurance does not require direct physical loss or damage to property, but merely the restriction of access to the property, then the virus exclusion has no effect on coverage for the policyholder. The cause of the loss is the governmental order, not the virus.

While the prevention of the virus was the impetus for the order, coverage cannot be ousted simply because the “topic” of the order was “about” the COVID-19 virus. The topic did not harm the policyholder, nor did the virus; the actual effect of the order did. Policyholders should not lose coverage because of the topic of the

times behind a governmental order or even the reasoning behind the order. Coverage should only be ousted when the order did not cause the harm claimed.

However, if the coverage grant for civil authority insurance requires direct physical loss or damage to property, then the policyholder would apparently need to prove that the reasoning behind the civil authority order was indeed related to property damage which occurred. Such can be alleged with the COVID-19 virus by indicating the virus was present in frankly any adjacent property that was in an area affected by COVID-19, so long as that jurisdiction will consider that the presence of the virus can constitute direct physical loss or damage.

The issue is, of course, less clear if the property policy contains a virus exclusion. Some virus exclusions have an anti-concurrent cause clause such that coverage is ousted as long as virus contamination played some role in the ensuing loss. One can argue that the virus did not play a concurrent role in the loss (although it may have been a reason for the order—but the exclusion does not ask about the ‘story’ behind the order—its focus is the cause of the loss claimed for insurance purposes).

An example of such a scenario occurred when the policyholder massage spa in *Elegant Massage, LLC v. State Farm Mutual Automobile Insurance Company*<sup>176</sup> was forced to close due to a specific governmental order that mandated the closure of spas and massage services due to the inability of those particular businesses to maintain safe social distancing in a time of particularly serious virus spread. The spa and massage business was thus forced to close as a direct result of this specific order. The spa also voluntarily closed even after the order was lifted, because it could not maintain the required social distancing measures and still conduct its business. The policyholder argued the order, not the virus, caused its losses. The court agreed, because the policyholder’s specific type of business was targeted by the order—it was not just a general health measure. The court also noted that Virginia does not support anti-concurrent causation clauses; insurers must draft specific language to oust coverage and there must be a direct connection between the exclusion and the loss (not some tenuous connection anywhere in the chain of causation).

The catch-22 is realized when a coverage grant tied to direct physical loss to property is coupled with a virus exclusion. In that instance, alleging that the civil authority coverage is a result of virus contamination may well trigger the virus exclusion.<sup>177</sup>

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<sup>176</sup> No. 2:20-cv-265, 2020 WL 7249624 (E.D. Va. Dec. 9, 2020) (applying Virginia law).

<sup>177</sup> Professor Dan Schwarcz has been quoted as taking the view that where a policy has a virus exclusion, the case against coverage is “open and shut.” Caroline Glenn, *Insurers Are Telling Businesses Their Policies Don’t Cover Coronavirus Shutdown*, John Morgan Attorneys Say They’re Wrong, ORLANDO SENTINEL (May 4, 2020),

#### 4. Ambiguity in Property Coverage for Pandemic-related Losses

It may well be that the coverage clause “direct physical loss of or damage to property” is by now so tortured and unpredictable in caselaw as to be rendered ambiguous in terms of insurance policy construction. Indeed, three courts have found just that.

In *Elegant Massage, LLC v. State Farm Mutual Automobile Insurance Company*,<sup>178</sup> the court noted that the coverage clause does not overtly require structural damage for coverage to attach. Because there was such a “spectrum” of meanings of “direct physical loss of or damage,” the court interpreted the clause in a light most favourable to the policyholder. If the property (here, a spa which requires close contact with, and touching of, patrons) was deemed uninhabitable, inaccessible and dangerous to use as a result of governmental orders because of the high risk for spreading COVID-19, then the policyholder suffered direct physical loss. The court drew analogies to those cases where the policyholder could not use its property due to toxic gasses from drywall or odor or asbestos.

In *North State Deli, LLC v. The Cincinnati Insurance Co.*,<sup>179</sup> the court scoured the wide variety of dictionary definitions and determined that “loss” can equate to the loss of a full range of rights and advantages of property use. It held the coverage clause was ambiguous and thus settled on a reasonable definition which favours coverage: that “direct physical loss” can mean loss of use or access, even if the property is not structurally altered.

Finally, in *Hill and Stout PLCC v. Mutual of Enumclaw Insurance Company*,<sup>180</sup> the court held that physical “loss” must mean something different than physical “damage.” “Loss” could mean “deprivation.” The dental practice at issue in that case had direct physical deprivation of its premises as a result of the

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<https://www.orlandosentinel.com/coronavirus/jobs-economy/os-bz-coronavirus-insurance-denials-morgan-lawsuits-20200504-pbrpq6z7ofbevau67cpgq4nzqi-story.html>. Although one of us (Stempel) tends to agree that coverage is probably inapt in most such cases, the other (Knutsen) is hesitant. In any event, we think the issue is closer than commonly thought because of the long history of causation doctrine that tends not to look beyond the immediate cause of loss if the cause is a sufficiently dominant factor in bringing about the loss. See Erik S. Knutsen, *Confusion About Causation in Insurance: Solutions for Catastrophic Losses*, 61 ALA. L. REV. 957 (2010); Peter Nash Swisher, *Insurance Causation Issues: The Legacy of Bird v. St. Paul Fire & Marine Ins. Co.*, 2 NEV. L.J. 351 (2002).

<sup>178</sup> 2020 WL 7249624 (E.D. Va. Dec. 9, 2020) (applying Virginia law).

<sup>179</sup> *North State Deli, LLC v. The Cincinnati Ins. Co.*, No. 20-CVS-02569, 2020 WL 6281507 (N.C. Super. Oct. 9, 2020) (Trial Order).

<sup>180</sup> No. 20-2-07925, 2020 WL 6784271 (Wash. Super.) (Trial Order).



governmental order stopping dental visits because the practice could not see patients or practice dentistry. To that end, because the pleadings were silent about the meaning of “loss,” the court held that physical “loss” is an ambiguous phrase, and the case could proceed.

A review of the various dictionary definitions above for these terms certainly should be leading other courts to also consider ambiguity. In some cases, asbestos contamination is a direct physical loss. In others, it is not. In some cases, prevention of access to property by a government order is a direct physical loss. In others, it is not. Under the doctrine of *contra proferentem*, a finding of ambiguity leads to the policy terms being interpreted in favor of the policyholder. If policyholders and insurers alike—and clearly courts—cannot predict the meaning of the phrase and what it is supposed to do as the main coverage trigger for perhaps the most prevalent insurance product on the market, and if so much litigation is produced resulting from this confusion, then ambiguity of the coverage clause may be a reasonable conclusion for courts to make.

C. THE POTENTIAL FOR COVID INSURANCE COVERAGE CASES AS A BLUEPRINT FOR BETTER DECISION-MAKING

A few cases (three decided by the same Western District of Missouri court) have found coverage for COVID-related losses, albeit in a motion to dismiss context and without a full factual record: *Studio 417, Inc. v. Cincinnati Insurance Company*,<sup>181</sup> *K.C. Hopps v. Cincinnati Insurance Company*,<sup>182</sup> *Blue Springs Dental Care v. Owners Insurance Company*,<sup>183</sup> and *Elegant Massage, LLC v. State Farm Mutual Automobile Insurance Company*.<sup>184</sup> The other cases denying coverage have attempted to distinguish these cases on a number of grounds primarily related to the specific facts plead by the policyholders (i.e. the presence of a virus-specific exclusion or the specific allegations of virus particles actually physically present on insured property).

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<sup>181</sup> No. 20-cv-03127-SRB, 2020 WL 4692385 (W.D. Mo. Sept. 12, 2020) (applying Missouri law).

<sup>182</sup> 2020 U.S. Dist. LEXIS 144285 (W.D. Mo. Aug. 12, 2020) (applying Missouri law). *K.C. Hopps v. Cincinnati* is a short opinion that incorporates the Court’s analysis in *Studio 417* because that case “involves the same Defendant, similar insurance provisions, and similar factual allegations as those asserted in this case. Defendant also moved to dismiss *Studio 417* under Rule 12(b)(6) based on similar legal arguments that it presents in this case.” *Id.* at \*2.

<sup>183</sup> 2020 U.S. Dist. LEXIS 172639 (W.D. Mo. Sep. 21, 2020).

<sup>184</sup> 2020 WL 7249624 (E.D. Va. Dec. 9, 2020) (applying Virginia law).

The *Studio 417* and *Elegant Massage* cases remain the most analytically satisfying decisions to date,<sup>185</sup> as they most thoroughly deal with competing precedents and convey a broader understanding of the importance of insurance as a risk-based commercial product packaged to commercial policyholders. The other decisions denying coverage, in the main, tend to resort to a restrictive line of case precedents that narrow insurance recovery based largely on a purely textual parsing of insurance policy language, on a “know it when I see it” basis. Those decisions do not convey a broader understanding of what the coverage clause or property policies generally are meant to do in the consumer marketplace.

The *Studio 417* case more fully accounts for the historical caselaw interpreting the “direct physical loss or damage” coverage clause—both for and against coverage. The case also demonstrates the most doctrinally defensible analysis of the insurance causation elements of the claim. The policyholders in that case operated restaurants and hair salons. They claimed for pandemic-related losses under their business interruption and civil authority coverage contained in their all-risk property policies. Their claims were denied. The policy in question provided coverage for a “direct loss,” which is defined as “accidental physical loss or accidental physical damage.” Notably, there was no virus exclusion in this policy.

The policyholders alleged that customers and employees were infected with COVID-19 and the insured property became contaminated with the virus as a result. They argued that the virus is a physical substance that is active on tangible surfaces, and renders property unsafe and unusable. This quality of the virus forced the policyholders to suspend operations or at least reduce them. The policyholders also alleged that civil authorities in Missouri and Kansas issued orders that required suspension of businesses at various places, including closure orders. The policyholders alleged that both the presence of COVID-19 on the property plus the government closure orders resulted in direct physical loss or damage to the property and denied the policyholders the full use of the property.

The court found that there is a possibility of coverage despite the fact that the virus could be cleaned from physical surfaces or dies naturally within a few days. The fact that access to the property was prohibited or severely restricted was enough to find a possibility of coverage at this stage. In this regard, the court relied on the *Gregory Packaging, Inc. v. Travelers Property and Casualty Co. of America*<sup>186</sup> case,

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<sup>185</sup> This is not said in derogation of *Blue Springs Dental v. Owners Ins.*, which unlike *K.C. Hopps* contains extensive discussion and analysis. Although *Blue Springs Dental* involved somewhat different policy language and business activities, its analysis is heavily shaped by *Studio 417*, discussed at length in this section.

<sup>186</sup> No. 2:12-cv-04418 (WHW)(CLW), 2014 WL 6675934, at \*1 (D.N.J. Nov. 25, 2014) (applying New Jersey law).

where ammonia contamination at a juice packaging plant triggered insurance coverage because the manufacturer's buildings were uninhabitable due to the contamination. Even though the policyholders in *Studio 417* likely could not prove that COVID-19 was specifically on their premises, the fact that the virus was so widespread was enough to obviate the issue for the court.

The court held that COVID-19 is a physical substance which lives on surfaces and is transmitted through the air. COVID-19 makes property unsafe and unusable, resulting in "direct physical loss of or damage to" property. One does not need to prove tangible physical alteration of property to trigger coverage.

The court also held that loss of use of property is different than "damage;" otherwise, the word "damage" would be rendered superfluous in the coverage clause. The fact that the property could not be used due to COVID-19 was enough for the court to hold the policyholders had suffered a potential loss of the property. The court distinguished the line of cases that require policyholders to prove a tangible physical alteration to the property in order to trigger the coverage clause. The court distinguished the *Source Food Technology, Inc. v. U.S. Fidelity & Guarantee Company*<sup>187</sup> case, which granted summary judgment to an insurer who denied coverage when the policyholder's meat could not cross the Canadian border due to meat infection concerns. The *Studio 417* court held that the policyholders' allegations posit contamination of the property with a physical substance: the COVID-19 virus. This was therefore a different situation than the *Source Foods* case where there was no evidence the beef was actually contaminated by mad cow disease.

The policyholders also had potential coverage under a claim for civil authority insurance. According to the court, government orders affected hair salons by forcing their closure and affected restaurants by not allowing diners to dine inside the premises. Only drive-through or pick-up or delivery orders were allowed for restaurants. This was sufficient for the court to find that access was prohibited to such a degree as to trigger the civil authority coverage. The court held that the virus was physically present in property other than the policyholder's, because it was "everywhere" and therefore that satisfied the "direct physical loss or damage" coverage requirement.

The court specifically held that the civil authority coverage clause required access to be prohibited but the language did not mandate that all access had to be fully prohibited. The fact that access to the policyholders' property was impeded to a significant degree was sufficient for coverage to attach. Along the same logic, the court held that the policyholders also had potential coverage under the property policy's ingress and egress, dependent property, and sue and labor provisions.

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<sup>187</sup> 465 F.3d 834, 835 (8th Cir. 2006) (applying Minnesota law).

The same federal court denied an insurer's motion to dismiss the claims of policyholder dental clinics in *Blue Springs Dental Care v. Owners Insurance Company*<sup>188</sup>. The dental clinics claimed business interruption and civil authority losses when Missouri and corresponding counties issued 'stay at home' orders to quell the virus spread. Three dental clinics completely closed and one remained open only for essential and emergency dental cases. The policyholder pled that its property was damaged because of the presence of COVID-19 on and around its property such that it had to either end or reduce its operations due to actual contamination. It also alleged that employees, customers, and other visitors likely were infected with the coronavirus and thus operations were suspended to prevent physical damage to property and to the people on it. The 'stay at home' orders and general fear of infection or spreading COVID-19 on the property itself meant that customers could not access the property.

The insurer in this case argued that the fact that the one clinic was offering some services meant that its operations were not suspended within the meaning of coverage under the policy. The insurer also argued that the policyholder's clinics suffered no "direct physical loss of or damage to" property. As was the case in *Studio 417*, there was no exclusion for pandemics or communicable diseases in the applicable policy.<sup>189</sup>

The court found that COVID caused the policyholder's alleged physical loss in that the virus physically occupied and contaminated the dental clinics. This deprived the policyholder of use of the clinics, making them unsafe. The court also held that the policyholder necessarily suspended its operations to prevent physical damage from COVID. The COVID virus was the cause of the suspension and implicated business interruption coverage.

The court also held that the policyholder would be entitled to civil authority coverage because the orders by the state and counties do not need to be directed specifically at insured property or property adjacent to it in order to trigger coverage. The court cited *Studio 417* with approval, reiterating that policyholders do not need to completely lose all access to property—coverage could be had for partial impeded access. In this case, although three of the clinics closed entirely and the other had only limited dental services for emergency patients, access was prohibited to such a

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<sup>188</sup> 2020 U.S. Dist. LEXIS 172639.

<sup>189</sup> Nor was there a virus exclusion in the policies at issue in *K.C. Hopps v. Cincinnati Ins. Co.*, 2020 U.S. Dist. LEXIS 144285 (W.D. Mo. 2020). It thus appears that Cincinnati sold a significant number of policies without a virus exclusion and may face significant coverage responsibility in cases where courts take a similar view of the "direct physical loss or damage" requirement and where government orders mandated closure.

degree as to trigger coverage. The court left open the question as to the effect of the order that targeted essential versus non-essential businesses.

The important factor in the *Studio 417* and *Blue Springs Dental Care* cases is that the policyholders alleged specific physical damage through the presence of COVID-19 virus on the insured property in question. That allowed the court to find a direct physical loss, and thus the potential for coverage. The fact that contamination was not permanent was not an issue restricting the coverage analysis. The court also held that direct physical loss could be had through loss of use of the property. The court also had little issue with connecting the causal chain of the presence of COVID-19 virus on property, its prevalence in the community, and the inability of the policyholders to use their property as a result of governmental orders arising directly from the presence of COVID-19.

The court in *Elegant Massage* granted coverage to a massage spa when the spa was forced to close due to governmental orders. The spa's business model required the touching and close proximity to customers which was the very risk the orders were trying to quell in prevention of the virus. After the mandatory closure order ended, the spa still voluntarily closed as it was exceedingly difficult to comply with the mandated physical distancing requirements and still provide massage services. As mentioned above, the court found the coverage clause "direct physical loss of or damage to property" ambiguous because the clause does not specifically require distinct, structural damage for coverage to attach. If the insurer wished such a requirement, it could have added that language. Therefore, by interpreting the clause in a fashion most favorable to the policyholder, the court held that the loss of use of the policyholder's property qualified as a "direct physical loss." The court, however, denied civil authority coverage to the policyholder as it would not show a causal link between any damaged surrounding properties and its own. Simply put, there was no structural damage to the policyholder's premises—only loss of use and access.

## V. CASELAW AND THE VIRUS EXCLUSION

As is by now clear, we are concerned, perhaps to the point of being dismayed, that so many courts have so credulously embraced the view that as an absolute matter of law viral infection of premises cannot be physical loss or damage to insured premises and that there is no coverage even where government authorities have deprived policyholders of use of their property. This reading of policy language—especially its cocksure construction that refuses to recognize alternative reasonable reading of the words—poses significant potential problems not only for COVID coverage cases but for property insurance disputes generally.

That said, this first wave of cases may be an example of erroneous judicial reasoning that nonetheless arguably reaches a correct result, at least in many instances. Of the COVID coverage decisions made as this article was written, all but a handful had favored insurers. In nearly all of these cases granting insurer dismissal motions on the basis of what we regard as incorrect application of the physical-loss-or-injury trigger, the policies at issue also contained a virus exclusion. As discussed below, the standard ISO virus exclusion is broadly drafted and was intended by insurers to preclude coverage for certain virus-related losses. In some cases, drafting, communication, or claims-handling errors of an insurer may make a virus exclusion ineffective. Or there may be particular facts of a claim that negate the virus exclusion, like issues of causation.<sup>190</sup>

As discussed below, despite the apparent clarity of the virus exclusion, it may well be ineffective in some loss situations. In addition, the prevalence of virus exclusions in policies is unclear. As noted above, in the decisions to date, a fourth of the policies at issue lacked a virus exclusion. A preliminary study of liability insurance policies suggests that the majority of these policies lack a virus exclusion.<sup>191</sup> Regarding property insurance, however, insurers contend that eighty percent or more of the policies contain virus exclusions. Although that figure that accords with the policies in court decisions to date,<sup>192</sup> it is a sufficiently high percentage that we harbor concerns that may be overstated. For example, the policies of Cincinnati Insurance Company, involved in nearly 200 cases filed, tend not to have a virus exclusion.<sup>193</sup>

Prior to the SARS tragedy of the early Twenty-first Century, insurance policies did not contain virus exclusions, although many did have bacteria, fungus, or mold exclusions. And there is, of course, the pollution exclusion that we think has no application to infection-related loss but that insurers continue to occasionally push as a defense to coverage. Insurers effectively accepted that their policies of the pre-SARS era did not exclude—at least not with sufficient clarity—viral infection losses and responded by drafting a rather comprehensive virus exclusion.

The exclusion and its rationale were presented to regulators in a 2006 ISO circular.<sup>194</sup> The key operative phrase of the exclusion reads: “We will not pay for

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<sup>190</sup> See, e.g., *Elegant Massage, LLC v. State Farm Mut. Auto. Ins. Co.*, No. 2:20-cv-265, 2020 WL 7249624 (E.D. Va. Dec. 9, 2020) (applying Virginia law) (finding no direct connection between exclusion and loss; governmental order, not virus, direct cause of loss; and exclusion inapplicable).

<sup>191</sup> See Baker, *supra*, note 10.

<sup>192</sup> See *id.* (identifying 174 cases filed against Cincinnati as of Oct. 21, 2020).

<sup>193</sup> *Id.*

<sup>194</sup> ISO VIRUS EXCLUSION, *supra* note 25.

loss or damage caused by or resulting from any virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease.”<sup>195</sup> Some virus exclusions also contain an anti-concurrent cause clause, which attempts to exclude coverage regardless as to whether the damaged complained of is concurrently caused with another non-virus-related cause or not.<sup>196</sup> In particular, the circular stated:

While property policies have not been a source of recovery for losses involving contamination by disease-causing agents, the specter of pandemic or hitherto unorthodox transmission of infectious material raises the concern that insurers employing such policies may face claims in which there are efforts to expand coverage and to create sources of recovery for such losses, contrary to policy intent.<sup>197</sup>

Case law to date has supported application of the ISO virus exclusion to exclude coverage for COVID-related losses in a near-automatic fashion, without subjecting the exclusion to any meaningful analysis.<sup>198</sup> The virus exclusion has been

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<sup>195</sup> *Id.*

<sup>196</sup> *See, e.g.*, the policy at issue in *Diesel Barbershop, LLC v. State Farm Lloyds*, No. 5:20-cv-461-DAE, 2020 WL 4724305 F.Supp.3d (W.D. Tex. 2020) (applying Texas law).

1. We do not insure under any coverage for any loss which would not have occurred in the absence of one or more of the following excluded events. We do not insure for such loss regardless of: (a) the cause of the excluded event; or (b) other causes of the loss; or (c) whether other causes acted concurrently or in any sequence with the excluded event to produce the loss; or (d) whether the event occurs suddenly or gradually, involves isolated or widespread damage, arises from natural or external forces, or occurs as a result of any combination of these: . . .

**j. Fungi, Virus Or Bacteria**

. . . (2) Virus, bacteria or other microorganism that induces or is capable of inducing physical distress, illness or disease.

*Id.*

<sup>197</sup> ISO VIRUS EXCLUSION, *supra* note 25.

<sup>198</sup> *See, e.g.*, *Seifert v. IMT Ins. Co.*, No. 20-1102 (JRT/DTS), 2020 WL 6120002 (D. Minn. Oct. 16, 2020) (applying Minnesota law) (holding that losses resulted from order, not virus, but anti-concurrent loss provision in virus exclusion ousts coverage because virus is part of causal chain of loss); *Founder Inst. Inc. v. Hartford Fire Ins. Co.*, No. 20-cv-04466-VC, 2020 WL 6268539 (N.D. Cal. Oct. 22, 2020) (applying California law) (rejecting

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policyholder argument that governmental orders were about spread of saliva and respiration droplets, not virus; virus exclusion applies); *Border Chicken AZ LLC v. Nationwide Mut. Ins. Co.*, No. CV-20-00785-PHX-JJT, 2020 WL 6827742 (D. Ariz. Nov. 20, 2020) (applying Arizona law); *Chattanooga Prof. Baseball LLC v. Nat'l Cas. Co.*, No. CV-20-01312-PHX-DLR, 2020 WL 6699480 (D. Ariz. Nov. 13, 2020) (applying Arizona law); *Franklin EWC, Inc. v. Hartford Fin. Servs. Grp., Inc.*, No. 20-cv-04434 JSC, 2020 WL 5642483 (N.D. Cal. Sept. 22, 2020) (applying California law); *Mark's Engine Co. No. 28 Rest., LLC v. Travelers Indem. Co. of Conn.*, No. 2:20-cv-04423-AB-SK, 2020 WL 5938689 (C.D. Cal. Oct. 2, 2020) (applying California law); *Raymond H Nahmad DDS PA v. Hartford Cas. Ins. Co.*, No. 1:20-cv-22833-BLOOM/Louis, 2020 WL 6392841 (S.D. Fla. Nov. 2, 2020) (applying Florida law); *W. Coast Hotel Mgmt., LLC v. Berkshire Hathaway Guard Ins. Co.*, No. 2:20-cv-05663-VAP-DFMx, 2020 WL 6440037 (C.D. Cal. Oct. 27, 2020) (applying California law); *Palmer Holdings & Invs., Inc. v. Integrity Ins. Co.*, No. 4:20-cv-154-JAJ, 2020 WL 7258857 (S.D. Iowa) (applying Iowa law); *Whiskey River on Vintage, Inc., v. Ill. Cas. Co.*, No. 4:20-cv-185-JAJ, 2020 WL 7258575 (S.D. Iowa Nov. 30, 2020) (applying Iowa law); *Natty Greene's Brewing Co. v. Travelers Cas. Ins. Co. of Am.*, No. 1:20-CV-437, 2020 WL 7024882 (M.D.N.C. Nov. 30, 2020) (applying North Carolina law); *Wilson v. Hartford Cas. Co.*, No. 20-3384, 2020 WL 5820800 (E.D. Pa. Sept. 30, 2020) (applying Pennsylvania law); *N&S Rest., LLC v. Cumberland Mut. Fire Ins. Co.*, No. 20-05289 (RBK/KMW), 2020 WL 6501722 (D.N.J. Nov. 5, 2020) (applying New Jersey law); *Long Affair Carpet & Rug, Inc. v. Liberty Mut. Ins. Co.*, No.: SACV 20-01713-CJC(JDEx), 2020 WL 6865774 (C.D. Cal. Nov. 12, 2020) (applying California law); *Real Hosp., LLC v. Travelers Cas. Ins. Co. of Am.*, No. 2:20-cv-00087-KS-MTP, 2020 WL 6503405 (S.D. Miss. Nov. 4, 2020) (applying Mississippi law); *Newchops Rest. Comcast LLC v. Admiral Indem. Co.*, No. CV 20-1869, 2020 WL 7395153 (E.D. Pa. Dec. 17, 2020) (applying Pennsylvania law); *Brian Handel DMD, PC v. Allstate Ins. Co.*, No. 20-3198, 2020 WL 6545893 (E.D. Pa. Nov. 6, 2020) (applying Pennsylvania law); *Hajer v. Ohio Security Ins. Co.*, No. 6:20-cv-00283, 2020 WL 7211636 (E.D. Texas Dec. 7, 2020) (applying Texas law); *Vizza Wash, LP v. Nationwide Mut. Ins. Co.*, No. 5:20-cv-00680-OLG, 2020 WL 6578417 (W.D. Tex. Oct. 26, 2020) (applying Texas law); *Terry Black's Barbecue, LLC v. State Auto. Mut. Ins. Co.*, No. 1:20-CV-665-RP, 2020 WL 7351246 (W.D. Tex. Dec. 14, 2020) (applying Texas law); *AFM Mattress Co. v. Motorists Com. Mut. Ins. Co.*, 2020 WL 6940984 (N.D. Ill. Nov. 25, 2020) (applying Illinois law); *Boulevard Carroll Ent. Grp. v. Fireman's Fund Ins. Co.*, No. 20-11771 (SDW)(LDW), 2020 WL 7338081 (D.N.J. Dec. 14, 2020) (applying New Jersey law); *Santo's Italian Café LLC v. Acuity Ins. Co.*, No. 1:20-cv-01192, 2020 WL 7490095 (N.D. Ohio) (applying Ohio law); *1210 McGavock St. Hosp. Partners, LLC v. Admiral Indem. Co.*, No. 3:20-cv-694, 2020 WL 7641184 (M.D. Tenn. Dec. 23, 2020) (applying Tennessee law); *Boxed Foods Company, LLC v. Cal. Capital Ins. Co.*, No. 20-cv-04571-CRB, 2020 WL 6271021 (N.D. Cal. Oct. 27, 2020) (applying California law); *LJ New Haven LLC v. AmGUARD Ins. Co.*, No. 3:20-cv-00751 (MPS), 2020 WL 7495622 (D. Conn. Dec. 21, 2020) (applying Connecticut law); *Mortar & Pestle Corp. v. Atain Specialty Ins. Co.*, No. 20-cv-03461-MMC, 2020 WL 7495180 (N.D. Cal. Dec. 21, 2020) (applying California law).



held to oust coverage because courts have found that, even though some policyholders lost business income due to governmental orders closing or limiting access to their buildings, that access was lost because the governmental orders were issued due to a virus. In short, the courts link the causal chain back to the virus, an excluded cause. Courts summarily find no coverage in those cases where the virus exclusion has an anti-concurrent cause clause (and such a clause is permissible in that particular state).

We are not so certain the application of the virus exclusion to COVID-19-related cases is as straightforward as these court decisions suggest, especially those involving losses caused by governmental orders.<sup>199</sup> We are reminded of the similar path taken by courts first interpreting another seemingly impenetrable exclusion: the absolute pollution exclusion.<sup>200</sup> We might suggest that a more nuanced, contextual approach to the ISO virus exclusion is at least warranted, paying attention to drafting and underwriting history and what was meant in that 2006 ISO circular sent to insurance regulators. No court to date has examined what insurers actually meant to exclude in 2006 and how that plays out—or not—in the property insurance context of the 2019–2020 COVID pandemic. Keep in mind—the 2006 ISO virus exclusion was drafted in response to the SARS crisis, a very different disease scenario without the marked and intermittent governmental closures of the COVID-19 pandemic. It may be that, after such an analysis, the exclusion does exclude most if not all COVID-19-related business interruption losses. But we think it is at least intellectually honest to run the gauntlet with it, as was done with the absolute

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*But see* *Elegant Massage, LLC v. State Farm Mut. Auto. Ins. Co.*, No. 2:20-cv-265, 2020 WL 72496234 (E.D. Va. Dec. 9, 2020) (applying Virginia law) (holding virus exclusion not applicable because cause of loss for massage spa is government closure order, not virus); *Taps & Bourbon on Terrace, LLC v. Underwriters at Lloyds London*, No. 20093025, 2020 WL 6380449 (Pa. Com. Pl. Oct. 26, 2020) (Trial Order) (refusing to dismiss case at pleadings stage, even though virus exclusion at issue).

<sup>199</sup> At least one court appears to have had the same concerns, although in a context where the complete insurance policy was not supplied to the court. In *Urogynecology Specialist of Fla., LLC v. Sentinel Ins. Co.*, No. 6:20-cv-1174-Orl-22EJK, 2020 WL 5939172 (M.D. Fla. Sept. 24, 2020) (applying Florida law), the court allowed the policyholder's case to proceed, despite the presence of a virus exclusion, because the court surmised that COVID-19 may be different than other "virus"-type claims and perhaps it may be inappropriate to lump it in with other environmental pollutants like fungi, bacteria, or dry rot.

<sup>200</sup> See Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the "Absolute" Pollution Exclusion in Context and in Accord with Its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1 (1998); Jeffrey W. Stempel, *Unreason in Action: A Case Study of the Wrong Approach to Construing the Liability Insurance Pollution Exclusion*, 50 FLA. L. REV. 463 (1998).

pollution exclusion before it (recall that exclusion was eventually found wanting, and certainly did not merit as broad an application as insurers enjoyed in the early years of the exclusion).

However, incredibly, a number of courts have dismissed cases at the pleadings stage because of a cursory read of the virus exclusion and, in so doing, also denied specific policyholder requests for discovery about the ISO virus exclusion and its genesis.<sup>201</sup> After raising what appear to be reasonable queries about what the ISO circular was meant to do, policyholders are apparently faced with a door slammed shut about further factual discovery on the issue. Still other courts have preferred instead to offer—without the assistance of any evidence or context beyond pleadings—their own guesses as to what the boundaries of the exclusion surely must be.<sup>202</sup>

Most noteworthy perhaps is this question: if a policy does not include a virus exclusion, must that then be taken to mean that it covers virus-related losses?<sup>203</sup> Such virus exclusion language has been available since 2006, in direct response to the SARS pandemic. If an insurer has not specifically excluded viruses as a cause of loss, then pandemic-related losses resulting from virus contamination or civil authority orders attempting to quell virus spread would appear to be within the concept of covered losses (as long as the policyholder can prove there was a “direct physical loss of or damage to” covered property).

#### A. CASES WITHOUT A VIRUS EXCLUSION

In those cases without a virus exclusion, courts did not outright dismiss the policyholder’s claim and instead at least inquired about the potential for “physical loss or damage.” Unlike the policyholders in *Studio 417*, the policyholder in *Mudpie, Inc. v. Travelers Casualty Insurance Company of America*<sup>204</sup> did not allege the virus

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<sup>201</sup> See, e.g., *Mortar & Pestle Corp. v. Atain Specialty Ins. Co.*, No. 20-cv-03461-MMC, 2020 WL 7495180 (N.D. Cal. Dec. 21, 2020) (applying California law) (denying restaurant policyholder leave to discover genesis of ISO form and circular); *Boxed Foods Co. v. Cal. Capital Ins. Co.*, No. 20-cv-04571-CRB, 2020 WL 6271021 (US Dist. Ct., N.D. Cal.) (applying California law) (denying discovery request about ISO circular and virus exclusion genesis on dismissal).

<sup>202</sup> See, e.g., *LJ New Haven LLC v. AmGUARD Ins. Co.*, No. 3:20-cv-00751 (MPS), 2020 WL 7495622 (D. Conn. Dec. 21, 2020) (applying Connecticut law) (citing ISO circular policyholder submits that exclusion likely limited to “on contact” or “on surface” contamination only; court disagrees and chastises policyholder for importing what is not in the policy (despite clause being an exclusion!)).

<sup>203</sup> See French, *supra* note 4.

<sup>204</sup> 2020 WL 5525171 (applying California law).

entered the property. Its business interruption claim rested solely on the governmental “stay at home” order in effect. Thus, the policyholder’s putative class action was dismissed. The court held that the lead plaintiff policyholder, a children’s clothing store, did not lose its property nor did it have that property damaged by the virus.

The court took a broad view of “direct physical loss of or damage to” property, in that it would consider loss of functionality as triggering coverage without requiring physical alteration of the property. However, to qualify for coverage, a policyholder would have to prove some intervening physical force made the premises uninhabitable or unusable (as was the case in *Gregory Packaging* with the ammonia).

The court did not accept that loss of property functionality or access due to governmental orders equated to “direct physical loss;” the policyholder could go back to its property after the “stay at home” order ended. Loss of use was thus held to be not a direct physical loss in this instance. The court distinguished this claim, based solely on the governmental order causing a loss of use, from that in *Studio 417* where the claimants had alleged actual physical virus microbes damaged the inside of their premises, rendering it unusable.

The court also denied coverage under the civil authority provisions of the store’s policy because it found no causal link between any damage to adjacent property and the subsequent denial of access to the store. Because the “stay at home” orders were preventative, and did not involve actual physical damage, there was no causation between the policyholder’s business losses and the government closure order.

The policyholder restaurant in *Malaube, LLC v. Greenwich Insurance Company*<sup>205</sup> alleged that Miami’s order to close all restaurants to indoor dining (and thus permit only takeout and delivery) as a result of COVID-19, plus the Florida governor’s statewide executive order closing all dining on-site restaurants, both resulted in prohibited access to its restaurants and thereby interrupted its business income. The policyholder argued that the full use of its property was limited by the government orders. The case did not survive a motion to dismiss.

The court cited *Mama Jo’s, Inc.* and *Source Foods* and held that, under Florida law, an actual, tangible change in insured property must accompany a claim for coverage for “direct physical loss of or damage to” insured property. It distinguished the *Studio 417* case because, in that case, the policyholders alleged the actual presence of virus microbes on the property. The only allegations of loss in *Malaube* involve losses arising from the two Florida emergency orders. Because

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<sup>205</sup> No. 20-22615-CIV, 2020 WL 5051581 (S.D. Fla. Aug. 26, 2020) (applying Florida law).

there was no physical intrusion of the property that resulted in an actual physical change to the property, under the *Mama Jo's/Source Foods* line of authority, the court held there was no potential for coverage and the claim was dismissed.

A similar result was reached in *Rose's 1 LLC v. Erie Insurance Exchange*,<sup>206</sup> on a motion for summary judgment in the Superior Court of the District of Columbia. Some DC restaurants were seeking business interruption coverage based on the DC mayor's order that closed all non-essential businesses (which included the restaurants) and told residents to stay inside except for essential reasons. The court held that there were no cases in this jurisdiction where a government edict, standing alone, is considered a direct physical loss, thereby triggering coverage, unless there was some physical damage to property. The court relied on *Brothers, Inc. v. Liberty Mutual Fire Insurance Company*,<sup>207</sup> a case where coverage was denied after a curfew was imposed in DC following riots after Martin Luther King's assassination. The curfew was held to be preventative in nature, and not a result of any physical damage to property. In fact, the point of the curfew was to prevent physical damage to property, so coverage could not possibly be triggered, according to the court.

The San Diego barbershop policyholder in *Pappy's Barber Shops, Inc. v. Farmers Group, Inc.*<sup>208</sup> had its claims for business interruption and civil authority coverage dismissed. The policyholder alleged that the local order banning non-essential gatherings plus then the state-wide "stay at home" order resulted in direct physical loss of or damage to their insured property. The policyholder argued that the precautionary measures taken by the government were the cause of the loss, not the actual presence of virus on any physical surface. The court held that the governmental orders did not prohibit access to the policyholder's place of business and the orders were not issued due to direct physical loss of or damage to either the policyholder's property or other property. Because there were no allegations of what the court considered were direct physical loss or damage, the claim was dismissed.

The overarching pattern is that cases without a virus exclusion at least prompt the courts to grapple with whether or not coverage is to be had for "direct physical loss of or damage to property." Nearly all cases which did not feature a virus exclusion have denied coverage if the policyholder did not allege actual physical loss on the premises.<sup>209</sup> And of course most right-thinking policyholders

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<sup>206</sup> 2020 WL 4589206 (D.C. Super. Ct. Aug. 6, 2020).

<sup>207</sup> 268 A.2d 611 (D.C. 1970).

<sup>208</sup> No. 20-CV-907-CAB-BLM, 2020 WL 5500221 (S.D. Cal. Sept. 11, 2020) (applying California law).

<sup>209</sup> See, e.g., *Infinity Exhibits, Inc. v. Certain Underwriters at Lloyd's London*, No. 8:20-cv-1605-T-30AEP, 2020 WL 5791583 (M.D. Fla. Sept. 28, 2020) (applying Florida law) (relying on *Mama Jo's* court requires actual physical damage for coverage; case dismissed

could not allege such loss because to do otherwise would bring the claim squarely within the virus exclusion. So, the common route taken by policyholders—if unsuccessful to date—has been to argue that the governmental orders closing or limiting property access are the cause of the business interruption loss, and not the virus.

#### B. CASES WITH A VIRUS EXCLUSION

As stated, insurers have been successful in having those cases that featured a virus exclusion dismissed by courts. In probably the earliest claim focusing on pandemic-related losses, a Michigan state court granted the insurer's motion to dismiss the policyholder's claim for business interruption losses in *Gavrilides Management Company v. Michigan Insurance Company*<sup>210</sup> The policyholder in that case owned two restaurants and alleged that it lost revenue due to COVID-19 related closure orders and restrictions. The court held that, because the restaurants only alleged loss of use of their facilities, and not physical loss or damage, the restaurants did not suffer any covered loss. The virus exclusion in the policy operated to oust coverage regardless of whether there had been direct physical loss or damage to property.

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as no facts plead to show physical property damage); *Uncork & Create LLC v. Cincinnati Ins. Co.*, No. 2:20-cv-00401, 2020 WL 6436948 (S.D.W. Va. Nov. 2, 2020) (applying West Virginia law) (distinguishing *Studio 417* as there was alleged virus contamination in that case; however, court goes on to state that even if virus was present, coverage would likely not attach as premises can be cleaned); *Oral Surgeons, PC v. The Cincinnati Ins. Co.*, No. 2-20-CV-222-CRW-SBJ, 2020 WL 5820552 (S.D. Iowa Sept. 29, 2020) (applying Iowa law) (finding no allegations of direct physical loss); *Promotional Headwear Int'l v. Cincinnati Ins. Co.*, No. 20-cv-2211-JAR-GEB, 2020 WL 7078735 (D. Kan. Dec. 3, 2020) (applying Kansas law) (declining to accept allegations that virus contaminated property court cites to *Source Food* and *Mama Jo's* to require physical alteration); *Water Sports Kauai, Inc. v. Fireman's Fund Ins. Co.*, No. 20-cv-03750-WHO, 2020 WL 6562332 (N.D. Cal Nov. 9, 2020) (applying Hawai'i law) (distinguishing *Studio 417* and *Mudpie*, where actual threats of contamination were alleged, court finds no actual exposure at stores in this case); *Terry Black's Barbecue, LLC v. State Auto. Mut. Ins. Co.*, No. 1:20-CV-665-RP, 2020 WL 7351246 (W.D. Tex. Dec. 14, 2020) (applying Texas law) (finding no allegations of virus on property; assuming virus there, it does not cause physical loss and can be cleaned); *S. Fla. ENT Assocs, Inc. v. Hartford Fire Ins. Co.*, No. 20-23677-Civ-WILLIAMS/TORRES, 2020 WL 6864560 (S.D. Fla. Nov. 13, 2020) (applying Florida law) (finding no allegations of virus presence); *Kirsch v. Aspen Am. Ins. Co.*, No. 20-11930, 2020 WL 7338570 (E.D. Mich. Dec. 14, 2020) (applying Michigan law) (finding no allegations of virus on property).

<sup>210</sup> No. 20-000258-CB (Mich. Cir. Ct., Ingham Cty. July 1, 2020).

In *Diesel Barbershop LLC v. State Farm Lloyds*,<sup>211</sup> a U.S. District Court in the Western District of Texas dismissed the policyholder barbershop's claims for pandemic-related losses. The policy featured a fungi, virus or bacteria exclusion, which had an anti-concurrent cause clause:

1. We do not insure under any coverage for any loss which would not have occurred in the absence of one or more of the following excluded events. We do not insure for such loss regardless of:
  - (a) the cause of the excluded event; or
  - (b) other causes of the loss; or
  - (c) whether other causes acted concurrently or in any sequence with the excluded event to produce the loss; or
  - (d) whether the event occurs suddenly or gradually, involves isolated or widespread damage, arises from natural or external forces, or occurs as a result of any combination of these:

**j. Fungi, Virus Or Bacteria**

...

- (2) Virus, bacteria or other microorganism that induces or is capable of inducing physical distress, illness or disease.

The policyholder sought business interruption coverage for COVID-related losses due to the state and county orders restricting access to, or closing altogether of, non-essential businesses. The court preferred the line of cases requiring a direct tangible injury in order to trigger property coverage for a "direct physical loss." It held that Texas law would mandate there be a tangible injury for coverage to be triggered. The policyholder did not allege that the virus was physically on its property and caused tangible harm. Rather, it alleged that the cause of its loss was the governmental orders restricting access to its properties. This was not sufficient to create the potential for coverage as no direct physical loss or damage was alleged, according to the court.

Regardless as to the issue of direct physical loss, the court found that the virus exclusion and its anti-concurrent cause clause would prohibit both business interruption and civil authority coverage for the policyholder. The underlying root cause of the alleged losses was the virus—an excluded cause—according to the court because the virus was the reason for the orders to be issued by the state and county in the first instance.

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<sup>211</sup> No. 5:20-CV-461-DAE, 2020 WL 4724305, at \*5 (W.D. Tex. Aug. 13, 2020) (applying Texas law).

The key to the court’s reasoning in *Diesel Barbershop* was the view that the virus exclusion negated any possibility for coverage for COVID-19 related losses. The court also preferred to interpret “direct physical loss” as requiring not only a tangible injury to the property in question but a physical injury of sufficient magnitude that the property had been permanently structurally altered—an injury not alleged by the policyholder in that case.

A similar result to *Diesel Barbershop* was reached in *Turek Enterprises, Inc. v. State Farm Mutual Automobile Insurance Company*<sup>212</sup> in a motion to dismiss heard in the U.S. District Court for the Eastern District of Michigan. In that case, a chiropractic clinic’s claim for business interruption coverage was dismissed. The clinic claimed for losses due to its inability to access its property as a result of governmental “stay at home” orders. Like *Diesel Barbershop*, the property policy in *Turek* had a similar virus exclusion with an anti-concurrent cause clause. The policyholder clinic specifically argued that COVID-19 virus particles did not attach to or damage any property (presumably to get around the virus exclusion). The court found that this case was similar to the *Source Food* case, in that there was no contamination of the insured property and therefore no possibility of coverage.

The court in *Turek* distinguished *Studio 417* and preferred the reasoning of *Diesel Barbershop* and *Gavrilides Management Company LLC v. Michigan Insurance Company*<sup>213</sup> in holding that Michigan law required a tangible injury to property to trigger the “direct physical loss or damage” coverage clause. The court did not accept the policyholder’s argument that COVID-19 was not the proximate cause of the loss and the virus exclusion was only limited in its applicability to the costs of decontamination. Instead, the court held that the governmental orders preventing property access were not the sole cause of the policyholder’s loss—the virus was also a cause, thus triggering the anti-concurrent cause portion of the virus exclusion. The court made this holding despite the policyholder raising the fact that the 2006 ISO virus exclusion circular submitted to insurance regulators indicated that the exclusion was meant to preclude losses due to contamination by disease-causing agents.

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<sup>212</sup> No. 20-11655, 2020 WL 5258484 (E.D. Mich. Sept. 3, 2020) (applying Michigan law).

<sup>213</sup> No. 20-000258-CB (Mich. Cir. Ct., Ingham Cty. July 1, 2020) (holding that, when a city order prevented customers from dining in the restaurant, it did not suffer a direct physical loss because there was no physical alteration or tangible damage to the integrity of the building).

Similarly, in *10E, LLC v. Travelers Indemnity Company of Connecticut*,<sup>214</sup> a restaurant in downtown Los Angeles had its claim for business interruption and civil authority-related losses dismissed on motion after it alleged that the Los Angeles Mayor's public health restrictions prohibiting in-person dining at restaurants resulted in lost income. The insurance policy in this case had an exclusion for losses due to virus and bacteria.<sup>215</sup>

The court held that there was no direct physical loss or damage triggering coverage as nothing physically changed in the property. Under California law, the court held that losses from inability to use property do not amount to "direct physical loss of or damage to property." A distinct, demonstrable physical alteration to the property is required for coverage to attach. Furthermore, the court held that temporary impairment to property does not equate to direct physical loss. The policyholder's civil authority claim was dismissed because the virus exclusion ousted coverage for COVID-19 related losses. The government-ordered dining restrictions were entirely attributable to the virus, an excluded cause. Additionally, the court found that no particular adjacent property was damaged so the civil authority coverage could not be triggered in the first place.

The court in *Martinez v. Allied Insurance Company of America*<sup>216</sup> dismissed a dental office's claim for business interruption insurance because the policy contained a virus exclusion.<sup>217</sup> The policyholder claimed that the COVID-19 virus and Florida's emergency shutdown orders, including orders limiting non-essential dental procedures, caused the interruption of its income stream. It also alleged damages due to decontamination of its office. The court dismissed the claim solely on the language of the virus exclusion by holding that all of the office's losses were related to the virus, an excluded cause of loss. This is, in fact, the predominant pattern of courts faced with the virus exclusion when deciding pandemic-related coverage issues: a knee-jerk dismissal.

In perhaps the most shocking example of all, the United States District Court for the Western District of Missouri in *Zwillo v. Corporation. v. Lexington Insurance*

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<sup>214</sup> No. 2:20-cv-04418-SVW-AS, 2020 WL 5359653 (C.D. Cal. Sept 2, 2020) (applying California law).

<sup>215</sup> *Id.* at \*1 (noting that the policy reads, "We will not pay for loss or damage caused by or resulting from any virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease.").

<sup>216</sup> No. 2:20-cv-00401-FtM-66NPM, 2020 WL 5240218 (M.D. Fla. Sept. 2, 2020) (applying Florida law).

<sup>217</sup> *Id.* at \*3 (noting that the exclusion was for loss or damage caused "directly or indirectly," by "[a]ny virus, bacterium or other microorganism that induces or is capable of inducing physical distress, illness or disease.").



*Company*<sup>218</sup> dismissed a policyholder's claim based on an extremely broadly worded pollution exclusion which included the word "virus" in a long list of possible pollutant contaminants. The court distinguished the *Studio 417*, *KC Hopps*, and *Blue Springs Dental* cases—cases in its own district!—on the basis that the word "virus" was here in an all-encompassing pollution exclusion and not a stand-alone "virus" exclusion. The court did not accept the policyholder's arguments that this pollution exclusion was obviously aimed at environmental or industrial pollution, not pandemic-related losses.

Where cases to date have ruled in favor of an insurer based on knee-jerk embrace of a faulty concept of direct physical loss or injury, the courts may nonetheless have blundered toward the right result in some situations involving the virus exclusion—if insurers win the causation battle. We think that is a big "if" but realize courts may decide to the contrary. If that becomes the majority rule, observers will tend to minimize the significance of judicial decisions construing the physical loss or injury trigger, at least where there is a virus exclusion. Notwithstanding this, we remain critical of the "no direct physical loss or damage" decisions even if they can be defended on the "no harm, no foul" grounds of a more persuasive basis such as the virus exclusion.

But it is far from clear how many policies at issue actually contain a virus exclusion or how that exclusion operates in all loss scenarios. Insurers have promoted the view that nearly all policies contain the exclusion but a quarter of the case law to date involves policies with no such exclusion. Consequently, better juridical reasoning regarding loss and damage may make thousands of policies and millions of dollars in coverage available to policyholders.

## VI. CONCLUSION

Insurers have won the bulk of the early COVID coverage battles, with analysis in too many of these early decisions that mangles fundamental insurance policy interpretation doctrine. Fortunately, there is a cluster of better reasoned cases that one hopes will be persuasive to the appellate courts that will ultimately determine the outcome of the COVID coverage war.

The insurance industry's media thrust at the early stages of the COVID pandemic which pushed the no-coverage-for-COVID message appeared to set the stage for the early salvo of claim dismissals from courts across the country. Whether due to media influence or simple subpar analysis, many court decisions fall short in that they have, in varying degrees:

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<sup>218</sup> No. 4:20-00339-CV-RK, 2020 WL 7137110 (W.D. Mo. Dec. 2, 2020) (applying Missouri law).

- a) ignored or wrongfully rejected state law precedents regarding the “direct physical loss or damage” coverage trigger;
- b) read pro-insurer precedents too broadly, failing to distinguish the ubiquity, reach, and impact of COVID as compared to the more distant and non-physical loss of these precedents;
- c) ignored or summarily distinguished similarly analogous cases of insurance coverage for contaminating substances, precedents which would have provided helpful guidance on the insurance coverage issue for COVID-related losses;
- d) artificially distinguished insurance policy wording from the wording in past precedents when, in fact, the relevant policy wording is identical to the cases at hand;
- e) provided no reasoning as to why one line of coverage cases is preferred over another;
- f) fallen into a hyper-literalist dictionary-based argument which cherry-picks only certain dictionary definitions and ignores others which run counter to the conclusions reached;
- g) refused to even consider insurance policy term ambiguity in the wake of conflicting dictionary definitions and case precedents, thereby failing to invoke the policyholder-friendly tools of insurance policy interpretation: *contra proferentem* and reasonable expectations;
- h) refused to read pleading allegations at face value and as presumptively true, as required at the motion to dismiss stage of litigation; and,
- i) dispensed with policyholder claims without any further factual findings or discovery, at the pleadings stage, in a context where factual knowledge of the COVID-19 virus is evolving on a near-daily basis, and where allegations should be enough to get the policyholder in the door of the litigation system.

In response to this list, insurers would certainly argue that the presence of a virus exclusion in the cases on which they have prevailed validates dismissal<sup>219</sup> even

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<sup>219</sup> And, as reflected in the tally of decisions to date, courts are receptive to this insurer argument. See Baker, *supra* note 10; Erin Ayers, *Insurers Prevail in Two More COVID-19-related BI Lawsuits*, ADVISEN, (last visited Jan. 25, 2020) [https://www.advisen.com/tools/fpnproc/fpns/articles\\_new\\_1/P/376369872.html?rid=376369872&list\\_id=1](https://www.advisen.com/tools/fpnproc/fpns/articles_new_1/P/376369872.html?rid=376369872&list_id=1) (discussing Tracker findings); Mike Curley, *Travelers Ducks Counterclaims*

if judicial analysis of the loss or damage questions has been unduly abrupt and reductionist. We reject a “no harm, no foul” justification because there is harm when courts warp prevailing contract and insurance law in a rush to judgment.<sup>220</sup> In particular, the collapsing and narrowing of the concepts of directness, physicality, loss and damage sets unwise precedent sure to wrongfully deprive policyholders of coverage in future non-COVID cases. If the virus exclusion is conclusive, bully for insurers—but if that is the case, decisions should be made on the basis of this express exclusion rather than tortured reasoning about loss and damage.

The judiciary’s excessively textual focus-cum-myopia also unnecessarily raises doubts about the correctness of the decisions. If it is fact correct that there cannot be loss or damage without structural change in tangible property or that the concept of damage requires a particularized showing of viral contamination of specific surfaces, one would expect supporting evidence in the drafting history of property policies or similar materials providing context and illuminating the policy purpose and coverage intent. But overconfident hermeneutics-lite decisions in favor of insurers deprive policyholders, the judicial system, and society of access to materials that can determine whether a court’s reading of policy verbiage is correct.

Ironically, this type of background information might support the insurer position. The drafting history of the standard ISO virus exclusion, for example, does strongly suggest that insurers were seeking to avoid contamination liability, although the case against civil authority shutdown is less clear.<sup>221</sup> We understand that insurers, who think they can consistently win drafting wars, are reluctant to concede the usefulness of contextual materials and undermine future arguments seeking to restrict court consideration to only policy text. But the insurers’ long term

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in *Geragos COVID-19 Suit*, LAW360, (last visited Jan. 25, 2020) <https://www.law360.com/articles/1321151/travelers-ducks-counterclaims-in-geragos-covid-19-suit> (California federal district court finds “a virus exclusion in [law firm] policy bars coverage.”).

<sup>220</sup> In addition, it appears that many insurance policies lack a virus exclusion. See Baker, *supra* note 10 (last visited Oct. 21, 2020) (noting that in cases with decisions, one-fifth of policies lack virus exclusions); Josh Czaczkas, et. al., *Why We Don’t Need COVID-19 Immunity Legislation*, BALKINIZATION (Sept. 26, 2020), <https://balkin.blogspot.com/2020/09/why-we-dont-need-covid-19-immunity.html> (noting that the majority of general liability insurance policies lack virus exclusion). In the rush to enact limitations on liability for COVID claims, state legislatures appear not to have investigated the prospect that such limitations on liability inure to the benefit of insurers rather than policyholders, at least in the short term. Insurers would presumably argue that in the absence of such legislation, they will be forced to raise premiums or restrict coverage.

<sup>221</sup> See ISO VIRUS EXCLUSION, *supra* note 25.

agenda should not strangle immediate judicial decision-making. Courts interested in correctly deciding COVID coverage cases would presumably be interested in seeing this material rather than making it moot through a Rule 12 dismissal.

Apart from its possible (we think probable) infection of the judiciary, the insurance industry's public relations narrative is troubling. The insurance industry claims that COVID coverage is a death knell even though it also claims that nearly all policies provide only four weeks of civil authority coverage while all policies of course have policy limits and perhaps even other sub-limits on business interruption coverage or applicable exclusions as well as conditions that policyholders may fail to meet. In light of the liability limiting tools at their disposal, the insurer claims of imminent poverty if COVID is covered seems melodramatic.

The insurer claim of disaster rings particularly hollow in light of the European experience more receptive to coverage. While insurer profitability may have declined for the moment, the insurance industry remains alive and well in both the E.U.<sup>222</sup> and the U.K., where a key test case went well for policyholders.<sup>223</sup> And in the U.S., insurers appear to be doing just fine in spite of—or in some cases because of—the pandemic.<sup>224</sup>

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<sup>222</sup> See *Munich Re Reports €800M of COVID-19-Related Losses During Q3*, INS. J. (Oct. 21, 2020), <https://www.insurancejournal.com/news/international/2020/10/21/587446.htm>. Although 800 million euros is of course a good deal of money, it is not the hundreds of billions of dollars American insurers claim they will lose (allegedly each month) if COVID business interruption claims must be paid. The Munich Re experience thus suggests that policy limits, sub-limits, and specific exclusions give carriers substantial economic protection even if their defenses of no-direct-physical-loss-or-damage are rejected by courts.

<sup>223</sup> See Carolyn Cohn & Kirstin Ridley, *London Court Rules Some Insurers Should Not Have Denied Business Interruption Claims*, INS. J. (Sept. 15, 2020), <https://www.insurancejournal.com/news/international/2020/09/15/582641.htm> (describing *Financial Conduct Authority v. Arch Insurance (UK) Ltd*, [2021] UKSC 1).

<sup>224</sup> See Leslie Scism & Allison Prang, *Travelers More Than Doubles Quarterly Income*, WALL ST. J. (Oct. 20, 2020), <https://www.wsj.com/articles/travelers-profit-rose-in-third-quarter-11603192181> (noting Traveler's \$827 million third quarter profit compared to \$396 million in 2019, which included \$400 million in subrogation revenue from claims against Pacific Gas & Electric in connection with California fires; and how Travelers stock rose by \$3.12 per share). Travelers was also aided in that its auto insurance business did better than usual because of pandemic-stimulated reductions in driving and hence in collisions. We realize that property insurance is expected to have a less successful 2020 than auto or liability insurance but note that insurers have multiple means of enduring difficult times and profiting over the proverbial long-haul, where their longevity records is considerably better than that of their small business policyholders.

Meanwhile, business policyholders appear to be experiencing the type of debacle insurers claim they face if coverage claims succeed. Insurers seem to sing this tune with ease when threatened. We have heard it before regarding asbestos, pollution, product liability, bad faith, and punitive damages claims. But even the massive asbestos mega-tort, Superfund, and other pollution claims—not to mention the credit swap defaults of the Great Recession—did minimal long-lasting damage to insurers and their ability to accumulate capital and regain profitability. In times of such stress, many more policyholders than insurers fail.

Although insurer claims of industry-wide doom tend to ring hollow, their means of survival is not without collateral consequence. The asbestos, pollution, and Superfund coverage wars produced broad exclusions in standard policies and made coverage more expensive and difficult (but not impossible) to obtain. COVID-19 will surely spur restrictions of coverage and increases in premiums—but this is likely even if insurers prevail in today's coverage battles.

The immediately relevant question is whether today's policyholders seeking coverage under policies issued prior to the pandemic—particularly those lacking a virus exclusion—are entitled to coverage. Too many initial decisions on the issue have implicitly embraced a flawed insurer narrative in abruptly turning policyholders away.

# HOMEOWNER’S INSURANCE AND CREDIT SCORE: A CRITICAL RACE THEORY PERSPECTIVE

ROBERT K. YASS, J.D., LL.M.\*

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## INTRODUCTION

Throughout U.S. history, the federal government has created a range of programs and policies to support homeownership. However, those programs and policies largely, and in some cases, exclusively, benefited whites. Barred by both overt discrimination and covert structures comprising barriers that are built into financial systems,

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\* Adjunct Faculty, University of Connecticut School of Law. The initial version of this paper was prepared for the course Critical Race Theory in the fall of 2018 at the University of Connecticut School of Law taught by Professor Jamelia Morgan, and reflects insights and illuminating class discussions in its development. I am in debt to the work done by Latonia Williams in her consideration of credit score as an impermissible tool in homeowner’s insurance underwriting and pricings, and by William E. Murray in his work on redlining both appearing in the Connecticut Insurance Law Journal and cited below. My goal is to appropriately advance their work. I have also been challenged and drawn much conceptual inspiration from the work of Professor Eddie S. Glaude, Jr. and cited below.

people of color have had great difficulty in accessing opportunities to fully achieve the American dream.<sup>1</sup>

This paper takes up a question which, despite significant consideration by courts and commentators, has yet to yield a satisfactory, much less definitive, resolution. Is the use of credit scoring in the underwriting and pricing of homeowner's insurance appropriate or should it be banned? Obtaining shelter through homeownership generally requires the purchase of hazard insurance, referred to here as homeowner's insurance, particularly if the property is obtained via mortgage financing. Beyond shelter, homeownership has traditionally been one of the surest routes to wealth accumulation and intergenerational transmission of such wealth. In this paper, I consider the role of credit scoring in the process for underwriting and pricing of homeowner's insurance, and I explore whether or not there is an appropriate role for government, at the state or federal level, to break the ongoing log jam over action on this question.

Credit score is a tool used by businesses to evaluate a variety of factors and determine an individual's creditworthiness. "Companies use a mathematical formula—called a scoring model—to create [a] credit score from the information in [the consumers] credit report."<sup>2</sup> Notably, the use of a credit score has been significantly criticized by commentators both as to the factors considered in the scoring process, and the relative weights applied in the algorithm used to deliver the actual score.

Application of Critical Race Theory (CRT) to this assessment has not been found in other materials. In this paper, I seek to use the CRT construct to expand existing criticism of the use of credit score in homeowner's insurance, and to suggest a better frame towards an ultimate conclusion on whether or not to allow the use of credit scores or what constraints to place on its continued use. I recommend that consideration be given to collecting race information from applicants and insureds as a means to determine with most certainty whether or not credit score has a disparate impact based on race. If so, and with CRT analysis, such a finding may

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<sup>1</sup> Lisa Rice, *The Fair Housing Act: A Tool for Expanding Access to Quality Credit*, in *THE FIGHT FOR FAIR HOUSING: CAUSES, CONSEQUENCES AND FUTURE IMPLICATIONS OF THE 1968 FEDERAL FAIR HOUSING ACT* (Gregory D. Squires ed., 2018).

<sup>2</sup> *Credit Reports and Scores Key Terms*, CFPB, <https://www.consumerfinance.gov/consumer-tools/credit-reports-and-scores/answers/key-terms/#credit-score> (last visited Oct. 4, 2020).

justify the use of appropriate regulatory tools to ban the use of credit scores in insurance underwriting and pricing. Alternatively, it may justify barring certain factors from being used in credit scoring for homeowner's insurance purposes.

Relevant to this is the process by which a credit score is used in the underwriting and rating of homeowner's insurance. Without becoming a primer on insurance fundamentals, four points should briefly be made. First, insurance underwriting is the process of:

[S]creening and evaluating applications to determine the degree of risk posed by prospective insureds; [insurers] classify insureds based on the degree of risk posed and set premium levels accordingly; [insurers] experience-rate, or charge premiums for coverage renewals based in part on the insured's loss experience during the previous policy period.<sup>3</sup>

Second, some distinguish underwriting as the initial yes/no decision as to whether or not to provide insurance for the risk from the "rating" process that, for certain coverages (homeowner's coverage is a good example), involves the application of a rating plan that has been filed, and, oftentimes, approved by a state-based insurance regulator to determine the premium a customer will pay.<sup>4</sup> Third, insurers have historically framed discussions on the use of credit information in insurance by labeling what is being used as an "insurance score" rather than a "credit score." While the terms are often used interchangeably a distinction may be maintained.<sup>5</sup> In

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<sup>3</sup> KENNETH S. ABRAHAM & DANIEL SCHWARCZ, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 7 (6th ed. 2015).

<sup>4</sup> NAT'L ASS'N OF INS. COMM'RS PRODUCT FILING REVIEW HANDBOOK 8 (Aug. 2016), [https://www.naic.org/documents/prod\\_serv\\_marketreg\\_pfr\\_hdb.pdf](https://www.naic.org/documents/prod_serv_marketreg_pfr_hdb.pdf).

<sup>5</sup> The Insurance Information Institute, an insurance industry supported organization, explains:

It is important to note that **insurance scores are not the same as credit scores**. Credit scores predict credit delinquency whereas insurance score predicts insurance losses. Though both are based on a person's credit report, an insurance score does not measure how much money a consumer makes; rather it serves to measure how well an individual *manages* their money. Emphasis is placed on those items associated with credit management patterns proven to correlate most closely with insurance risk, such as outstanding



part, it serves to differentiate the insurance underwriting process from the provision of financial credit. As many of the factors are the same for both, and what differs is the algorithmic calculations, I will use the term “credit score” even when discussing it in an insurance context. Finally, the use of credit scores alone to make a yes/no decision on eligibility for coverage has receded over time. This is due to increasing legislation and regulation that prohibits the sole use of credit score in a binary process for insurance decisions. Insurers are using credit scores in a more granular way as part of a robust rating system that makes the score just one of an increasing number of factors that are variable in weight and impact.<sup>6</sup>

In advance of considering the issues for this paper, note that insurers have a long history of directly using race as a criterion in making underwriting decisions. Early insurer textbooks pointed out that knowing the applicant’s racial descent could readily determine whether or not they would be a good risk.<sup>7</sup> The conclusion was that Black applicants were uninsurable and certainly not to be part of the same risk pool as whites.<sup>8</sup> Due to changes in company practices, and law, and regulation, I acknowledge that such blatant practices are no longer in use.

The Insurance Information Institute (III) (a public relations arm of the insurance industry), in describing the use of credit score, points out that every insurer strives to relate rates for insurance policies as closely as it can with the cost of claims. Rates that are too high will force market share losses. Rates that are too low will impact profitability. It is asserted that the majority of consumers will benefit when unsatisfactory insurance risks are not subsidized. Further, it is argued that actuarial studies show that how one manages one’s financial affairs are a good predictor of insurance claims and that related insurance scores help differentiate between higher and lower risks. Finally, the III states that “carriers do not use income or race/ethnicity when calculating insurance scores.”<sup>9</sup>

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debt, length of credit history, late payments, collections and bankruptcies, and new applications for credit.

Ins. Info. Inst., *Background on: Credit Scoring*, III. (Apr. 8, 2018), <https://www.iii.org/article/background-on-credit-scoring>.

<sup>6</sup> Latonia Williams, *African American Homeownership and the Dream Deferred: A Disparate Impact Argument Against the Use of Credit Scores in Homeownership Insurance Underwriting*, 15 CONN. INS. L.J. 295, 305 (2008).

<sup>7</sup> *Id.* at 304.

<sup>8</sup> *Id.*

<sup>9</sup> Ins. Info. Inst., *supra* note 5.

In Part I of this paper, I offer a general overview of the importance of housing in meeting basic and extended human needs. Part II provides a review of relevant history and summarizes pertinent case law as to the application of the federal Fair Housing Act (FHA)<sup>10</sup> to homeowner's insurance and includes a description of disparate impact and disparate treatment standards relevant to this consideration. Part III reviews the evolving rule making process at the U.S. Department of Housing and Urban Development (HUD) to define how the FHA applies to the provision of homeowner's insurance and considers the ongoing litigation by insurers to prevent a rule from being finalized. Part IV expands the discussion of the role credit score plays in the availability and affordability of homeowner's insurance and the views of insurers and critics. Part V brings the framework of CRT to this analysis, provides a summary of the subject, and applies it to housing. Part VI suggests that the debate on the use of credit score may be advanced towards a resolution if state insurance department administrative action be taken to require insurers to collect race-based data, from applicants and insureds, to enable more granular correlation studies between credit score results and race. I will consider the use of racial surveys from a CRT standpoint as well as the real-world experience of one state that took the step of collecting race-based demographic information that customers supplied voluntarily to insurers. Part VII summarizes this exploration and makes recommendations for action.

## I. THE SIGNIFICANCE OF HOUSING

In Abraham Maslow's Hierarchy of Needs, shelter is one of the most basic human requirements that must be met before an individual can progress up a metaphorical pyramid towards the ultimate goal of reaching self-actualization, at the pyramid's apex. While not necessarily supported by empirical data, it is a popular and simple approach to considering primal human requirements.<sup>11</sup> The identification of shelter, which is housing in our context, as one of the most basic human needs will ultimately be relevant to the CRT analysis.

Beyond considerations of homeownership as a form of shelter, scholars also consider it as key to wealth accumulation. The traditional view of the importance of asset accumulation is that it is "a fundamental

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<sup>10</sup> 42 U.S.C. §§ 3601–19 (2018)

<sup>11</sup> Alma Acevedo, *A Personalistic Appraisal of Maslow's Needs Theory of Motivation: From "Humanistic" Psychology to Integral Humanism*, 148 J. BUS. ETHICS 741, 741–63 (2015), <https://doi.org/10.1007/s10551-015-2970-0>.

determinant of the long-run well-being of families and individuals.”<sup>12</sup> The experience of the 2008 housing bust certainly tempered unbridled faith in this view. However, researchers have found that “even during the tumultuous period from 1999 to 2009 (and) while homeownership is associated with somewhat lower gains in wealth among minorities and lower-income households, these gains are on average still positive and substantial.”<sup>13</sup> This view is not universal. Some have suggested that homeownership is not the best route to wealth accumulation, urging renting and investing the difference, as noted in a report on one 2017 study.<sup>14</sup> While this debate may rage, there is also a recognition that other, perhaps intangible, factors add to the significance of homeownership beyond basic shelter and wealth accumulation. “Homeownership’s appeal lies strongly in association with having control over one’s living situation, the desire to put down roots in a community, and the sense of efficacy and success that is associated with owning.”<sup>15</sup>

Studies have found that the rate of homeownership among Blacks in the United States significantly lags behind that of whites. Looking at the fifty years since the report of the National Advisory Commission on Civil Disorders (the Kerner Commission report),<sup>16</sup> a study by the Economic Policy Institute found in 2015 that the Black homeownership rate was just over forty percent (and largely unchanged since 1968) and behind a white homeownership rate of about seventy percent.<sup>17</sup> The same report goes on to

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<sup>12</sup> Christopher E. Herbert, Daniel T. McCue & Rocio Sanchez-Moyano, *Is Homeownership Still an Effective Means of Building Wealth for Low-Income and Minority Households? (Was it Ever?)* 1 (Sept. 2013) (paper originally presented at *Homeownership Built to Last: Lessons from the Housing Crisis on Sustaining Homeownership for Low-Income and Minority Families – A National Symposium*).

<sup>13</sup> *Id.* at 2.

<sup>14</sup> Diana Olick, *Homeownership Doesn’t Build Wealth, Study Finds*, CNBC (Nov. 16, 2017, 12:00 AM), <https://www.cnbc.com/2017/11/16/homeownership-doesnt-build-wealth-study-finds.html>.

<sup>15</sup> Herbert et al., *supra* note 12, at 49 (citation omitted).

<sup>16</sup> NAT’L ADVISORY COMM’N ON CIV. DISORDERS, REPORT OF THE NATIONAL ADVISORY COMMISSION ON CIVIL DISORDERS 1 (1968) *microformed on The Nat’l Crim. Just. Reference Serv.* (NCJRS), <https://www.ncjrs.gov/pdffiles1/Digitization/8073NCJRS.pdf>.

<sup>17</sup> Janelle Jones, John Schmitt & Valerie Wilson, *50 Years After the Kerner Commission: African Americans are Better Off in Many Ways but Are Still Disadvantaged by Racial Inequality*, ECON. POL’Y INST. (Feb. 26, 2018), <https://www.epi.org/publication/50-years-after-the-kerner-commission/>.

note that over the same period average Black family wealth increased almost six times, from \$2,467 to \$17,409, although Black wealth is still low when compared to the present median of \$171,000 for a white family.<sup>18</sup> The significance of housing as to one's life chances cannot be overstated. As Lisa Rice, of the National Fair Housing Alliance, has said, "[a]n address alone, a mere zip code, can dictate a person's life expectancy, educational attainment, personal income, net worth, likelihood of graduating from high school, chances of attending college, health outcomes and probability of getting arrested. Where you live also influences where and how you access credit."<sup>19</sup>

Ultimately, what is relevant to this paper is the effect credit score has on homeownership due to its impact on a person's ability to be approved for (underwriting) and then afford (pricing) the homeowner's insurance product. Studies have established a connection between mortgage lending and racial inequality. Data collected from reports filed under the U.S. Home Mortgage Disclosure Act<sup>20</sup> in 2014 continues to show significant differences in mortgage approvals, at average income levels, for whites (seventy-one percent), Latinx (sixty-two percent), and Blacks (fifty-four percent) with even a significant difference in the higher approval rate for whites in the lowest income level over Blacks in the most affluent level.<sup>21</sup> As discussed in Part VI, aside from being a marker of variable determinations of mortgage qualification among groupings, which may be influenced by factors including credit score, the above data also indicate that matching racial categories against actions by financial institutions may yield data salient to making relevant public policy determinations.

## II. RELEVANT HISTORY AND CASE LAW

Over fifty years ago, the FHA was enacted with the aim to eliminate racial discrimination in the sale, rental, or financing of housing.<sup>22</sup> "Congress recognized that widespread racial discrimination in the housing market was preventing integration and interfering with minority access to jobs and

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<sup>18</sup> *Id.*

<sup>19</sup> Rice, *supra* note 1, at 88.

<sup>20</sup> Home Mortgage Disclosure Act of 1975, Pub. L. No. 94-200, Stat. 1124 (1975) (codified at 12 U.S.C. §§ 2801–09).

<sup>21</sup> Jacob William Faber, *Segregation and the Geography of Creditworthiness: Racial Inequality in a Recovered Mortgage Market*, 28 HOUSING POL'Y DEBATE 215, 224 (2018), <https://doi.org/10.1080/10511482.2017.1341944>.

<sup>22</sup> *See generally*, 42 U.S.C. §§ 3601–19 (2018).

quality education.”<sup>23</sup> As noted in Part I, significant differences in the pattern of homeownership continue to exist between whites and Blacks.

The adoption of the FHA was contentious. Access to quality housing was recognized as a serious gap in the various civil rights laws passed earlier in the 1960's. A version of the FHA was considered by Congress in 1966 but did not advance due to criticism that the legislation lacked Commerce Clause<sup>24</sup> authority, was a violation of property rights, and a manifestation of communism.<sup>25</sup> Urban riots in the summer of 1967, and waning public support for additional civil rights legislation, further eroded the effort.<sup>26</sup> However, a change of heart by Senate Minority Leader Everett Dirksen succeeded in getting the legislation out of the Senate.<sup>27</sup> Perhaps, in part due to the report of the Kerner Commission,<sup>28</sup> and the assassination of Rev. Dr. Martin Luther King, Jr. on April 4, 1968, the legislation was passed on April 10 and signed into law on April 11.<sup>29</sup>

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<sup>23</sup> Dana L. Kaersvang, *The Fair Housing Act and Disparate Impact in Homeowners Insurance*, 104 MICH. L. REV. 1993, 1995 (2006).

<sup>24</sup> U.S. CONST., art. I, § 8, cl. 3.

<sup>25</sup> Rice, *supra* note 1, at 29.

<sup>26</sup> *Id.* at 32.

<sup>27</sup> *Id.* at 34. Observers have suggested that this change in position was motivated by President Johnson bringing political influence to bear in Illinois to guarantee that Dirksen would receive only token Democratic opposition in his upcoming reelection and an agreement to add a “Mrs. Murphy” exception to the bill that would exempt from its scope owner-occupied rental units below a certain size.

<sup>28</sup> Its most dramatic passage on its opening page stating, “Our nation is moving toward two societies, one black, one white—separate and unequal.” NAT'L ADVISORY COMM'N ON CIV. DISORDERS, *supra* note 16, at 1. As to housing it stated:

Federal housing programs must be given a new thrust aimed at overcoming the prevailing patterns of racial segregation. If this is not done, those programs will continue to concentrate the most impoverished and dependent segments of the population into the central-city ghettos where is already a critical gap between the needs of the population and the public resources to deal with them.

*Id.* at 13.

<sup>29</sup> U.S. Dep't. Hous. & Urb. Dev., *History of Fair Housing*, HUD.Gov, [https://www.hud.gov/program\\_offices/fair\\_housing\\_equal\\_opp/aboutfheo/history](https://www.hud.gov/program_offices/fair_housing_equal_opp/aboutfheo/history) (last visited Oct. 4, 2020).

As enacted, the FHA had no real enforcement powers. A 1979 study conducted by HUD concluded that there were two million acts of housing discrimination per year, but only five thousand complaints filed.<sup>30</sup> Even President Ronald Reagan, in his 1983 State of the Union message, called for effective enforcement of the law. Combined with a growing interest in considering fair housing for people with disabilities, the Fair Housing Amendments Act<sup>31</sup> was adopted with broad support and signed into law by President Reagan in 1988.<sup>32</sup>

In response to the decision in *Mackey v. Nationwide Insurance Companies*,<sup>33</sup> concluding that the FHA did not apply to insurance, HUD published a regulation<sup>34</sup> specifying that refusing to provide property or hazard insurance due to, among other characteristics, race was prohibited.<sup>35</sup> Most specifically this applies to Section 3604(a) which declares unlawful anything that makes a dwelling “unavailable.”<sup>36</sup> Realizing a gap in how this would be established, HUD sought to define how this would be determined via rule making, as discussed below in Part III.<sup>37</sup>

It is generally viewed as beyond dispute among appellate courts that the FHA applies to disparate impact claims.<sup>38</sup> However, relevant holdings have varied as to the exact mechanism of the test to be applied.<sup>39</sup> As more fully addressed below, the Supreme Court also enunciated the same view in the decision of *Texas Department of Housing and Community Affairs v. Inclusive Communities Project, Inc.*<sup>40</sup> In addition to the HUD regulation, the FHA has also been held to apply to insurers through various decisions at the

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<sup>30</sup> Rice, *supra* note 1, at 36

<sup>31</sup> H.R. Res. 1158, 100th Cong. (1988) (enacted).

<sup>32</sup> Rice, *supra* note 1, at 38.

<sup>33</sup> 724 F.2d 419 (4th Cir. 1984).

<sup>34</sup> 24 C.F.R. § 110.70(d)(4) (2020).

<sup>35</sup> William E. Murray, *Homeowners Insurance Redlining: The Inadequacy of Federal Remedies and the Future of the Property Insurance War*, 4 CONN. INS. L.J. 735 (1998).

<sup>36</sup> Relevant language of 42 U.S.C. § 3604 provides: “It shall be unlawful—(a) To refuse . . . or otherwise make unavailable or deny, a dwelling to any person because of race, color . . . .”

<sup>37</sup> Part III considers the recent FHA rulemaking by HUD and related litigation on disparate impact in housing.

<sup>38</sup> Williams, *supra* note 6, at 311.

<sup>39</sup> *Id.* at 312.

<sup>40</sup> 576 U.S. 519 (2015).

appellate court level.<sup>41</sup> However, the Supreme Court has yet to rule on this issue.

Insurers sought refuge from the application of the FHA by arguing that the McCarran-Ferguson Act of 1945<sup>42</sup> shields them from application of the FHA. The relevant provisions of McCarran-Ferguson provide that the business of insurance will be regulated at the state level and, where regulated by a state, federal regulation is not authorized to invalidate, impair, or supersede such state oversight unless the federal law specifically provides for such.<sup>43</sup> While it has been argued that the clear language of McCarran-Ferguson provides this immunity, contrary arguments assert that the initial intent of the law was to create a shield against federal antitrust enforcement and taxation and not to any intent by Congress to protect insurers from the application of later civil rights legislation.<sup>44</sup> “Every circuit court that has considered this issue has held that federal anti-discrimination laws do not conflict with state insurance laws.”<sup>45</sup> Chief among these decisions is *DeHoyos v. Allstate Corp.*<sup>46</sup> which “held that the McCarran-Ferguson Act did not preempt a claim that the use of credit scores by [Allstate] violated the anti-discrimination measures of the Fair Housing Act.”<sup>47</sup> The complaint in *DeHoyos* asserted that Allstate used a credit scoring methodology to get “non-Caucasian applicants into more expensive policies than those policies into which Caucasian applicants were placed.”<sup>48</sup> Allstate sought dismissal

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<sup>41</sup> Williams, *supra* note 6, at 311.

<sup>42</sup> 15 U.S.C. §§ 1011–15 (2018).

<sup>43</sup> 15 U.S.C. § 1012 (2018) in relevant part provides:

(a) State regulation

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

(b) Federal regulations

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulation the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance . . .

<sup>44</sup> Kaersvang, *supra* note 23, at 2005.

<sup>45</sup> *Id.* at 2006.

<sup>46</sup> 345 F.3d 290 (5th Cir. 2003).

<sup>47</sup> Williams, *supra* note 6, at 321.

<sup>48</sup> *DeHoyos*, 345 F.3d at 293.

arguing that McCarran-Ferguson preempted the action under the FHA. After losing in the District Court, Allstate appealed on the sole question of McCarran-Ferguson preemption. In holding that the FHA was not preempted by McCarran-Ferguson, the Fifth Circuit noted the controlling Supreme Court decision on this point as *Humana Inc. v. Forsyth*.<sup>49</sup> The *DeHoyos* court articulated a three-part test<sup>50</sup> for whether or not to apply McCarran-Ferguson preemption with the third part being the most relevant to the analysis here.<sup>51</sup> While Allstate asserted that the FHA would impair state rate regulation, the court held that merely regulating insurance contracts or rates would not be sufficient state regulation to activate McCarran-Ferguson preemption. The court called attention to an earlier FHA challenge in Wisconsin in *NAACP v. American Family Mutual Insurance Co.*<sup>52</sup> where the court said, “[i]f Wisconsin wants to authorize redlining, it need only say so.”<sup>53</sup> Perhaps this was said with a touch of irony and with the expectation that a state would be unlikely to take up the challenge. One would expect other normative standards of law to be applied if a state so acted. However, it is most clear that, in this isolated comment made in 1992, the court was identifying the level of specificity that must be found to activate McCarran-Ferguson preemption. The court held that general regulation of insurance is not sufficient to claim the federal law was interfering with the state system.<sup>54</sup>

In *Ojo v. Farmers Group, Inc.*,<sup>55</sup> an insured challenged the use of a credit scoring system that made use of “undisclosed factors” and asserted that such factors caused him to pay more for his homeowner’s insurance. The court pointed out that the relevant Texas insurance statutory provision, arguably the grounds that would allow for McCarran-Ferguson Act preemption, by its own terms precluded the use of credit scoring factors that would constitute unfair discrimination.<sup>56</sup> The court found nothing in the

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<sup>49</sup> 525 U.S. 299 (1999).

<sup>50</sup> *DeHoyos*, 345 F.3d at 295 (citation omitted) (stating “(1) the federal law in question must not be specifically directed at insurance regulation; (2) there must exist a particular state law (or declared regulatory policy) enacted for the purpose of regulating insurance; and (3) application of the federal law to the controversy in question must invalidate, impair or supersede that state law.”).

<sup>51</sup> *Id.* (stating that “application of the federal law to the controversy in question must invalidate, impair or supersede that state law.”).

<sup>52</sup> 978 F.2d 287 (7th Cir. 1992).

<sup>53</sup> *Id.* at 297.

<sup>54</sup> *Id.*

<sup>55</sup> 565 F.3d 1175 (9th Cir. 2009).

<sup>56</sup> TEX. INS. CODE ANN. § 559.051 (West 2005) (“Permissible Use of Credit Scoring”).



Texas statute that would conflict with the FHA and remanded the case for further action. A dissent suggested that there was a conflict as the underlying claim was one of disparate impact and the factor would be allowed under Texas law as long as race itself was not used in the rate methodology. This is borne out by the findings of a Texas Department of Insurance study<sup>57</sup> discussed below. The dissent did not find that a sufficient showing of discrimination had been made to allow the matter to move forward and would have dismissed the complaint.<sup>58</sup>

A key element of the analysis is the issue of disparate impact. How it comes to bear upon FHA analysis is significant. In most circuits, one starts from a first principle that the policy under review is facially neutral with the plaintiff bearing the initial burden of establishing that the policy has a greater adverse impact on minorities.<sup>59</sup> Having met this test, the burden shifts to the defendant to assert that there is a legitimate business purpose to the policy. Satisfying this test shifts the burden back to the plaintiff to identify other ways in which the goal could be met without the negative racial impact.<sup>60</sup> While other similar tests have been enunciated, “[i]t has been noted that it is unlikely that the different [tests] will produce substantially different results.”<sup>61</sup>

In *Inclusive Communities*,<sup>62</sup> the Supreme Court held that disparate impact claims are “consistent with the FHA’s central purpose”<sup>63</sup> and may be recognized under the FHA.<sup>64</sup> Some view *Inclusive Communities* in a limited fashion, and not as an across-the-board endorsement of all approaches to

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<sup>57</sup> TEX. DEP’T. OF INS., REPORT TO THE 79TH LEGISLATURE: USE OF CREDIT INFORMATION BY INSURERS IN TEXAS 1, 14, 18 (Dec. 30, 2004). The study found that Blacks and Hispanics made up an increased percentage in credit score ranges as compared to whites as credit score deteriorated. However, it also found that there was a strong correlation between credit scores and aggregate claims experience. This is more fully discussed in Part IV.

<sup>58</sup> Ojo, 565 F.3d at 1194

<sup>59</sup> Williams, *supra* note 6, at 312.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at 315.

<sup>62</sup> Tex. Dep’t of Hous. & Cmty. Affs. v. Inclusive Cmty. Project, Inc., 576 U.S. 519 (2015).

<sup>63</sup> *Id.* at 539.

<sup>64</sup> *Id.* at 545–46 (announcing the decision for the court, Justice Kennedy held “[t]hat disparate-impact claims are cognizable under the Fair Housing Act upon considering the results-oriented language . . . against the backdrop of the unanimous view of nine Courts of Appeals, and the statutory purpose”).

proving disparate impact, and not as an easy way to support FHA based claims.<sup>65</sup> *Inclusive Communities* makes clear that liability may not be imposed “based solely on a showing of statistical disparity”<sup>66</sup> and, applying disparate impact analysis, a claim “must fail if the plaintiff cannot point to a defendant’s policy or policies causing that disparity.”<sup>67</sup> Of note, this decision did not mention any application to insurance.

To summarize the current state across the federal judiciary, Morgan Williams and Stacy Seicshnaydre have said “[a]dvocates have successfully challenged underwriting variables such as credit scoring for their unjustified adverse effects on neighborhoods of color.”<sup>68</sup> However, a final definitive ruling by the Supreme Court, or closure on rulemaking on the FHA on this subject, is still elusive.

For this paper, this issue is being examined through the lens of disparate impact rather than disparate treatment. As explained in the context of employment discrimination by D. Wendy Greene, disparate impact does not require a showing of intent while disparate treatment takes as a given that the defendant has chosen to act in a discriminatory manner.<sup>69</sup> It bears noting that after remanding the case for further action, the District Court ultimately dismissed the disparate impact complaint in *Inclusive Communities* for failure to prove a prima facie case and satisfy the robust causality requirements.<sup>70</sup>

### III. CURRENT FHA RULEMAKING AND RELATED LITIGATION

In 2013, suit was filed in the U.S. District Court by the American Insurance Association (AIA) and the National Association of Mutual Insurance Companies (NAMIC) against HUD<sup>71</sup> seeking declaratory and

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<sup>65</sup> Robert G. Schwemm & Calvin Bradford, *Proving Disparate Impact in Fair Housing Cases after Inclusive Communities*, 19 N.Y.U. J. LEGIS. & PUB. POL’Y 685, 690 (2016).

<sup>66</sup> Tex. Dep’t Hous. & Cmty. Affs., 576 U.S. 519 at 539–40.

<sup>67</sup> *Id.* at 526.

<sup>68</sup> Morgan Williams & Stacey Seicshnaydre, *The Legacy and the Promise of Disparate Impact*, in THE FIGHT FOR FAIR HOUSING: CAUSES, CONSEQUENCES AND FUTURE IMPLICATIONS OF THE 1968 FEDERAL FAIR HOUSING ACT 169, 174 (Gregory D. Squires ed., 2018).

<sup>69</sup> D. Wendy Greene, *Title VII: What’s Hair (and Other Race Based Characteristics) Got to Do With It?*, 79 U. COLO. L. REV. 1355, 1376–77 (2008).

<sup>70</sup> No. 3:08-CV-0546-D, 2016 WL 4494322, at \*13 (N.D. Tex. Aug. 26, 2016).

<sup>71</sup> Complaint for Declaratory & Injunctive Relief, Am. Ins. Ass’n v. U.S. Dep’t of Hous. & Urb. Dev., No. 1:13-cv-00966-RJL (D.D.C. June 26, 2013)

injunctive relief against the implementation of the final HUD rule entitled “Discriminatory effect prohibited.”<sup>72</sup> The rule established the three-part test for determining when a practice with discriminatory effect violates the Fair Housing Act.<sup>73</sup> In other words, it sought to apply the *DeHoyos* disparate impact standard to harmonize the slightly varying rules across the circuits. As described in the complaint, the rule “purports to interpret the Fair Housing Act to prohibit housing-related activities that, although not motivated by intent to discriminate, result in a disparate impact on certain protected groups.”<sup>74</sup> It goes on to note that the preamble of the Rule extends disparate impact liability to the “[underwriting] and pricing of homeowner’s insurance” and does so for the first time.<sup>75</sup> After a lengthy recitation of the appropriate factors that are taken into consideration in making underwriting and pricing decisions and citing the many state laws that require the use of sound actuarial principles and those reasonably related to expected experience, the plaintiffs argued that “treating similar risks differently for reasons unrelated to actuarial justification is impermissible. Under state insurance codes, that principle is typically referred to as a prohibition against ‘unfair discrimination.’”<sup>76</sup> Put another way, plaintiffs argued that insurance underwriting and pricing must be and is color blind. Further, the plaintiffs asserted the applicability of McCarran-Ferguson to this issue and the primacy of state laws to this question.<sup>77</sup>

The FHA rule was promulgated during the pendency of *Magner v. Gallagher*.<sup>78</sup> for which the Supreme Court granted certiorari review and was anticipated to be a potential vehicle for undermining the holdings of the many circuits on this question. In what was a political *cause celebre*, the U.S. Department of Justice was alleged to have prevailed upon the City of St. Paul, MN, the petitioner in *Manger*, to withdraw its petition.<sup>79</sup> St. Paul did

[hereinafter Complaint]. Due to trade association consolidation, this case is now led by NAMIC. Order of Dismissal at 2, *Am. Ins. Ass'n v. U.S. Dep't of Hous. & Urb. Dev.*, No. 1:13-cv-00966-RJL (D.D.C. Mar. 26, 2019).

<sup>72</sup> 24 C.F.R. § 100.500 (2020).

<sup>73</sup> *Id.*

<sup>74</sup> Complaint, *supra* note 71, at ¶ 2.

<sup>75</sup> *Id.* at ¶ 3.

<sup>76</sup> *Id.* at ¶ 24.

<sup>77</sup> *Id.* at ¶ 7.

<sup>78</sup> 565 U.S. 1187 (2012).

<sup>79</sup> Adam Serwer, *The GOP Wants to Use This Bizarre Case to Scuttle Obama's Most Progressive Cabinet Nominee*, MOTHER JONES (Mar. 22,

so in 2012.<sup>80</sup> This cleared the field for the HUD rulemaking, and the elimination of a perceived threat that would undermine the cases to date holding that the FHA was to utilize a disparate-impact test and that it could be made to apply to insurers.<sup>81</sup> A later case,<sup>82</sup> for which certiorari was granted after the commencement of the HUD rulemaking, was similarly settled and withdrawn from Supreme Court consideration.

This NAMIC litigation is still pending as of late January 2021 (the most recent docket entry). In late 2017, the Treasury Department communicated its view that insurers should be exempt from the pending rule as part of a series of papers dealing with the financial services industry. The statement was viewed as a Hail Mary to aid AIA and NAMIC in the long-pending lawsuit.<sup>83</sup>

As noted, the *Inclusive Communities* decision was the vehicle by which the Supreme Court, in a 5-4 decision, held that disparate-impact claims are cognizable under the FHA. However, the holding did not clarify the open question, at least at the Supreme Court level, of whether insurers are bound by this rule. Despite the number of circuit decisions on this

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2013), <https://www.motherjones.com/politics/2013/03/thomas-perez-grassley-st-paul-darrell-issa-quid-pro-quo/>.

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Twp. of Mount Holly v. Mount Holly Gardens Citizens in Action Inc.*, 571 U.S. 1020 (2013).

<sup>83</sup> Lorraine Woellert, *Trump HUD Vacancy Prompts Insurers to Seek Treasury Help in Pushing Lawsuit*, POLITICO (Oct. 31, 2017, 4:40 PM), <https://www.politico.com/story/2017/10/30/trump-hud-vacancy-treasury-lawsuit-244331>. As this article states:

In the insurance case, fair housing advocates say the Treasury recommendation fights years of case law. ‘It’s established case law; that’s one reason HUD promulgated the disparate impact rule,’ said Lisa Rice, executive vice president of the National Fair Housing Alliance. ‘It was safe for them to do it.’ Several court rulings have gone against the insurance industry after the alliance and other fair-housing groups showed ‘statistically significant’ harm caused by industry policies, Rice said. ‘There are dozens of cases in which disparate impact has been alleged. The insurance industry has lost,’ Rice said. ‘This is an issue that the insurance industry has been raising since the 1990s; it’s not a new issue at all.’

*Id.*

question, the HUD initial rulemaking, rule challenges, and more recent efforts by HUD (discussed below) are where the issue is currently most intensely contested.

The HUD rule on the FHA is ostensibly in effect. In October 2016, HUD supplemented the 2013 rule to specify the application of the FHA's discriminatory effects standard to insurers and determined "that categorical exemptions or safe harbors for insurance practices are unworkable and inconsistent with the broad fair housing obligations embodied in the [FHA]."<sup>84</sup> However, in June 2018, HUD threw a wrench into the works by announcing that it would now "reconsider" the 2013 rule and the 2016 supplement to see if changes were necessitated because of the *Inclusive Communities* decision.<sup>85</sup> Lawsuits based on the range of circuit court holdings, the decision in *Inclusive Communities*, and the HUD rule and supplement could obviously continue to advance. In fact, the General Counsel of AIA was quoted to say, "[w]e have companies that are being sued by fair housing advocates in federal court . . . . We're hoping [the Treasury policy view] will help facilitate a break."<sup>86</sup>

In an effort to move this to a resolution, HUD indicated that further rule making would be commenced. In August 2019, new rulemaking was undertaken with the ostensible goal of integrating prior rulemaking and the Supreme Court decision in *Inclusive Communities*.<sup>87</sup> The proposed rule would repeal the 2013 rule, and in HUD's view align better with *Inclusive Communities* and state laws regulating insurers and provide for certain defenses.<sup>88</sup> After accepting comments HUD published a final version of the rule effective October 2020.<sup>89</sup> The new HUD rule certainly clouds forward progress on this issue at the federal level. "Critics of the rule change say that

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<sup>84</sup> Application of the Fair Housing Act's Discriminatory Effects Standard to Insurance, 81 Fed. Reg. 69012 (proposed Oct. 5, 2016) (to be codified at 24 C.F.R. pt. 100).

<sup>85</sup> Reconsideration of HUD's Implementation of the Fair Housing Act's Disparate Impact Standard, 83 Fed. Reg. 28560-01 (proposed June 20, 2018) (to be codified at 24 C.F.R. pt. 100).

<sup>86</sup> Woellert, *supra* note 83.

<sup>87</sup> HUD's Implementation of the Fair Housing Act's Disparate Impact Standard, 84 Fed. Reg. 42854-01 (proposed Aug. 19, 2019) (to be codified at 24 C.F.R. pt. 100).

<sup>88</sup> *Id.* at 42857.

<sup>89</sup> HUD's Implementation of the Fair Housing Act's Disparate Impact Standard, 85 Fed. Reg. 60288-01 (proposed Sept. 24, 2020) (to be codified at 24 C.F.R. pt. 100).

HUD has made the standard [disparate impact] basically worthless by setting too high a bar to prove discrimination.”<sup>90</sup> In the discussion of the draft rule, HUD took special note of the significance of “algorithmic models to assess factors such as creditworthiness, (that) should be provided a safe harbor.”<sup>91</sup> However, this general deference to any algorithm with non-discriminatory characteristics was dropped in the final rule.<sup>92</sup> Not surprisingly, several challenges have been filed on the final rule and are in their early stages.<sup>93</sup> Clearly, this latest rule-making round recognizes that credit score is potentially impactful to insurers and homeowners insurance, and leaves room for a state-action defense which previous appellate court decisions appeared loath to provide.

#### IV. CREDIT SCORE AND ITS IMPACT OF AVAILABILITY AND AFFORDABILITY

In part, some of the roots of credit score issues hark back to the early years of federal assistance for housing costs and its contribution to the establishment of a dual credit system. This duality has contributed to several of the factors that I consider in Part VI for possible exclusion from credit scoring systems.<sup>94</sup>

Lisa Rice, of the National Fair Housing Alliance, points out that the federal programs and policies that have been created over time to support home ownership have largely and sometimes exclusively, benefited whites.

The premise of the American dream is that people have the ability to work hard, obtain a safe and stable place to live, achieve upward mobility and build a legacy and inheritance to pass on to future generations. The ability to build wealth, be upwardly mobile and leave a financial legacy are deeply

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<sup>90</sup> Ryan Smith, *Fair Housing Groups Slam Newly Finalized Disparate Impact Rule Change*, MPA MAG (Sept. 28, 2020), <https://www.mpamag.com/news/fair-housing-groups-slam-newly-finalized-disparate-impact-rule-change-234630.aspx>.

<sup>91</sup> 84 Fed. Reg. at 42859.

<sup>92</sup> 85 Fed. Reg. at 60288.

<sup>93</sup> See *Mass. Fair Hous. Ctr. v. U.S. Dep’t of Hous. & Urb. Dev.*, No. 3:20-cv-11765-MGM (D. Mass. Sept. 28, 2020); *Open Cmty. All. v. U.S. Dep’t of Hous. & Urb. Dev.*, 3:20-cv-01587-JBA (D. Conn. Oct. 22, 2020); *Nat’l Fair Hous. All., Inc. v. Carson*, No. 4:20-cv-07388-JSW (N.D. Cal. Oct 22, 2020).

<sup>94</sup> Such might include information on the source of credit extended to a borrower and examining all other factors used in developing a credit score as to whether they reflect attributes of the dual system.

connected to one's opportunity to purchase a home and build equity as a holder of that asset.<sup>95</sup>

In the depression period, the federal Home Owners Loan Corporation (HOLC) was established in 1933 to provide for refinancing and reduce the rate of home foreclosures. As part of its loan underwriting process, appraisers were instructed to assess communities and to consider a neighborhood's racial composition to determine the security of the neighborhood for federal financing assistance. Black neighborhoods invariably received the lowest ratings.<sup>96</sup> The Federal Housing Administration (FH Admin) program was created in 1934 to provide federal insurance for mortgage loans originated by private lenders. This program picked up on the mapping system initially developed by the HOLC. An economist working for the FH Admin even developed a coding system that rank ordered neighborhoods with English, Germans, Scotch, Irish and Scandinavians at the top and Negroes and Mexicans at the bottom.<sup>97</sup> Of significance was the high value placed on homogeneous neighborhoods and the usage of racially restrictive covenants in deeds.<sup>98</sup> In the post-World War II period, the HOLC practices continued and new suburban areas were required to have restrictive covenants to obtain the highest A or B ratings. Thus, the HOLC and the FH Admin solidified the association between risk and race.<sup>99</sup>

Rice succinctly summarizes:

The result of centuries of misguided beliefs, practices, policies and laws, our financial system has grown into a complex matrix of products, rules, tools, formulas and infrastructures that continue to perpetuate two different mechanisms for extending credit to people. The dual financial market was, in part, developed by the ways our government distributed land and homeownership opportunities to people, largely based on race. It was established by how our government supported credit access to different consumers based, again, upon race. America's

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<sup>95</sup> Rice, *supra* note 1, at 77.

<sup>96</sup> *Id.* at 78.

<sup>97</sup> *Id.* at 81.

<sup>98</sup> *Id.* at 79–82.

<sup>99</sup> *Id.* at 85.

bifurcated financial market was a product of engineering by our government and the private market.<sup>100</sup>

A dual system of credit plays a key role in directly influencing home ownership and its financing as well as down-stream impacts, specifically credit score as it pertains to insurance. Banking services that were available for whites were not generally available to emancipated slaves who relied mostly on the Freedman's Bank which was only cursorily regulated and limited to only taking deposits and unable to make customer loans.<sup>101</sup> While mainstream financial products were largely available to white customers, an alternative market arose for the marginalized Black clientele. The products in the traditional sector were generally more regulated and thus safer for customers while those developed for other customers, such as payday loans and personal finance companies, were often unsafe. These alternative products typically engender high delinquency rates.<sup>102</sup> Further, even when consumers of such alternative products perform well on repayment, some of these entities do not provide information to credit bureaus, thus increasing the number of individuals who remain credit invisible.<sup>103</sup> Thus, they do not get to reap the benefits of a demonstrated positive financial history. Also, nothing precludes these secondary mechanisms from the less costly path of just reporting negative information.<sup>104</sup> Finally, it has been noted that the type of credit, when it is reported, can negatively impact one's credit score as is the case with borrowings from finance companies as contrasted with deposit taking banks.<sup>105</sup>

The use of credit score and possible impact on different races has been considered by several insurance regulators and by the National Association of Insurance Commissioners. It has also been considered by the Federal Trade Commission (FTC). Findings of a 2004 study by the Texas Department of Insurance had findings that significantly frame the issue under consideration here. Using insurance company data on customers and matching it against information supplied by the Texas motor vehicle department (i.e. self-reported race data on drivers and a Hispanic surname match for ethnicity), the study found that there were patterns of difference among different racial groups with Blacks and Hispanics having worse

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<sup>100</sup> *Id.* at 88.

<sup>101</sup> *Id.* at 89.

<sup>102</sup> *Id.* at 92.

<sup>103</sup> *Id.* at 98.

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* at 99.



scores than whites and Asians. However, the report also substantiated a strong relationship between credit score and claims experience for auto and homeowner's insurance. Thus, the department concluded that the results were actuarially supported and not unfairly discriminatory under Texas law.<sup>106</sup> In a final report the next month, the Insurance Commissioner pointed out that, in setting policy, he had to consider the distinction between unfair discrimination and intentional discrimination. He advised that underwriting and rating classifications are not "unfair" under Texas law if actuarially supported. He concluded that he could not ban "a practice that has a disproportionate impact if it produces an actuarially supported result and is not unfairly or intentionally discriminatory."<sup>107</sup> He invited the legislature to consider this question— a clash between actuarial fairness and what is just from a public policy perspective—if it so desired. The legislature has not taken up this offer as the Texas Department of Insurance website currently states that insurers may use credit information for the sale and rating of insurance.<sup>108</sup>

In 2007 the FTC released a report on the use of credit-based scores for auto insurance. The press release summarizing the results said:

The study found that these scores are effective predictors of the claims that consumers will file. It also determined that, as a group, African-Americans and Hispanics tend to have lower scores than non-Hispanic whites and Asians. Therefore, the use of scores likely leads to African-Americans and Hispanics paying relatively more for automobile insurance than non-Hispanic whites and Asians.<sup>109</sup>

A similar study on homeowner's insurance was expected the following year. As recently as January 2014, there were reports that this report would be issued shortly but it has not surfaced as of now.

<sup>106</sup> TEX. DEP'T. OF INS., *supra* note 57, at 3–4.

<sup>107</sup> Cover Letter from Jose Montemayor, TEX. DEP'T OF INS., SUPPLEMNETAL REPORT TO THE 79TH LEGISLATURE: USE OF CREDIT INFORMATION BY INSURERS (Jan. 31, 2005).

<sup>108</sup> *Credit Scoring and Insurance*, TEX. DEP'T OF INS., <https://www.tdi.texas.gov/credit/index.html> (last updated Sept. 25, 2020).

<sup>109</sup> *FTC Releases Report on Effects of Credit-Based Ins. Scores*, FTC (July 24, 2007), <https://ftc.gov/news-events/press-releases/2007/07/ftc-releases-report-effects-credit-based-insurance-scores>.

On a national level, the National Association of Insurance Commissioners (NAIC) has studied this issue and held hearings in 2009 where industry representatives and consumerists had a chance to weigh in.<sup>110</sup> Commissioner Joel Ario (PA) noted that “[credit score] doesn’t fall on all populations equally”<sup>111</sup> (no factor would) “but this particular one falls particularly disproportionately on certain minority groups . . . the kind of constituencies that we, as regulators, are most worried about in terms of affordability and availability of insurance.”<sup>112</sup> In response, a speaker representing the American Insurance Association made these points: 1) ninety percent of one particular company’s customers paid less or were unaffected due to credit score; 2) eighty percent of insureds would pay more if credit score was banned; and 3) the effectiveness of credit score allowed insurers to offer coverage with confidence to many more applicants.<sup>113</sup> Most recently, the NAIC has engaged in this issue by stating its opposition to the Preventing Credit Score Discrimination in Auto Insurance Act of 2019<sup>114</sup> asserting that most states limit the use of credit score and vigilantly oversee its use to guard against discriminatory impact on certain classes of policyholders and emphasizing that remedial actions in this area should be led by the states.<sup>115</sup>

Broadly stated, one can synthesize two broad concepts from these deliberations that ultimately provides the frame for analysis. First, in a pure sense, the factors that make up credit score, as it is used, generally correlates with loss results. As such, its use provides a less expensive product for more insureds. Second, the factors that make up credit score and the algorithms that deliver the score have a disparate impact on certain marginalized groups. As identified by the Texas Commissioner of Insurance in 2005, we see two supportable propositions. For the most part, and except where banned by statute, regulators have come down on the side of allowing the use of credit

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<sup>110</sup> Public Hearing, Prop. & Cas. Ins. (C) Comm. Mkt. Regul. & Consumer Affs. (D) Comm., The Use of Credit-Based Insurance Scores (June 15, 2009), [https://www.naic.org/documents/committees\\_c\\_090615\\_public\\_hearing\\_transcript.pdf](https://www.naic.org/documents/committees_c_090615_public_hearing_transcript.pdf).

<sup>111</sup> *Id.* at 1–2.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.* at 6.

<sup>114</sup> Preventing Credit Score Discrimination in Auto Insurance Act, H.R. 1756, 116th Cong. (2019).

<sup>115</sup> Issue Brief, Nat’l Ass’n of Ins. Comm’rs., Use of Insurance Credit Scores in Underwriting (July 2019), [https://www.naic.org/documents/government\\_relations\\_190507\\_credit\\_based\\_scores.pdf](https://www.naic.org/documents/government_relations_190507_credit_based_scores.pdf)

score, as long as it is not the sole determinant of action, acknowledging the fact that this works for the greater number of insureds. However, consideration through the lens of CRT may afford a different result and point towards a new public policy.

## V.       CRITICAL RACE THEORY

In this paper, I consider questions of possible inappropriate discrimination in the use of an otherwise legal insurance underwriting and pricing tool, and I apply the analytical approach of CRT for a richer and more nuanced analysis. This approach lends clarity to my conclusions and helps determine whether the suggested remedial tools for making a positive impact are legitimate. As the debate to date on the use of credit score smacks of color blind analysis and conclusions, CRT offers a different approach and, if determinative of some of the open questions, suggests avenues for remedial regulatory action.

We live in a post-civil rights era. A mantra of color blindness prevails and collides with “the intrinsic and ineluctable presence of racial rule and racial domination.”<sup>116</sup> CRT arose as an analytical tool to confront this collision. In part, it rejects the primacy of color blindness and neutrality. It gives voice to knowledge of historic oppression and recognizes the overwhelming power of racism as a hegemonic force. It acknowledges the existence of race consciousness as a shield to preserve the system as it is and also serves as a tool for those who would oppose it. Foundationally, it accepts that race is a social and not biological construct. It also takes a needs-based rather than rights-based approach to any ultimate determination.<sup>117</sup>

Gloria Ladson-Billings and William Tate provided a brief summary of the key elements of CRT in summarizing its standard features as described by Delgado: 1) racism is not merely isolated acts but endemic to American life and ingrained legally, culturally, and psychologically; 2) civil-rights laws must be reinterpreted as these laws are often ineffectual and undermined; 3) claims of legal neutrality, objectivity, color blindness, and meritocracy should be challenged as they serve to camouflage the interests of those who are dominant in society; 4) legal doctrine must be reformulated

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<sup>116</sup> RACE LAW STORIES xiii (Rachel F. Moran & Devon W. Carbado eds., 2008).

<sup>117</sup> For a complete treatment and introduction to critical race theory see KHIARA M. BRIDGES, CRITICAL RACE THEORY: A PRIMER (2019).

to reflect the views of marginalized people; and 5) stories and personal narratives should be used to illuminate this process.<sup>118</sup>

Ultimately CRT calls upon us to consider the primary question of fairness and what is just from a different perspective and challenges the majority's own primacy as the chief concern. The appealing ethical construct of Utilitarianism which holds "that the greatest happiness of the greatest number should be the guiding principle of conduct[.]"<sup>119</sup> is not sustainable under CRT review.

Eddie S. Glaude, Jr. suggests that we consider this issue from the perspective of what "white supremacy" is and what it is not. While it "conjures images of bad men in hooded robes who believe in white power . . . that is not quite what [he] mean[s] . . . white supremacy involves the way a society organizes itself, and what and whom it chooses to value."<sup>120</sup> Glaude points out that "no matter our stated principles or how much progress we think we've made, white people are valued more than others in this country, and that fact continues to shape the life chances of millions of Americans."<sup>121</sup> This is the nature of the value gap that drives so much of the disconnect between maintenance of the status quo and confronting what, arguably, must be addressed.

The value gap has long standing roots. In the post-reconstruction *Civil Rights Cases*, Justice Bradley framed the notion suggesting nothing more needs to be done when he said:

[W]hen a man has emerged from slavery, and by the aid of beneficent legislation has shaken off the inseparable concomitants of that state, there must be some stage in the progress of his elevation when he takes the rank of a mere citizen, and ceases to be the special favorite of the laws.<sup>122</sup>

As Glaude suggests,<sup>123</sup> we can find an echo of this today in the language of Justice Roberts in *Shelby County, Alabama v. Holder* on voting

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<sup>118</sup> Gloria Ladson-Billings & William F. Tate IV, *Toward a Critical Race Theory of Education*, 97 TCHRS. COLL. REC. 47, 52 (1995).

<sup>119</sup> *Utilitarianism*, Oed.com, <https://www-oed-com.ezproxy.lib.uconn.edu/view/Entry/220768?redirectedFrom=Utilitarianism#eid> (last visited Oct. 18, 2020).

<sup>120</sup> EDDIE S. GLAUDE, JR., *DEMOCRACY IN BLACK: HOW RACE STILL ENSLAVES THE AMERICAN SOUL* 30 (2016).

<sup>121</sup> *Id.* at 31.

<sup>122</sup> 109 U.S. 3, 57 (1883).

<sup>123</sup> GLAUDE, *supra* note 120, at 41.

rights where he said “the conditions that originally justified these measures no longer characterize voting in the covered jurisdictions.”<sup>124</sup> Further, Justice Roberts, in an effort to speed matters along to a period of post-racial consciousness, asserted in *Parents Involved in Community Schools v. Seattle School District No. 1* that “[t]he way to stop discrimination on the basis of race is to stop discriminating on the basis of race.”<sup>125</sup>

In both of these decisions there is apparently a process of erasing from history what inconveniently would have led to a different conclusion. Part of what one does in considering issues through the lens of CRT is to consciously decide what we need to remember and to confront what we have chosen. The opposite, to use the phrase that Glaude ascribes to Toni Morrison, is to “disremember.”<sup>126</sup> Applying “disremembering” to reach legal conclusions may completely reframe what may have appeared on the surface to be fair-minded decisions. As Glaude notes: “How we collectively remember is bound up with questions of justice. Or, to put the point differently, what we choose to forget often reveals the limits of justice in our collective imaginations.”<sup>127</sup> Also, “[r]emembering our national sins serves as a check and balance against national hubris. But when we disremember . . . we free ourselves from any sense of accountability.”<sup>128</sup>

The recognition and acceptance that there is an operative value gap informs consideration of an issue when CRT analysis is used. Glaude suggests what would be most transformative is “[a] revolution of value [that] upends the belief that white people are more valued than others.”<sup>129</sup>

Of particular relevance here is an analysis of how credit score for homeowner's insurance can be viewed as a racialized tool in its usage in a property context. As Ladson-Billings and Tate have pointed out, in considering Bell's writings, individual rights have long been connected with property rights. "From the removal of Indians (and later Japanese Americans) from the land, to military conquest of the Mexicans, to the construction of Africans as property, the ability to define, possess, and own property has been a central feature of power in America."<sup>130</sup>

<sup>124</sup> 570 U.S. 529, 535 (2013).

<sup>125</sup> 551 U.S. 701, 748 (2007) (plurality opinion).

<sup>126</sup> GLAUDE, *supra* note 120, at 46.

127 *Id.*

<sup>128</sup> *Id.* at 188.

<sup>129</sup> *Id.* at 182 (emphasis omitted).

<sup>130</sup> Ladson-Billings and Tate, *supra* note 118, at 53 (citation omitted).

With the recent presidential election, the prospect for consideration of whether the FHA can be applied to insurance and, if so, whether credit score should be banned may be closer to a resolution. Pursuant to a Memorandum issued by President Biden on January 25, 2021, the Secretary of Housing and Urban Development was ordered to “take all steps necessary to examine the effects of the September 24, 2020, rule entitled ‘HUD’s Implementation of the Fair Housing Act’s Disparate Impact Standard.’”<sup>131</sup>

It does not seem likely that any move contemplated here will be grounded in the notion of interest convergence as outlined by Professor Derrick Bell. Bell said that “[t]he interests of blacks in achieving racial equality will be accommodated only when it converges with the interests of whites.”<sup>132</sup>

Finally, consideration from a CRT perspective requires that we note the significance housing (shelter) has as a basic human need. Accepting that the use of credit score will be shown to be impactful on the cost of housing due to the mandated purchase of insurance when a mortgage loan is involved, CRT requires that we pay more than lip service to considering what actions will remove this obstacle to satisfying this basic human need.

In sum, consideration of this issue from a CRT perspective empowers regulators, if they can be moved to do so, to act on credit score usage for homeowner’s insurance in a way that goes beyond a narrow view of what otherwise would be justified as a purely actuarial decision. It empowers the exclusion of a tool that is not justified based on recognizing that a negative value placed on minorities is embedded in historic patterns that have led to that result. As was framed by the Insurance Commissioner of Texas, policymakers should take up this possible clash between actuarial fairness and a just public policy. Viewed through a CRT lens, actuarial fairness here may be neither fair nor just.

#### VI. THE POSSIBLE ROLE DATA ON RACE MAY PLAY IN THIS DEBATE AND OTHER SUGGESTIONS

As has been noted above, the insurance industry has asserted and it is generally accepted by regulators, that the use of credit score makes homeowner’s insurance more affordable for a large number of insureds at

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<sup>131</sup> Memorandum on Redressing Our Nation’s and the Federal Government’s History of Discriminatory Housing Practices and Policies, 2021 DAILY COMP. PRES. DOC. 90 (Jan. 26, 2021).

<sup>132</sup> Derrick A. Bell, Jr., Comment, *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 523 (1980).

the cost of increased premiums for those with lower scores. Expecting those who have enjoyed the benefits of this approach to voluntarily forgo this seems unlikely. Interest convergence, as described by Bell, is not going to be found.

This paper was prepared at a time when the political likelihood of resolving these issues by HUD or by legislation, that must pass the Senate, appeared to be remote. Progress in bringing this to a definitive resolution was advancing during President Obama's administration with a proposed rule finalized in the closing months of his term in office. The past administration and leadership at HUD, and its pending regulation as well as litigation challenging the 2013 and 2016 rules, did not auger well for a positive regulation becoming effective. The recent election of President Biden and narrow control of the senate by the Democratic Party may portend a change at the federal level.

State insurance regulators can, if they have the will, advance this debate by using tools at their disposal to resolve the question that has not been answered definitively through all of the litigation to date. Is there unassailable data that shows the use of credit score has a disparate impact on people of color? The Texas study noted above suggests that it does, as does the FTC study on auto insurance. However, the FTC study was inferential and not directly tied to a database of customers and applicants.

In 1994, the California Department of Insurance required by regulation that insurers commence reporting information on policyholders that would include race and national origin information where such info was voluntarily supplied by the customer.<sup>133</sup> This requirement could be applied to such personal lines of coverage as automobile and homeowner's insurance. The form requesting this info included a statement to the effect that: 1) the information was intended to allow the Department to monitor the insurers responsibility to meet the needs of underserved communities; 2) the policyholder is not required but encouraged to supply the requested information; and 3) the insurer may not use the information for underwriting or rating purposes. However, the program did not yield information deemed actionable by the Department. In February 2017, the Department released a draft set of revisions that, if effectuated, will eliminate the collection of the demographic information. In the proposal it cites the voluntary response rate

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<sup>133</sup> CAL. CODE REGS. tit. 10, § 2646.6 (1994) (West).

as being poor.<sup>134</sup> As of January 2021, this change has not been placed into effect. It should be noted that California is one of a small number of states that does not allow for the use of credit score at all in the insurance underwriting or rating process. Therefore, even with a more robust response rate from applicants in addition to policyholders, this database would not have been germane to the matters under consideration here. However, it does point to the underlying legitimacy of seeking such information.

Subject to significant data collection hurdles, this methodology could be deployed in states that allow for the use of credit score to answer with much greater certainty the question of disparate impact in the use of credit score for homeowner's insurance. Anticipating questions of whether enough data will be collected to properly consider this question, we can look to the way lenders obtain similar information to enable compliance with the Home Mortgage Disclosure Act<sup>135</sup> which requires lenders to collect demographic information on applicants. One of the requirements of the Dodd-Frank<sup>136</sup> legislation was that, starting in 2018, credit information on the applicant must also be supplied.

With reasonable effort, it is hoped that a definitive view may be reached on the question of the disparate impact of credit score on marginalized populations purchasing homeowner's insurance. Armed with this information, regulators can reasonably be challenged to use the CRT lens to determine if credit score, while perhaps benefiting a mass of insureds, should be eliminated from usage, much as separate tables for rating whites and Blacks were eliminated from usage in the life insurance industry years ago—notwithstanding the potential marginal increase in life insurance rates it created for white applicants.

Failing such general action, I urge regulators to consider several steps that may significantly soften the impact of credit score on such disadvantaged populations. First, credit score factors that are reflective of the negative impact of the dual credit system should be stricken from use. An example would be negative treatment due to the source of any credit extended to a borrower (e.g. payday lenders or finance companies). All factors used in developing a credit score should be qualitatively considered as to whether or not the factor reflects a legacy of the dual system. Second,

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<sup>134</sup> State of California Department of Insurance, Draft, Summary of Proposed Revisions to the 2017 Community Service Statement and Fire Availability Data Call (Feb. 1, 2017) (on file with author).

<sup>135</sup> Home Mortgage Disclosure Act of 1975, *supra* note 20.

<sup>136</sup> Dodd-Frank Wall Street Reform and Consumer Protection Act, 12 U.S.C. §§ 5301-5612 (2010).



subject to the decision of a renter, experience in making timely rental payments should be reported to and considered in developing a credit score. As was pointed out in 2017 by New York City Comptroller Scott Stringer, in a city of renters this is “an issue of inequality” and would benefit credit scores for seventy-six percent of such tenants.<sup>137</sup> Finally, insurers should consider the adoption of supplements for credit score that would consider bank account balances and cash management behavior. The developers of these scores assert that such features could well serve individuals who currently fall into the subprime range for credit score and is viewed favorably by such consumer advocates as the National Consumer Law Center.<sup>138</sup>

## VII. SUMMARY AND RECOMMENDATIONS

I have explored the significance of homeownership in the U.S. as a form of wealth accumulation and legacy transference. The history of property rights and how race considerations inform conceptions of property rights makes this issue, specifically in the context of homeowner's insurance, even more meaningful. As such, the use of credit score, which may impact the overall homeowner's price equation, becomes a central consideration, even if not the largest consideration, but a consideration nonetheless.

Housing is a significant factor in a person's life outcomes. However, homeownership and the credit score necessary to achieve and afford it has been undermined by a system of dual credit which traces its roots back to the immediate post-Civil War period; it plays through to federal programs and agencies created during the Great Depression and continues into the post-World War II period in which housing and suburbanization boomed. This set back Black and other minority groups in their efforts to acquire property at an affordable price, and build credit records which would aid in that effort, as well as influencing other spheres such as credit score for homeowner's insurance purchase and pricing calculations.

Regulators have available tools to directly answer any remaining debate over the likely disparate impact of credit score on marginalized groups. Armed with this information, they can act to ban the use of credit score as other inappropriate tools have been banned in the past. In the

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<sup>137</sup> Nikita Stewart, *Comptroller Wants Paying Rent on Time to Count Toward Credit Score*, N.Y. TIMES (Oct. 22, 2017), <https://nyti.ms/2gYeOyn>.

<sup>138</sup> Ann Carrns, *New Type of Credit Score Aims to Widen Pool of Borrowers*, N.Y. TIMES (Oct. 26, 2018) <https://www.nytimes.com/2018/10/26/your-money/new-credit-score-fico.html>.

absence of a willingness to so act, they can move on a more limited basis to make the use of credit score less objectionable by stripping away features that reflect the legacy of a dual credit system and, likely, soften the ongoing deleterious impact of credit score as used for homeowner's insurance.

HUD should initiate a study of homeowner's insurance similar to the 2007 FTC study on auto insurance. Such a study may provide some definitive findings on the existence of disparate impact on the use of credit score.

The public policy challenge remains clear. The use of credit score as a tool for underwriting and pricing homeowner's insurance creates an apparent clash between actuarial fairness and a just public policy. With CRT we may ultimately conclude that such a tool is neither fair nor just.

# MANAGING THE NEW POLITICAL RISKS: POPULISM, DEMOCRATIC INSTABILITY, AND THE RISE OF POLITICAL RISK INSURANCE IN DEVELOPED DEMOCRACIES

JAMES R. BRAKEBILL\*

*Developed democracies in the West are facing a surge of political risk. Democratic institutions are showing their weaknesses as polarization, populism, and trade conflicts sweep across the developed world. Firms and investors with multinational interests have been turning to political risk insurance to mitigate potential losses due to adverse government action. Once limited to emerging markets to insure against risks such as civil war or expropriation, political risk insurance is increasingly being purchased to protect assets from emerging risks in developed economies. While private insurers have been able to respond to the increase in demand for coverage, they are not as well-equipped as their public counterparts. Private insurers lack the information back-channels that only government intelligence networks can provide and do not have the political clout to advocate on behalf of their insureds. Public providers of political risk insurance are typically prohibited from offering coverage for investments outside developing markets and are thus unable to respond appropriately to the new political risks emerging in western democracies. This Note argues that these restrictions should be relaxed in light of the new threats facing multinational firms and investors that need the backing and support of their home governments.*

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## I. INTRODUCTION

Transnational investments and trade are generally recognized as carrying greater risk than transactions performed domestically. This is especially true when the investment is made in a country with a developing economy or unstable political institutions. In addition to the usual economic risks associated with any business or financial venture, investments that cross national boundaries face unique political risks. Dealing internationally often involves dealing with different currencies, unfamiliar forms of government, changing regimes, trade restrictions, capital controls, or, in some regions of the world, political violence and warfare. In fact, investors have ranked political risk as the most significant obstacle to investing abroad.<sup>1</sup> Political risk insurance (PRI) is a form of specialized insurance designed to protect firms and investors against the risks that attach to foreign investment and trade.<sup>2</sup> Historically, PRI has been purchased by firms doing business in developing countries where risks such as civil war or government expropriation were much greater than in developed nations.<sup>3</sup> Today, the market for PRI is evolving. The rise of globalization combined with

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<sup>1</sup> James J. Waters, *A Comparative Analysis of Public and Private Political Risk Insurance Policies with Strategic Applications for Risk Mitigation*, 25 DUKE J. COMP. & INT'L L. 361, 366 (2015); NIGEL GOULD-DAVIES, TECTONIC POLITICS: GLOBAL POLITICAL RISK IN AN AGE OF TRANSFORMATION 13 (2019) (showing that five of the top eight risks CEOs are “extremely concerned” about were of a political nature).

<sup>2</sup> WALTER J. ANDREWS & SERGIO F. OEHNINGER, 2 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 15A.03(6)(b) (2019).

<sup>3</sup> Julian M. Campisi, *Reconsidering Political Risk in Developed Economies*, 4 J. POL. RISK (2016) (explaining that political risks have generally been greater in developing economies but that growing risks in the West warrant further study and consideration); see also AREND LIJPHART, PATTERNS OF DEMOCRACY: GOVERNMENT FORMS AND PERFORMANCE IN THIRTY-SIX COUNTRIES 269–71 (2d ed. 2012) (discussing the correlation between democracy in developed countries and political violence).

changing political attitudes towards trade, increasing geopolitical tensions, and challenges facing traditionally-stable western governments has altered PRI as insurance markets respond to investors' new demands and fears.<sup>4</sup>

PRI is an understudied area of insurance and little has been written about the new risks in developed democracies or the inadequacy of coverage options available in these areas. The purpose of this Note is to examine these growing political risks and argue that government-backed PRI should be expanded to include the political threats facing firms and investors in the developed world. Following this introduction, Part II discusses the fundamental aspects of PRI, including the main categories of coverage, the characteristics that separate it from other forms of insurance, and the primary distinctions between public and private PRI. Part III analyzes the new political risks rising in developed democracies and looks at the private insurance industry's response. Part IV argues that public providers of PRI should loosen restrictions and expand coverage options to better serve the interests of firms and their home governments. Current eligibility and coverage restrictions limit access to public PRI and thus leave a gap to be filled by the private insurance market. This shifts the risk of adverse government action onto a private sector that is normally ill-equipped to evaluate or mitigate such risks. The United States International Development Finance Corporation is used as an example of how restrictive requirements and coverage limitations impede important policy goals and leave American firms operating abroad exposed to a greater risk of adverse government action.

## II. THE BASICS OF POLITICAL RISK INSURANCE

Political risk insurance typically covers a composite of various non-commercial risks associated with commercial development, investment, and international trade.<sup>5</sup> Unlike other forms of commercial insurance that may

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<sup>4</sup> *Insurance Marketplace Realities 2020—Political Risk Insurance*, WILLIS TOWERS WATSON (Nov. 13, 2019), [https://www.willistowerswatson.com/en-us/insights/2019/11/~link.aspx?\\_id=32A4E687F855486F92AE5385461D45F6&\\_z=z](https://www.willistowerswatson.com/en-us/insights/2019/11/~link.aspx?_id=32A4E687F855486F92AE5385461D45F6&_z=z); Gabriel Olano, *Willis Towers Watson Reveals Political Risk Loss Figures*, INS. BUS. UK (Dec. 5, 2019), <https://www.insurancebusinessmag.com/uk/news/war-political-risk/willis-towers-watson-reveals-political-risk-loss-figures-194043.aspx> (discussing that among forty-one major corporations surveyed, sixty-one percent said political risk levels rose in 2019 and seventy percent cited trade sanctions as a concern).

<sup>5</sup> Vishrut Kansal, *Political Risk: Conceptualization, Definition, Categorization, and Methodologies*, 3 J. POL. RISK (2015).

cover risks associated with construction, operation, or solvency, PRI provides multinational firms with protection against adverse governmental action and political instability that may threaten their physical assets, investments, or contracts.<sup>6</sup>

#### A. THREE TRADITIONAL CATEGORIES OF POLITICAL RISKS

There is no generally accepted definition of political risk, but it has typically been divided into three broad categories: expropriation, currency inconvertibility, and political violence.<sup>7</sup> These categories are neither exhaustive nor meant to be narrowly construed, however, as many policies cover a range of adverse government actions that do not fit neatly into any one category.<sup>8</sup>

Expropriation coverage is one of the most common forms of PRI.<sup>9</sup> It protects foreign investors from government action that either reduces or eliminates ownership and control over an asset or investment. This includes government seizure and nationalization as well as adverse sequences of regulatory changes that combine to reduce ownership or control, a risk known as “creeping expropriation.”<sup>10</sup> All investments suffer from a risk that laws and regulations may change in a way that negatively impacts the investment. However, this risk is much greater when dealing internationally in countries with less stable legal structures and fewer protections for investors.<sup>11</sup>

Currency inconvertibility refers to the inability to convert foreign currency for transfer abroad, thereby depriving the investor of profits or other assets.<sup>12</sup> Some governments find currency restrictions necessary to conserve

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<sup>6</sup> Waters, *supra* note 1, at 363.

<sup>7</sup> *Id.* at 361.

<sup>8</sup> Kansal, *supra* note 5 (“The expansiveness of political risk highly counteracts any systematized approach towards categorizing its different manifestations.”); see also Alicia N. Ellis, *Making Political Risk More Politically Relevant*, 7 J. POL. RISK (2019) (stating that political risk can be expanded to include many government measures, both formal and informal, yet it remains an “understudied and little understood niche”).

<sup>9</sup> Waters, *supra* note 1, at 365.

<sup>10</sup> *Id.*

<sup>11</sup> S. Linn Williams, *Political and Other Risk Insurance: OPIC, MIGA, Eximbank, and Other Providers*, 5 PACE INT’L L. REV. 59, 62 (1993).

<sup>12</sup> KAUSAR HAMDANI, ELISE LIEBERS & GEORGE ZANJANI, AN OVERVIEW OF POLITICAL RISK INSURANCE 2 (2005), <https://www.bis.org/publ/cgfs22fedny3.pdf>.

currency when facing balance-of-payments difficulties.<sup>13</sup> Currency devaluation or currency inflation, however, are distinct and uninsurable risks.<sup>14</sup>

PRI also covers property losses from political violence, including civil war, revolution, rebellion, domestic unrest, or other forms of politically-motivated violence that are excluded from standard property insurance coverage.<sup>15</sup> The line between political violence and outright war or terrorism is not always clear.<sup>16</sup> For example, a violent political protest against a government could be classified as political violence or as terrorism. That classification would determine whether the event is covered under a traditional PRI policy or a standalone terrorism insurance policy.<sup>17</sup> This has led some multinational firms to protect themselves using a combination of the two products.<sup>18</sup>

#### B. ATYPICAL CHARACTERISTICS OF PRI

The nature of political risks separates PRI from other insurance products and helps explain the somewhat atypical characteristics of PRI.<sup>19</sup> Political events can occur over many years and the effects are not always easily assessable. Unlike other insurable risks where the adverse event is said to be independent of the will of the insured, political events may be directly influenced by the insured's specific investor-state relationship.<sup>20</sup> This complicates the idea that insurable risks must include many insureds that can

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<sup>13</sup> Waters, *supra* note 1, at 365.

<sup>14</sup> HAMDANI, ET AL., *supra* note 12, at 8.

<sup>15</sup> Waters, *supra* note 1, at 367. Notably, such losses are generally excluded from property insurance policies. See TOM BAKER & KYLE D. LOGUE, *INSURANCE LAW AND POLICY* 161 (4th ed. 2017) (showing losses caused by war or government action is excluded under an ISO standard form property insurance policy).

<sup>16</sup> Evan Freely, *What's Covered? Distinguishing Among Political Risk, Political Violence, and Terrorism Insurance*, MARSH (July 1, 2015), <https://www.marsh.com/us/insights/risk-in-context/distinguishing-among-political-risk-violence-terrorism-insurance.html>.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> Kathryn Gordon, *Investment Guarantees and Political Risk Insurance: Institutions, Incentives and Development*, in OECD INVESTMENT POLICY PERSPECTIVES 91, 95 (2008).

<sup>20</sup> *Id.*

join to form a risk community where risk is shared and diversified.<sup>21</sup> The risk of political activity also cannot be accurately calculated or explained, which means PRI providers cannot rely on statistical modelling to evaluate risks the way other insurance sectors commonly do.<sup>22</sup> These characteristics explain why the PRI sector relies heavily on bespoke insurance products tailor-made for specific risk events.<sup>23</sup> Such situation-specific policies rarely cover all foreseeable political events and increase the likelihood of a dispute over coverage following a claim.<sup>24</sup>

### C. PUBLIC VERSUS PRIVATE PROVIDERS

The market for PRI is divided into public and private providers with each carrying their own advantages and disadvantages.<sup>25</sup> The distinctions below are important for understanding why private PRI has grown despite its inadequacies and why public providers are in a better position to insure political risks.

The first providers of political risk insurance were all government agencies. Examples include the Overseas Private Investment Corporation (OPIC), now called the U.S. International Development Finance Corporation (DFC),<sup>26</sup> the Nippon Export and Investment Insurance Agency (NEXI) in Japan, and Export Finance Australia (EFA).<sup>27</sup> Multilateral agencies play a significant role in the PRI market as well, such as the World Bank Group's Multilateral Investment Guarantee Agency (MIGA), which offers PRI coverage to citizens of 179 World Bank members.<sup>28</sup> Public providers of PRI are sometimes considered insurers of last resort as they offer coverage that private insurers either refuse to provide or would otherwise be cost-prohibitive if offered by a private insurer.<sup>29</sup> This perception has not always been the case. In 1969, the Overseas Private Investment Corporation (OPIC)

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<sup>21</sup> Elizabeth A. Kessler, *Political Risk Insurance and the Overseas Private Investment Corporation: What Happened to the Private Sector?*, 13 N.Y.L. SCH. J. INT'L & COMP. L. 203, 207 (1992).

<sup>22</sup> Gordon, *supra* note 19, at 95.

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> Waters, *supra* note 1, at 374–81.

<sup>26</sup> As of 2018, DFC is the successor agency to OPIC. *Overview*, DFC, <https://www.dfc.gov/who-we-are/overview>.

<sup>27</sup> See Gordon, *supra* note 19, at 111 for a list of public institutions providing PRI.

<sup>28</sup> Waters, *supra* note 1, at 370.

<sup>29</sup> Gordon, *supra* note 19, at 104.



was formed out of the United States Agency for International Development, which guaranteed investments under the post-World War II Marshall Plan.<sup>30</sup> The goal was to eventually encourage a private PRI industry to insure developments that investors might otherwise avoid without such coverage.<sup>31</sup>

In the 1970s, Lloyds of London and American International Group (AIG) began expanding into the field. At the time, many in the business community felt that political risk could not be insured by the private sector and were drawn to the status of OPIC as a government entity.<sup>32</sup> Only those rejected by OPIC sought private coverage, leaving private PRI providers with greater risk and higher prices due to an information gap. This gap was due to the fact that governments are in a better position to evaluate risk and obtain information about foreign regimes.<sup>33</sup> For example, U.S. embassies monitor American interests abroad and the U.S. State Department routinely shares its information with DFC.<sup>34</sup> Prior to fast-speed electronic communication, the government held a significant advantage in its ability to understand and evaluate political risks. Technological developments have helped private insurers neutralize the information advantage once held by government-backed insurance agencies.<sup>35</sup> As communication improved and information flowed more quickly, private providers began to monitor risk more effectively.<sup>36</sup> While private providers still lack the information backchannels available to public providers, technological advancements have helped them reduce the information gap enough to allow them to expand their PRI coverage options.<sup>37</sup> Private options have also become more attractive to insureds unwilling to comply with the social, environmental, and labor standards that apply to those insured by public insurers.<sup>38</sup> As the

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<sup>30</sup> Waters, *supra* note 1, at 363; *Political Risk Insurance*, NAT'L ASS'N INS. COMM'RS, [https://content.naic.org/cipr\\_topics/topic\\_political\\_risk\\_insurance.htm](https://content.naic.org/cipr_topics/topic_political_risk_insurance.htm) (last modified Mar. 4, 2020).

<sup>31</sup> Jennifer M. DeLeonardo, Note, *Are Public and Private Political Risk Insurance Two of a Kind? Suggestions for a New Direction for Government Coverage*, 45 VA. J. INT'L L. 737, 741 (2005).

<sup>32</sup> *Id.* at 742.

<sup>33</sup> Waters, *supra* note 1, at 375.

<sup>34</sup> DeLeonardo, *supra* note 31, at 756.

<sup>35</sup> *Id.* at 755.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.* at 751–53.

<sup>38</sup> Waters, *supra* note 1, at 377; Gordon, *supra* note 19, at 120 (providing a summary of agency monitoring of client compliance with contractual obligations). For an example of the social and environmental requirements often imposed on

PRI market has matured, private providers have made significant gains in market share and no longer face poor stigma as they did before.<sup>39</sup> Today, there are over 60 companies offering political risk insurance.<sup>40</sup>

### III. CHANGING POLITICAL RISKS AROUND THE WORLD

Political risk is surging around the globe.<sup>41</sup> Historically, risk-prone regions such as the Middle East, Africa, and South America continue to face substantial threats from terrorism, war, sanctions, and government instability. The most noteworthy changes, however, come not from developing economies, but rather the large-scale political risks emerging in advanced western democracies and the geopolitical tensions spanning from Asia to North America.<sup>42</sup> More firms and investors in North America and Europe are facing threats on a macro level.<sup>43</sup> These include trade tensions

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insureds covered by public PRI, see *Investment Policies*, DFC, <https://www.dfc.gov/what-we-offer/eligibility/our-investment-policies>.

<sup>39</sup> Waters, *supra* note 1, at 377–78.

<sup>40</sup> NAT'L ASS'N INS. COMM'RS, *supra* note 30.

<sup>41</sup> GOULD-DAVIES, *supra* note 1, at 16–17 (“A wider range of actors and transactions, more exposed to political risks than ever before, now faces a more rapid growth in these risks than at any time since 1945.”); see, e.g., *Marsh's Political Risk Map 2019: Unprecedented Uncertainty Ahead*, MARSH (Feb. 27, 2019), <https://www.marsh.com/us/media/political-risk-map-2019.html>; MARSH, *POLITICAL RISK MAP 2019: RISING GEOPOLITICAL TENSIONS* (Feb. 2019) [hereinafter MARSH RISK MAP 2019] (“Businesses have arguably never faced such a breadth of challenges as they do today.”); AON RISK SOLUTIONS, *RISK MAPS 2019: AON'S GUIDE TO POLITICAL RISK, TERRORISM & POLITICAL VIOLENCE* (2019) [hereinafter AON RISK MAP 2019]; see also Bethan Moorcraft, *What is Political Risk Insurance?*, INS. BUS. ASIA (Mar. 19, 2019), <https://www.insurancebusinessmag.com/asia/guides/what-is-political-risk-insurance-162505.aspx> (“The geopolitical risk landscape is more tumultuous and diverse than it has been in decades.”).

<sup>42</sup> In a survey report, WILLIS TOWERS WATSON, *HOW ARE LEADING COMPANIES MANAGING TODAY'S POLITICAL RISKS? 2019 SURVEY AND REPORT 12* (2019), one panelist noted: “Most political risk issues previously related to ‘third-world problems.’ However, increasingly I have more concerns about the US and the UK.” A second panelist agreed: “The political risks we see in more mature economies are longer term and perhaps more fundamental in nature. There is a crisis in democracy and institutions, and the opposition isn't from traditional parties; it's from populist parties and civil society.”

<sup>43</sup> Terry Gangcuangco, *OECD Countries Now More Vulnerable to Credit and Political Risk?*, INS. BUS. UK (Feb. 22, 2019), <https://www.insurancebusinessmag.com/uk/news/war-political-risk/oecd-countries-now-more-vulnerable-to-credit>

between the United States and China, the uncertainties following Great Britain's exit from the European Union, or Brexit, and rising political instability among western democracies. The risks differ both in nature and scope from risks in other parts of the world, which continue to involve losses of physical assets by expropriation or political violence.<sup>44</sup> The widescale political risks arising in developed democracies threaten the institutions that set these countries apart from those in the developing world.<sup>45</sup>

#### A. POPULISM AND DEMOCRATIC INSTABILITY

It is generally understood that democracy decreases political risk. This is because democratic institutions tend to protect the status quo and provide opportunities for investors to influence the policy-making process or at least observe and anticipate policy changes.<sup>46</sup> There are circumstances, however, when democracy increases political risk. It has long been acknowledged that political polarization has an adverse effect on government stability.<sup>47</sup> As parties become more polarized, passing legislation can become nearly impossible and changes in administration have a more significant impact when there is greater ideological conflict between controlling parties.<sup>48</sup> This increases the risk that policy will become unstable

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-and-political-risk-159726.aspx; Georgi Kantchev, *The Return of the Political Risk-Trade*, WALL ST. J. (June 11, 2018), <https://www.wsj.com/articles/political-risk-returns-to-markets-as-tide-of-stimulus-wanes-1528719648>; Brenna H. Neghaiwi & Carolyn Cohn, *Demand Rises for Political Risk Cover as Buyers Think the Unthinkable*, INS. J. (Apr. 25, 2017), <https://www.insurancejournal.com/news/international/2017/04/25/448835.htm>.

<sup>44</sup> *Insurance Markets and Risk Priorities in 2019*, MARSH, <https://www.marsh.com/us/insights/research/insurance-markets-and-risk-priorities-in-2019.html>; see WILLIS TOWERS WATSON, *supra* note 42, at 5 (showing that trade sanctions were the highest rated political risk outside Africa and the Middle East).

<sup>45</sup> WILLIS TOWERS WATSON, *supra* note 42.

<sup>46</sup> NATHAN M. JENSEN, GLEN BIGLAISER, QUAN LI, EDMUND MALESKY, PABLO M. PINTO, SANTIAGO M. PINTO, & JOSEPH L. STAATS, *POLITICS AND FOREIGN DIRECT INVESTMENT* 31–32 (2012).

<sup>47</sup> ANTHONY DOWNS, *AN ECONOMIC THEORY OF DEMOCRACY* 120 (1957) (“[Political polarization] means that government policy will be highly unstable, and that democracy is likely to produce chaos.”).

<sup>48</sup> JENSEN ET AL., *supra* note 46, at 31–32 (discussing the relationship between political risk and policy swings resulting from changes in administration); BARBARA SINCLAIR, *UNORTHODOX LAWMAKING* 140–42 (4th ed. 2012) (arguing that polarization has forced Congress to adopt unorthodox procedures even for legislation that just keeps government functioning).

and that political leaders will pursue policies to obtain short term political gains at the expense of long term investment.<sup>49</sup>

The same societal issues increasing polarization may trigger waves of populism.<sup>50</sup> Polarized governments are less effective at finding solutions and these failures may be exploited by populists from both the left and the right.<sup>51</sup> Targeting multinational firms can be politically popular and political leaders will often resort to such tactics when trying to gain the support of voters.<sup>52</sup> Globalization has nearly been put on hold as these sentiments gain ground in many governments.<sup>53</sup> Prominent members of both major parties in the United States are skeptical of multilateral trade agreements and populist parties critical of the E.U. have increased their share of votes in Germany, France, Sweden, Italy, and Spain.<sup>54</sup>

Changes in trade policy are now among the top concerns for investors. Surveys of large corporations and PRI providers show that the uncertain future of American trade policy and Brexit are driving much of the increased demand for PRI.<sup>55</sup> This has redrawn the map for PRI as more businesses are concerned about how these developments will impact their supply chains. The British automobile industry, for instance, has shown concern over Brexit's impact on their supply chain. As a result, the industry is moving some investments to continental Europe so they remain in the E.U.

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<sup>49</sup> JENSEN ET AL., *supra* note 46, at 31–32.

<sup>50</sup> WORLD ECON. FORUM, THE GLOBAL RISKS REPORT 2019, at 10 (14th ed. 2019); Jean-Francois Lambert, *Trade in Flux*, in BERNE UNION YEARBOOK 2019, at 58–61 (2019) (describing the deep-rooted issues affecting trade tensions around the world); see also David Fontana, *Unbundling Populism*, 65 UCLA L. REV. 1482, 1486–95 (2018) (explaining the issues driving populism in the United States and differentiating between left- and right-wing populism); Ariane Chebel d'Appollonia, *A Transatlantic Perspective on Populism(s): What's Going on*, 12 Revista Internacional Pensamiento Político 189, 191–92 (2017) (offering a European perspective on the causes of populism, such as economic inequality and cultural backlash).

<sup>51</sup> Bart Bonikowski, *Three Lessons of Contemporary Populism in Europe and the United States*, 23 BROWN J. WORLD AFFS. 9, 21 (2016); Frances E. Lee, *How Party Polarization Affects Governance*, 18 ANN. REV. POL. SCI. 261 (2015).

<sup>52</sup> JENSEN ET AL., *supra* note 46, at 32–33 (describing how elected leaders may target multinationals when facing populist pressures).

<sup>53</sup> MARSH RISK MAP 2019, *supra* note 41, at 1 (“Isolationist and protectionist sentiments and practices have risen in some countries, halting, at least momentarily, the process of globalization.”).

<sup>54</sup> AON RISK MAP 2019, *supra* note 41, at 7 (“Populism, aided by subtle and divisive use of multi-media platforms, has gained ground and continues to spread.”).

<sup>55</sup> Waters, *supra* note 1, at 366–67; Olano, *supra* note 4.

customs zone.<sup>56</sup> The European aircraft manufacturer Airbus, which exports to Britain, has also demonstrated concern over its future presence in the U.K. following Brexit.<sup>57</sup> Even Lloyds of London, an insurance market founded in 1688, opened a Europe-focused subsidiary in Brussels in case London becomes less attractive for business.<sup>58</sup> Most businesses have some concerns with the cost of compliance if tariffs or other trade barriers arise; while capital mobility has been raised as another potential risk for businesses doing trade in the region.<sup>59</sup>

This mirrors concerns of American businesses with interests in China, or even Mexico and Canada where U.S. actions have resulted in retaliatory tariffs by all three nations.<sup>60</sup> The potential consequences of a trade conflict can be devastating for some industries. Tariffs could destroy the economic viability of many businesses, which would disrupt supply chains and lead to a loss of income for any investor along the chain.<sup>61</sup> Tariffs on vital resources for example have wide-ranging impacts that increase business costs for any manufacturer requiring those materials.<sup>62</sup> Other trade barriers that restrict certain products entirely could destroy industries that fail to secure alternative sources or severely dampen their competitiveness.

It is important to note that avoiding the disruption of a supply chain may carry risks of its own. When a relatively stable, developed country announces a series of new import taxes or trade restrictions, firms may be forced to relocate to less economically developed countries with greater political risks.<sup>63</sup> In fact, some have suggested that the only way to

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<sup>56</sup> *Uncovering New Markets and New Products Amid Brexit Uncertainty*, THE ONE BRIEF, <https://theonebrief.com/uncovering-new-markets-and-new-products-amid-brex-it-uncertainty/>.

<sup>57</sup> *Id.*

<sup>58</sup> *Our Base in the Heart of Europe*, LLOYD'S BRUSSELS, <https://lloydsbrussels.com/about/>; see Oliver Suess & Ross Larsen, *Lloyds of London Chooses Brussels for Post-Brexit EU Hub*, BLOOMBERG (Mar. 30, 2017, 2:23 AM), <https://www.bloomberg.com/news/articles/2017-03-30/lloyd-s-of-london-picks-brussels-for-post-brex-it-eu-headquarters>.

<sup>59</sup> *Brexit: Business Uncertainty Does Not End if the U.K. Leaves the EU*, THE ONE BRIEF, <https://theonebrief.com/brexit-global-business-uncertainty/>.

<sup>60</sup> *U.S. and China: Navigating Trade Uncertainty*, THE ONE BRIEF, <https://theonebrief.com/u-s-and-china-navigating-trade-uncertainty-2/>.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.*

<sup>63</sup> ASIAN DEV. BANK, ASIAN DEVELOPMENT OUTLOOK 2019 UPDATE 12–15, 21–24 (2019) (explaining how global trade conflicts and supply chain disruptions

realistically improve the trade balance between the United States and China may be to shift a portion of the U.S.–China trade deficit to third-party countries.<sup>64</sup> If this is correct, and the U.S. remains committed to its current goals, such a shift may be inevitable.

There is also a risk that new import taxes or even heated political rhetoric will encourage host governments to take retaliatory action against foreign investors.<sup>65</sup> American companies operating in countries targeted by import taxes may face additional scrutiny or regulatory burdens.<sup>66</sup> Such action may not be as significant as a trade embargo or outright nationalization, but a series of regulatory actions can compound to have a crippling effect on industry by making projects or contracts impossible to complete. This form of so-called “creeping expropriation” places the actions squarely within the realm of traditional PRI.<sup>67</sup>

#### B. THE PRI MARKET’S RESPONSE TO INCREASED DEMAND

Multiple insurers, brokers, and risk management firms expect demand for PRI to rise even further.<sup>68</sup> Uncertainty in the U.K. and Europe will persist for many years after Brexit.<sup>69</sup> The change in administration in the United States will not reverse the impact trade conflicts have already had on

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have caused companies to shift production to less economically developed countries).

<sup>64</sup> AON RISK MAP 2019, *supra* note 41, at 11.

<sup>65</sup> See, e.g., Dave Graham, *Mexican Senator to Propose Anti-Trump Expropriation Law*, REUTERS (Sept. 2, 2016, 5:45 PM), <https://www.reuters.com/article/us-usa-election-mexico-idUSKCN1182PL> (discussing possible retaliatory action if the U.S. causes Mexico economic harm in order to fund construction of a border wall).

<sup>66</sup> *Tariffs and Trade Wars: Dealing With Uncertainty, Planning For The Future*, THE ONE BRIEF, <https://theonebrief.com/tariffs-and-trade-wars-dealing-with-uncertainty-planning-for-the-future/>; see also Mercedes Ott, *Stop Tariffs From Decimating Your Supply Chain with these 3 Insurance Products*, RISK & INS. (July 11, 2018), <https://riskandinsurance.com/stop-tariffs-from-decimating-your-supply-chain-with-these-3-insurance-products/>.

<sup>67</sup> *Types of Coverage*, DFC, <https://www.dfc.gov/what-we-offer-our-products/political-risk-insurance> (last visited Oct. 24, 2020); *Expropriation*, MIGA, <https://www.miga.org/product/expropriation> (last visited Oct. 24, 2020) (specifying that “creeping expropriation” is covered).

<sup>68</sup> See *supra* text accompanying note 41.

<sup>69</sup> See THE ONE BRIEF, *supra* note 59.

supply chains across the globe.<sup>70</sup> The events of the past few years have shaped the world's appetite for PRI for years to come and private providers have grown to meet it.

The PRI market is expanding both in size and in its variety of coverage options. Many insurers see opportunity and thus are expanding their PRI options or are entering the field for the first time.<sup>71</sup> There are around sixty carriers around the world today, compared to only thirty a decade ago.<sup>72</sup> Political risk claims now account for nearly one-third of all credit and investment claims among Berne Union insurers, a group of eighty-five public and private insurance agencies.<sup>73</sup> Claims among this group doubled between 2017 and 2018.<sup>74</sup> In 2018, nearly half of new commitments covered risks in North America, Western Europe, and East Asia while total indemnifications were seventy five percent higher than the annual average over the last ten years.<sup>75</sup> However, while some see opportunity, others view the risks as too uncertain.<sup>76</sup> Unlike other forms of insurance which can

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<sup>70</sup> See Lambert, *supra* note 50, at 58–61 (explaining the deep-rooted issues affecting trade tensions around the world).

<sup>71</sup> Waters, *supra* note 1, at 368; Matthew Lerner, *Demand for Political Risk Cover Increasing*, BUS. INS. (May 1, 2019), <https://www.businessinsurance.com/article/20190501/NEWS06/912328040/> (reporting that Willis Towers Watson and Aon PLC are both growing their PRI practices while others, such as Hartford Financial Services Group, have recently joined the PRI market).

<sup>72</sup> Natasha Keats, *When Stakes are High: Political Risk and Trade Credit (Re)Insurance*, AXCO INS. INFO. SERVS. (Dec. 9, 2018), [https://www.axcoinfo.com/press/political-risk-and-trade-credit-\(re\)insurance.aspx](https://www.axcoinfo.com/press/political-risk-and-trade-credit-(re)insurance.aspx).

<sup>73</sup> BERNE UNION, INDUSTRY REPORT 2019 H1 (2019), <https://www.berneunion.org/DataReports>; see also *Political Risk: A Market for All Seasons*, REACTIONS (June 11, 2019), <https://reactionsnet.com/articles/3592449/political-risk-a-market-for-all-seasons> (providing industry commentary on the 2019 Berne Union data report).

<sup>74</sup> Paul Heaney, *Rainclouds on the Horizon: Temporary Break in Sunshine, or Impending Storm?*, in BERNE UNION SPRING PERIODICAL 11, 13 (2019), <https://www.berneunion.org/Newsletter>.

<sup>75</sup> *Id.*

<sup>76</sup> CEO Evan Greenberg of Chub Ltd., one of the largest insurance companies in the world, has warned that there is too much uncertainty for PRI providers to be taking on more risk. See Jonathan Levin, *Lloyd's Sees Political Risk Insurance Opportunity in Trump, Brexit*, INS. J. (Feb. 15, 2017), <https://www.insurancejournal.com/news/national/2017/02/15/441797.htm> (“I wish them a lot of luck because that's all they got going for them.”).

benefit from data collected over many decades, PRI involves bespoke coverage of more complicated risks that are difficult to quantify.<sup>77</sup>

Despite the challenges involved, coverage is still obtainable and prices remain relatively low due to overcapitalization.<sup>78</sup> This sets the current wave of political risks apart from previous risk events where coverage soon became nonexistent. For example, insurers stopped offering coverage in Ukraine following political unrest and Russian aggression in 2014.<sup>79</sup> The binary nature of the market for PRI means that coverage is usually either cheap and abundant or unavailable.<sup>80</sup> Today, total capacity per risk has more than doubled from a decade ago as PRI markets see an increase in capital.<sup>81</sup> However, this will not last forever and analysts urge investors affected by U.S. trade policy and Brexit to seek coverage while markets remain competitive.<sup>82</sup> Capacity is already diminishing in some markets, including China and Mexico, where political risks have risen since the United States has taken a more populist stance on North American trade.<sup>83</sup> It is uncertain what will happen to the PRI industry in the event of a catastrophic geopolitical event. PRI is a volatile business and is not profitable without loss recoveries. Many newer entrants to the market may not have the

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<sup>77</sup> Gordon, *supra* note 19, at 93.

<sup>78</sup> For example, a commodities trader could purchase \$100 million in coverage across 50 countries for about \$750,000. *See* Neghaiwi & Cohn, *supra* note 43.

<sup>79</sup> *Political Risk Insurance: Implications of Political Instability in Ukraine and Russia*, MARSH, <https://www.marsh.com/uk/insights/research/political-risk-insurance-implications-of-political-instability-ukraine-russia.html>.

<sup>80</sup> Stephen Kay, managing director for political risk at Marsh USA, has explained that volatility is a problem in PRI. The combined ratio for PRI can be as low as forty percent then spike to 130 percent when there is a series of loss events. *See* John Dizard, *No Insurance Policy Covers the Perils of a Trump Presidency*, FIN. TIMES (Mar. 4, 2016), <https://www.ft.com/content/f436b44c-e200-11e5-8d9b-e88a2a889797> (interviewing various insurance insiders, including Mr. Kay, regarding the rising demand for PRI).

<sup>81</sup> WILLIS TOWERS WATSON, *supra* note 4 (“The total capacity per risk has surpassed \$3B, more than doubling the capacity of \$1.3B available a decade ago, which has kept the marketplace competitive.”); CREDIT AND POLITICAL RISK INSURANCE: REPORT AND MARKET UPDATE, ARTHUR J. GALLAGHER 18 (July 2018).

<sup>82</sup> MARSH RISK MAP 2019, *supra* note 41, at 7.

<sup>83</sup> WILLIS TOWERS WATSON, *supra* note 4 (“[W]e are starting to see capacity shrinking in high-demand countries, such as China and Mexico, where rates may rise due to increased political risk.”).



resources to pursue these recoveries and makes their long-term outlook less optimistic.<sup>84</sup>

#### IV. PUBLIC PRI OPTIONS SHOULD BE EXPANDED TO INCLUDE COVERAGE FOR INVESTMENTS IN DEVELOPED DEMOCRACIES

Political risk around the world has changed and the efforts to manage that risk must change with it. It is no longer limited to large, multinational corporations investing in developing economies.<sup>85</sup> Today, political risk also affects small- to medium-sized businesses and investors with interests in more familiar places, such as the E.U. or U.K.<sup>86</sup> Though the largest corporations may have enough political influence to shape policy, this is not true of small- to medium-sized firms or investors, and even large corporations may still be unfairly targeted by political leaders.<sup>87</sup>

There is very little a targeted firm can do to manage political risks without the protection of their home-government.<sup>88</sup> Unfortunately, public PRI providers do not offer the proper kind of coverage for recent risks and restrict coverage to new investments in developing countries.<sup>89</sup> Government-backed PRI is typically unavailable for firms wishing to protect existing assets in North America or Europe that may be adversely affected by trade

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<sup>84</sup> Dizard, *supra* note 80; *see also* Kessler, *supra* note 21, at 214 (noting that in 1992 only a handful of private insurers offered PRI due to the “the enormous expertise required to underwrite political risk policies”).

<sup>85</sup> GOULD-DAVIES, *supra* note 1, at 18 (“Political risk is no longer only a concern of big western companies. It no longer arises only in developing countries. It is no longer caused only by states. It is no longer synonymous with ‘sovereign risk’ or ‘emerging market risk.’ And it can no longer be dealt with in the old ways.”).

<sup>86</sup> *Id.* at 19 (“[C]ompanies have found, to their costly surprise, that political risks are among the biggest they face—not only in ‘different and difficult’ countries like China, but familiar democratic western ones.”).

<sup>87</sup> Ellis, *supra* note 8 (“[T]rade policy is often a reflection of the most powerful business interests, the effect of which has been to relocate jobs to areas where lower wages and no benefits are the norm.”); JENSEN ET AL., *supra* note 46 (mentioning that large foreign corporations may become political targets).

<sup>88</sup> Ellis, *supra* note 8 (“The only real insurance policy a firm has against this type of political risk is the power of the U.S. government and the world institutions backed by that power.”).

<sup>89</sup> Waters, *supra* note 1, at 368–70 (describing public PRI providers’ eligibility and compliance issues).

conflicts, Brexit, or other hostilities towards foreign investment.<sup>90</sup> The high transaction costs of private PRI may prevent smaller investors from obtaining any coverage at all, placing them at severe risk of loss in the event of further escalation.<sup>91</sup> For those that can afford it, private options still lack the special benefit of deterrence inherent in public coverage. To better serve the needs of investors and government policy interests, public providers of PRI should be allowed to expand their coverage options to insure the political risks emerging in the developed world. This should include expanding eligibility for new and existing investments in developed countries in order to combine the flexibility of private PRI with the inherent advantages of government-backed coverage. Doing so will protect the interests of many small-to-medium-sized firms while also advancing government foreign policy goals.

A. PUBLIC PRI IS UNIQUELY SUITED FOR THE NEW POLITICAL RISKS

Government-backed PRI has a clear advantage over coverage offered by private insurers because public providers possess unique abilities to assess risks and prevent or recover losses.<sup>92</sup> Despite the improvements made by private insurers and the regulatory drawbacks of public options, there are clear advantages to purchasing coverage through a public insurer. These advantages cannot be replicated by the private sector because they stem from a public provider's position as a government entity. A government-backed insurer such as DFC is in the best position to be aware of current trade negotiations as well as other possible retaliatory actions by host-governments. In contrast to private PRI options, public providers have the tools and resources to assess, prevent, and mitigate losses resulting from adverse government actions.<sup>93</sup> They can use their existing diplomatic

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<sup>90</sup> *Id.* at 369–70; Williams, *supra* note 11, at 76.

<sup>91</sup> Waters, *supra* note 1, at 376.

<sup>92</sup> Gordon, *supra* note 19, at 105 (“[I]n this sector, governments have unique competitive strengths . . . primarily from governments’ ability to use their diplomatic networks as risk management and asset recovery tools—in this way, governments create economies of scope by using their existing assets to provide services that private sector insurers cannot produce.”).

<sup>93</sup> P. Georgia Bullitt & Laura I. Lagomarsino, *Protecting Intellectual Property Rights Abroad: New Uses for Political Risk Insurance and Standby Letters of Credit*, 5 INT’L TAX & BUS. LAW. 283 (1987) (noting that given public agencies’ information advantage collection abilities, “it is difficult to conceive of how the private market could adequately compete with it”).

networks to obtain information about pending government actions in host-countries. Public insurers can then intervene to prevent the action or recoup the value of the loss later.<sup>94</sup> By utilizing their information-sharing networks to quickly gather and disseminate intelligence, public PRI providers use their political clout to discourage adverse governmental action.<sup>95</sup> They would also be able to alert investors as events are unfolding to allow them to mitigate any potential losses.

Allowing public options such as DFC to insure risks arising from political conflicts in developed nations would in effect shift government-created risks away from the private sector. Placing that risk in a government agency would then encourage the sharing of information about the potential impact of proposed home-government actions. Just as DFC and MIGA closely monitor risks in developing nations and hold discussions with host-governments when necessary, the agencies could similarly share their risk assessments with their own governments regarding possible retaliatory action.<sup>96</sup>

PRI backed by the U.S. government or the World Bank has a built-in deterrent effect and these agencies often use their positions to prevent or mitigate losses.<sup>97</sup> A host government may be less likely to seize assets or enact adverse legislation knowing they will face repercussions if they cause a loss to assets insured by a government entity. Besides having a passive deterrent effect, public coverage may also have the benefit of active deterrence. Public options like DFC and MIGA can use their global information networks to learn of potential threats and then use their political weight to pressure a host government against retaliatory actions.<sup>98</sup> Thus, having the backing of the U.S. government or the World Bank is a significant advantage for not only insuring assets, but also for proactively protecting them. Some public insurers may intervene to dissuade a host government

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<sup>94</sup> Gordon, *supra* note 19, at 94 (discussing agency interventions, known as “advocacy”).

<sup>95</sup> *E.g., id.* at 102 (describing an instance where OPIC, DFC’s predecessor, sent a letter to a provincial tax ministry to defer enforcement actions until the case was fully adjudicated).

<sup>96</sup> Waters, *supra* note 1, at 376 (discussing the information back channels available to public insurers and OPIC’s close consultation with the U.S. State Department).

<sup>97</sup> Gordon, *supra* note 19, at 94 (“If the host government believes that the home government is more of a force to be reckoned with than the investor, then it is less likely to engage in the behaviour . . .”).

<sup>98</sup> Waters, *supra* note 1, at 376.

from taking action that adversely impacts assets that they insure.<sup>99</sup> For example, MIGA policies require prompt notification of any event that might lead to a loss in order to give MIGA the ability to use their political influence as part of the World Bank Group to prevent adverse government actions.<sup>100</sup> Public insurers may also use their position to mitigate losses even where they are unable to prevent the adverse action from occurring. For instance, a government-backed provider facing a currency inconvertibility claim can simply buy that currency and sell it to its local embassy to use for other government purposes.<sup>101</sup> This procedure—which is not available to any private insurer—allows the agency to sidestep a central bank’s currency restriction and significantly reduce losses.<sup>102</sup>

Another advantage is that government-backed PRI providers function more as tools of foreign policy than as for-profit enterprises.<sup>103</sup> Volatility is high in PRI and one adverse event or series of correlated events may extinguish years of profits.<sup>104</sup> Therefore, private providers set premiums far in excess of expected losses because they have no method of reliably assessing risk or calculating probability.<sup>105</sup> In contrast, public insurers only operate on a break-even basis and may rely on their network of embassies and intelligence agencies to collect information to help them assess risk and set premiums. Though private insurers have narrowed the information gap by turning to private consultants, they are not privy to confidential information that can only be accessed by government actors.<sup>106</sup> These consultants will always lack access to communications between state actors, such as a host government’s interactions with the U.S. State Department.<sup>107</sup>

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<sup>99</sup> *Id.* at 377.

<sup>100</sup> See MULTILATERAL INV. GUAR. AGENCY, CONTRACT OF GUARANTEE FOR EQUITY INVESTMENTS, art. 12.1(i) (2018), <https://www.miga.org/sites/default/files/2020-06/MIGA%20Equity%20Investments%20Template%20October%202018.pdf>.

<sup>101</sup> Gordon, *supra* note 19, at 105; Robert B. Shanks, *Insuring Investment and Loans Against Currency Inconvertibility, Expropriation, and Political Violence*, 9 HASTINGS INT’L & COMPAR. L. REV. 417, 426–27 (1986).

<sup>102</sup> Shanks, *supra* note 101, at 427.

<sup>103</sup> Waters, *supra* note 1, at 375; Kessler, *supra* note 21, at 224.

<sup>104</sup> HAMDANI ET AL., *supra* note 12, at 4–5.

<sup>105</sup> *Id.* at 4 (“Given this potential for catastrophic loss, as well as the difficulties in assessing the underlying risk . . . [i]t is not surprising that PRI, like other insurance lines with catastrophe potential (e.g., earthquake), exhibits prices well in excess of expected losses.”).

<sup>106</sup> DeLeonardo, *supra* note 31, at 756.

<sup>107</sup> Waters, *supra* note 1, at 375–76.

DFC regularly consults with the State Department and can obtain confidential information from the Central Intelligence Agency.<sup>108</sup> This intelligence gathering network allows them to set higher premiums for riskier investments and reduce premiums for those of a lower risk grade.<sup>109</sup> While calculating probability is a challenge for public providers due to the nature of the risks involved,<sup>110</sup> they still benefit from superior intelligence-gathering, deterrence, and lack of profit-motive.

Public providers' ability to remove profit from the equation results in a significant price-advantage that appeals to smaller businesses and investors. Because PRI policies are often tailor-made for each investment, they carry significant transaction costs that often make private options cost prohibitive for smaller investments.<sup>111</sup> This is particularly true when examining the kinds of threats facing firms and investors in developed democracies. These businesses may be less likely to suffer losses from political violence than they are from adverse actions taken by politically-motivated populist leaders. This is precisely the kind of political risk event that is impossible to predict and which private insurers are powerless to prevent.<sup>112</sup> Most off-the-shelf political risk indicators attempt to measure risk on a country-level basis and users relying on such data will still have to conduct extensive analysis because political risks are often industry- or firm-specific.<sup>113</sup> In many situations, there will be few to zero similar events in the past from which to calculate probabilities and past events may be difficult to define, such as differentiating between legitimate regulatory action and creeping expropriation.<sup>114</sup>

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<sup>108</sup> Kessler, *supra* note 21, at 207.

<sup>109</sup> Waters, *supra* note 1, at 375.

<sup>110</sup> E.g., Derek Baas, *Approaches and Challenges to Political Risk Assessment: The View from Export Development Canada*, 12 RISK MGMT. 135, 158 (2010) (explaining the challenges that Canada's primary public provider of PRI has experienced when trying to calculate the probability of political risk events).

<sup>111</sup> Waters, *supra* note 1, at 376.

<sup>112</sup> Jason Webb Yackee, *Political Risk and International Investment Law*, 24 DUKE J. COMPAR. & INT'L L. 477, 487 (2014).

<sup>113</sup> *Id.* at 484 (explaining that project-specific analysis is important because even in countries rated as low-risk, the risk of a specific permit being denied may be quite high).

<sup>114</sup> *Id.* at 485–88.

## B. FLEXIBLE PUBLIC PRI OPTIONS ADVANCE POLICY GOALS

The restrictions placed on public PRI providers leaves private insurers with a gap to fill in the market. The success of the private PRI market can be attributed to private insurers' policy flexibility and general lack of categorical prohibitions. Investors that are unable to comply with the eligibility requirements of public insurers like DFC or MIGA may instead choose a private policy.<sup>115</sup> Public options, such as DFC or MIGA, have coverage restrictions and insureds must comply with various social and environmental standards.<sup>116</sup> Public providers restrict coverage to a limited set of risks in developing nations and typically set upper limits on the amount covered under the policy.<sup>117</sup> MIGA has restrictive requirements, requiring not only that insureds be citizens of member states, but that the investment be new and be carried out in a member state covered under a Bilateral Investment Treaty or be protected under a local law or local agreement with MIGA.<sup>118</sup> Additionally, public providers must follow any applicable statutory mandates, such as DFC's mandate from Congress to promote the development of new projects in emerging markets.<sup>119</sup>

Loosening eligibility restrictions would end the requirement to refuse coverage to an expanding U.S.-based firm moving a production plant from the U.K. to Italy, now under the control of populists, but provide insurance if they moved it to a risk-prone developing state in South Asia. This forces firms to choose between investing in a lower risk but politically volatile country with inadequate private coverage, or a higher risk unstable emerging market with the full backing of their home government. It may be desirable to refuse support for business actions that harm domestic workers, such as off-shoring jobs, but allowing agencies to extend PRI coverage to firms with existing interests in developed countries would not necessarily violate such mandates. There may be good policy reasons for promoting

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<sup>115</sup> Waters, *supra* note 1, at 377.

<sup>116</sup> *Id.* at 377; Williams, *supra* note 11, at 75–76; *Who We Are*, DFC, <https://www.dfc.gov/who-we-are> (last visited Mar. 11, 2021); *What We Do*, MIGA, <https://www.miga.org/products> (last visited Mar. 11, 2021).

<sup>117</sup> See, e.g., *Eligibility Checklist*, DFC, <https://www.dfc.gov/what-we-offer-eligibility/eligibility-checklist> (offering coverage up to \$500 million for projects in lower- and middle-income countries subject to environment and worker rights policies); *Our Process*, MIGA, <https://www.miga.org/our-process> (Mar. 11, 2021) (limiting coverage to investments in developing member countries for up to \$250 million).

<sup>118</sup> Williams, *supra* note 11, at 83–85.

<sup>119</sup> *Id.* at 76; Waters, *supra* note 1, at 369.

development in emerging markets but there are also compelling reasons to protect existing investments in developed economies.

Countries such as China have actively promoted development in continental Europe and government-backed Chinese companies have invested billions of dollars throughout the region.<sup>120</sup> The United States has taken some action in response, such as passing the Better Utilization of Investment Leading to Development Act<sup>121</sup> (BUILD Act) in 2018, but the act was limited to low- and middle-income countries.<sup>122</sup> The United States may understandably have no need or desire to actively promote American investment in the E.U. but it does have a legitimate interest in protecting assets of citizen-investors in the region. At the very least, the BUILD Act should have loosened restrictions to allow purchases of PRI in more regions. This makes sense given that the BUILD Act was passed, at least in part, in response to China's investments in Europe. The Act states that DFC is meant to serve as an alternative to authoritarian government-backed investments.<sup>123</sup> By excluding entire regions such as Europe, where China's influence is growing, this limitation undercuts one of the purposes of the Act. Therefore, allowing public insurers to offer more flexible coverage for the emerging political risks in developed countries not only satisfies the needs of small- to medium-sized businesses but also advances home-government policy goals.

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<sup>120</sup> FRANÇOIS GODEMENT & ABIGAËL VASSELIER, CHINA AT THE GATES: A NEW POWER AUDIT OF EU–CHINA RELATIONS, 37–39 (2017); *see also* Janosch Delcker, *Germany's Chinese Investment Problem*, POLITICO EUR. (Nov. 25, 2016), <https://www.politico.eu/article/germanys-chinese-investment-problem-sigmar-gabriel-eu/> (reporting the conflict arising from China's plan to invest heavily in Europe).

<sup>121</sup> The BUILD Act was enacted as Division F of the FAA Reauthorization Act of 2018, Pub. L. No. 115-254 § 1401 et. seq., 132 Stat. 3485.

<sup>122</sup> Under the BUILD Act, §§ 1402 and 1411, DFC's activity is limited to low- and middle-income markets. This is in contrast to its predecessor OPIC's governing statute, 22 U.S.C. § 2191, which only required that developing countries be given preferential treatment. *See* SHAYERAH ILLIAS AKHTAR & MARIAN L. LAWSON, CONG. RSCH. SERV., R45461, BUILD ACT: FREQUENTLY ASKED QUESTIONS ABOUT THE NEW U.S. INTERNATIONAL DEVELOPMENT FINANCE CORPORATION 1, 14 n.27 (2019).

<sup>123</sup> The BUILD Act, Pub. L. 115-254, 132 Stat. 3486, does not mention China by name but alludes to it in § 1411 by stating that one of the Act's goals is to "to provide countries a robust alternative to state-directed investments by authoritarian governments . . . ."

## V. CONCLUSION

The market for political risk insurance is evolving. Public options are often preferable but are less flexible than private policies. New political risks emerging in the developed world, primarily as a result of rising populism, democratic instability, and trade conflicts, are currently not insurable by public PRI providers. In the absence of eligibility changes, investors must rely on private coverage to fill the gap in the PRI market. Allowing government-backed options to expand coverage and loosen eligibility requirements would combine some of the flexibility seen in the private market with the widely recognized benefits inherent in public PRI coverage.



# RACIST ROBOTS AND THE LACK OF LEGAL REMEDIES IN THE USE OF ARTIFICIAL INTELLIGENCE IN HEALTHCARE

TYLER DUENO\*

*This article examines the rapidly accelerating use of powerful artificial intelligence to make healthcare decisions. Artificial intelligence promises many benefits: affordable and accessible healthcare; diagnostic accuracy; and efficiently streamlining tasks related to prior authorization procedures. However, the perils involve proxy discrimination—an insidious form of a disparate impact claim—involving biases inadvertently coded into an algorithm disproportionately harming members of a protected class. As most Americans have employer-provided health insurance governed by the Employee Retirement Income Security Act of 1974 (ERISA), this paper argues there are no adequate legal remedies for consumers injured by proxy discrimination. The history of health insurance explains why employer-provided health insurance has exploded, which has exacerbated our ability to fashion a suitable remedy. This paper concludes federal legislation is needed to bring our regulatory structure into the computational age.*

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## I. INTRODUCTION

Predictive health analytics, also known as artificial intelligence (AI),<sup>1</sup> promises vast benefits and is now widely used in the delivery of healthcare. But AI poses a danger: unintentional proxy discrimination. Like other forms of disparate impact claims, proxy discrimination involves facially neutral practices that disproportionately harm members of a protected class.<sup>2</sup> Unintentional proxy discrimination is an especially dangerous form of a disparate impact claim because its biases are inadvertently coded into AI's rational step-by-step decision-making process. The most prominent use of AI is in workplace hiring practices to predict future performance; however, some algorithms reject women when hiring a new candidate.<sup>3</sup> In the health care context, AI can ruthlessly harm patients by denying medically-necessary healthcare. Surprisingly, however, the lack of legal remedies to address an unintentional disparate impact claim arising from the use of AI in health care is largely unexplored in academic literature.

AI can harm patients by denying expensive medically necessary treatments. This is a widely recognized problem by insurance regulators, with many scholars discussing ways to correct the situation, including the use of an "algorithm audit."<sup>4</sup> What is conspicuously absent from this

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<sup>1</sup> *Artificial Intelligence*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/artificial%20intelligence> (last visited Nov. 21, 2020). AI is a computer program using a step-by-step procedure to make calculations giving it the ability to imitate human decision-making.

<sup>2</sup> Disparate impact discrimination occurs when "practices that are facially neutral in their treatment of different groups . . . in fact fall more harshly on one group than another. . . ." *Int'l Brotherhood of Teamsters v. United States*, 431 U.S. 324, 335 n.15 (1977).

<sup>3</sup> Jeffrey Dastin, *Amazon Scraps Secret AI Recruiting Tool That Showed Bias Against Women*, REUTERS (Oct. 10, 2018, 7:04 PM), <https://www.reuters.com/article/us-amazon-com-jobs-automation-insight/amazon-scraps-secret-ai-recruiting-tool-that-showed-bias-against-women-idUSKCN1MK08G>.

<sup>4</sup> See generally Max Dorfman, *Algorithms, A.I. and Insurance: Promise and Peril*, INS. INFO. INST. (Dec. 12, 2019), <https://www.iii.org/insuranceindustryblog/algorithms-a-i-and-insurance-promise->

discussion, however, and what this article seeks to add, is how our current segmented system of employer-sponsored health insurance exacerbates this problem and leaves the consumer with limited legal remedies. This paper argues the United States' segmented system cannot adequately address this unintentional discrimination despite our growing dependence on algorithms to make healthcare decisions. Moreover, current legal remedies are ill-equipped to safely regulate society's growing dependence on AI in healthcare.

The scope of this paper is not to explain the many ways that AI can go awry. This has been discussed elsewhere.<sup>5</sup> Rather, the intention of this paper is to shed light on the lack of legal remedies in AI-driven healthcare highlighting the high administrative costs of solutions arising from our current disjointed healthcare system. Legal remedies are limited because of the unique historical development of health insurance in the United States.

This Article proceeds as follows: Part I describes the promises of AI to increase access to affordable healthcare and the perils of AI-driven harm to patients; Part II identifies how the United States' current segmented health financing system contributes to the problem of regulation and creates the problem of inadequate legal remedies; Part III then explains the limitations and shortcomings of remedies in their current form; and, Part IV highlights the solution of federal legislation that allows class-actions and agency oversight, thus permitting our regulatory system to enter the computational age.

## II. THE PROMISE AND PERILS OF ARTIFICIAL INTELLIGENCE IN HEALTHCARE

### A. THE PROMISES

AI is playing a more prominent role in healthcare. The increasing complexity of medical care, the rising costs of treatment, and the abundance of patient medical data has increased the use and demand of predictive health analytics. AI is an efficient means to make complex medical decisions and

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and-peril/ (investigating a healthcare algorithm used to determine who requires expensive health care services disproportionately harmed minorities by denying medically necessary treatments).

<sup>5</sup> James Guszczka et al., *Why We Need to Audit Algorithms*, HARV. BUS. REV. (Nov. 28, 2018), <https://hbr.org/2018/11/why-we-need-to-audit-algorithms>.

reduce administrative costs moving into the domain of diagnosing patients and developing treatment options, making healthcare available to those that cannot access or afford it.<sup>6</sup> In a study of 1,634 images of cancerous and healthy lung tissues, AI correctly predicted the type of lung cancer with comparable precision to three pathologists.<sup>7</sup> Here, AI had the same diagnostic competency as a pathologist.

AI promises to reduce gaps in health outcomes caused by geographic barriers and racial disparities. One example of this is rural access to health care. Technologies like telemedicine allow health providers to bring a portable health facility to patients in rural areas. Health organizations can bring sophisticated medical care to a rural community, rather than force the community to travel to them.

The Centers for Disease Control and Prevention (CDC) noted that the highest mortality rates occur in the most rural sections of the United States.<sup>8</sup> A CDC report explains that minorities residing in rural areas are much more likely to report to never having seen a physician over the past year because of the prohibitive cost.<sup>9</sup> Likewise, the CDC also found that residents in rural areas suffered from higher incidences of cancer-related deaths.<sup>10</sup> The report suggests that access to preventative visits with a doctor is an underlying reason for the disparity in cancer-related deaths.<sup>11</sup>

The benefits of AI are not confined to vulnerable communities. AI promises to optimize and even automate the insurer's prior authorizations decisions for medical care.<sup>12</sup> The prior authorization process is complex,

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<sup>6</sup> Mary Anne Bobinski, *Law and Power in Health Care: Challenges to Physician Control*, 67 BUFF. L. REV. 595, 637 (2019).

<sup>7</sup> Nariman Noorbakhsh-Sabet et al., *Artificial Intelligence Transforms the Future of Healthcare*, 132 AM. J. MED. 795 (2019).

<sup>8</sup> Cara V. James, PhD, et al., *Racial/Ethnic Health Disparities Among Rural Adults — United States, 2012–2015*, 1–2 CTRS. FOR DISEASE CONTROL AND PREVENTION (Nov. 17, 2017), <https://www.cdc.gov/mmwr/volumes/66/ss/ss6623a1.htm>.

<sup>9</sup> *Id.*

<sup>10</sup> *New CDC Report shows deaths from cancer higher in rural America*, CTRS FOR DISEASE CONTROL AND PREVENTION (July. 6, 2017), <https://www.cdc.gov/media/releases/2017/p0706-rural-cancer-deaths.html> (last visited Mar. 11, 2021).

<sup>11</sup> *Id.*

<sup>12</sup> Pre-authorizations are a cost-containment device whereby the insurer is verifying whether a treatment or medication is medically necessary to avoid the over-consumption of healthcare. *See generally* Prior Authorization Services CIGNA, <https://www.cigna.com/medicare/resources/prior-authorization-services> (last visited March 12, 2021).

time-consuming, and administratively burdensome, sometimes resulting in conflicting medical decisions causing harmful delays in treatment. These problems generated by prior authorization are so widespread and acute that the American Hospital Association, America's Health Insurance Plans, the American Medical Association, and the BlueCross BlueShield Association have jointly released a statement identifying problematic areas and urging corrective action.<sup>13</sup>

It is in this environment that public health experts are hailing AI, which promises to automate the entire process, by considering all risk factors and patient health information—and recommending a logical treatment decision for the patient. In 2011, Jeopardy showcased this capability of fast automated decision-making when IBM Watson defeated all-time champions, Ken Jennings and Brad Rutter.<sup>14</sup> In 2021 and beyond, the health industry has embraced future IBM Watsons to automate its decision-making for treatment decisions.<sup>15</sup>

AI can increase access to healthcare in rural areas that lack medical personnel through telemedicine. AI also promises to identify at-risk health populations for current diseases where symptoms have not manifested, and diseases that may emerge in the future. As a result, many healthcare systems and commercial insurers are now relying on algorithms to proactively identify higher-risk individuals to help manage complex patient diagnoses.<sup>16</sup>

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<sup>13</sup> Press Release, Consensus Statement on Improving the Prior Authorization Process, AM. MED. ASS'N, <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf> (on file with author).

<sup>14</sup> John Markoff, *Computer Wins on 'Jeopardy!': Trivial, It's Not*, N.Y. TIMES (Feb. 16, 2011), <https://www.nytimes.com/2011/02/17/science/17jeopardy-watson.html>.

<sup>15</sup> Alicia Phaneuf, *Use of AI in Healthcare & Medicine is Booming—Here's How the Market is Benefiting from AI in 2020 and Beyond*, BUS. INSIDER (July 31, 2019), <https://www.businessinsider.com/an-algorithm-treatment-to-white-patients-over-sicker-black-ones-2019-10>.

<sup>16</sup> Obermeyer et al., *Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations*, 366 SCIENCE 447, 447 (Oct. 25, 2019), <https://science.sciencemag.org/content/366/6464/447/tab-pdf>.

Some estimates predict annual spending on healthcare AI to have a compound annual growth rate of nearly fifty percent.<sup>17</sup>

## B. THE PERILS

An insurer's decision on whether to reimburse a procedure or medication can be complex and time-consuming. The pre-authorization process involves an antiquated procedure: relying on fax machines, physicians calling busy signals, blurry print on documents, and messages misdirected to wrong numbers, which can cause delays.<sup>18</sup> A 2019 AMA survey revealed physicians, on average, wait three business days for a decision, and that these delays have both harmed and occasionally led to patient hospitalization.<sup>19</sup> AI offers a time and cost-saving solution.<sup>20</sup> But when AI is tasked with pre-authorizations or other medical decisions, which party should be held responsible for unsafe results? Transparency must exist to ensure the clinical safety and quality of this burgeoning technology. Yet, AI can still be a black box that issues verdicts without accompanying reasons.

Observers of the health care sector have criticized the adoption of algorithms arguing the users have not adequately considered the implications of the use of such technology—such as relying on questionable inputs. When these faulty inputs are codified into algorithms, they can perpetuate injustices and lead to the misapplication of healthcare resources.<sup>21</sup>

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<sup>17</sup> Allana Akhtar, *New York is Investigating UnitedHealth's Use of a Medical Algorithm that Steered Black Patients Away from Getting Higher-Quality Care*, BUS. INSIDER (Oct. 28, 2019, 11:02 AM), <https://www.businessinsider.com/an-algorithm-treatment-to-white-patients-over-sicker-black-ones-2019-10> (“[S]pending on healthcare AI is projected to grow at an annualized 48% between 2017 and 2023.”).

<sup>18</sup> Pharmacy Insights Closer Look, *Prior Authorization Delays: Causes and Impacts*, OPTUMRX (2018), [https://www.optum.com/content/dam/optum3/optum/en/resources/articles-blog-posts/m54610-b4\\_prechksript\\_deeper\\_dive.pdf](https://www.optum.com/content/dam/optum3/optum/en/resources/articles-blog-posts/m54610-b4_prechksript_deeper_dive.pdf).

<sup>19</sup> Andis Robeznieks, *1 in 4 Doctors Say Prior Authorization Has Led to a Serious Adverse Event*, AMA (Feb. 5, 2019), <https://www.ama-assn.org/practice-management/sustainability/1-4-doctors-say-prior-authorization-has-led-serious-adverse> (highlighting that twenty-eight percent of 1,000 practicing physicians surveyed “report[] that prior authorization has led to a serious adverse event . . .”).

<sup>20</sup> Phaneuf, *supra* note 15.

<sup>21</sup> Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 IND. HEALTH L. REV. 139, 168 (2018).

A rejoinder to criticism of AI is that everyone has hidden biases, and that opaque decision-making is common in healthcare. In this respect, AI is no different than our current healthcare system, and therefore concern about AI is exaggerated. Although the similarities may be correct as an empirical matter, it ignores the larger context of AI within healthcare. The use of powerful machine learning software is rapidly accelerating in development. The allure to consumers and clinicians is the ability to allow a computer to make rational decisions using vast stores of medical data—without subjective biases—and achieving diagnostic accuracy. But the risks are minimized. Whereas before, when bias may have existed on a case-by-case basis, the unfettered use of AI can systemize bias in health facilities across the country. Simply because there are other causes of disparate impact does not mean this problem should be ignored.

For example, imagine an AI-based clinical decision support software helping physicians diagnose skin cancer.<sup>22</sup> Patients can now upload an image of suspect skin into an algorithm-based smartphone application that tells the patient whether the patient must go see a dermatologist, and, if so, instantly generates the referral.<sup>23</sup> The software could be harmful when the recommendations are erroneous causing a delay in people in obtaining medical care. As studies have already shown, the incidence of skin cancer depends on the color of one's skin.<sup>24</sup>

MIT researchers have demonstrated that AI can retain skin biases—with the AI essentially guessing at random— but can still claim a high success rate.<sup>25</sup> The studies used to attest to AI safety may be misleading due to fundamentally flawed data sets used in the statistical analysis. The MIT study analyzed over 1,200 images finding the facial-recognition software had a thirty-four percent error rate when identifying darker skin tones, especially

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<sup>22</sup> Images of lesions are categorized high or low risk for skin cancer (usually melanoma).

<sup>23</sup> Freeman et al., *Algorithm Based Smartphone Apps to Assess Risk of Skin Cancer in Adults: Systematic Review of Diagnostic Accuracy Studies*, BMJ (Feb. 10, 2020), <https://www.bmj.com/content/368/bmj.m127>.

<sup>24</sup> Porcia T. Bradford, *Skin Cancer in Skin of Color*, DERMATOLOGY NURSING, 170, 171 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2757062/>.

<sup>25</sup> Larry Hardesty, *Study Finds Gender and Skin-Type Bias in Commercial Artificial-Intelligence Systems*, MIT NEWS (Feb. 11, 2018), <https://news.mit.edu/2018/study-finds-gender-skin-type-bias-artificial-intelligence-systems-0212>.

among women.<sup>26</sup> But the data set claimed the error was never less than 0.8 percent—substantially different than the thirty-four percent.<sup>27</sup> This discrepancy arose because the patient data used to assess the software’s performance was seventy-seven percent male and eighty-three percent white. This same problem of defective statistical analysis can exist within clinical AI.

The clinical software could be guessing at diagnosis but still claim a high success rate. If the underlying data is underinclusive for subpopulations, then AI can produce skewed results. This is a concern many researchers have already voiced about poor-performing software.<sup>28</sup> The results are either disparate health outcomes or claim denials because the insurer believes the requested treatment is not medically necessary.<sup>29</sup>

Under this set of facts, due to the disparate treatment of a protected class of individuals with skin cancer, the insurers would be liable under state and federal laws, such as New York’s Insurance Law,<sup>30</sup> Human Rights Law,<sup>31</sup> a deceptive business practice under N.Y. General Business Law,<sup>32</sup> and Title VII of the Civil Rights Act<sup>33</sup> which prohibits discrimination.<sup>34</sup>

Instances of AI health inconsistencies are well-documented. One recent example is the New York insurance regulator’s investigation into Impact Pro, the creator of an algorithm that is widely used in healthcare.<sup>35</sup> A

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<sup>26</sup> *See id.*

<sup>27</sup> Hardesty, *supra* note 25.

<sup>28</sup> Freeman et. al., *supra* note 23, at 1, 2.

<sup>29</sup> “Medically necessary” or a “medical necessity” exists when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or alleviate severe pain. This explanation typically comes in a document called an Explanation of Benefits (EOB) from the insurer.

<sup>30</sup> N.Y. INS. LAW § 2606(a)(1) (McKinney 2019) (providing, in pertinent part, that no insurer “shall because of race, color, creed, national origin, or disability: (1) Make any distinction or discrimination between persons as to the premiums or rates charged for insurance policies or in any other manner whatever.”).

<sup>31</sup> N.Y. EXEC. LAW § 296 (McKinney 2014) (New York State Human Rights Law).

<sup>32</sup> N.Y. GEN. BUS. LAW § 349(a) (McKinney 2014), “Deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state are hereby declared unlawful.”

<sup>33</sup> Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(k).

<sup>34</sup> *See* Letter from Linda A. Lacewell, Superintendent of N.Y. State Dep’t of Fin. Servs. & Howard A. Zucker, Comm’r N.Y. State Dep’t of Health to UnitedHealth Group (Oct. 25, 2019), available at <https://dfs.ny.gov/system/files/documents/2019/10/20191025160637.pdf>.

<sup>35</sup> Akhtar, *supra* note 17.



prominent peer-reviewed journal discovered white patients were treated more favorably and received more expensive health procedures than sicker black patients between 2013 and 2015 because the algorithm made distinctions based on race.<sup>36</sup> The AI excluded black patients from receiving costlier complex health procedures at a higher rate than white patients.<sup>37</sup> The bias arose because healthcare costs were used as a proxy for the severity of illness but, “[d]espite health care cost appearing to be an effective proxy for health by some measures of predictive accuracy, large racial biases ar[o]se.”<sup>38</sup> Here, the AI relied on a rational reason to distinguish between healthy and sick people: by reasoning by proxy that lower health costs meant people were generally healthier. But lower healthcare costs did not mean the patient was healthier. As a result, black patients were excluded from receiving medically necessary treatments.<sup>39</sup> AI can promote the same race-based discrimination that we have seen elsewhere, despite purporting to be race-neutral. Here though, it is more hidden.

The algorithm created by data scientists is not the only problem that can cause harm. The algorithm may be perfectly programmed within the machine-learning process (a step-by-step procedure for solving a problem) by treating everyone the same when making its decision, but it can still produce discriminatory results. Even in a perfect world, where the data scientists carefully program the algorithm so that it does not discriminate based on factors such as race, ethnicity, religion, or any other socio-economic factor—the underlying data could be skewed—with the data producing skewed results.<sup>40</sup>

Examples abound with AI making questionable decisions. In 2014, Amazon developed software to aid in its recruitment of qualified engineers. However, the algorithm discriminated against women and Amazon

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<sup>36</sup> *Id.*

<sup>37</sup> Melanie Evans & Anna Wilde Mathews, *New York Regulator Probes UnitedHealth Algorithm for Racial Bias*, WALL ST. J. (Oct 26, 2019, 7:00 AM), <https://www.wsj.com/articles/new-york-regulator-probes-unitedhealth-algorithm-for-racial-bias-11572087601/>.

<sup>38</sup> Obermeyer, *supra* note 16, at 1.

<sup>39</sup> Akhtar, *supra* note 17.

<sup>40</sup> If the data is flawed, then the algorithm is fundamentally flawed, so these components go together. For example, in an algorithm:  $w(xy) + w(yz) \geq w(xz)$ ; the “w” is the weight assigned to the data points. If the data points are erroneous, the entire equation will yield the wrong results.

subsequently abandoned the software in 2017.<sup>41</sup> Likewise, in 2016, judges used AI to help predict the likelihood of recidivism when making sentencing decisions. But the algorithm discriminated against black individuals and was subsequently abandoned.<sup>42</sup> In 2019, law enforcement used a facial-analysis program to identify criminal suspects—and the algorithm falsely identified blacks as criminal suspects.<sup>43</sup>

Insurance regulators are already performing “algorithm audits,” but are not equipped to understand the nuances of machine-learning algorithms and are only prepared to respond once a disparity has been discovered. Insurance regulators are not computer scientists and cannot examine AI ex-ante to ensure its safety. AI is designed to predict future outcomes so unless ex-ante legal remedies are developed, then the harm can only be remedied once it has already been done.<sup>44</sup> A regulatory regime must be tailored to avoid these disparities in the future. This ongoing discussion in assessing legal remedies is important, but it is conspicuously absent from the academic literature.

### III. OUR HEALTH CARE FINANCING SYSTEM

To understand the use of AI in healthcare, we must first understand our healthcare financing system which is dominated by employer-provided health insurance. First, the current healthcare financing system is tied to AI

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<sup>41</sup> Jonathan Shaw, *Artificial Intelligence & Ethics*, HARV. MAG., Jan.–Feb. 2019, at 44, 45.

<sup>42</sup> *Id.*; see also Julia Angwin, Jeff Larson, Surya Mattu & Lauren Kirchner, *Machine Bias*, PROPUBLICA (May 23, 2016), <https://www.propublica.org/article/machine-bias-risk-assessments-in-criminal-sentencing>. But see Ed Yong, *A Popular Algorithm Is No Better at Predicting Crimes Than Random People*, THE ATLANTIC (Jan. 17, 2018), <https://www.theatlantic.com/technology/archive/2018/01/equivant-compas-algorithm/550646/> (citing studies showing the recidivism algorithm had equal predictive accuracy).

<sup>43</sup> See *NIST Study Evaluates Effects of Race, Age, Sex on Face Recognition Software*, NAT’L INST. STANDARDS & TECH. (Dec. 19, 2019), <https://www.nist.gov/news-events/news/2019/12/nist-study-evaluates-effects-race-age-sex-face-recognition-software>; Larry Magid, *Facial Recognition Loses Support as Bias Claims Rise*, MERCURY NEWS, (July 3, 2020, 6:19 AM), <https://www.mercurynews.com/2020/07/02/magid-facial-recognition-accused-in-racial-bias-being-pulled-back-by-cities-and-companies/>.

<sup>44</sup> Solon Barocas & Andrew D. Selbst, *Big Data’s Disparate Impact*, 104 CALIF. L. REV. 671, 707 (2016) (“Data mining is designed entirely to predict future outcomes”).

through the experience-rating system,<sup>45</sup> which looks to reduce costs when possible. Second, I argue ERISA governing employer-based health insurance contributes to the lack of legal remedies for injured consumers.

The health insurance market is divided into four different categories: the self-insured, large employers, small employers, and individual markets, each of which is governed by different regulations and laws. Access to remedies varies by market, a consequence of our fragmented health care system and its disjointed development.

A. THE CREATION OF HOSPITAL INSURANCE AND THE PHYSICIAN'S  
REACTION

Modern health insurance began in the United States during the Great Depression in Dallas, Texas. The Great Depression left wealthy donors poor and patients with less disposable income. Hospitals were going broke once these sources of income disappeared.<sup>46</sup> In 1929, Baylor University created a program of prepaid hospitalization benefits to generate steady income. In exchange for fifty cents a month, Baylor provided three weeks of hospitalization to Dallas County school teachers.<sup>47</sup> The program was a success and other hospitals began to offer the same type of plan.

These hospital pre-payment plans inspired physicians to establish similar plans with employers to care for injuries and sicknesses for employers' workers.<sup>48</sup> The first version of physician-benefit plans began in 1929—the same year hospital pre-payment plans began.<sup>49</sup> From the beginning, health insurance for hospitals and physicians—despite the common purpose to finance healthcare decisions—developed as separate regimes.

This emergence of the private market for health insurance excluded the population that could not afford health insurance or were historically too sick to qualify: the elderly, poor, and unemployed. Because of this gap, the federal government created a new avenue to access health insurance. In July

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<sup>45</sup> Experience-rating uses the individual or business's unique risk profile to develop a unique rate. See *Experience-Rating*, BLACK'S LAW DICTIONARY (11th ed. 2019).

<sup>46</sup> PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 295 (1982).

<sup>47</sup> *Id.*

<sup>48</sup> *Id.* at 301.

<sup>49</sup> *Id.*

1965, President Lyndon B. Johnson signed into law legislation that established the Medicare and Medicaid programs. Subsequently, in 2010, President Barack Obama signed the Affordable Care Act (ACA), which created new health insurance exchanges within each state where eligible consumers could purchase health insurance with a government subsidy to help pay for the plan.<sup>50</sup> Exchanges were created for individuals to purchase health insurance.<sup>51</sup>

Thus, the development of health insurance in the United States has been fragmented in the ways by which a consumer accesses health insurance. Consumers access health insurance via state-exchanges, employer-provided health insurance, Medicare, Medicaid, individual and small-group marketplace through commercial insurers, association plans that are not within the scope of the ACA, or short-term disability plans. The federal and states agencies are scattered over fifty states since the states primarily regulate the business of insurance. Federal laws govern remedies in some cases, and state laws govern remedies in others. Because of these developments, uniformity in legal remedies to regulate AI is nearly impossible given our current system.

#### B. THE RISE OF EXPERIENCE-RATING AND EMPLOYER-CENTRIC HEALTH INSURANCE

During World War II, tax advantages helped to make employer-based coverage more desirable.<sup>52</sup> A favorable change to the tax code exempting employer-payments to an employee's health insurance coverage incentivized more spending by employers on health insurance premiums.<sup>53</sup> This favorable tax benefit led to the explosion of employer-provided health insurance, which still exists today. Group insurance provided four core benefits: reduced adverse selection, lower administrative costs, federal tax advantages, and greater access to insurance since there is no underwriting

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<sup>50</sup> Affordable Care Act, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/affordable-care-act/> (last visited Nov. 1, 2020).

<sup>51</sup> 45 C.F.R. pt. 155 (2014) (establishing the exchanges).

<sup>52</sup> John A. Cogan, Jr., *Does Small Group Health Insurance Deliver Group Benefits? An Argument in Favor of Allowing the Small Group Market to Die*, 93 WASH. L. REV. 1121, 1141 (2018).

<sup>53</sup> *Id.*

requirement.<sup>54</sup> As of 2018, over half of the United States' total population receives health insurance from their employer-sponsored health insurance.<sup>55</sup>

#### IV.      LIMITATIONS      AND      SHORTCOMINGS      FOR      CURRENT      LEGAL REMEDIES

A wrongful pre-authorization denial for an expensive medical procedure is challenging in the health insurance context because, unlike other sales of goods in the marketplace, substitution is not available for health insurance. Normally, substitution occurs after a breach of contract where the buyer may “cover” by obtaining the original goods from another seller and recovering the difference in cost from the breaching party.<sup>56</sup> However, within the health insurance marketplace, the buyer who discovers the contract has been breached cannot then go and find another health insurance company to contract with to cover the procedure or medication.<sup>57</sup> This is like any other unilateral insurance contract where the marketplace offers no remedy to the non-breaching party.

##### A.      ERISA REMEDIES

Most Americans get their private health insurance through an employer-provided group plan.<sup>58</sup> The bulk—about sixty-one percent—of these plans are self-funded.<sup>59</sup> Thus ERISA, which governs group health plans that are not government or church plans has two effects. First, for self-funded plans, all state laws are preempted.<sup>60</sup> Second, and more importantly for

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<sup>54</sup> Cogan, Jr., *supra* note 53, at 1125.

<sup>55</sup> KATHERINE KEISLER-STARKEY & LISA N. BUNCH, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2019, U.S. CENSUS BUREAU (Sept. 15, 2020) (showing in 2019, 55.4 percent of people had employer-provided health insurance) <https://www.census.gov/library/publications/2020/demo/p60-271.html>

<sup>56</sup> *E.g.*, N.Y. U.C.C. Law § 2-712(1)-(2).

<sup>57</sup> Insurance is excluded from the UCC since it is not a transaction in goods. Thus, the non-breaching party may not employ the UCC substitute provision in § 2-712. U.C.C. § 2-102 (AM. LAW INST. & UNIF. LAW COMM'N 2013)

<sup>58</sup> KEISLER-STARKEY & BUNCH, *supra* note 55.

<sup>59</sup> 2019 Employer Health Benefits Survey, KFF (Sept. 25, 2019), <https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/>.

<sup>60</sup> 29 U.S.C. § 1144(a).

ERISA-covered group plans—all state remedies are preempted. ERISA will often govern the available legal remedies in employee health plans.

Assuming ERISA governs the plan, ERISA preempts all state law causes of action that duplicate, supplement, or supplant the civil enforcement remedy provided in the ERISA statute.<sup>61</sup> There are two types of ERISA preemption: complete and conflict. “Complete preemption exists when a *remedy* falls within the scope of or is in direct conflict with [ERISA].”<sup>62</sup> Therefore, ERISA preempts state laws that coincide with civil enforcement mechanisms and are replaced by a limited number of causes of action. However, under conflict preemption, ERISA preempts state laws “insofar as they relate now or hereafter to any employee benefit plans.”<sup>63</sup> As an exception, ERISA’s savings clause allows state laws “which regulate[] insurance, banking, or securities”<sup>64</sup> and thus allows those state laws to survive ERISA preemption.

ERISA’s remedies are inadequate and often fail to make an injured patient whole. For instance, if a health plan denied or delayed authorization of a medical service causing the patient’s death, his or her family would have no right to collect any damages for their loss.<sup>65</sup> This is due to ERISA’s broad, sweeping preemption framework. Complete preemption is typically invoked as a defense to a party’s state law claims.<sup>66</sup> The outcome of this regime is that self-funded employer-sponsored benefit plans are immune from attempts by the states to regulate them.<sup>67</sup>

ERISA plans are further insulated from claims-related liability through the existence of a “discretionary clause.”<sup>68</sup> Discretionary clauses protect an ERISA-covered benefits plan administrator from liability by mandating the least demanding standard of judicial review for their conduct.

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<sup>61</sup> *Aetna Health, Inc. v. Davila*, 542 U.S. 200, 209 (2004). An exhaustive discussion on ERISA preemption exceeds the scope of this article.

<sup>62</sup> *Haynes v. Prudential Health Care*, 313 F.3d 330, 333 (5th Cir. 2002) (emphasis added).

<sup>63</sup> 29 U.S.C.A. § 1144(a) (2006).

<sup>64</sup> 29 U.S.C.A. § 1144(b)(2)(A) (2006).

<sup>65</sup> Katherine T. Vukadin, *Delayed and Denied: Toward an Effective ERISA Remedy for Improper Processing of Healthcare Claims*, 11 YALE J. HEALTH POL’Y L. & ETHICS 331, 353 (2011).

<sup>66</sup> *Gutierrez v. Flores*, 543 F.3d 248, 252 n.5 (5th Cir. 2008).

<sup>67</sup> Vukadin, *supra* note 65, at 689.

<sup>68</sup> *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). The default standard would be *de novo* unless the plan contained a clause conferring discretion upon the administrator; then the standard of review in federal court would be the arbitrary or capricious standard.

De novo is the default standard for claims review unless the plan contained a clause conferring discretion upon the administrator; then the standard becomes the arbitrary or capricious standard.<sup>69</sup> Today these discretionary clauses are ubiquitous in ERISA plans.<sup>70</sup>

Plan participants are not completely left out in the cold. ERISA does provide a remedial scheme but there are substantial procedural limitations. Class action suits must comply with Rule 23 of the Federal Rules of Civil Procedure (FRCP) because ERISA preempts state laws and thus the federal courts have jurisdiction.<sup>71</sup> Class certification under FRCP Rule 23 is problematic. The type of health insurance plan will affect whether a plaintiff can satisfy the class certification requirements of Rule 23. Different insurance plan types could lead to a plaintiff failing class certification if other members of the class have different plans. Common questions of diagnosis and coverage could require lengthy trials destroying class certification.<sup>72</sup> There are substantial procedural limitations when the plaintiffs attempt class certification under the FRCP.

Compensatory damages are not an available remedy in class actions. Section 1132(a)(2)-(3) states: “A civil action may be brought by the Secretary, or by a participant, beneficiary or fiduciary . . . to obtain appropriate equitable relief.”<sup>73</sup> Interpreting the phrase “appropriate equitable relief” Justice Scalia, writing for the majority held the statute refers to “categories of relief that were typically available in equity (such as injunction, mandamus, and restitution, but not compensatory damages).”<sup>74</sup> Thus, extracontractual compensatory or punitive damages arising from an alleged wrongful denial of benefits are not recoverable as “appropriate equitable relief” under ERISA.

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<sup>69</sup> *Id.*

<sup>70</sup> Vukadin, *supra* note 65, at 698.

<sup>71</sup> CRAIG C. MARTIN, ET AL., JENNER & BLOCK PRACTICE SERIES ERISA LITIGATION HANDBOOK 177 (5th ed. 2012).

<sup>72</sup> See *Doe v. Guardian Life Ins. Co. of Am.*, 145 F.R.D. 466, 476–77 (N.D. Ill. 1992) (participants claiming breach of fiduciary duties in health insurance plan met commonality and typicality requirement, but common questions did not predominate).

<sup>73</sup> 29 U.S.C. § 1132(a)(2)-(3).

<sup>74</sup> See *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255–56 (1993) (holding that plan participants cannot bring civil actions for money damages to obtain “appropriate equitable relief” to redress violations of statute or plan when it is not authorized).

Further, the Supreme Court has held that Health Maintenance Organizations (HMOs) cannot be sued in federal court under ERISA for adverse treatment decisions.<sup>75</sup> This is true even if the adverse treatment causes death. Courts ordinarily reason that since ERISA's regulatory scheme only allows for a limited set of remedies the courts will not permit additional remedies that Congress did not establish.<sup>76</sup>

In summary, ERISA is the biggest obstacle to fashioning an adequate and uniform legal remedy for patients harmed by AI insured under a group health plan. Plaintiffs are limited to those specific remedies listed under ERISA; therefore, no consequential, non-economic, or punitive damages.<sup>77</sup> Furthermore, any state law remedy functioning as a deterrence mechanism would be preempted if it was an ERISA health plan.

B. FIRST POTENTIAL LEGAL REMEDY: DISPARATE IMPACT CLASS ACTIONS

"Disparate impact" was first used in the context of employment decisions. The Supreme Court held it was illegal under Title VII of the Civil Rights Act for a company to use intelligence test scores and high school diplomas, factors which disproportionately disqualified people of color, to make hiring or promotion decisions, even if discrimination was unintentional.<sup>78</sup> The absence of discriminatory intent did not redeem a practice where factors were used that were unrelated to measuring job capability.<sup>79</sup>

Scholars have advocated for adopting the disparate impact doctrine to protect from discrimination in data mining.<sup>80</sup> In a disparate impact case, the plaintiff must show:

A particular facially neutral employment practice causes a disparate impact with respect to a protected class. If shown,

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<sup>75</sup> Pegram v. Herdrich, 530 U.S. 211, 211 (2000).

<sup>76</sup> See Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

<sup>77</sup> John Morrison & Jonathan McDonald, *Exercising Discretion: The Death of Caprice in ERISA Claims Handling*, 56 S.D. L. REV. 482, 484 (2011) (citing 29 U.S.C. § 1132 (2006)).

<sup>78</sup> Griggs v. Duke Power Co., 401 U.S. 424, 430 (1971) ("Under the [Title VII] Act, practices, procedures, or tests neutral on their face, and even neutral in terms of intent, cannot be maintained if they operate to 'freeze' the status quo of prior discriminatory employment practices.").

<sup>79</sup> *Id.*

<sup>80</sup> Barocas & Selbst, *supra* note 44, at 701.



the defendant-employer may “demonstrate that the challenged practice is job related for the position in question and consistent with business necessity.” If the defendant makes a successful showing to that effect, the plaintiff may still win by showing that the employer could have used an “alternative employment practice” with less discriminatory results.<sup>81</sup>

The analysis is similar to the problems within AI. Since class members share similar data points, the argument is that unintentional discrimination could be treated as a disparate impact claim. Class actions—with extracontractual damages—under a legal theory of unintentional discrimination against AI architects, hospitals, and insurers would theoretically function as a legal-deterrence mechanism. By enabling class actions against the users of AI, the law could incentivize running repeated quality assurance trials to ensure AI safety and fairness.

However, healthcare decisions are normally insulated from large extracontractual awards because of ERISA. As previously discussed, ERISA preempts any state remedy for self-funded employer-sponsored benefit plans—with only the equitable remedies explicitly set out in ERISA. Therefore, ERISA is a barrier for class-actions suits as a deterrence mechanism.

Even if the plan is not preempted by ERISA, the litigation is too little, too late since not receiving medically necessary treatments means a patient will likely die when those treatments are denied. Additionally, it is harder to identify an injury within AI compared to an individual denied a job despite the applicant’s competent credentials. Lastly, bringing a claim would be expensive with needed expert testimony, including health experts, computer scientists, engineers, and physicians to testify to the design of the algorithm and the standard of care for the medical diagnosis.

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<sup>81</sup> *Id.*

C. SECOND LEGAL REMEDY: THE AFFORDABLE CARE ACT SOLUTION

The discussion for legal remedies must touch upon the Affordable Care Act (ACA).<sup>82</sup> The goal of the ACA is to increase access to healthcare and decrease the costs of healthcare.<sup>83</sup> The ACA has a significant anti-discrimination provision which mirrors other federal laws like the Civil Right Act.<sup>84</sup> Section 1557 of the ACA prohibits discrimination due to race, color, national origin, sex, age, or disability.<sup>85</sup> However, only some employers are subject to § 1557 since the regulations only apply to health programs and activities that receive federal funding from Health and Human Services (HHS).<sup>86</sup> As a result, § 1557 only has limited applicability to employer-sponsored health benefit programs. But even if they do apply, the claims are still ERISA-based and subject to the same problems outlined above.

The ACA is not equipped to handle this rapidly accelerating technology. The ACA focuses on community-rating requirements, making it illegal for qualifying health insurers to discriminate against individuals with pre-existing conditions in *pricing* the coverage or *rescinding* an offer of coverage with exceptions for charging higher rates based on age, tobacco use, and geography.<sup>87</sup> It is not intended to focus on the patient at the point of service.

Proponents of the ACA may argue this problem can be solved by allowing policymakers to ensure equal access across the marketplace by defining the coverage requirements for *all* health insurers, including the dominant employer-provided insurance segments.

Currently, the ACA authorizes the Secretary of HHS to define Essential Health Benefits (EHBs) that ACA-covered plans must offer to its

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<sup>82</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>83</sup> Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2580 (2012) ("The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care.").

<sup>84</sup> 42 U.S.C. §§ 1981(a)-(c) (2018).

<sup>85</sup> 42 U.S.C. § 18116 (2018).

<sup>86</sup> 45 C.F.R. § 92.1 (2018) (The enforcement provision of § 1557 states "[t]his part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Title I entities that administer health programs or activities, and Department-administered health programs or activities.").

<sup>87</sup> 42 U.S.C. § 300gg.

subscribers.<sup>88</sup> To ensure consistency in plan designs, the ACA requires specific coverages ranging from emergency services, mental health, to primary care. Within these categories, the ACA lists four general considerations when the HHS Secretary designs coverage: (1) the benefit must be balanced without undue weights given to a single category; (2) the coverage cannot discriminate based on age, disability, or life expectancy; (3) the needs for diverse groups; (4) and the benefits should not be denied based on age or health demographics. In effect, the HHS Secretary has broad latitude and flexibility to define which procedures should be included within these ACA-covered plans. Arguably the ACA gives a pathway to solving the problem of unequal treatments across different plans. However, an attempt to solve the problem of defining which services would be covered is dangerous.

There are at least three reasons for this. First, there are hundreds of insurers each with multiple plan types with different policy definitions. As a result, it would be unreasonable to expect each insurer to have identical definitions for coverage across the marketplace. Second, it would be impossible to define in detail exactly which procedures should be covered, and any attempt to would run thousands of pages long and would be incomprehensible to a patient. Also, each year novel treatments are created as scientific drugs and procedures advance. These new, novel treatments would likely be excluded from an authorized list, while obsolete procedures would be preferred. Third, at the patient level, it is impossible to predict ex-ante the types of procedures that should be covered in each instance. A physician must look at several health risk factors and prescribe treatments. Authorizing a specific list of procedures ex-ante could harm the patient. Therefore, a top-down approach to address unequal treatment is misguided. Any solution should be tailored to safeguard a physician's ability to prescribe the safest treatments.

Also, although the ACA contains an appellate process to provide consumers with assistance when denied coverage disparate impact discrimination is harder for an individual to prove. For many patients, an overturned decision based on an appeal is only good news if it is overturned in time. Many of these pre-authorizations are for a time-sensitive procedure; thus, measuring the number of successful legal challenges is likely under-

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<sup>88</sup> 42 U.S.C. § 18022(b)(1).

inclusive. As the data from the previously mentioned study showed, black individuals were less likely to receive necessary healthcare services.

#### D. THIRD POTENTIAL REMEDY: DISCLOSURE

The ACA is the largest piece of legislation in the area of disclosure. Health insurers must report “claims payment policies, enrollment, disenrollment, number of claims denied, cost-sharing requirements, out-of-network policies, and enrollment rights in plain language.”<sup>89</sup> Although the ACA requires insurers to disclose its actuarial rates, this focus is more concerned with pricing than decision-making.

Qualified health plans covered under the ACA and self-funded employers are not required to disclose the data behind the rates or the algorithms. This missing information is the potential threat causing disparate health treatments. Disclosure requirements under the ACA do not provide an effective legal remedy.

Even if the law was amended to require disclosure of machine-learning software, this requirement would face significant legal hurdles. First, this complex software is subject to patent rights and protections.<sup>90</sup> Patent protections exist to incentivize new inventions by rewarding the patent holder and to encourage further research and development. Requiring the patent holders of AI to broadly disclose their work product is contrary to the purpose of patent protection. Since AI is considered intellectual property, patent holders would vociferously challenge disclosure requirements and any regulatory attempt to release AI to public scrutiny. Second, insurance regulators are not engineers and are not trained to analyze complex data sets to determine whether consistent results are produced. Lastly, broad access to third-party agencies or law enforcement to protected health information may violate a patient’s privacy. In sum, disclosure rules are not adequately equipped to deal with the safety of AI.

#### V. THE NEED FOR FEDERAL LEGISLATION

Some questions must be answered before we can appropriately determine the proper regulatory regime. Can regulators even gain access to

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<sup>89</sup> *Focus on Health Reform: Summary of the Affordable Care Act*, HENRY J. KAISER FAM. FOUND. 5 (last modified Apr. 23, 2013), <https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>.

<sup>90</sup> 35 U.S.C. § 101 (1952) (requiring individuals who invents or discovers any new and useful process or machine to obtain a patent in accordance to the title).

the data to proactively identify faulty steps in the algorithm? Is the data granular enough to identify whether the data set itself is flawed? If regulators could do so, what is the financial cost for each agency to find and identify these flaws? The current fragmented health system adds enormous administrative costs to properly regulating AI if each agency had to answer the questions above.

Therefore, I argue that federal legislation is needed in this area for a new regulatory agency and to fix the legal remedies allowed to a consumer. Regulating AI has significant transaction costs and information asymmetry, so a new regulatory agency can improve efficiency through uniform legal and regulatory remedies. Regulators can hold data-centric firms more accountable and correct market failures. By appointing computer scientists and policymakers to oversee algorithms in different industries, such as the credit markets, banking, insurance, health care, and judicial systems, the U.S. current basic regulatory structure could function in the computational age.

In 2019, U.S. lawmakers introduced a bill called the Algorithm Accountability Act which would require large companies to “audit machine learning-powered system—like facial recognition or ad-targeting algorithms,” with the Federal Trade Commission responsible for creating rules for evaluating “highly sensitive automated systems” and ensure data integrity.<sup>91</sup> This concept should be extended to machine-learning software used in healthcare decision-making.

Second, modifying ERISA’s broad, complete preemption to allow for extracontractual damages toward benefit administrators for self-insured plans would incentivize quality assurance measures. Due to ERISA preemption, many consumers are stripped of remedies available under state law, allowing only the recovery of entitled medical benefits under the plan. These limitations must be changed to avoid the burden of wrong health diagnoses and disparate outcomes to fall on the patient.

As a quality assurance measure, hospitals and algorithm creators would conduct test-runs on algorithms to ensure their safety and detect any

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<sup>91</sup> Algorithmic Accountability Act of 2019, H.R. 2231, 116th Cong. (2019); Adi Robertson, *A new bill would force companies to check their algorithms for bias*, THE VERGE (Apr. 10, 2019), <https://www.theverge.com/2019/4/10/18304960/congress-algorithmic-accountability-act-wyden-clarke-booker-bill-introduced-house-senate> (discussing the bill primarily followed the algorithmic discrimination lawsuit filed against Facebook and is aimed at regulating technology companies, or any company making over \$50 million).

adverse treatment recommendations. These test runs would be variable sets to identify problems in healthcare decisions. For example, the control data set would contain 1,000 correct diagnoses with statisticians properly accounting for age, race, and demographics. The variable set includes the AI diagnosing these 1,000 cases.<sup>92</sup> The distribution created is the standard deviation between the correct treatment decision and an erroneous decision. The higher the standard deviation, the more flawed the algorithm is in making treatment decisions. One practical solution is for the National Institute of Health (NIH). More public funding from organizations like the NIH or stakeholders of AI to provide peer-reviewed statistical analyses would be a practical way to increase this type of analysis.

#### VI. CONCLUSION

Justice Brandeis said, “The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding.”<sup>93</sup> Although AI promises advances in healthcare, more thought is needed to ensure the safety of its use. Legal remedies must also make injured patients whole. Advocates of AI argue machines eliminate human biases from the decision-making process. However, AI is only as good as the underlying data and the computer scientists who create them.

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<sup>92</sup> The effect of sample size can affect the empirical results. If the goal is accurate prediction (correct diagnosis), then the sample size must be representative to ensure an accurate prediction rate (the proportion of correct diagnoses). 1,000 control-cases compared to the 1,000 AI-generated outputs would be a baseline in the statistical analysis. In some cases, using more control-cases to variable-cases will be warranted due to large population sizes or to test the independence of results.

<sup>93</sup> *Olmstead v. U.S.*, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

# UNDERWRITING CRITERIA, PRACTICES, AND TOOLS OF PET HEALTH INSURANCE COMPANIES

KIMBERLY L. WILSON

*This article examines the underwriting criteria, practices, and tools of pet insurance companies. While companies that sell pet insurance policies are generally transparent about who their underwriting company is, underwriting rules are not as readily available and require consumers to navigate the System for Electronic Rates and Forms Filing (SERFF) online interface. Because pet “health” insurance is actually a form of property and casualty insurance, the underwriters are, as expected, typically property and casualty companies. This paper explores the current pet health insurance landscape and how pet insurance underwriters incorporate quasi-medical underwriting into their pet insurance policies.*

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## I. AN OVERVIEW OF PET HEALTH INSURANCE

Pet health insurance may seem like a straightforward product at first glance, but the reality is that it is a poorly understood product by consumers, who often have little idea what underwriting criteria is used to calculate premiums, what is covered under the policy, and even how the policy functions in terms of veterinary bill payment or reimbursement.<sup>1</sup> Consumers' unfamiliarity with pet health insurance may be because it is a newer insurance product than car insurance, homeowners insurance, or life insurance, which are immediately recognizable to the average consumer.<sup>2</sup> Confusion may also stem from the atypicality of the pet health insurance product itself, because it functions similarly to traditional health insurance, yet it is actually property and casualty insurance as a result of pets' legal classification as property. Lastly, some of the confusion may be because there is significant variance in policies and how companies manage claims.<sup>3</sup> This variance in policy operation may be partly because pet health insurance is currently a lightly regulated insurance product in comparison to most major, more established insurance lines.<sup>4</sup>

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<sup>1</sup> While a comprehensive survey regarding consumer understanding of pet health insurance has not been performed, a sampling of consumer complaints reveals that many consumers did not understand their pet health insurance policies. *See Trupanion Complaints*, BETTER BUS. BUREAU, <https://www.bbb.org/us/wa/seattle/profile/insurance-companies/trupanion-1296-22429232/complaints> (last visited Feb. 21, 2021).

<sup>2</sup> The first pet health insurance policy in the United States was issued in 1982, according to the National Association of Insurance Commissioners (NAIC), which is a state-based, standard-setting organization governed by the insurance regulators from each state and territory in the United States. NAT'L ASS'N INS. COMM'RS, A REGULATOR'S GUIDE TO PET INSURANCE 4 (2019), [https://naic.org/prod\\_serv/PIN-OP-19.pdf](https://naic.org/prod_serv/PIN-OP-19.pdf) [hereinafter NAIC REGULATOR'S GUIDE].

<sup>3</sup> Specifically, the NAIC notes that a lack of consistent definitions across pet insurance policies results in varying coverage. Consumer complaints from the Better Business Bureau reveal this is a frequent source of policyholder confusion. *See* BETTER BUS. BUREAU, *supra* note 1.

<sup>4</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 13. While the guide does not explicitly juxtapose a lack of regulation in the pet health insurance industry with the more robust regulation of major lines, the guide notes that the classification of pet health insurance as a limited line in some states results in fewer regulatory requirements.



Pet health insurance provides accident and illness coverage for family-owned pets, primarily dogs and cats.<sup>5</sup> While some pet insurance plans also provide reimbursement for wellness procedures like vaccinations, heartworm testing and spaying or neutering, pet health insurance is primarily used to cover costs for accidents and unexpected illness.<sup>6</sup> It differs from other types of insurance on pets, such as life and theft insurance, which designed to insure the lives of highly valuable animals, such as show dogs and cats.<sup>7</sup> Life and theft policies reimburse owners for stolen animals and pay a death benefit if an animal dies during transport or other covered events.<sup>8</sup> Pet owner liability to third parties from injuries caused by common household pets is generally covered by the owner's homeowners or renters insurance policy, as long as the animal is not an excluded breed and does not have a history of aggression.<sup>9</sup> Unlike life and theft insurance, or the pet liability coverage in a standard homeowners policy, pet health insurance's singular purpose is to cover veterinary expenses.

Pet health insurance is unique because it functions fundamentally like traditional health insurance in that the policyholder pays a premium to cover future medical expenses for the insured. Like traditional health insurance prior to the Affordable Care Act, pet health insurance underwriting incorporates factors such as gender, medical history, and pre-existing conditions when setting premiums for individual pets.<sup>10</sup> Breed, age, size, and spaying/neutering are also common factors in pet health insurance underwriting formulas.<sup>11</sup> The claims process is different from traditional health insurance; pet health insurers generally require the pet owner to pay the veterinary bill upfront, and the company will refund any covered portions after the owner files a claim.<sup>12</sup> Pet "health" insurance is also a bit of a misnomer because this type of policy is actually a specific line of property and casualty insurance, not true health insurance. Generally, it is classified

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<sup>5</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 1.

<sup>6</sup> *Id.* at 9.

<sup>7</sup> *Facts About Pet Insurance*, INS. INFO. INST., <https://www.iii.org/article/facts-about-pet-insurance> (last visited Feb. 21, 2021). The Insurance Information Institute is a non-profit association dedicated to improving consumer understanding of insurance.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *SERFF Filing Access: California*, *infra* note 67.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

as a type of inland marine insurance for regulatory purposes.<sup>13</sup> This is because pets are legally considered the property of their owners,<sup>14</sup> and inland marine insurance incorporates several miscellaneous coverages and functions as a catch-all for niche types of property and casualty insurance.<sup>15</sup>

The categorization of pet health insurance as inland marine may seem rather curious, and as the pet health insurance market continues to expand, it makes sense to consider placing pet health insurance in its own category. The National Association of Insurance Commissioners (NAIC) is currently investigating whether pet insurance should be removed from the State Licensing Handbook Uniform Licensing Standard<sup>16</sup> as a limited line at the request of a pet health insurer that is unidentified in the NAIC report.<sup>17</sup> “Reasons cited [by the insurer<sup>18</sup>] include: 1) tremendous growth in the pet insurance market; 2) policy premiums that far exceed the cost of the covered item (i.e. the pet); 3) complex policies with multiple coverage options and exclusions.”<sup>19</sup> This change would be significant since, in states that do not require a full property and casualty license to sell pet health insurance, insurers are largely exempt from the compliance requirements that major lines must meet, making the pet health insurance market an area that still appears to lack much regulation and oversight.

While most states require a full property and casualty license to sell pet health insurance, some states require only a limited-line license of property and casualty insurance.<sup>20</sup> Limited-lines products are generally designed to be incidental to the sale of another product, which is not typically

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<sup>13</sup> NAIC REGULATOR’S GUIDE, *supra* note 2, at 5.

<sup>14</sup> 3B C.J.S. *Animals* § 4 (2020).

<sup>15</sup> NAIC REGULATOR’S GUIDE, *supra* note 2, at 32.

<sup>16</sup> This NAIC handbook serves as a guide for state insurance departments in establishing effective licensing regulations. NAT’L ASS’N INS. COMM’RS, STATE LICENSING HANDBOOK 1 (2018), [https://www.naic.org/documents/prod\\_serv\\_marketreg\\_stl\\_hb.pdf](https://www.naic.org/documents/prod_serv_marketreg_stl_hb.pdf) [hereinafter STATE LICENSING HANDBOOK].

<sup>17</sup> *Id.* at 251–53; NAIC REGULATOR’S GUIDE, *supra* note 2, at 1.

<sup>18</sup> While the identity of the insurer that petitioned the NAIC for additional regulations is uncertain, it is surely a pet insurer that already requires its agents to have full property and casualty licenses in every state and therefore has a business purpose in urging additional regulation that would provide barriers for its competitors.

<sup>19</sup> NAIC REGULATOR’S GUIDE, *supra* note 2, at 1.

<sup>20</sup> *Id.*

the case with pet insurance.<sup>21</sup> Pet health insurance policies are underwritten for individual pets and are often sold separately from other types of insurance. Indeed, of the top five companies in the pet health insurance arena by market share, only one pet insurance branding company (Nationwide) sells policies other than pet health insurance.<sup>22</sup> As evidenced by numerous pet health insurance branding companies that only sell pet policies, pet insurance is frequently being purchased on its own, not merely in addition as part of a bundle of other insurance products.

Additionally, as noted by the NAIC's report, the categorization of pet health insurance policies as inland marine policies makes it difficult to ascertain data specific to the pet health insurance industry because pet policies are not isolated for purposes of regulation and tracking premium volume.<sup>23</sup> Because pet policies are not isolated and reported separately from other inland marine policies, the NAIC data, which offers detailed market share breakdowns for policy lines, is insufficient for the purpose of analyzing the market share of pet health insurance companies. Thus, it is apparent that pet health insurance underwriting lacks comprehensive understanding not only by consumers, but by insurance regulators as well.

Another area of confusion in the pet health insurance industry is the commonplace practice for pet health insurers to operate under a brand name or managing general agent (MGA) (i.e., Petplan<sup>24</sup>), but to outsource the underwriting to one or more underwriting companies (i.e., XL Specialty Insurance). The NAIC notes that this practice can cause confusion among consumers when they are trying to determine which entity is responsible for paying claims or which should be named if the consumer files a complaint with their state insurance department.<sup>25</sup> Among the top five pet health insurers by market share, all five utilize a brand name and different underlying underwriter (including Nationwide, a major personal auto and homeowners insurer). In these cases, the brand name acts as the purveyor of policies underwritten by a different, underlying company.

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<sup>21</sup> *Id.*

<sup>22</sup> NATIONWIDE, <https://qec.petinsurance.com/quote1> (last visited Feb. 25, 2021) (showing option to insure “[b]ird or exotic pet”).

<sup>23</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 5.

<sup>24</sup> Petplan is a branding company that sells pet health insurance policies underwritten by XL Specialty Insurance Company. *See generally* PETPLAN, [https://www.gopetplan.com/?utm\\_campaign=G-\[B\]-Petplan-Core-US-BMMD&utm\\_source=google&utm\\_medium=cpc&gclid=EAIaIQobChMik9Snws3B6QIVj4jICh0REwS5EAAAYASAAEgKftPD\\_BwE](https://www.gopetplan.com/?utm_campaign=G-[B]-Petplan-Core-US-BMMD&utm_source=google&utm_medium=cpc&gclid=EAIaIQobChMik9Snws3B6QIVj4jICh0REwS5EAAAYASAAEgKftPD_BwE) (last visited Feb. 21, 2021).

<sup>25</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 7.

While the NAIC notes the potential for confusion in this common practice in the pet insurance industry, using a brand name and a different underwriter is not unique to pet health insurance. For example, Allstate, an insurance company that is probably best known for its car insurance policies, utilizes multiple underwriting companies, some of which are not recognizable as Allstate subsidiaries.<sup>26</sup> While most of Allstate's underwriting companies are immediately recognizable as subsidiaries of the parent company (i.e., Allstate Fire and Casualty Insurance Company, which is one of the Allstate underwriters in Northbrook, Illinois)<sup>27</sup> other underwriters for the company are not so quickly recognizable, such as Castle Key Insurance Company, an Allstate underwriting company in St. Petersburg, Florida.<sup>28</sup> However, the underwriting companies that are unrecognizable as the underwriters for an insurance brand are generally subsidiaries of the insurer, while with pet health insurance, underwriting is often outsourced to an entirely different company. While the practice is not unique to the pet health insurance industry, it may be less of a concern in more established insurance lines with greater regulatory oversight.

Indeed, the expansion of the pet health insurance market and relative lack of regulatory supervision has attracted the attention of the NAIC, which created the Pet Insurance (C) Working Group in April 2019.<sup>29</sup> The working group is currently drafting a pet insurance model law with the goal of “develop[ing] of a model law to establish appropriate regulatory standards for the pet insurance industry.”<sup>30</sup> The model law, in its working form, would force pet health insurers to make additional disclosures and would disallow the exclusion of coverage based on preexisting conditions beyond six months after the policy's effective date of coverage.<sup>31</sup> The model law does not address underwriting formulas and rates, though, like other forms of insurance, pet health insurance rates are already subject to state regulation

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<sup>26</sup> *Underwriting Companies*, ALLSTATE, <https://www.allstate.com/about/name-location.aspx> (last visited Feb. 21, 2021).

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Pet Insurance*, NAT'L ASS'N INS. COMM'RS (Sept. 9, 2020), [https://content.naic.org/cipr\\_topics/topic\\_pet\\_insurance.htm](https://content.naic.org/cipr_topics/topic_pet_insurance.htm).

<sup>30</sup> *Pet Insurance (C) Working Group*, NAT'L ASS'N INS. COMM'RS, [https://content.naic.org/cmte\\_c\\_pet\\_wg.htm](https://content.naic.org/cmte_c_pet_wg.htm) (last visited Feb. 21, 2021).

<sup>31</sup> *Pet Insurance Model Act: Discussion Draft for Pet Insurance (C) Working Group* (Feb. 19, 2020), [https://content.naic.org/sites/default/files/call\\_materials/NAIC%20Pet%20Insurance%20Model%20Law%20DiscussionDraft20200226.pdf](https://content.naic.org/sites/default/files/call_materials/NAIC%20Pet%20Insurance%20Model%20Law%20DiscussionDraft20200226.pdf) [hereinafter *Pet Insurance Model Act*].

and approval.<sup>32</sup> While the NAIC's model law would only have the force of a statute when a state legislature adopts it (often in a modified form), NAIC models are influential and it is likely that some states would adopt the model act or variations of it.

#### A. INDUSTRY GROWTH AND PROJECTIONS

Since the first pet policy in the U.S. was issued in 1982 by Veterinary Pet Insurance<sup>33</sup> (now Nationwide), the pet health insurance market has expanded beyond a niche submarket of property and casualty insurance to a common purchase for pet owners looking to protect their finances from extraordinary vet bills. Households in the U.S. spent a combined \$72 billion in 2018 on pet medical insurance care, which was 4.5 percent higher than in 2017.<sup>34</sup> The U.S. pet insurance industry was worth slightly more than \$1 billion in 2017 and is expected to nearly double to \$2 billion by 2022.<sup>35</sup>

Despite the staggering amount of money spent on pet health insurance and the increase in popularity of the policies, only a small fraction of pet owners in the U.S. carry pet insurance.<sup>36</sup> An estimated one to two percent of the nation's nearly ninety million pet dogs and more than ninety-four million pet cats are insured.<sup>37</sup> However, the pet insurance market is expected to grow more than fourteen percent per year, supported by several trends—most importantly, increased consumer awareness of the existence of pet health insurance as an existing, available policy type.<sup>38</sup>

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<sup>32</sup> SERFF Filing Access: *California*, *infra* note 67.

<sup>33</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 4. The first pet policy issued in 1982 by VPI covered the dog playing Lassie on television; INS. INFO. INST., *Facts and Statistics: Pet Statistics*, <https://www.iii.org/fact-statistic/facts-statistics-pet-statistics> (last visited Oct. 17, 2020). This policy was almost certainly a pet life and theft insurance policy rather than a health insurance policy, but it served as the United States' introduction to pet policies generally.

<sup>34</sup> INS. INFO. INST., *supra* note 33.

<sup>35</sup> *Id.*

<sup>36</sup> Interestingly, pet insurance is more common in European countries than in the United States, with half of all pets in Sweden covered by pet health insurance. *Id.*

<sup>37</sup> Susan Jenks, *Pet Insurance is the Latest Work Perk*, N.Y. TIMES (June 7, 2017), <https://www.nytimes.com/2017/06/07/well/family/pet-insurance-is-the-latest-work-perk.html>.

<sup>38</sup> Ryan Smith, *Pet Insurance Market Set to Double by 2022*, INS. BUS. MAG. (Oct. 4, 2018), <https://www.insurancebusinessmag.com/us/news/breaking-news/pet-insurance-market-set-to-double-by-2022-113038.aspx>.

Some of the pet health insurance market's growth may be attributed to the expanding popularity of the "pet humanization concept," which refers to the increasing demand for pet grooming and care products as humans continue to treat pets more like family members.<sup>39</sup> The emotional appeal of pet health insurance is undeniable for those who see their pets as part of the family and do not want finances to limit them from providing treatment to their pet. After all, veterinarians have no obligation to treat animals when the owner cannot pay, and only forty-one percent of Americans report they would be able to cover a \$1,000 emergency with savings.<sup>40</sup> Pet health insurance coverage can help pet owners avoid having to euthanize their pet simply because they cannot afford to treat the condition.<sup>41</sup> This appeal, combined with Americans' increasing conceptualization of pets as bona fide family members,<sup>42</sup> may in part account for the pet health insurance market boon over the last decade. Pet owners, especially millennials, are increasingly more willing to spend more on their animals to ensure a healthy and long life.<sup>43</sup> As pets become more entrenched in the inner family life of Americans, benefits like "pawternity leave" for new dogs and cats, as well as pet health insurance offered as a benefit at work, are gaining traction.<sup>44</sup>

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<sup>39</sup> *Pet Insurance is the New Millennial Pink*, BUS. INS. (Jan. 31, 2020), <https://www.businessinsurance.com/article/20200131/NEWS06/912332853/Pet-insurance-is-the-new-millennial-pink>.

<sup>40</sup> Megan Leonhardt, *41% of Americans Would be Able to Cover a \$1,000 Emergency with Savings*, CNBC (Jan. 22, 2020), <https://www.cnbc.com/2020/01/21/41-percent-of-americans-would-be-able-to-cover-1000-dollar-emergency-with-savings.html>.

<sup>41</sup> *NAPHIA's Pet Insurance Buying Guide*, N. AM. PET HEALTH INS. ASS'N, <https://naphia.org/find-pet-insurance/naphias-pet-insurance-buying-guide/> (last visited Oct. 4, 2020).

<sup>42</sup> Ninety-five percent of respondents to a Harris Poll survey said they consider their pets to be members of the family. See Larry Shannon-Missal, *More Than Ever, Pets are Members of the Family*, THE HARRIS POLL (July 16, 2015), <https://theharrispoll.com/whether-furry-feathered-or-flippers-a-flapping-americans-continue-to-display-close-relationships-with-their-pets-2015-is-expected-to-continue-the-pet-industrys-more-than-two-decades-strong/>.

<sup>43</sup> *Americans are Spending More on Pets than Ever Before: \$72 Billion*, CISION PR NEWswire (March 21, 2019, 6:40 PM), <https://www.prnewswire.com/news-releases/americans-are-spending-more-on-pets-than-ever-before-72-billion-300816835.html>.

<sup>44</sup> Mark Williams, *Pawternity Leave: More Companies Offering Time off When Employees Adopt a Pet*, CHI. TRIB. (Jan. 7, 2020), <https://www.chicagotribune.com/>

The juxtaposition of pet owners' conceptualization of pets as members of the family deserving of their own form of health insurance and the insurance industry's conceptualization of pets as property is partly why pet health insurance is such an enigma in the industry. Indeed, while pets are categorized as property, the NAIC's draft model law indicates there is an aspect of morality at play in this particular line of property and casualty insurance, since, for example, the model law severely limits insurers' ability to deny coverage due to pets' preexisting conditions. Thus, the unique intersection of pets as property, but also as members of the family unit, may ultimately be a driving force in the industry's regulation.

## II. POLICY MARKETING AND ISSUANCE

The most common distribution methods for pet health insurance policies are web-based marketing and referrals from veterinary clinics or friends and family.<sup>45</sup> Pet insurance may also be sold via pet stores, shelters, and animal support and rescue organizations, or word of mouth referrals.<sup>46</sup> Some pet health insurance brands, like Trupanion, offer a free month of pet health insurance on dogs who are adopted from partner rescues and shelters, incentivizing adopters to continue the coverage by reducing the hassle of signing up.<sup>47</sup> The process of insuring a pet is relatively easy and can be done online. Signing up for a policy simply requires a potential policyholder to input the data for the underwriting rating factors as prompted via an online quote.<sup>48</sup> Then, the applicant will be prompted to complete the application and provide their own information and a payment source.

"The fastest-growing form of distribution [of pet health insurance] is through an employee benefit package."<sup>49</sup> According to Nationwide, about fifty percent of Fortune 500 companies offer pet insurance as an employee

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[pets/sns-companies-offering-time-off-for-pet-adoption-20200107-phkqs573u5ccdk-i7f4tes4pp6y-story.html](https://www.pets.com/news/sns-companies-offering-time-off-for-pet-adoption-20200107-phkqs573u5ccdk-i7f4tes4pp6y-story.html).

<sup>45</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 11.

<sup>46</sup> *Id.*

<sup>47</sup> *Shelter and Rescue Support*, PETPARTNERS, <https://www.petpartners.com/partnerships/shelters-and-rescues> (last visited Apr. 5, 2020); *What's an Offer?*, TRUPANION, <https://trupanion.com/ec/certificates/what-is-a-certificate> (last visited Apr. 5, 2020).

<sup>48</sup> *See Tell Us About Your Pet*, NATIONWIDE, <https://qec.petinsurance.com/quote1> (last visited Sept. 28, 2020) (showing a typical pet health insurance quote landing page).

<sup>49</sup> NAIC REGULATOR'S GUIDE, *supra* note 2, at 12.

benefit,<sup>50</sup> and around 5,000 companies offer pet insurance to employees in an effort to lure talent.<sup>51</sup> Coverage may be sponsored in part by the employer or paid entirely by the employee. Special employee pricing is sometimes offered with group discounts, and some underwriting formulas account for such discounts in their rating factors.

Since the process of becoming a policyholder of a pet health insurance policy is often done online, without an agent ever reviewing or assessing the insured pet in-person, some consumers might be tempted to commit insurance fraud and input data into their policy application that they believe will yield a lower premium in the underwriting algorithm (i.e., report that their dog is only one year old when it is actually four or that their cat a different breed than it truly is). Naturally, this would backfire on the policyholder if they were ever to file a claim, as insurers typically require the premium payor to submit all veterinary records with the claim so the company can determine whether to approve or deny the request on the basis of a pre-existing condition.<sup>52</sup> Discrepancies would be revealed at that time. Additionally, falsifying information on an application for pet health insurance coverage is a criminal offense and falsifiers could face punishment, which might be motive enough to keep policyholders from fudging their applications.<sup>53</sup> Several pet health insurance companies require the purchaser to upload an image of their pet to the website, which might also be used as a way to detect obvious fraudulent information in the application. Applicants could, of course, use any photo to represent their pet, but if the image does not match the description in the veterinary records, the discrepancy could be discovered.

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<sup>50</sup> Anthony Sharett named President and Chief Pet Insurance Officer for Nationwide, NATIONWIDE (Jan. 9, 2019), <https://news.nationwide.com/anthony-sharett-named-president-and-chief-pet-insurance-officer-for-nationwide/>.

<sup>51</sup> Jenks, *supra* note 37.

<sup>52</sup> E.g., NATIONWIDE, NATIONWIDE PET CLAIM FORM, [https://www.petinsurance.com/images/VSSImages/media/pdf/Claim\\_form.pdf](https://www.petinsurance.com/images/VSSImages/media/pdf/Claim_form.pdf) (requiring veterinary records to be submitted as part of a Nationwide pet health claim).

<sup>53</sup> The California Insurance Fraud Division warns consumers that insurance fraud is a felony. *See Insurance Fraud is a Felony*, CAL. DEP'T OF INS., <http://www.insurance.ca.gov/01-consumers/105-type/95-guides/15-gen/insur-fraud-is-felony.cfm> (last visited Oct. 18, 2020). Consumers may not be familiar with the particular laws of their state penalizing insurance fraud, but fraud is punishable in every state. E.g., CAL. PENAL CODE § 550 (West 2020); N.Y. PENAL LAW § 176.10 (McKinney 2020).



### III. UNDERWRITING RATING FACTORS

Even though pet health insurance is a form of property and casualty insurance rather than true health insurance, pet health insurance functions and is built upon a framework similar to that of traditional health insurance. Pet health insurance incorporates quasi-medical underwriting into the premium structure, accounting for variables such as breed of pet and age. Before the Affordable Care Act, which went into effect on January 1, 2014, health insurance companies could deny applicants for pre-existing conditions, charge them more money, or subject them to a waiting period.<sup>54</sup> Essentially, pet health insurance incorporates many of these aspects of medical underwriting that are now disallowed in the health insurance industry by incorporating underwriting rules that are, naturally, designed to decrease the risk borne by pet insurance companies. By the same token, pet health insurers have the regulatory leeway to accurately underwrite risk. Thus, there are two main ways to view the underwriting criteria of pet health insurance: (1) as discriminatory underwriting that disadvantages certain breeds and pets with preexisting conditions, or (2) accurate pricing that fairly takes risk into account. Or, perhaps a third alternative is that both of these views are simultaneously true.

It appears the NAIC leans toward the view that at least denial of coverage for pets based on preexisting conditions should be disallowed. The model law in progress by the NAIC Pet Insurance Working Group would prohibit pet health insurers to exclude coverage on the basis of a preexisting condition provision for a period beyond six months following the insured's effective date of coverage, but would not disallow differing rating factors based on breed.<sup>55</sup> However, the model law has not been completed, and the NAIC's proposed restrictions in their model law do not appear to have yet been adopted by any states.

Pet health insurers are required to file policy rates and forms with their state insurance departments. An August 2018 regulation in California also requires underwriting rules included in property and casualty rate applications to be made public, even if such rules contain confidential or proprietary information.<sup>56</sup> While proponents of the insurance industry

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<sup>54</sup> *Pre-Existing Conditions*, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, <https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html> (last visited Feb. 25, 2021).

<sup>55</sup> Pet Insurance Model Act, *supra* note 31.

<sup>56</sup> Cal. Ins. Code § 1861.05 (b).

naturally balked at the code provision, arguing that it could have far-reaching effects on the property and casualty market in California and beyond, particularly for InsurTech innovation, the provision offers an excellent opportunity for consumer transparency.<sup>57</sup> Underwriting rules for pet health insurance underwriting companies (and indeed all underwriting companies) that operate in California can be accessed via the System for Electronic Rates and Forms Filing (SERFF) online interface. SERFF is an online platform managed by the NAIC that provides an electronic method for insurers to submit documents and for insurance regulators to review them. Many state insurance departments also offer consumers online access to public filings.<sup>58</sup> The underwriting rules available on SERFF contain the rating factors and equations used to calculate premiums. This paper uses the underwriting formulas for the underwriters of the top five largest pet health insurers filed in California. While underwriting formulas may change depending on the state filed in, some underwriting rules, such as those in Healthy Paws pet health insurance policies, account in their California filing for the ZIP Codes in every state in which they write policies. It is reasonable to infer that underwriting rules that account for different states would not have differing formulas from state to state, since the rule published in California already accounts for all states.

California serves as an apt state in which to study underwriting filings, since the state represents a significant portion of the total number of pet health insurance policies issued as well as the gross written premium.<sup>59</sup> As of 2017, California accounted for 19.8 percent of the number of policies issued in the United States, and for 21.4 percent of the gross written premium.<sup>60</sup> For comparison, the state with the next largest percent of number of policies is New York, with 9.8 percent of the total policies and 10.4 percent of the gross written premium.<sup>61</sup> On the other hand, California is also the only state to have enacted a law directly referencing pet health insurance,

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<sup>57</sup> John F. Finston, *California Department of Insurance Requires Underwriting Rules to be Made Public*, NAT. LAW REV. (Aug. 14, 2018), <https://www.natlawreview.com/article/california-department-insurance-requires-underwriting-rules-to-be-made-public>.

<sup>58</sup> Web users from any state may access filings with the California Department of Insurance via SERFF. *E.g.*, *SERFF Filing Access: California*, NAT'L ASS'N INS. COMM'RS, <https://filingaccess.serff.com/sfa/home/CA>.

<sup>59</sup> NAIC REGULATOR'S GUIDE, *supra* note 2 at 6.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.*

so insurers operating in that state may have different underwriting practices than they would implement in other states.<sup>62</sup> Enacted in 2015, the law requires pet health insurance policies sold in California to be written in clear language and adequately explain coverage limits, co-insurance, waiting periods, and deductibles.<sup>63</sup> California consumers of pet health insurance also must receive full refunds for policies canceled within 30 days of purchase.<sup>64</sup> While a requirement for clear language and disclosures in insurance policies is nearly universal in every state and pet insurance is likely included in these requirements, California uniquely addresses pet insurance in its own statutory provision.<sup>65</sup>

This paper considers the top five pet health insurers to be the insurers with the largest percentage of market share. According to the 2018 North American Pet Health Insurance Association (NAPHIA), the top five pet health insurers are as follows in the below chart.

A. TOP FIVE INSURERS BY MARKET SHARE PERCENTAGE (IN MILLIONS):<sup>66</sup>

1. Nationwide \$ 374.60 36.33%
2. Trupanion \$ 191.60 18.58%
3. Healthy Paws Pet Insurance and Foundation \$ 123.20 11.95%
4. Petplan Pet Insurance \$ 83.60 8.11%
5. Crum & Forster Pet Insurance Group \$ 69.20 6.71%

The following findings were made by conducting a comprehensive review of the underwriting rules of the top five pet health insurers in California, accessed via SERFF. The underwriting rules can be found on SERFF by searching the California public-facing SERFF database.<sup>67</sup> One

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<sup>62</sup> *Id.* at 7.

<sup>63</sup> Cal. Ins. Code § 12880.2 (West 2019).

<sup>64</sup> *Id.*

<sup>65</sup> *Id.*

<sup>66</sup> NAIC Regulator's Guide, *supra* note 2, at 4 (citing N. AM. PET HEALTH INS. ASS'N, STATE OF THE INDUSTRY REPORT 2018 (2018), <https://naphia.org/industry/research-and-reports/terms-conditions-use-state-industry-report>.)

<sup>67</sup> *SERFF Filing Access: California*, NAT'L ASS'N INS. COMM'RS, <https://filingaccess.serff.com/sfa/home/CA> [hereinafter *SERFF Filing Access: California*]. This author's review included the SERF filing system, the organization

weakness in this review is that the rationales for the underwriting rules are not publicly available on SERFF. Thus, the commentary in this paper regarding variances in rating factors is speculative and is based on assumptions regarding the industry and the risk factors.

To retrieve specific underwriting rules, consumers can filter the database by selecting “Property & Casualty” for the business type, inputting the underwriting company’s name, and entering “pet” into the field for the insurance product name. This will yield all publicly available forms filed by the specified underwriting company that pertain to pet insurance. SERFF provides dates as well as the status of the form (approved, withdrawn, etc.), so consumers can see which approved underwriting rules are the most recent. Some discretion may be needed in the event the searched underwriting company underwrites for more than one branding company operating in California. However, the underwriting rules for the top five insurers were labeled by branding company as well, eliminating this concern.<sup>68</sup> Navigating the SERFF interface requires an unrealistic level of sophistication and diligence from consumers (inputting the branding company name, for example, would not yield results for underwriting rules), but it is a valuable tool for regulators and researchers.

An examination of the top five pet health insurance companies’ underwriting rules and criteria available on SERFF in California reveals few surprises and several universal rules. Cats are less expensive to insure than dogs.<sup>69</sup> Mixed-breed dogs are generally less expensive to insure than purebred dogs.<sup>70</sup> Younger dogs are less expensive to insure than older dogs.<sup>71</sup> Smaller dogs are generally less expensive to insure than larger dogs.<sup>72</sup> Interestingly, female cats are less expensive to insure than male cats, but the opposite is true for dogs.<sup>73</sup> As would be expected, premiums are partly based on average vet expenses for the policyholder’s geographic area, and the higher the deductible selected, the less expensive the policy premium will be. Some underwriters provide discounts for selected affinity groups and for policies provided by employers.<sup>74</sup> Owners would also be well-advised to skip

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of policies located within the SERFF website, and policies from the top five insurers by market share in California located on the website.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

extra treats for their pets—not just for their pets’ general health, but because it could save owners on the pet’s health insurance premium, depending on the company.<sup>75</sup> Among the top five pet health insurers, Healthy Paws was (perhaps surprisingly) the only company to offer a discount for pets who are not considered overweight or obese. Healthy Paws gives a five percent discount to all policyholders whose insured pet is within a normal weight category,<sup>76</sup> likely in an effort to reduce the frequency of loss costs associated with overweight or obese pets.

Cat breeds were largely undifferentiated in the rating factors, but breed is a very important consideration in determining the premium for dogs, with the exception of Nationwide, which does not account for individual dog breeds.<sup>77</sup> Owners may be surprised to see that mixed-breed dogs are generally less expensive to insure than purebred dogs. The debate between whether mixed-breed dogs are generally healthier than purebred dogs is still ongoing among veterinary professionals.<sup>78</sup> However, while mixed breed dogs may be carriers of genetic mutations that lead to health issues, they are less likely than purebreds to develop the disorders themselves, and thus carry less risk to insure.<sup>79</sup>

There are some outlier mixed-breeds that do not follow the trend of being less expensive to insure, however. The review of the underwriting rules available on SERFF reveals that mixed-breed bulldogs, mixed-breed pitbulls, mixed-breed boxers, and mixed-breed mastiffs are typically among the breed groups with the highest rating factor, making them among the most

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<sup>75</sup> *Id.*

<sup>76</sup> INDEM. INS. CO. OF N. AM., PET INSURANCE RATE AND RATING MANUAL – CALIFORNIA 12 (June 2018), <https://filingaccess.serff.com/sfa/search/filingSummary.xhtml?filingId=12874877>.

<sup>77</sup> It is noteworthy that Nationwide’s underwriting formula does not account for breeds. Accounting for breed would increase the accuracy of the policy risk assessment and lead to more accurate pricing. A rationale for this practice is not publicly available. Perhaps Nationwide has priced its policies to account for this lack of precision, but the practice does appear to leave Nationwide susceptible to adverse selection, with riskier breeds migrating to their coverage—if consumers with riskier breeds are savvy enough to recognize this peculiarity.

<sup>78</sup> *Are Purebred Dogs More Disease Prone?*, TUFTS YOUR DOG (Feb. 1, 2013), <https://www.tuftsyourdog.com/doghealthandmedicine/are-purebred-dogs-more-disease-prone/>.

<sup>79</sup> *Study Reveals Genetic Diseases of Mixed-breed, Purebred Dogs*, AM. VETERINARY MED. ASS’N (May 30, 2018), <https://www.avma.org/javma-news/2018-06-15/study-reveals-genetic-diseases-mixed-breed-purebred-dogs>.

expensive dogs to insure.<sup>80</sup> It is unclear why these mixed breeds are among the groups with higher ratings factors. It may be because these breeds, when purebred, are so prone to illnesses and injuries that require veterinary care that diluting their breed's genes with another breed does not offset the risk of the mixed-breed pet developing an illness or injury. Bulldogs, for example, are prone to major respiratory issues,<sup>81</sup> while pit bulls, boxers, and mastiffs frequently suffer from hip dysplasia.<sup>82</sup> These traits may be likely to develop even when the dog is mixed with another breed.

Another possibility is that breeds typically considered to be more aggressive are more expensive to insure, though this paper posits that quality is unlikely to significantly affect the rating factor. While breeds with purported aggression tendencies often raise the premium of a homeowner's policy, due to liability concerns, pet health insurance policies do not include liability insurance and strictly cover veterinary medical costs. Thus, a breed's aggression tendency appears unlikely to have any significant weight on the cost of veterinary care—unless breeds with a higher aggression tendency are themselves at a higher risk of injury by, for example, getting into a skirmish with another animal. However, this proposed rationale is merely theoretical.

While it is unclear why breeds fall within their specific rating factor groups, the bottom-line answer is likely quite succinct: the insurers' data says they should. The rationales behind individual breed classifications are not publicly available on SERFF, and the insurers may not know themselves why some breeds are more expensive than others. The data insurers have collected from issued policies likely informs the breed rating factors.

#### IV. A SURVEY OF THE TOP FIVE MARKET-SHARE PET INSURANCE PROVIDERS' UNDERWRITING RATING FACTORS

The following information regarding the underwriting rules was obtained via the SERFF California web access via the method described in Part III of this paper.

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<sup>80</sup> *SERFF Filing Access: California*, *supra* note 67.

<sup>81</sup> *Get the Facts about Brachycephalic Airway Syndrome*, TUFTS CUMMINGS SCH. OF VETERINARY MED. (Dec. 4, 2013), <https://news.vet.tufts.edu/2013/12/get-the-facts-about-brachycephalic-airway-syndrome/>.

<sup>82</sup> *Breed Statistics*, ORTHOPEDIC FOUND. FOR ANIMAL, <https://www.ofa.org/diseases/breed-statistics#detail> (last visited Mar. 11, 2021).

A. NATIONWIDE

Nationwide, the largest and oldest pet health insurer,<sup>83</sup> has a relatively simple underwriting formula with only five factors, including a base rate, for its major medical plan.<sup>84</sup> A policy's base rate is the premium amount before it is adjusted for risk factors. The base rate is multiplied by the independent rating factors, which can independently raise or lower the premium. The formula to calculate premium for Nationwide's California underwriter, Veterinary Pet Insurance Company, is as follows: Multiply (Base Rate)  $\times$  (Age Factor)  $\times$  (Species Factor)  $\times$  (Size Factor)  $\times$  (Deductible Factor).<sup>85</sup> This formula applies to both dogs and cats. Veterinary Pet Insurance Company is a wholly owned subsidiary of Nationwide.<sup>86</sup>

**Nationwide age rating:** Younger dogs and cats are considered less risky, with lower ratings factors than older pets.<sup>87</sup> The age rating factor starts at 1 for pets ages 2–11 months and increases to 4.5 for pets over 20 years old.<sup>88</sup>

**Nationwide size rating:** The size rating incorporates both breed and size in the same rating factor. Mixed-breed dogs have lower rating factors than purebred dogs, and smaller dogs of both categories have lower rating factors.<sup>89</sup> Mixed breed dogs of all sizes have a rating factor of .97, while the risk factor increases for purebred dogs as size increases.<sup>90</sup> Purebred “Tiny” dogs start with a size factor of .97, increasing to a factor of 1.3 for an “X-Large pet.”<sup>91</sup> All sizes of cats have the same rating factor of 1.<sup>92</sup>

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<sup>83</sup> *Find the Best Pet Insurance*, NAPHIA (Dec. 14, 2015), <https://naphia.org/news/phi-news/find-the-best-pet-insurance/>.

<sup>84</sup> *See infra* Figure 1.

<sup>85</sup> *Id.*

<sup>86</sup> KPMG LLP, SUPPLEMENTAL REPORT OF VETERINARY PET INSURANCE COMPANY 2 (2007), <https://www.sec.gov/Archives/edgar/data/1427257/000119312508099073/dex99a5.htm>.

<sup>87</sup> *See infra* Figure 1.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

**Nationwide species factor:** Based on species alone, cats are less expensive to insure. Canines have a rating factor of 1, while felines have a rating factor of .55.<sup>93</sup>

**Nationwide deductible factor:** A lower deductible equates to a higher rating factor. A \$100 deductible has a rating factor of 1, while a \$1,000 deductible has a rating factor of .5.<sup>94</sup>

## B. TRUPANION

Trupanion's underwriting formula is significantly more complex than Nationwide's and involves sixteen factors as opposed to Nationwide's five factors (including base rate).<sup>95</sup> Trupanion's underwriter is American Pet Insurance Company, which was acquired by Trupanion in 2007.<sup>96</sup> For dogs, the Trupanion formula is as follows: (Base Rate) × (Geographical Factor) × (Age Factor) × (12 Month Continuous Enrollment Discount Factor) × (Breed Factor) × (Gender Factor) × (Spay/Neuter Factor) × (Working Pet Factor) × (Deductible Factor) × (Exam Fee Factor) × (Co-Insurance Factor) × (Recovery & Complementary Care Factor) + (Pet Owner Assistance Rider Rate) + (Expense Rate) × (Web Link Partner Factor)<sup>97</sup> × (Affinity Group Factor) × (Employee Benefit Factor).<sup>98</sup> The cat formula varies only in the base rate, which is lower for cats than for dogs.

**Trupanion geographical factor:** The geographic factor represents the relative local cost of veterinary care for a specific geographical area defined by zip (or postal) code(s).<sup>99</sup> The formula for calculating the factor is as follows:  $\text{Geographical Factor} = 1.1^{\frac{\text{Group \#}}{3}}$ .<sup>100</sup> The assigned group numbers are not available in the underwriting rules.<sup>101</sup>

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *See infra* Figure 2.

<sup>96</sup> TRUPANION, INC., FORM S-1 REGISTRATION STATEMENT (June 16, 2014), <https://www.sec.gov/Archives/edgar/data/1371285/000119312514237894/d661590ds1.htm>.

<sup>97</sup> Only one of the last three factors can apply.

<sup>98</sup> Trupanion will also be adding another rating factor, the Landpath Food Program Discount in July 2020, but information on the program is not available online. *See infra* Figure 2.

<sup>99</sup> *See infra* Figure 2.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*



**Trupanion age factor:** Unlike Nationwide, Trupanion has different age rating factors for canines and felines, ranging from less than a year old to thirteen years old. The rating factor for dogs starts at .817 for dogs less than one year old and goes up to 3.423 for dogs that are at least thirteen years old.<sup>102</sup> The age rating factor for cats ranges from .662 for cats less than one year old, and goes up to 3.985 for cats that are at least thirteen years old.<sup>103</sup>

**Trupanion twelve months continuous enrollment discount:** Continuous enrollment discounts are relative to the age at enrollment and apply in the month following twelve continuous months of enrollment. Premium factors are multiplicative over successive twelve-month periods where enrollment is continuous.<sup>104</sup> For instance, if a cat is enrolled at age 1 and is continuously enrolled for 2 years, the applicable factor would be  $0.662 = (0.882)^2$ .<sup>105</sup>

**Trupanion breed factor:** Trupanion's filed underwriting rules do not include the breed table within the underwriting manual. The breed factor is designed to represent the relative cost of veterinary care for a specific breed.<sup>106</sup>

**Trupanion gender factor:** Female cats have a lower rating factor than male cats (.95 for female cats versus 1.05 for male cats), but the opposite is true for dogs (1.01 for female dogs versus .99 for male dogs).<sup>107</sup>

**Trupanion spay/neuter factor:** Perhaps surprisingly, the rating factor remains the same for all animals regardless of whether they are spayed or neutered, with the exception of intact females that are bred. The rating factor for intact females that are bred is 1.733, as opposed to 1 for all other groups.<sup>108</sup> The distinction that intact females do not have a high rating classification unless they are bred suggests the risk is due to medical costs associated with pregnancy and delivery.

**Trupanion working pet factor:** Trupanion's underwriter has six groups of working pets, which are not described or elaborated on in the underwriting rules. Only working group 1 has a rating factor of .949; the other five groups have a factor of 1.<sup>109</sup>

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<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

<sup>108</sup> *Id.*

<sup>109</sup> See *infra* Figure 2.

**Trupanion deductible factor:** The factor for a \$0 deductible is 1.896. The formula for all other deductible levels ranging from \$50 to \$1,000 is as follows: Deductible Factor =  $1 - \frac{D^{0.1904}}{4.3210} \times 2.9590$  where D = the selected deductible amount.

**Trupanion coinsurance factors:** Co-insurance of one-hundred percent has a factor of 1.167, while co-insurance of only fifty-percent has a factor of .63.<sup>110</sup>

**Trupanion exam fee coverage factor:** If the policy includes exam coverage, the factor is 1.2, and if not, the factor is 1.<sup>111</sup>

**Trupanion recovery and complementary care factor:** If the policy has this type of extra coverage, the factor is 1.137, and if not, the factor is 1.<sup>112</sup> Types of care that would fall under this optional coverage include acupuncture and rehabilitative therapy.<sup>113</sup>

**Trupanion pet owner assistance package rate:** If this rider is elected, the cost is \$4.95 per monthly premium.<sup>114</sup> This rider covers more unusual costs, such as advertising in the event your pet is lost or stolen, boarding fees if you, the owner, are hospitalized, and cremation or burial expenses if your pet dies from an accident.<sup>115</sup>

**Trupanion web link partner factor:** Trupanion's underwriting rules do not offer context to this factor, but it is likely that a favorable rating is given to applicants who are directed to the Trupanion site from another online landing page through which Trupanion has a web link partnership agreement. If the applicant is a web link partner, the factor is .94, and if not, the factor is 1.<sup>116</sup>

**Trupanion affinity group factor:** If the policyholder is part of an affinity group, the factor is .89, and if not, the factor is 1.<sup>117</sup> The underwriting rules do not define organizations or businesses that are considered affinity groups.

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<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.*

<sup>113</sup> *Extra Coverage*, TRUPANION, <https://trupanion.com/pet-insurance/recovery-complementary-care-coverage> (last visited Oct. 24, 2020).

<sup>114</sup> *See infra* Figure 2.

<sup>115</sup> *Extensive Coverage for Dogs and Cats*, TRUPANION, <https://trupanion.com/pet-insurance/pet-insurance-coverage> (last visited Oct. 24, 2020).

<sup>116</sup> *See infra* Figure 2.

<sup>117</sup> *Id.*

**Trupanion employee benefit factor:** If the employer contributes less than \$10 to the premium, the factor is .94, and if the employer contributes \$10 or more, the factor is .92.<sup>118</sup>

### C. HEALTHY PAWS PET INSURANCE COMPANY

Healthy Paws Pet Insurance Company is underwritten by Indemnity Insurance Company of North America in California. Healthy Paws is a brand name; Indemnity Insurance Company of North America is the underlying provider and is not a subsidiary of Healthy Paws.<sup>119</sup> The rating formula for Dogs and Cats has eight variable factors that are applied to the monthly base rate.<sup>120</sup> Each pet's monthly premium incorporates the factors for: age, breed, ZIP Code, co-insurance, deductible, weight control, affinity group sponsorship, employer group benefit, plus a fixed administrative expense fee.

The formulas for dogs and cats differ only in base rate and administrative expense fee. The Dog Rating Formula is as follows: (Dog Base Rate \$64.88)  $\times$  (Age of Pet Factor)  $\times$  (Breed of Dog Factor)  $\times$  (Territory Factor)  $\times$  (Co-insurance Factor)  $\times$  (Deductible Factor)  $\times$  (Weight Control Risk Management Factor)  $\times$  (Affinity Group Sponsorship Factor)  $\times$  (Employer Group Benefit Factor) + (Administrative Expense Fee of \$8.75).<sup>121</sup> The base rate for cats is \$36.99, and the administrative expense fee is \$5.75.<sup>122</sup>

**Healthy Paws pet age factor:** Dogs and cats less than one year old have an age rating factor of .85, while pets aged 13 and older have a rating factor of 4.05.<sup>123</sup>

**Healthy Paws co-insurance factors:** A payout of ninety percent (the highest amount) has a factor of 1.05, while the lowest payout rate of fifty percent has a factor of .55.<sup>124</sup>

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<sup>118</sup> *Id.*

<sup>119</sup> *Frequently Asked Questions*, HEALTHY PAWS, <https://www.healthypawspetinsurance.com/frequent-questions> (last visited Oct. 2, 2020) (under “*Who is the Insurance Carrier for the Healthy Paws Program?*”).

<sup>120</sup> *See infra* Figure 3.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

**Healthy Paws deductible factors:** The lowest deductible factor of \$0 has a factor of 1, while the highest deductible factor of \$1,000 has a factor of .4.<sup>125</sup>

**Healthy Paws territory rating factors:** ZIP Codes in every state are assigned a territory rating factor reflecting the relativity of veterinary costs.<sup>126</sup>

**Healthy Paws weight control risk management factor:** A five percent discount (.95 factor) is available to all policyholders as an incentive to promote diet and weight control of their pet, which will reduce the frequency of loss costs associated with overweight or obese pets.<sup>127</sup>

**Healthy Paws affinity group sponsorship:** A five percent discount (.95 factor) is available to members of Sponsoring Affinity Groups based upon reduced marketing and underwriting expenses that will accrue from the economies of scale and relationship leveraging that occurs through public awareness and group education.<sup>128</sup>

**Healthy Paws employer group benefit:** A ten percent discount (.90 factor) is available to any corporation that enrolls a group of employees as a Group Benefit Plan.<sup>129</sup> The discount is based upon reduced marketing and underwriting expenses that will accrue from the economies of scale.

**Healthy Paws breed factor:** Dog breeds are classified into 10 different breed groups.<sup>130</sup> Group 1 has a ratings factor of .7 and includes breeds such as chihuahua mixes, shih tzus, and toy schnauzers.<sup>131</sup> Group 10 has a rating factor of 2.75, and includes breeds such as rottweilers, Doberman pinschers, cane corsos, and mastiff mixes. Pitbull mixes are in Group 8, and boxer mixes are in Group 9.<sup>132</sup> It is atypical for mixed breeds to have such a high ratings factor; the majority of dogs in Groups 8 and higher are purebred dogs.<sup>133</sup>

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<sup>125</sup> *Id.*

<sup>126</sup> *See infra* Figure 3.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

Cat “breeds” are classified as mixed breed, other, or domestic long-hair, medium-hair, or short-hair.<sup>134</sup> Mixed breeds have a factor of 2, domestic breeds of all hair lengths have a factor of 3, and others have a factor of 4.<sup>135</sup>

D. PETPLAN PET INSURANCE

Petplan’s underwriter is XL Specialty Insurance Company, which is an independent underwriter and not a subsidiary of Petplan.<sup>136</sup> The underwriter does not set forth the formula for calculating premium in its rate filing, but like other pet health insurance underwriting rules, we can assume the factors are multiplied by the base rate.<sup>137</sup> Factors the underwriter states are considered in the filed form are base rate by state relativity factor, rating trend factor,<sup>138</sup> annual policy maximum limits, rating territories, rating territory definitions, co-pay options, deductible options, coverage of examination fees, breed factor, initial age factor, working dog factor, and discounts applied for corporate group plans and animal shelter partners.

E. CRUM & FORSTER PET INSURANCE GROUP

Crum & Forster Pet Insurance Group’s most recognizable pet health insurance brand is the ASPCA Pet Health Insurance.<sup>139</sup> ASPCA Pet Health Insurance is underwritten by C&F Insurance Agency and United States Fire Insurance Company.<sup>140</sup> This paper examines the rate/rule form filed by United States Fire Insurance Company, since it appears pet policies in

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<sup>134</sup> *Id.*

<sup>135</sup> *Id.*

<sup>136</sup> XL Grp. Ltd., Subsidiaries of the Registrant (Exhibit 21) (Dec. 31, 2017), [https://www.sec.gov/Archives/edgar/data/875159/000087515918000015/xlgroup-12312017xex\\_21.htm](https://www.sec.gov/Archives/edgar/data/875159/000087515918000015/xlgroup-12312017xex_21.htm).

<sup>137</sup> See *infra* fig. 4.

<sup>138</sup> The rating trend factor accounts for an expected increase in veterinary care each year the pet is covered.

<sup>139</sup> *Our History*, CRUM & FORSTER PET INSURANCE GROUP, <https://www.cfpetinsurance.com/about-us/our-history/> (last visited Sep. 24, 2020).

<sup>140</sup> *Underwriting and Administrative Information*, ASPCA, <https://www.aspcapetinsurance.com/more-info/underwriting/> (last visited Sep. 24, 2020).

California are exclusively written by this underwriter.<sup>141</sup> United States Fire Insurance Company is a wholly-owned subsidiary of Crum and Forster.<sup>142</sup> The rating formula is as follows: (Base Rate)  $\times$  (Annual Maximum Factor)  $\times$  (Age Factor (if applicable))  $\times$  (Breed Factor (if applicable))  $\times$  (Discount Factor (if applicable))  $\times$  (Factor(s) for Coverage exclusions (if applicable)) + (Preventive Care Endorsement Rate (optional)).<sup>143</sup>

**Crum & Forster base rate:** Monthly base premium rates by deductible, co-insurance and territory are designated.<sup>144</sup> Territories are assigned based on ZIP Code.<sup>145</sup>

**Crum & Forster deductible and copay factors:** A zero percent copay has a rating factor of 1.15, while a \$1,000 deductible has a rating factor of .67.<sup>146</sup>

**Crum & Forster annual maximum factors:** The lowest annual maximum of \$1,000 has a rating factor of .70, while unlimited has a rating factor of 1.67.<sup>147</sup>

**Crum & Forster age factors:** Age factors differ for dogs and cats. Dogs less than one year old have a rating factor of .7, while dogs 18 and older have a rating factor of 3.<sup>148</sup> Cats less than one year old also have a rating factor of .6, but cats 18 and older only have a rating factor of 2.5.<sup>149</sup>

**Crum & Forster breed factors:** The underwriting rule contains a comprehensive, eight-page spreadsheet of dog and cat breeds and their accompanying rating factors, considering everything from a “morkie” (a Maltese and Yorkshire terrier dog mix) to the Scottish fold cat.<sup>150</sup> Crum & Forster policies differentiate based on individual cat breed, which the other insurers do not. The highest rating factor for dogs is 1.3, and includes breeds

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<sup>141</sup> *SERFF Filing: Crum & Forster*, NAT’L ASS’N INS. COMM’RS, <https://filingaccess.serff.com/sfa/search/filingSummary.xhtml?filingId=130564724> (last visited Sep. 26, 2020).

<sup>142</sup> CRUM & FORSTER HOLDINGS CORP., FORM S-1 REGISTRATION STATEMENT UNDER THE SECURITIES ACT OF 1933 (Mar. 8, 2002), <https://sec.report/Document/0000950123-02-002331/>.

<sup>143</sup> *See infra* Figure 5.

<sup>144</sup> *See infra* Figure 5.

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.*

<sup>148</sup> *Id.*

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

like the golden retriever and Newfoundland.<sup>151</sup> The lowest rating factor for dogs is .8, and generally includes smaller dogs such as the “Malti-poo” and chihuahua.<sup>152</sup> The highest and lowest rating factors are the same for cat breeds. Cat breeds in the highest (most expensive) group include the Oriental and Burmese breeds, while those in the lowest group include Angora and Bombay cats.<sup>153</sup>

## V. CONCLUSION

It is perhaps reassuring to see that, at least in the state of California where insurers are required to publish their underwriting rules, there are few surprises in the rating factor structures of the top five pet health insurers. Pet health insurance is a unique property and casualty product in that it is essentially medical insurance that accounts for the insured pet’s individuality, but insurers seem to have channeled this uniqueness into practical and conventional underwriting rules that identify risks and manages marketing objectives. Age, gender, species, breed, weight, and geographic locations are reasonable criteria to include in underwriting rating formulas for pet health insurance. While the rationales behind differences in breed rating factors is uncertain, it is logical that different breeds have varying levels of health risks. This sample of the five largest pet health insurers in California reveals that the approved underwriting rules are exactly what one would likely expect—pricing based on medical risk and veterinary care costs in the policyholder’s geographic area.

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<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

*Figure 1: Nationwide/Veterinary Pet Insurance Company Underwriting Rate Manual filed in California, accessible via SERFF<sup>154</sup>*

**VETERINARY PET INSURANCE COMPANY  
PERSONAL LINES  
VETERINARY PET INSURANCE PROGRAM  
CALIFORNIA**

**MAJOR MEDICAL PLAN - RATING FACTORS**

Age Factors		
Age	Canine	Feline
0 – 11 Mo	1.00	1.00
1 year	1.00	1.00
2 years	1.00	1.00
3 years	1.07	1.08
4 years	1.31	1.10
5 years	1.54	1.35
6 years	1.73	1.54
7 years	1.90	1.78
8 years	2.13	1.96
9 years	2.42	2.50
10 years	2.70	2.88
11 years	2.99	3.16
12 years	3.28	3.48
13 years	3.62	3.83
14 years	4.03	4.21
15 years	4.22	4.21
16 years	4.22	4.21
17 years	4.22	4.23
18 years	4.50	4.44
19 years	4.50	4.50
20+ years	4.50	4.50

Size Factors		
Size	Canine	Feline
Tiny	0.97	1.00
Small	0.97	1.00
Medium	1.00	1.00
Large	1.00	1.00
X-Large	1.30	1.00
Mixed Tiny	0.97	1.00
Mixed Small	0.97	1.00
Mixed Medium	0.97	1.00
Mixed Large	0.97	1.00
Mixed X-Large	0.97	1.00
Species Factor		
Canine	1.00	
Feline	0.55	
Deductible Factor		
\$100	1.00	
\$250	0.86	
\$500	0.70	
\$1,000	0.50	

N-VPI-R-CA-14.3


(10-17)

<sup>154</sup> SERFF Filing Access: California, *supra* note 67.



*Figure 2: Trupanion/American Pet Insurance Company  
Underwriting Rate Manual filed in California, accessible via  
SERFF<sup>155</sup>*

Underwriting Rules and Rate Guidelines  
#12.2020  
Effective July 1, 2020



American Pet Insurance Company

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**trupanion**

**PET INSURANCE PROGRAM**  
Underwriting Rules and Rate Guidelines

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**EFFECTIVE:**  
July 1, 2020

**COMPANY DIRECTORY**

**UNDERWRITING**  
ADDRESS: 6100 4<sup>th</sup> Ave S, STE 200  
Seattle, Washington 98108  
PHONE: 877-569-1841

**CLAIMS**  
ADDRESS: 6100 4<sup>th</sup> Ave S, STE 200  
Seattle, Washington 98108  
PHONE: 855-268-2151

**BILLING**  
ADDRESS: 6100 4<sup>th</sup> Ave S, STE 200  
Seattle, Washington 98108  
PHONE: 855-268-2152

6100 4<sup>th</sup> AVE S, STE 200 | 800-569-7913  
SEATTLE, WA 98108 | APIC-PETINSURANCE.COM

CALIFORNIA      PET INSURANCE PROGRAM | 2

<sup>155</sup> SERFF Filing Access: California, *supra* note 67.

**Underwriting Rules and Rate Guidelines**  
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Effective July 1, 2020

**UNDERWRITING RULES & RATE GUIDELINES****PREMIUM**

1. Your premium will not change due to your pet aging.
2. Your premium will not change due to your pet's individual claims experience.

**ELIGIBLE PETS**

1. All domesticated dogs and cats less than 14 years old are eligible for enrollment.
2. Cloned dogs and cats are not eligible for coverage under this policy.
3. Hybrid dogs and cats (domestic animals that are bred with wild animals) are not eligible for coverage under this policy.

**POLICY TERM**

1. This policy is continuous until cancelled, and will renew automatically each month as long as your premium payments are current.

**COVERAGE OPTIONS** (not necessarily available on all plans – see plan details below):

1. **Co-Insurance** – Plans may be offered with co-insurance amounts ranging from 50% to 100% (this is the company's share of the cost of claims). Policy premiums will be adjusted according to the co-insurance offered/selected.
2. **Deductible** – Policy deductibles may be offered in amounts ranging from \$0 to \$1,000. Policy premium will be adjusted according to the deductible amount offered/selected.
3. **Veterinarian Exam Fees** – An additional surcharge will be applied if this coverage is offered/selected.
4. **Recovery & Complementary Care** – For an additional surcharge, the policy coverage will be expanded to include: acupuncture, behavioral assessment, chiropractic, homeopathy, hydrotherapy, naturopathy, physical therapy (rehabilitative therapy).
5. **Pet Owner Assistance Rider** (formerly known as 'Rider B') – These benefits include third party property damage liability, advertising and reward, boarding fees, holiday cancellation costs, and pet cremation or burial.

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#### POLICY PLANS

1. **Trupanion** – This plan will be offered by Trupanion Managers USA, Inc; American Pet Insurance Company's Managing General Agency
  - a. Premiums are payable monthly.
  - b. For pets less than 14 years old.
  - c. 90% co-insurance (only option).
  - d. A Deductible from \$0 to \$1,000 to be determined by the owner.
  - e. Veterinarian Exam Fee is not offered as an optional additional coverage.
  - f. Recovery & Complementary Care Rider is included with all new policies unless the policyholder declines the coverage during enrollment.
  - g. Pet Owner Assistance Rider (formerly known as 'Rider B') is available to the policyholder.
  - h. Discounts Available – Web Link Partner, or Affinity Group, or Employee Benefits discounts may be applied if owner is eligible
    - i. Only one of these will be applied to eligible pets.
2. **Exam Day Offer (Veterinary Examination Program):** This plan will be offered by Trupanion Managers USA, Inc; American Pet Insurance Company's Managing General Agency.
  - a. For pets less than 14 years old.
  - b. 90% co-insurance.
  - c. A deductible level of \$250.
  - d. An 8.33% discount will be applied to the premium for the first year of the policy.
  - e. The standard waiting periods will be waived.
  - f. All other conditions of the policy will apply
  - g. Pets must be enrolled within 24 hours after the pet has had a veterinary examination and after receiving a signed exam certificate.
  - h. Premiums are payable monthly.
  - i. The first month's premium will be deferred and will be billed and collected from the insured during months 2 through 12 of the policy.
3. **Daily Premium Plan** – This plan will be offered by Trupanion Managers USA, Inc; American Pet Insurance Company's Managing General Agency
  - a. For pets less than 14 years old.
  - b. The standard waiting periods will be waived
  - c. The Daily Premium Rate will apply
  - d. 100% co-insurance.
  - e. \$0 Deductible

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4. **White Label Plan** – This plan will be made available to customers by agencies that are not affiliates of American Pet Insurance Company.
- a. For pets less than 14 years old.
  - b. 50%-100% co-insurance.
  - c. A set deductible ranging from \$50 to \$500.
  - d. Veterinarian Exam Fee Coverage may be included.
  - e. Recovery & Complementary Care Rider coverage may be included.
  - f. Pet Owner Assistance Rider coverage may be included.
  - g. Discounts Available – Web Link Partner, Affinity Group, or Employee Benefits discounts may be applied if owner is eligible.
  - i. Only one of these discounts will be applied to eligible pets.

**MEMBERSHIP BENEFIT FEE**

1. A \$35 administration fee charged to new customers when enrolling their first pet. Additional pets enrolled are not charged this fee. This fee is designed to cover the administrative costs of collecting medical records, and related to pet ID tags given to each pet enrolled. This includes the cost of 24/7 telephone coverage for lost dog services. These costs are spread over the duration of policy coverage.

**PROMOTIONAL ITEMS**

Each named insured may receive from time to time certain promotional offers. These offers include but are not limited to gift cards, coupons, gift certificates, items of merchandise, and similar promotional items.

**Exclusions and stipulations, which restrict coverage, are contained in the Pet Health Insurance Policy.**

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#### RATING ORDER OF CALCULATIONS

##### RATE FORMULA

Base Rate  
 × Geographical Factor  
  
 × Age Factor  
 × 12 Month Continuous Enrollment Discount Factor  
 × Breed Factor  
 × Gender Factor  
 × Spay/Neuter Factor  
 × Working Pet Factor  
  
 × Deductible Factor  
 × Exam Fee Factor  
 × Co-Insurance Factor  
 × Recovery & Complementary Care Factor  
 × Landspath Food Program Discount  
 + Pet Owner Assistance Rider Rate  
  
 + Expense Rate  
  
 × Web Link Partner Factor<sup>1</sup>  
 × Affinity Group Factor<sup>1</sup>  
 × Employee Benefit Factor<sup>1</sup>

**= Monthly Premium Rate**

**Daily Premium Rate = Monthly Premium Rate \* 12 / 365.25**

<sup>1</sup> Only one of these will be applied to eligible pets

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**BASE RATE: \$99.70**

**GEOGRAPHICAL FACTOR:** Represents the relative local cost of veterinary care for a specific geographical area defined by zip (or postal) code(s) and implied by the assigned Group # given in Table 1 – Geographical Factors. The formula for calculating the factor is as follows:

$$\text{Geographical Factor} = (1.1)^{((\text{Group \#} - 50)/3)}$$

Example: A geographical area assigned Group # 52.0 implies a Geographical Factor of 1.066.

**AGE FACTORS:**

Age	Cat	Dog
Less than 1 year old	0.662	0.817
1 year old	0.792	0.949
2 years old	0.898	1.048
3 years old	1.020	1.157
4 years old	1.157	1.277
5 years old	1.314	1.489
6 years old	1.491	1.701
7 years old	1.692	1.913
8 years old	1.921	2.125
9 years old	2.206	2.337
10 years old	2.491	2.549
11 years old	2.989	2.841
12 years old	3.487	3.132
13 years old	3.985	3.423

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**12 MONTH CONTINUOUS ENROLLMENT DISCOUNT FACTORS <sup>(\*)</sup>:**

Age	Cat	Dog
Puppy/Kitten to 1 year old	0.836	0.861
1 year old -> 2 year old	0.882	0.906
2 year old -> 3 year old	0.880	0.906
3 year old -> 4 year old	0.882	0.906
4 year old -> 5 year old	0.881	0.858
5 year old -> 6 year old	0.881	0.875
6 year old -> 7 year old	0.881	0.889
7 year old -> 8 year old	0.881	0.900
8 year old -> 9 year old	0.871	0.909
9 year old -> 10 year old	0.886	0.917
10 year old -> 11 year old	0.833	0.897
11 year old -> 12 year old	0.857	0.907
12 year old -> 13 year old	0.875	0.915

<sup>(\*)</sup> Continuous Enrollment Discounts are relative to the age at enrollment and apply in the month following 12 continuous months of enrollment. Premium factors are multiplicative over successive 12 month periods where enrollment is continuous.

**BREED FACTORS:** Represents the relative cost of veterinary care for a specific breed as implied by the assigned Group # given in Table 2 – Breed Factors. The formula for calculating the factor is as follows:

$$\text{Breed Factor} = (1.1)^{((\text{Group \#} - 50)/3)}$$

Example: A breed assigned to Group # 46.0 implies a Breed Factor of 0.881.

**GENDER FACTORS:**

Coverage	Factor
Cat – Female	0.950
Cat – Male	1.050
Dog – Female	1.010
Dog – Male	0.990

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**SPAY/NEUTER FACTORS:**

Status	Factor
Spay/Neutered	1.000
Intact Male	1.000
Intact Female	1.000
Intact Female - Breeding	1.733

**WORKING PET FACTORS:**

WP Group	Factor
1	0.949
2	1.000
3	1.000
4	1.000
5	1.000
6	1.000

**DEDUCTIBLE FACTOR:**

The factor for a \$0 deductible is 1.896.

The formula for all other deductible levels ranging from \$50 to \$1,000 is as follows:

$$\text{Deductible Factor} = (1 - (D \times 0.1904) / 4.3210) \times 2.9590$$

where D = the selected deductible amount

Example: The factor for a \$500 deductible is 0.724.

**CO-INSURANCE FACTORS:**

Co-Insurance	Factor
100%	1.167
90%	1.050
80%	0.945
70%	0.840
60%	0.735
50%	0.630

**EXAM FEE FACTORS:**

Coverage	Factor
YES	1.200
NO	1.000



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**RECOVERY & COMPLEMENTARY CARE FACTORS:**

Coverage	Factor
YES	1.137
NO	1.000

**LANDSPATH FOOD PROGRAM DISCOUNT FACTORS:**

Coverage	Factor
YES	0.950
NO	1.000

**PET OWNER ASSISTANCE PACKAGE RATE:**

Rider	Rate
YES	\$4.95
NO	\$0.00

**EXPENSE RATE: \$6.97****WEB LINK PARTNER FACTOR:**

Web Link Partner	Factor
YES	0.940
NO	1.000

**AFFINITY GROUP FACTOR:**

Affinity Group	Factor
YES	0.890
NO	1.000

**EMPLOYEE BENEFIT FACTOR:**

Representation & Employer Premium Contribution	Factor
Employer Contributes less than \$10 to premium	0.940
Employer Contributes \$10 or more to premium	0.920

Applies to employer groups of 50+ employees. To be eligible, policyholder must enroll through the employer's voluntary benefit or employee discount program. Coverage is completely portable for employees who leave their employer as long as premiums continue to be paid as required per the Pet Health Insurance Policy. If an employee leaves their employer and elects to continue coverage, the premiums are no longer eligible for the Employee Benefit Factor discount.

**TABLE 1 – Please see the attached URM – Table 1 GEO FACTORS****TABLE 2 – Please see the attached URM – Table 2 BREED FACTORS**

*Figure 3: Healthy Paws/Indemnity Insurance Company of North America Underwriting Manual filed in California, accessed via SERFF<sup>156</sup>*

**Indemnity Insurance Company of North America  
Pet Insurance - Inland Marine  
Rate and Rating Manual – California**

**Base Rate**

The Base Rates (which include the claims administrative costs at a fixed rate of \$20 per closed claim) per covered animal per monthly policy period are:

Dog	\$ 64.88
Cat	\$ 36.99

**Pet Rating Formula**

The Rating Formula for Dogs & Cats has 8 variable factors that are applied to the monthly base rate. Each pet's monthly premium incorporates the factors for: age, breed, zip code, co-insurance, deductible, weight control, affinity group sponsorship, employer group benefit, plus a fixed administrative expense fee.

**Dog Rating Formula**

- 1) Dog Base Rate \$64.88
- 2) x Age of Pet Factor
- 3) x Breed of Dog Factor
- 4) x Territory Factor
- 5) x Co-insurance Factor
- 6) x Deductible Factor
- 7) x Weight Control Risk Management Factor
- 8) x Affinity Group Sponsorship Factor
- 9) x Employer Group Benefit Factor
- 10) + Administrative Expense Fee of \$8.75

**Cat Rating Formula**

- 1) Cat Base Rate \$36.99
- 2) x Age of Pet Factor
- 3) x Breed of Cat Factor
- 4) x Territory Factor
- 5) x Co-insurance Factor
- 6) x Deductible Factor
- 7) x Weight Control Risk Management Factor
- 8) x Affinity Group Sponsorship Factor
- 9) x Employer Group Benefit Factor
- 10) + Administrative Expense Fee of \$5.75

\* The Administrative Expense Fee was set at an estimate of 25% of the average final rate for dogs and cats. A flat fee more appropriately reflects the actual cost of policy administration without regard for the consumers' product selection and corresponding rate (i.e. relative to deductible, coinsurance, breed, age, geography, etc.).

<sup>156</sup> SERFF Filing Access: California, *supra* note 67.

**Indemnity Insurance Company of North America**  
**Pet Insurance - Inland Marine**  
**Rate and Rating Manual – California**

**Rating Variable Factors**

**Pet Age Factors**

The covered pet's age is determined by its date of birth. If the exact date of birth is not known the pet owner may be asked to obtain an estimate of their pet's age from the pet's veterinarian. The Pet Age Factor applied at the policy inception will not change through the life of the pet as long as it is continuously insured under the policy (including any rewrite of the policy).

For renewals of policies originally written prior to 8/1/2017:

Age	<1	1	2	3	4	5	6	7	8	9	10	11	12	13+
Factor	0.85	0.90	0.95	1.13	1.26	1.42	1.62	1.84	2.10	2.39	2.73	3.11	3.55	4.05

For policies written on or after 8/1/2017 and renewals of policies originally written on or after 8/1/2017:

Age	<1	1	2	3	4	5	6	7	8	9	10	11	12	13+
Factor	0.92	0.935	0.95	1.13	1.26	1.42	1.62	1.84	2.10	2.39	2.73	3.11	3.55	4.05

**Co-insurance Factors**

There are five co-insurance options. Rating factors are:

Pay Out	90%	80%	70%	60%	50%
Factor	1.05	0.85	0.75	0.65	0.55

**Deductible Factors**

Eight deductible levels are offered. Rating factors are:

Deductible	\$0	\$50	\$100	\$200	\$250	\$500	\$750	\$1,000
Factor	1.000	0.910	0.900	0.770	0.700	0.550	0.480	0.400

**Territory Rating Factors**

Zip codes in every state are assigned a territory rating factor reflecting the relativity of veterinary costs. Rating factors are as follows:

Please refer to the next sheet

**Indemnity Insurance Company of North America**  
**Pet Insurance - Inland Marine**  
**Rate and Rating Manual – California**

**Discount Factors**

Three types of discounts are offered as follows:

Weight Control Risk Management - A 5% discount (.95 factor) is available to all policyholders as an incentive to promote diet and weight control of their pet, which will reduce the frequency of loss costs associated with overweight or obese pets. Such credit shall be removed upon notification by a Vet of weight or obesity.

Affinity Group Sponsorship - A 5% discount (.95 factor) is available to members of Sponsoring Affinity Groups based upon reduced marketing and underwriting expenses that will accrue from the economies of scale and relationship leveraging that occurs through public awareness and group education.

Employer Group Benefit - A 10% discount (.90 factor) is available to any corporation that enrolls a group of employees as a Group Benefit Plan. The discount is based upon reduced marketing and underwriting expenses that will accrue from the economies of scale.

Final Discount Factor Determination

Maximum discounts available for each group are determined from the following table. Regardless of the total number of discounts for which a covered pet is eligible, the maximum total discount is 15%.

Discount Type	Discount Factor	Factor
Weight Control Risk Management Credit	5%	.95
Affinity Group Credit	5%	.95
Corporate Group Benefit Plan Credit	10%	.90

**Breed Factors**

Dog and Cat Breed and Pure Breed Factor Table:

Breed Group	1	2	3	4	5	6	7	8	9	10
Factor	0.70	0.80	0.90	1.00	1.10	1.20	1.30	1.40	1.75	2.75

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**Rate and Rating Manual – California**

Dog Breed	Breed Group	Dog Breed	Breed Group
Bichon Mix	1	Bichpoo	1
Cavachon	1	Chihuahua	1
Chihuahua Mix	1	Chiveenie	1
Chorkie	1	Chug	1
Crossbreed Small: 11 - 30 lbs	1	Crossbreed Toy: 1 - 10 lbs	1
Havashu	1	Jug	1
Mal-Shi	1	Mixed Breed Small: 11 - 30 lbs	1
Mixed Breed Toy: 1 - 10 lbs	1	Morkie	1
Peekapoo	1	Pomapoo	1
Shih Tzu	1	Teacup Poodle	1
Teacup Yorkie	1	Toy Maltese	1
Toy Schnauzer	1	Bagel	2
Beabull	2	Bichon Frise	2
Border Collie Mix	2	Chow Chow Mix	2
Crossbreed Medium: 31 - 59 lbs	2	Havanese	2
Miniature Yorkie	2	Mixed Breed Medium: 31 - 59 lbs	2
Samoyed Mix	2	Schnauzer Mix	2
Shar Pai Mix	2	Sharpo	2
Shih-poo	2	Yorkiepoo	2
Yorkshire Terrier	2	American Hairless Terrier	3
Beagle	3	Border Collie	3
Boston Terrier	3	British Shorthair	3
Cavapoo	3	Cockapoo	3
Collie Mix	3	Dorgie	3
Goldendoodle	3	Harlequin Pinscher	3
Jack Russell Terrier	3	Labradoodle	3
Lhasa Apso	3	Lhasa Apso Mix	3
Maltese	3	Maltipoo	3
Mix Ki	3	Miniature Pinscher	3
Mixed Breed	3	Parson Russell Terrier	3
Pomeranian	3	Paroie	3
Puggle	3	Rat Terrier	3
Schnoodle	3	Terrier Mix	3
Tibetan Spaniel	3	Toy Fox Terrier	3
Afghan Hound	4	Ainu Dog	4
Alaskan Husky	4	Alaskan Klee Kai	4
American Indian	4	American Water Spaniel	4
Arigeois	4	Australian Cattle Dog Mix	4
Australian Shepherd	4	Austrian Short Haired Pinscher	4
Beagle Horner	4	Beagle Mix	4
Bearded Collie	4	Bedlington Terrier	4
Border Terrier	4	Bracco Italiano	4
Canadian Husky	4	Catahoula Leopard Dog	4
Central Asian Shepherd Dog	4	Chinese Crested	4
Crossbreed Large: 60+ lbs	4	Dalmation Mix	4
English Toy Terrier	4	Fel Terrier	4
Field Spaniel	4	Finnish Lapphund	4
German Pinscher	4	Glen of Imaal Terrier	4
Harrier	4	Husky	4
Husky Mix	4	Ibizian Wolfhound	4
Itizan Hound	4	Icelandic Sheepdog	4
Inca Hairless Dog	4	Italian Setter	4
Japanese Spitz	4	Japanese Terrier	4

**Indemnity Insurance Company of North America  
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Dog Breed	Breed Group
Pembroke Welsh Corgi	8
Staffordshire Bull Terrier	8
Beauce Shepherd	9
Belgian Shepherd Tervuren	9
Bloodhound	9
Boxer	9
Bulldog	9
French Bulldog	9
Landseer	9
Mountain Cur	9
Pekingese Mix	9
Shar-Pei	9
American Bandogge Mastiff	10
Appenzell Mountain Dog	10
Bernese Mountain Dog	10
Boerboel	10
Broholmer	10
Canary Dog	10
Caucasian Mountain Dog	10
Doberman Pinscher Mix	10
English Bulldog	10
Entlebucher Mountain Dog	10
Fila Brasileiro	10
French Mastiff	10
Great Bernese	10
Great Dane Mix	10
Greater Swiss Mountain Dog	10
Irish Wolfhound	10
Italian Spitz	10
Japanese Kishu	10
Kangal Dog	10
Lapland Spitz	10
Mastiff	10
Neapolitan Mastiff	10
Norrbottenspets	10
Old English Bulldogge	10
Pyrenean Mountain Dog	10
Rottweiler Mix	10
Spanish Mastiff	10
Tibetan Mastiff	10

Cat Breed	Breed Group
Domestic Short Hair	3
Domestic Medium Hair	3
Domestic Long Hair	3
Mixed Breed	2
All Other	4

Dog Breed	Breed Group
Pit Bull Mix	8
Borzoi	9
Beauceron	9
Black Mouth Cur	9
Bouvier des Flandres	9
Boxer Mix	9
French Bulldog	9
Frenchton	9
Leonberger	9
Pekingese	9
Sealyham Terrier	9
African Boerboel	10
American Mastiff	10
Appenzeller Sennenhunde	10
Black Russian Terrier	10
Brazilian Guard Dog	10
Bulldog	10
Cane Corso	10
Doberman Pinscher	10
Dogue de Bordeaux	10
English Mastiff	10
Eurasier	10
Finnish Spitz	10
German Spitz	10
Great Dane	10
Great Pyrenees	10
Greenland Dog	10
Italian Mastiff	10
Japanese Fighting Dog	10
Jindo	10
King Shepherd	10
Lundehund	10
Mastiff Mix	10
Newfoundland	10
Norwegian Buhund	10
Pyrenean Mastiff	10
Rottweiler	10
Saint Bernard	10
Spitz	10
Victorian Bulldog	10

Figure 4: Petplan/XL Specialty Insurance Company Underwriting Manual filed in California, accessed via SERFF<sup>157</sup>

PETPLAN PET HEALTH INSURANCE PROGRAM

RATE MANUAL

Policy Option Pricing

Rating Plan Base Rates

The Rating Plan Base Rates per covered animal per 12-month policy period are:

Base Rates	
Dogs	Cats
\$531.37	\$493.24

State Relativity Factor

The Base Rates for a specific state may be calculated by applying the following relativities to the Base Rates shown above:

State	Dogs	Cats
AK	1.020	0.960
AL	1.000	1.000
AR	0.940	0.960
AZ	1.040	1.000
CA	1.058	1.040
CO	1.060	1.120
CT	1.040	1.080
DC	1.060	1.060
DE	1.000	1.000
FL	1.230	1.212
GA	1.040	1.040
HI	0.960	0.940
IA	0.960	0.940
ID	1.000	1.000
IL	1.060	1.060
IN	1.000	1.000
KS	0.980	1.000

State	Dogs	Cats
KY	1.000	1.000
LA	0.960	0.960
MA	1.000	1.000
MD	1.040	1.040
ME	1.000	1.040
MI	1.060	1.000
MN	1.060	1.040
MO	1.000	1.000
MS	1.000	1.000
MT	1.000	1.000
NC	1.000	0.980
ND	1.060	1.060
NE	1.000	1.000
NH	1.060	1.080
NJ	1.020	1.020
NM	1.000	1.000
NV	1.000	1.000

State	Dogs	Cats
NY	1.040	1.040
OH	1.060	0.960
OK	1.020	1.020
OR	1.040	1.060
PA	1.080	1.120
RI	1.000	1.000
SC	0.960	0.960
SD	1.000	1.000
TN	1.000	1.000
TX	1.020	1.040
UT	1.000	1.020
VA	1.060	1.040
VT	1.060	1.060
WA	1.080	1.060
WI	1.020	1.000
WV	1.000	1.000
WY	1.020	1.000

<sup>157</sup> SERFF Filing Access: California, *supra* note 67.

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*Rating Territory Definitions*

Rating Territories are defined by the varying degrees of relative veterinary costs using information in consumer resources.

Territory	Description
1	This Rating Territory encompasses the most expensive 5% of zip codes in terms of relative veterinary costs.
2	This Rating Territory encompasses the top 6-15% of zip codes in terms of relative veterinary costs.
3	This Rating Territory encompasses the top 16-30% of zip codes in terms of relative veterinary costs.
4	This Rating Territory encompasses the top 31-70% of zip codes in terms of relative veterinary costs.
5	This Rating Territory encompasses the top 71-90% of zip codes in terms of relative veterinary costs.
6	This Rating Territory encompasses the lowest 10% of zip codes in terms of relative veterinary costs.

*Co-pay Options*

There are a range of co-pay options. Rating factors for the co-pay options are:

Co-pay	Dogs	Cats
10%	1.000	1.000
15%	0.900	0.900
20%	0.800	0.800
25%	0.740	0.740
30%	0.680	0.680
35%	0.630	0.630
40%	0.580	0.580
45%	0.530	0.530
50%	0.480	0.480

*Deductible Options*

There are a range of deductibles. Rating factors for these deductible options are:



PETPLAN PET HEALTH INSURANCE PROGRAM  
RATE MANUAL

Specific Animal Pricing

*Breed*

There are 32 breed groups for dogs and 9 breed groups for cats, which represent the relative cost of veterinarian care for a specific breed. Rating factors by breed group are:

Group	Dogs	Cats
1	0.830	0.990
2	0.920	1.100
3	0.980	1.130
4	1.050	1.170
5	1.120	1.210
6	1.190	1.250
7	1.290	1.290
8	1.350	1.320
9	1.380	1.380
10	1.480	-
11	1.540	-
12	1.610	-
13	1.710	-
14	1.850	-
15	1.920	-
16	1.970	-

Group	Dogs	Cats
17	2.070	-
18	2.200	-
19	2.240	-
20	2.410	-
21	2.490	-
22	2.550	-
23	2.660	-
24	3.220	-
25	3.380	-
26	3.680	-
27	3.870	-
28	3.970	-
29	4.080	-
30	4.310	-
31	4.840	-
32	5.120	-

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RATE MANUAL

*Pet Age*

The covered pet's age is determined by its date of birth. If the exact date of birth is not known the pet owner may be asked to obtain an estimate of their pet's age from their veterinarian. Rating factors by animal age are:

Current Age	Dogs	Cats
<1	0.850	0.800
1	0.893	0.840
2	0.937	0.882
3	1.078	0.926
4	1.239	0.972
5	1.425	1.118
6	1.639	1.286
7	1.885	1.478
8	2.168	1.700
9	2.493	1.955
10	2.867	2.249

Current Age	Dogs	Cats
11	3.297	2.586
12	3.791	2.974
13	4.360	3.420
14	5.014	3.933
15	5.766	4.524
16	6.631	4.750
17	7.625	4.987
18	8.769	5.237
19	10.085	5.498
20+	11.597	5.773

In addition, there is a rating factor based on the age of a pet in the initial year of coverage. This factor continues to be charged upon subsequent renewals. Rating factors are:

Initial Age	Dogs	Cats
<1	1.000	1.000
1	1.000	1.000
2	1.000	1.000
3	1.000	1.000
4	1.100	1.100
5	1.200	1.200
6	1.300	1.300
7	1.300	1.300
8	1.400	1.400
9	1.400	1.400
10	1.400	1.400

Initial Age	Dogs	Cats
11	1.400	1.400
12	1.400	1.400
13	1.400	1.400
14	1.400	1.400
15	1.400	1.400
16	1.400	1.400
17	1.400	1.400
18	1.400	1.400
19	1.400	1.400
20+	1.400	1.400

*Working Dogs*

The Rating Factor for Working Dogs is 1.10.

Figure 5: Crum & Forster/ United States Fire Insurance Company  
Underwriting Manual filed in California, accessed via SERFF<sup>158</sup>

<b>AGE FACTORS</b>		
Note: Age factors do not apply to accident only products.		
0	0.70	0.60
1	0.70	0.60
2	0.70	0.60
3	0.75	0.60
4	0.80	0.70
5	0.85	0.70
6	1.00	0.80
7	1.20	0.90
8	1.40	1.00
9	1.60	1.10
10	1.80	1.25
11	2.00	1.50
12	2.25	1.75
13	2.25	2.00
14	2.50	2.15
15	2.50	2.25
16	2.75	2.50
17	2.75	2.50
18+	3.00	2.50

<b>BREED FACTORS</b>	
Note: Breed factors do not apply to accident only products.	
Breed factors for dogs and cats shown in Appendix 2.	
New breeds will be compared to the current list of breed factors for the most similar breed and categorized the same.	

**12. OPTIONAL MONTHLY PREVENTIVE CARE ENDORSEMENT RATES**  
Policy form # PET-AE-20000-0918

The preventive care endorsement can be added to both accident only and accident/illness policies. The endorsement provides coverage for specific wellness treatments up to specified limits. Benefits under this endorsement are not subject to deductibles or co-insurance.

Option 1	\$9.95
Option 2	\$14.95
Option 3	\$24.95

**13. COVERAGE EXCLUSIONS ENDORSEMENTS**

Factor to remove knee and ligament conditions coverage:  
Policy form # PET-AE-4KC-30000-0918  
Accident Only 0.75  
Accident and illness 0.92

Factor to remove examination fee coverage:  
Policy form # PET-AE-EF-30000-0918  
Accident Only 0.93  
Accident and illness 0.87

**14. RATING FORMULA**

= Base Rate  
x Annual Maximum Factor  
x Age Factor (if applicable)  
x Breed Factor (if applicable)  
x Discount Factor (if applicable)  
x Factor(s) for Coverage exclusions (if applicable)  
+ Preventive Care Endorsement Rate (optional)

**Note:**  
In circumstances where the rate must be rendered to two decimal points, the rate will always be rounded to the nearest cent. (If the number to the right of the nearest cent is 4 or below, the cent remains the same; if the number to the right is 5 or higher, the cent increases by 1). In no event will a customer be reimbursed more premium than what was paid.

<sup>158</sup> SERFF Filing Access: California, *supra* note 67.

UNITED STATES FIRE INSURANCE COMPANY  
Pet Insurance Program  
Policy Form # PET-P-20000-0918

## APPENDIX 1 - PROPOSED MONTHLY BASE PREMIUM RATES

DOG RATES												
Accident Only	\$100 Deductible w/ co-pay of:			\$150 Deductible w/ co-pay of:			\$250 Deductible w/ co-pay of:			\$500 Deductible w/ co-pay of:		
	10%	20%	30%	10%	20%	30%	10%	20%	30%	10%	20%	30%
Territory 1	\$26.21	\$24.15	\$21.94	\$25.00	\$23.07	\$21.00	\$22.84	\$21.17	\$19.33	\$18.78	\$17.56	\$16.19
Territory 2	\$25.05	\$23.14	\$20.99	\$23.87	\$22.10	\$20.08	\$21.78	\$20.23	\$18.43	\$17.90	\$16.79	\$15.43
Territory 3	\$22.44	\$20.44	\$18.30	\$21.28	\$19.41	\$17.40	\$19.22	\$17.58	\$15.79	\$15.46	\$14.25	\$12.83
Territory 4	\$19.10	\$17.42	\$15.86	\$18.13	\$16.56	\$14.90	\$16.41	\$15.04	\$13.56	\$13.43	\$12.34	\$11.20
Territory 5	\$18.15	\$16.46	\$14.66	\$17.13	\$15.54	\$13.86	\$15.30	\$13.91	\$12.43	\$11.96	\$10.99	\$9.85
Accident + Illness	\$100 Deductible w/ co-pay of:			\$150 Deductible w/ co-pay of:			\$250 Deductible w/ co-pay of:			\$500 Deductible w/ co-pay of:		
	10%	20%	30%	10%	20%	30%	10%	20%	30%	10%	20%	30%
Territory 1	\$81.11	\$74.61	\$67.49	\$74.08	\$68.24	\$61.82	\$64.82	\$59.88	\$54.40	\$53.26	\$49.58	\$45.85
Territory 2	\$73.93	\$68.05	\$61.56	\$67.29	\$62.03	\$56.20	\$58.48	\$54.08	\$49.15	\$47.46	\$44.24	\$40.53
Territory 3	\$70.59	\$64.57	\$58.06	\$63.98	\$58.60	\$52.76	\$55.17	\$50.68	\$45.77	\$44.03	\$40.74	\$37.05
Territory 4	\$63.84	\$58.40	\$52.53	\$57.61	\$52.78	\$47.55	\$49.30	\$45.32	\$40.94	\$38.79	\$35.98	\$32.74
Territory 5	\$60.96	\$55.48	\$49.65	\$54.88	\$50.02	\$44.82	\$46.71	\$42.70	\$38.37	\$36.34	\$33.44	\$30.25

CAT RATES												
Accident Only	\$100 Deductible w/ co-pay of:			\$150 Deductible w/ co-pay of:			\$250 Deductible w/ co-pay of:			\$500 Deductible w/ co-pay of:		
	10%	20%	30%	10%	20%	30%	10%	20%	30%	10%	20%	30%
Territory 1	\$17.39	\$16.11	\$14.74	\$16.64	\$15.44	\$14.16	\$15.30	\$14.26	\$13.12	\$12.78	\$12.02	\$11.17
Territory 2	\$16.67	\$15.48	\$14.15	\$15.94	\$14.84	\$13.58	\$14.64	\$13.68	\$12.56	\$12.23	\$11.54	\$10.70
Territory 3	\$15.05	\$13.81	\$12.48	\$14.33	\$13.17	\$11.92	\$13.05	\$12.09	\$10.92	\$10.71	\$9.97	\$9.09
Territory 4	\$12.90	\$11.93	\$10.84	\$12.37	\$11.40	\$10.37	\$11.31	\$10.45	\$9.54	\$9.46	\$8.78	\$8.07
Territory 5	\$12.39	\$11.34	\$10.22	\$11.76	\$10.77	\$9.72	\$10.62	\$9.75	\$8.84	\$8.54	\$7.94	\$7.24
Accident + Illness	\$100 Deductible w/ co-pay of:			\$150 Deductible w/ co-pay of:			\$250 Deductible w/ co-pay of:			\$500 Deductible w/ co-pay of:		
	10%	20%	30%	10%	20%	30%	10%	20%	30%	10%	20%	30%
Territory 1	\$53.16	\$48.66	\$43.91	\$48.41	\$44.36	\$40.09	\$42.04	\$38.63	\$35.02	\$33.81	\$31.29	\$28.59
Territory 2	\$49.07	\$44.85	\$40.28	\$44.51	\$40.74	\$36.61	\$38.42	\$35.25	\$31.78	\$30.66	\$28.31	\$25.67
Territory 3	\$46.33	\$42.18	\$37.78	\$41.82	\$38.12	\$34.19	\$35.76	\$32.69	\$29.40	\$27.89	\$25.66	\$23.25
Territory 4	\$40.53	\$36.94	\$33.23	\$36.44	\$33.26	\$29.96	\$30.94	\$28.35	\$25.61	\$23.91	\$22.11	\$20.17
Territory 5	\$37.44	\$33.86	\$30.13	\$33.33	\$30.18	\$26.89	\$27.77	\$25.22	\$22.52	\$20.60	\$18.85	\$16.92

UNITED STATES FIRE INSURANCE COMPANY  
Pet Insurance Program  
Policy Form # PET-P-20000-0918

APPENDIX 2 - BREED FACTORS

Species	Breed	Factor
Cat	Ragamuffin	1.00
Cat	Ragdoll	1.10
Cat	Russian Blue	1.20
Cat	Savannah	0.90
Cat	Scottish Fold	1.20
Cat	Selkirk Rex	1.20
Cat	Siamese	1.10
Cat	Siberian	0.80
Cat	Singapura	1.30
Cat	Snowshoe	0.80
Cat	Somali	1.30
Cat	Sphynx	1.30
Cat	Tonkinese	0.80
Cat	Turkish Van	1.20

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