Three Functions of Insurance

- Protect insured in case of loss – transfers risk from risk averse to risk neutral or less risk averse
- Risk Pooling or diversification – “the whole risk is smaller than the sum of its parts” Law of Large Numbers
- Risk Allocation – “insurers set a price that is proportional to the degree of risk posed by each insured”

“Insurance law is a set of answers to basic questions about the proper role of law in regulating the sharing of risk among private citizens and their institutions.”

Risk – defined as the chance that events will deviate from expectations in significant ways – maybe better, maybe worse. We can deal with risk by (1) accepting it (2) avoiding it (3) minimize the chance of loss/risk or (4) transfer the risk to someone else.

- For most types of insurance, 60% of the premium is paid out, 40% kept – life is the most profitable type of insurance b/c until the insured dies the premiums are invested or otherwise used. Most states require $5 million reserve to sell ins.

Other Options

- Traditionally, most property insurers are stock companies and life insurance companies were mutual companies because of the investment nature of life insurance. This has changed as most companies have become stock companies.
- Other groups offer insurance Reciprocals – a group of people get together and pool a risk. When a loss happens everyone helps pay. The problem is that there is a finite pool of revenue to draw from – when it is gone no more payments. These are run by an attorney in fact who distributes all the payments. Fraternal Society – group of people in the same industry who agree to support fellow members. Lloyd’s Associations – A group of natural people/principals who have unlimited liability as they have no defined reserves but their word is enough for people to accept coverage on a policy.
- States control the licenses for insurance companies to sell in the state and there is no license to sell insurance – they are differentiated.
• The normal process of insurance is subject to two disruptive effects. (1) **Adverse Selection** – A party facing loss is more likely to insure against it – this forces prices up and (2) **Moral Hazard due to informational deficiencies** – An insured is more likely to behave recklessly because he knows he is covered by insurance.

**Protections of the Insurance Companies**

Insurance companies use a variety of methods to fight these disruptive effects in the policy and in the courts.

• **Warranty** – statement/promise by the policyholder in the policy itself must be strictly complied with or the policy is void. Any breach of a warranty voids the policy. This splits into
  - **Promissory Warranties** – must be true throughout the policy
  - **Affirmative Warranties** – must be true at issuance of policy

• **Representations** – may be equitably and substantially answered and just provides info to the company not a warranty on the part of the insured

Courts temper the insurance companies desire to make everything a warranty especially when expectations differ or the policyholder was inexperienced. Although a breach of a warranty is usually material if it contributes or increases the risk of loss.

**Misrepresentations**

If an insured makes misrepresentations to the company, then how should the company handle this. To void the policy, the misrepresentation must be false, material, and induce justifiable reliance by the party who suffers damages.

• **False** – it does not mean a lie, just incorrect info, so even innocent misrepresentations can void a policy – this is a holdover from insuring british ships. This is usually judicially mitigated.

• **Material** – Material to what? If a smoker says he is a non-smoker for life insurance and then gets hit by a truck was the misrepresentation material? Not to the loss but to the risk. The test for materiality is to state the truth and see if the policy would be issued – if yes, then the misrepresentation is not material. If no, then the misrepresentation is material. The next question is --
• Should the test for justifiable reliance be subjective or objective? Would every insurer have relied or just that insurer? Most courts say objective because all insurance companies will deny coverage after the fact.

• what level of reliance or materiality is required? Is it that an company would have never issued a policy had the insured not lied? Or Will proof that the misrepresentation increased the insurer’s risk or would have changed the policy terms be enough to void coverage?

Making the K of Insurance

• The Insurance Service Office traditionally set rates and drafted the standardized forms that companies used. In the 1990s, the ISO was split off from the companies and does not recommend rates but still recommends rates and gives claims experience.

• The use of standardized forms creates a bias in the courts against the companies b/c the K is unilateral and the company created the language that was confusing or misleading.

• “The affirmative grant of coverage in a policy is broadly construed, whereas exclusions from or limitations on coverage are narrowly construed. A policy is to be read as a whole and referring to itself consistently throughout.

• Ambiguous policy provisions are always interpreted in favor of coverage, but depending on the court this can alter results. One group looks for pro-coverage interpretations while another only construes against the company if the policy language could have been drafter more clearly and the insured could have reasonably expected the coverage at issue.

• Stacking – sometimes allowed in auto insurance when a P tries to collect under the uninsured motorist provision. P has insurance wherever he is and if he split his insurance between two companies to insure two cars – he could collect on both policies. Most companies say that a policy only covers each occurrence/accident, so stacking is not allowed.
The Insured’s Expectations of the Policy

- While a policy may not be ambiguous it might not be understood by the insured. The expectations of the insured are often intertwined with ambiguity – some courts directly recognize “the reasonable expectations of the insured.” A majority of jurisdictions have not recognized the expectations principle. Most courts have gone beyond the logic behind the expectations principle – to not allow insured to benefit when he expected less than the court gave him – to ask what the insured thought the policy covered.

- Is it the insured actual or reasonable expectations? Does it matter what insured read or understood or signed? Does it make a difference if the insured is a corporation who negotiated the policy?

- “The objectively reasonable expectations of the insured will be honoured even though painstaking study of the policy would have negated those expectations.”

- Ex: A court redefined the unambiguous definition of a burglary in a commercial policy to provide coverage for a job that left no signs of forced entry. The policy required evidence of forced entry to prevent it from covering inside jobs.

Role of Agents and Brokers in Making the K

- An agent has the ability to create a binding K of insurance between insured and insurer if he was acting with apparent authority for the company even if the company would not make that K. Any problems with the policy do not harm the insured, but the insurer can sue the agent for indemnity. Agents can have general or limited authority depending on the K.

- Insureds also use waiver and estoppel to fight the company for denial of claims. Both of these turn on actions taken or not taken by an agent of the insurer.

- **Waiver** -- the voluntary relinquishment of a known right – a question of fact. Ex: Late premiums are always accepted until a loss happens before the premium gets paid – the company by accepting late premiums must accept the claim.

- **Estoppel** -- results from a change of position by the insured as a consequence of some representation/act by the insurer.

- While waiver and estoppel are frequently used and used almost interchangeably, but estoppel can not create coverage for those risks never in a policy or expressly
excluded by it – Majority Rule. **Minority Rule** – Will allow estoppel to give coverage if an agent/insurer misrepresents the coverage of a policy at the inception or before the creation of a policy and the insured relies on it to his loss, then the insured is estopped to deny coverage.

- Whenever there is a procedural defense look for waiver and estoppel.
- In a group relationship context, if an employer is actively involved in the administration of the plan it can create a pseudo agency relationship such that the employee/insured is protected by his reliance on his employer’s/agent statements.
- Finally, public policy arguments can be used by an insured to expand or gain additional coverage. There is a split on whether or not public policy should allow liability insurance to provide coverage for punitive damages as insurance would diminish the punishment factor. Ex: Policy provides coverage if limb is amputated 90 days after accident – doctors give up on saving the limb on day 100. Court will order coverage b/c unconscionable to force insured to cut off leg at 89.

**Property Insurance**

- Property insurance is sold in $100k increments – encourages over insurance by agents and underinsuredness by insureds. The insured figures to have many partial losses but rarely a total loss, so underinsurance.
- For an policy to be effective you need an insurable interest – w/o that there is no ability to recover on the face amount of the policy. This is to prevent windfalls and possible speculation or moral hazard. There are four tests for insurable interest
  - **Legal/equitable interest** – sometimes the interest must have value
  - **Factual expectancy/Economic Benefit** – party expected coverage
    “Lawrence test”
  - **Contract Right** – Relationship depends on the continued existence of the property (secured creditors)
  - **Legal Liability** – liability for the destruction of the property will support an insurable interest in it.
• Only the insurance company can raise the lack of an insurable interest. It must be present at the time of loss. The requirement of an insurable interest to collect proceeds is usually linked to the principle of indemnity – the insured can only collect what he lost while the insurer can seek compensation from the cause of loss or absorb the loss if natural causes are present.

• **Ex:** An insured insures a car only to find out it is stolen – he did have an interest in the car so he gets compensation as it is returned to its rightful owner. Also, a building designated for destruction burns – the insured tries to collect on the policy. Courts split – some allow the owner to collect.

**Subrogation**

• **Subrogation** – a sort of legal substitution -- one party steps into the shoes of another and assumes their rights and an insurer can not have subrogation against its own insured. This splits into two types of subrogation
  o **Equitable subrogation** – arises by operation of law no language has to be in the policy
  o **Contractual Subrogation** -- results from an agreement of the parties

• Almost all property insurance has a right of subrogation in the policy and all modern policies have subrogation provisions. Subrogation shows the principle of indemnity as it prevents the insured from recovering more than he lost. Also, it helps allocate financial responsibility.

• An insured that interferes with the right of subrogation usually voids his coverage, but the third party is not released from subrogation liability to the insurer if he knew about the possibility of subrogation. If the release of subrogation is before the loss, then the insured might be ok depending on the policy language.

• If the insured pays on the policy but was not obligated (mistake, business decision), then it has no subrogation rights against the party to blame. When subrogating, the insurer steps into the shoes of the insured so all liabilities and defenses are assumed by the insurance company. The company may not fight counterclaims and to make sure that it is a party in interest the insurer “loans” the insured the money that will be repaid from the subrogation.
• A property insurance policy will often pay off the bank’s mortgage first and then go to the insured’s interest. Problems can arise when the insured has prevented his own recovery or is responsible for the loss – then the company can go after the insured to get its money back for paying the bank off.

• When a lease calls for fire insurance, a tenant can claim that he is a co-insured and exempt from subrogation for a fire that he N started if the lease does not exclude that behavior from its coverage.

• **Sale of Property** -- At common law, the risk of loss during the closing period pass to the buyer as equitable title had passed so the risk of loss did as well. Currently, the court often order the seller to hold the insurance proceeds in a trust and order the buyer’s specific performance. Buyer becomes a “co-insured.”

• A policy can payout for a life estate that ends after the fire destroys a house – there was an insurable interest that was lost.

• Insurance covers property in possession of the bailee for which he is responsible and does not cover the legal liability of the bailee to respond in damages.

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**Exclusions and Exceptions**

• **Exclusions** – are designed to address the following concerns (a) adverse selection (b) moral hazard (c) catastrophic loss and (d) desire to avoid duplicate coverage. If an excluded event causes the loss then the insurer has no obligation to pay.

• **Problems with exclusions** – concurrent causation – if a loss has more than one cause how do you determine what was excluded? and Increased risk – how do you balance the combat of moral hazard with the insured’s expectation of total coverage.

• **Efficient proximate cause** – when multiple possible causes exist, the court determined cause of loss. Three approaches
  o **Washington Rule** – Insurer must pay if loss results from a combo of covered and excluded causes if the efficient proximate cause is covered.
  o **California Rule** – Insurer must give coverage if efficient proximate cause is an insured risk
• **Utah Rule** – Only use efficient proximate cause when parties have not chosen to contract out.

- An alternative to efficient proximate cause is immediate physical cause.

- Companies try to avoid paying when insureds have violated a moral hazard clause. These seek to limit exposure when the insured was in some way responsible for the loss through knowledge or control of the insured. Generally refers to long term material changes in risk – the increase in hazard does not have to be the cause of the loss – mere violation of the clause can void the policy.

- Some property insurance policies have an exclusion for vacant and unoccupied property – vacant usually means furnishings and unoccupied means people. But the court can construe these to be ambiguous especially during a change of ownership.

- **Recovery** – Three ways to award lost value for property insurance
  - **Market Value** – cost of new model of lost property
  - **Replacement Cost Minus Depreciation**
    - **Broad Evidence Rule** – allows all evidence needed to get a figure of loss

- Most policies do not have a depreciation component and some policies are valued policies – if you have a total loss then the insured recovers the face amount of the policy. Most car policies allow for repair/replacement rather than market value or some other test.

- Some policies have a Replacement Value Rider – provides full replacement w/o depreciation if property is insured to a certain amount and the insured has to actually repair/replace the damaged item.

- **Coinsurance** – If you underinsure (usually 80% less than replacement cost) and suffer a loss – the company only has to pay (a) the actual cash of the part of the building damaged or (b) a proportional amount equal to the ratio of policy value to 80% of the real replacement cost of the home. The requirement of coinsurance forces insureds to buy enough coverage

- Some policies are written for business interruptions. These allow companies to keep paying workers and bills when a loss has occurred at a business site. These
policies are frequently litigated b/c of estimates over profits lost, company must rebuild as soon as possible, and other duties to mitigate.

**Life Insurance**

- The party that is insured is the **cqv**. Only one type of life insurance but there are different ways to finance
  - Term Life – premiums go up as you age – healthy people drop out
  - Whole Life – Premiums stay the same and the excess cash is put into an interest bearing account that the insured can borrow from and it pays for the policy later in the insured’s life. In case of death, the insurance co keeps the cash.
  - Single Premium – Insured pays flat amount and gets a set amount of coverage forever.
  - 20 Pay Life – You pay for 20 years and you are covered at the end of the term.
  - 10/5 Life – You can lock in a premium for a time frame.
  - Variable Life – Takes premiums and invests them for the insured to get higher rates of return – obvious risk of loss of funds.
- Most policies have an incontestability provision after two years of coverage. No coverage for suicide within a year of issuance. Misstatement of sex/age changes coverage to the real standard upon death. Policy is assignable/transferable and the insured has a 31 day grace period to pay premiums.
- When a company gets a prepaid premium, courts frequently held that it created two policies – one until the real policy was approved and then the permanent one. Sometimes the temporary policy does not end until the premium is refunded.
- While anyone can be a beneficiary, a policyholder must have an insurable interest to take out a life insurance policy on another life – “lawful economic interest or substantial interest through love and affection.” Again only the insurance company can challenge insurable interest.
- A creditor is sometimes allowed to take out insurance on a debtor’s life but is restrained from collecting its debts, premiums, and interest.
• Most courts recognize the substantial compliance rule when a policyholder tries to change a beneficiary – If intent is manifest and substantial affirmative action has been taken, then the beneficiary is considered changed. There is no common law right to change a beneficiary – must come from the policy. This often causes problems in divorces where people forget to change beneficiaries most courts still allow the ex-spouse to get the money unless there was a settlement where a spouse renounced all rights in the marital property, then some will allow the estate to get the money.

• While formerly looked on as wagering, life insurance is an investment and wise. We do not allow the cqv to transfer his policy to just anyone but we do not want to over restrict an economic commodity. Debtors often assign creditors life insurance policies to secure loans – the bank could change the beneficiary but they rarely do this. The bank takes before the beneficiary and settles its debts.

• If a policy is obviously obtained for murder and not for investment/protection, then the company is under no obligation to pay. However, the estate of the insured may bring suit against the insurance company for N issuing a policy that had no basis and caused a death.

• When the policy is issued correctly, but the beneficiary is implicated in the death of the insured, then most states require an acquittal in criminal proceedings before collection and some require a relitigation of the issue in an interpleader proceeding.

• Incontestability – the incontestability after two years provides the insured with some knowledge that his beneficiary will be taken care of. This eliminates several defenses of the insurer – fraud, concealment, and breach of warranty. This is not a total waiver of all defenses of the insurer. For example, if an impostor got a policy and named himself as a beneficiary, then a contract was never created b/c there was never a meeting of the minds. However, if a company never discovered that another person than the cqv took a physical, then after two years the company can not contest the coverage.

• The test is usually discoverability – if discoverable at the outset, then a denial of coverage is barred. Defenses that can be raised after the fact are those that relate
to the specific cause of death. **Exception** – When the policy is provided under group insurance, there is no discoverability test and the company has all of its defenses.

- Some policies place limitations on coverage or benefits for lower premiums or provide double coverage for loss that happens because of an accident. But what is an accident? Most courts use the term commonly and allow coverage “when there is a frail general condition so that powers of resistance are easily overcome or a tendency to disease that causes death.” This is common in double indemnity today. The key is use the foreseeability of the cause of death – recognizing a difference between prior knowledge and unknown conditions. Some also void coverage if death is cause by participation in a criminal activity.

- Recovery for suicide is often excluded regardless of the mental state of the insured – you look for the intent of insured to end his life/self-destructive behavior. It also will rarely qualify for double indemnity.

- When a company fails to act promptly on a policy, it can be held responsible for any loss suffered in the applicable period – whether general coverage for premature death or for an excluded cause of death that the company would not have fought had the policy been processed promptly – suicide or incontestability.

**Disability Insurance**

- Disability Insurance is only needed for off the job injuries or injuries untraceable to the job – if anything else then workers comp or government programs will take care of it. Most policies give a defined period of defined coverage and then re-evaluate the insured for total disability.

- You are either totally disabled or not. The definition for totally disabled differ depending on the policy – some policies refuse coverage if the insured is able to do any job, other provide coverage if the insured is unable to return to his or a comparable job. Reasonable expectations courts find that most insured think that a disability policy covers their or a similar job.

- Does social disability count? Depression, AIDS etc?
• A policy can require medical care as a requirement of coverage but this does not force the insured to undergo any medical treatment that the company hopes will cure his condition.

• An insurer that refuses to comply with the policy can be liable for bad faith breach – this can allow for compensatory and punitive damages. **Test** – An insured has a duty to accept a reasonable settlement to absolve its insured of liability is implied in the policy in a covenant of good faith. Some question about whether or not the cause of action lies in contract (damages for breach) or in tort of bad faith (punitive and compensatory damages allowed). Some courts have required an independent tort within the insurer’s behavior to support a cause of action.

**CGL Policy**

• CGL policies traditionally were intended to protect against “slip and fall” suits. Most modern claims were never intended to be covered by a CGL policy. But courts have altered the terms of the policy somewhat – companies are liable for injuries that happened years ago. Most policies have pollution exclusions unless it was sudden or accidental

• When the government forces an environmental cleanup, most courts have held CGL companies liable b/c of the term damages in the policy. The costs to repair the property and prevent further environmental harm can be considered damages.

• When the EPA and polluter agree to a clean up plan, some insurers will deny coverage – state courts have usually provided coverage while federal courts have not. Insurers feel that such plans are not fixed damages under policy.

• There is a difference over when an injury occurs under a CGL policy.
  o **Exposure** – coverage is triggered by an exposure to a harmful substance that could result in bodily injury (injury and occurrence are ambiguous in a progressive disease context)
  o **Manifestation** – Since policies provide coverage for defined claims, an insurer is not liable for mere exposure. When the P manifests an injury is the trigger of coverage.
o **Injury in Fact** – The P must show that the injury arose during the policy period – an injury that overwhelmed the body’s defenses or when a real injury first arose during the policy period. This is not diagnosis but the first point that the P could have known something was wrong. Individual test

o **Triple Trigger** – The most popular test combines all three above and divides liability for every insurer that was on the risk for exposure, manifestation, or injury-in-fact

- When damage has happened over a period of time (to land from pollution), courts again have different ways to split liability between the different insurers for the period of damage

  o **Pro Rata by the Limits** – Since damage occurred continuously since the trigger, all policies were triggered and liability should be assessed against all insurers based on their coverage level.

  o **New Jersey Approach** – Coverage is allocated by year but the amount of each year’s responsibility is proportional to the total amount of insurance in force for that year – years with greater amounts of insurance get more responsibility for the damage.

  o **Joint and Several Liability** – The insured can sue one insurance company for all the damages and let that insurer go after the rest.

  o **Pro Rata on the Risk** – Since damage was likely equally spread throughout the policy period, the damages are divided by the time each company spent on the risk.

- What constitutes an occurrence – a common problem when coverage is limited. Some jurisdictions use the effects test – the number of occurrences is equal to the number of claims and the cause test -- # of occurrences is determined by the cause/causes of damage not the # of injuries. Some policies have a unifying directive – all damage from exposure to substantially the same general condition are one occurrence.

- You can not insure against a loss that is known before the policy period.
• Insurance companies have the burden of proving that an insured intended or expected a loss and evidence that an insured was ordinarily negligent does not meet this standard – this standard for exclusion is subjectively based.

• You have to distinguish between means and results when dealing with the exclusion for intentional or expected acts. **General Rule** – requires an intent to cause the specific harm for the exclusion to void coverage for the insured. This is not applied to instances of sexual abuse of minors and when you take drugs and alcohol negative consequences can follow so the intentional exclusion applies.

• A CGL does not provide coverage for the replacement of poorly performed work – it does provide coverage if the defective workmanship causes personal injury or damage to other property. The coverage is for tort damages from work not for K damages. Another approach is to award the property owner the property value loss b/c of faulty workmanship.

• Policies since 1986 have a total pollution exclusion – some courts have found this exclusion to be too broad as it denies coverage for almost anything. Some older policies covered pollution emissions unless the discharge was sudden or accidental.

• An insured has a duty to provide notice to the insurance company when a claim has arisen. The standard is as soon as genuinely practicable – “rough general notice.” Generally failure to provide notice does not void coverage unless it somehow harms the insurance company. An insured has the duty to cooperate – to turnover facts and tell insurance co your side of the story – there is no obligation to deny liability but an insured can not collude with an injured party.

• An injured party can provide notice to the insured company and this can create the duty to defend by the company even though the insured did not give notice.

• The burden of showing prejudice from delay by the insured falls on the insurance company. Prejudice will be found when the delay materially impairs an insurer’s ability to contest liability.

• Some CGL policies are claims made policies that cover any claim reported from the retroactive date up to when the policy ends – a claim must be made or an
extension granted during the policy for coverage. There is no coverage if a claim that arose within the policy period was told to the company outside of the policy.

- For claims made policies, a claim is made when the insured becomes aware that a 3rd party is seeking some sort of relief.

- Every insurance policy creates a duty to defend by the company even when an insured feels that allegations made by the P are not covered under the policy – it must preserve its rights to contest coverage with its insured after the suit and continue to defend the insured until it determines that the claims are outside the policy. And since a P can always amend its complaint this duty can extend for a while. When a company withdraws defense, it can lose its rights to deny coverage and can be held liable for legal expenses and damages.

- As long as the possibility of coverage exists, then a duty to defend exists. The general rule is that the insurance company can not send the insured a bill for the cost of defending non-covered claims. Most courts require an insurance company to defend to preserve its right to contest coverage, but a minority of courts hold that an insured does not have to defend if (a) there is a conflict between the interests of the insured and the company or if (b) the trial of liability will not resolve the question of coverage. When the insured has a limited policy, then the insurance company has the duty to defend until that policy cap is reached in settlement or in judgement – no withdrawal until an official settlement has been reached.

- An insurance company can not use information it gathered in the defense of the insured against the insured in a later suit for coverage. Sometimes an insurance company will bring a declaratory suit to determine if it has to provide coverage – usually connected with some other policy provision that might void coverage.

- An insurer who has a limited policy is liable for any amount that a jury awards when it has rejected a settlement offer within the policy cap. Furthermore, if the insured has suffered personal loss can also get tort damages when a insurance company has rejected a settlement within its coverage cap.

- The situation is a little different for malpractice – insureds rarely want settlement so most policies require the approval of the insured before settlement gets entered.
But, if the insured rejects a settlement and the jury returns a verdict above the settlement amount, then the insured is liable for expenses beyond settlement and excess verdict.

**Federal and State Regulation**

- Paul v. Virginia established that individual states retained the authority to regulate insurance companies, but US v South Eastern Underwriters Association overruled Paul v. Virginia and held that insurance transactions were subject to federal regulations under the Commerce Clause. In response, Congress passed McCarran-Ferguson Act to clear up confusion between federal and state law.
- McCarran Ferguson exempted people involved in the business of insurance from federal regulation but § 3(b) stated that the Sherman Act would apply to some insurer activities regardless of whatever regulations the states might enact – “any agreement to boycott coerce or intimidate or act of boycott, coercion, or intimidation” is still governed by the Sherman Act.
- The state insurance commissioners formed the NAIC and they set about making model rate regulations and fair trade practice statutes.
- Most ambiguities arise under what is the business of insurance? The Sup Ct has articulated a three part test for the business of insurance:
  - Does the activity involve the underwriting or spreading of risk?
  - Does the activity involve an integral part of the insurer-insured relationship?
  - Is the activity limited to entities within the insurance industry?
- To satisfy the first part of the test the insurer’s activity must both transfer and distribute risk. For example, insurer activities after the distribution of risk like settling claims or paying proceeds do not constitute the business of insurance.
- To satisfy the second part, the insurer’s activity must relate to an integral part of the contract between insured and insurer.
- To satisfy the third part, the activity alleged must be specific to the insurance industry.
- Most suits arise over the “boycott coercion or intimidation” exception of McCarran-Ferguson. St. Paul Fire v. Barry held that the boycott exception
extends to insurer activities affecting parties outside the industry – this narrowed the areas of state regulation.