Chapter 1: Introduction

- Concept of Risk: The possibility that the actual result is different from the anticipated result
- 2 kinds of risk
  1. Upside: Possibility things will turn out better than expected
  2. Downside: Possibility things will turn out worse than expected

-Risk is a probability—the risk of occurrence can be from 0-100%
-Greatest concern is when risk = 50%

-4 things to do about risk:
  1. Accept it and do nothing
  2. Try to minimize with security & safety devices
  3. Avoid the risk
  4. Transfer risk to somebody else (insurance)

-Insurance = “risk transfer agreement”
-Other arrangements: lease, set up a corporation, try to pass the risk to somebody else (special warranty)
-Insurance has subjective ramifications
-Some people pursue risk for shits & giggles
-Most people are risk averse and prefer to reduce as much as possible
-Risk transfer: why is it that somebody else is willing to take it?
  1. They love risk (not likely)
  2. Lease from a fleet (large volume/lower prices)
  3. Insurance: law of large numbers

-The larger the population, the more likely the actual experience = anticipated experience
-1 coin flip is not a scientific predictor, but 1 million flips will yield roughly 50/50 heads & tails
-Much less risk in 1 million flips than 1 flip

-Mortality Tables
-Expected death at age 29 = 1.03
-This means for every 1000 people age 29 on 1/1/98, 1.03 died by the end of the year
-For any individual age 29 on 1/1/98, the chances of dying are virtually unknown, but out of 1000, someone will die.
-Economic consequences can be addressed (loss of income), but the non-economic cannot be (emotional suffering)
-For parents leading families, risk addressed by pooling; for each 1000, 1 will die, each can put in $100 and the family of the one who dies gets $100K

-BUT insurers have costs-goal is for losses to equal 60% of premium
-The other 40% covers admin expenses/profits
-For 29 yr olds, each would have to pay $172 for $100K of insurance
-Gov’t statistics are the basis for calculation
-Cannot use law of large numbers w/o knowing what anticipated loss would be-traditionally broken down by age and race: white women have low risk; black women & white men have higher risk; black men have highest risk.
-Statistics must give way to mortality; unjust to have different rates for different races; insurance company was busted w/ higher black rate and had to refund-abiding by morals can create $$ problems
- **Moral Hazard**: risk of intentional destruction b/c of insurance
- If people take out insurance on their own lives, chances of suicide for $$ are small
- Much bigger risk for property insurance; insurers can discount for people who undertake risk prevention (club, theft alarm, etc.)
- Some people in an insurance pool are better off than others
- On 1/1/98, some 29 yr olds were terminally ill and some were in superb health
- Insurer is worried that pool = random sample of population
- Problems with **redlining** where insurers target only low risk insureds
- Life insurance: clean tables, steady progression of risk, easy to document
- Property/casualty: much harder to get appropriate statistics/premiums
- Essence of insurance: pooling device-comparable risks are pooled
- Everything that is “insurance” is not necessarily insurance and some things that are not really are insurance.

- Definition of **Insurance** given (tight, but not universal)
- If insurance definition is satisfied, there’s a number of consequences:
  1. Business of insurance is regulated in every state
     a. Cannot become an insurance company w/o a license
     b. Cannot sell insurance for a provider w/o a license
  2. Most state insurance directors are appointed; some are elected; desirable elected position; good steppingstone to governor/senator/lots of P.R.
  3. Insurance companies/policies have important tax consequences; if someone dies & leaves $$, the $$ is not part of the taxable estate if it’s insurance;
  4. Insurance for tax purposes is different than for regulatory purposes.
- Warranties are unconditional; non-insurance companies can be stuck in an insurer’s role, (i.e. a warranty to replace auto tires)
- Lots of borderline cases where it’s crucial to decide whether they’re regulated by insurance, b/c then it must be regulated/only sold by licensed insurers.
- CB 175: Exclusions: (1) ordinance; (2) Earth movement; (3) Water damage; (4) power failure; (5) Neglect; (6) War; (7) Nuclear Hazard; (8) Intentional Loss
- Some people thought that 9/11 fell within war exception, insurers were criticized, covered the 9/11 damages then began to add terrorism exclusion which created problems-reluctance to build/loan $$ to build resulted
- Congress required insurers to cover $0-$10 bln in damage, then Congress covers $10-$100 bln
- Issue of what rate of coverage-this varies from state to state
- Un like life insurance rate calculation, it’s very difficult to develop a rate chart for terrorism insurance

- **Insurance Services Organization (ISO)**: pools info from insurers, develops statistics, provides rates to companies, helps give guidance for setting premiums

- **Why Regulate Insurance**
  1. It’s important & vital & necessary (home, care, health, dependents, property, etc.)
  2. If insurers don’t perform, a lot of problems are created
     Why more concern than other entities non-performance? Premiums are paid in advance, while other business transactions tend to have performance upon payment
- More reliance on a promise in an insurance setting
- Real concern about fraud
- Concern about necessity to make sure there will be performance, owing to the need for insurance

3. "The lag"
- Consequence of lag: insurance cos. can be viewed as a cash cow: they take in all kinds of $$ but only make periodic payouts
- Insurance cos. have lots of $$ to invest-normal investors get 5% return on investment-if insurers get 30% returns the rest is all gravy
- People are @ insurers’ mercy for premiums
- Difficult to appraise reasonableness of premiums
- Insurers are much more knowledgeable about cost
- Policies are enormously complicated

- **Re-Insurance Companies**: Insure insurance companies; insurer with too much risk in a small area can go to the re-insurance company to take on some of the concentrated risk
- Insurance cannot be self-regulated by re-insurance b/c of re-insurer’s self-interests
- Typical interaction w/ insurer is after a “disastrous occurrence”-insured is unusually vulnerable; can be taken advantage of; needs somebody to protect their interest
- Similar to gambling-gambling deemed to be sinful throughout history-concern that insurers would “gamble” under “insurance” pretext

- Must have license to sell insurance-cannot sell insurance with a standard sales/business license
- Need a license for life or property/casualty
- With exception of Lloyd’s, individuals cannot be licensed as insurance companies-can only be done by entities w/ perpetual existence (corporations) – must have reserves – required amount varies – now requires at least $5 million

- 2 Organizations
  1. Stock Company: Investors get dividends
  2. Mutual Company: Policy owners put up the reserve

- Property and Casualty were originally stock companies
- Life insurance was originally a mutual company
- B/c of cash cow phenomenon, large life insurers have been de-mutualizing and becoming stock companies

- Insurance is regulated, but unlike utilities, insurers are not obligated to insure anybody
- In fact, many insurers specialize any only serve a specific group (i.e. Lutherans only)
- Lack of obligation can create a problem, esp. w/ property & liability insurance, b/c what if someone cannot find a willing, licensed insurer
- Supreme Court established that people have Constitutional right to be insured, even if the provider is not licensed in their own state
- Known as excess/surplus line insurers-provide insurance to those who cannot insure on reasonable terms from licensed companies (i.e. Lloyd’s of London)-NY & TX allow Lloyd-like companies to be started
- Individuals cannot be insurers-Lloyd’s is comprised of “nothing but individuals”
Originally the only people who could be principals of Lloyd’s were the landed gentry-landed gentry had to make all assets liable to pay claims-people w/ lots of assets were admitted as principles

Lloyd’s is a group of individuals organized into syndicates-people seeking unusual insurance can go to Lloyd’s (i.e. stripper insuring her tits, movie producers insure against actors playing hooky, Caribbean resorts insure against bad weather)

Lloyd’s always operated on the notion that shit happened, but could turn a profit expanded membership in 1970’s

Lloyd’s has no reserves-principals didn’t have to put up any $$, just gave profits every yr

Started opening up to Americans including Justice Breyer-had a conflict w/ joining federal bench so he sold his status at Lloyd’s

Late 70’s-80’s: Lloyd’s started issuing policies on computers that were going obsolete; other bad risks were taken; members began losing $$; filed suit claiming fraud

Lloyd’s actually went bankrupt, but restored to viable status and still works the same way-syndicates still decide on what to insure

A number of excess/surplus line cos still exist-states have begun to regulate

MO gives a list of approved, non-admitted carriers

**Warranty/Representation**

**Breach of Warranty**

*Vlastos*, (CA3 1983), CB 4: Fire in commercial bldg; owner denied insurance coverage b/c of warranty made to insurer

- No belief that insurer wasn’t responsible – but specific warranty that “3rd floor would be occupied as a janitor’s residence”
- This was a special endorsement on top of the basic policy
- What reason for special endorsement? Not clear from the record
- Trial judge ruled that insurers were not required to produce evidence that warranty was material to risk insured against-found there was a breach unless 3rd floor was occupied exclusively by a janitor
- Trial Judge: Unless 3rd floor was used exclusively for janitor’s residence, warranty is breached and insurer off the hook-found materiality of breach to be completely irrelevant
- Policy was issued 11/79; fire was 4/80
- Trial judge instructed jury to decide if at time of fire, 3rd floor was not used exclusively as janitor’s residence, then insurer not liable; trial judge also does not care why warranty was insured in policy.

-Pigeonholes: **Warranties and representations**: If warranty is breached, regardless of its importance, no liability
- If representation is breached and it’s material it’s a defense to the insurance company
- Trial court in *Vlastos* says it’s a warranty and plaintiff loses
- Policy does not clearly provide that 3rd floor must be exclusively occupied as a janitor’s residence: all ambiguities are to be construed against the insurance company
- 3rd Circuit in *Vlastos* holds: Warranty applies to the time the policy was executed. At that time, the janitor did take up the entire 3rd floor
- Question for Jury on remand: The insurer is gutted and the defense is shredded by CA3
- How do we get this peculiar result?
-Start from Lloyd’s coffeehouse: In 17th-18th Centuries, Lloyd’s was a popular hangout for landed gentry; patrons wanted to invest in overseas trade, but were afraid of the risk of shipwrecks—people purchased insurance against risk—Lloyd’s became an informal place to buy and sell insurance
-This was before modern communication—only letters available—this delayed the process—often dealt with stale news
-When a policy was written, everything included in the language was a warranty; insurers, regardless of reason, thought warranties were important and were absolute—basic foundation was laid.
-By contrast, representations were spoken not written—these were only enforced if material

-Continuing problem of docs giving up practice b/c they can’t afford med mal premiums—in WV, a number of surgeons went on strike, refusing to perform elective surgery
(1) Juries giving wildly excessive verdicts
(2) Greedy trial lawyers getting 30-40% of verdict on contingency exaggerate cases/bring them excessively
(3) Insurers have been boosting rates—insurance cos can be considered cash cows in malpractice;
-“tail” means time between payment of premiums and claims
-In life insurance, within 6 mos of premium payment, most policies are paid out
-W/ auto insurance payouts, SOL/litigation can create a lag of 6-10 years between time of accident and time of payout
-With medmal, this lag can be close to 20 years
-During the lag time, insurance co invests the $$; used to be invested only in gov’t securities; now it can be invested in real estate, hi-tech and even common stocks
-While insurer sits on the $$, the investments were highly profitable; insurers lusted to get more premium $$; lowered premiums to get more enrollment
-Loss ratio was over 100%, but this did not matter b/c of market; Now that market’s down, insurers must revert to 60% loss ratio, resulting in rising premiums

-Historically significant categories of warranties, representation and concealment
-Law arose out of dealings @ Lloyd’s w/ private parties wanting to be insured
-Warranty Rule: any qualification that was in the policy itself was considered a warranty and the policy was void if not complied with, w/o regard to why the provision was included or whether compliance/noncompliance was significant
-DeHahn, p.10 (1786): ship sailed from Liverpool w/o full crew, then picked up the rest of the crew within one day—this was grounds to void the policy
-If working for insurer, everything becomes a warranty: “over-assistance of counsel”
-Policies became too onerous and lengthy, too many warranties; courts began to back off from the strict rule of compliance with warranties
(1) Decided that substantial compliance was all that counted; i.e. grist mill had slow business, converted to a paper mill, paper mill burned down, insurer refused to cover, court upheld coverage b/c paper was similar enough to grist.
(2) Cure of breach makes policy effective, as in DeHahn
(3) Vlastos: warranty conditions construed as affirmative (@ time of policy becoming effective) as opposed to promissory (entire life of policy)
(4) Statutes were passed saying all warranties should be treated the same as representations—most state courts/legislatures have modified the old common law warranty rule
-Common Law Representation: Statement made to insurer that was not written into policy itself; breach voided policy only if material to the risk

-2 representations involved (1) High blood pressure; (2) DUI charges.
-Insured died in car crash; representation about high blood pressure probably had nothing to do with the loss; BUT if material to the risk, the question to ask is “would the same policy have been issued had the question been answered truthfully?”
-Misleading b/c of difference between subjective and objective materiality
-Subjective: Would this company act differently with true facts?
-Objective: Would the insurance industry act differently with true facts?
-Most courts follow the objective standard; RATIONALE: if subjective standard was used, issue would always arise after loss and insurers could bullshit about their “standards”
-By using objective, other insurers could be queried and consumer has a fighting chance

-McDowell: Last information inconsistent with truth; required representation to be made precisely; material misrepresentation can void a policy, whether or not innocent or false

-State of mind qualification

-Bryant: Someone sought insurance on ship about to embark; insurance issued on basis of payload; payload contents were misrepresented, ship sank, insurer refused to pay out
-court said misrepresentation was not as to fact but as to state of mind, i.e. present intent of payload
-Unless insurer could show that insured was lying at the time of misrepresentation, the insurer must pay out; innocent misrepresentation as to state of mind is not voidable

-Problem with life insurance: If applicant represents good health on application, dies soon after receiving coverage, and autopsy reveals health problems, this is deemed to be a state of mind question if insured didn’t know about health problem, they’re still entitled to coverage
-Insurer must prove: (1) Insured had health problem; (2) insured knew about health problem at time of application.
-If insured omits a doctor’s visit and this visit was material, the policy can be voided

**Rule is materiality**

-Concept of concealment: Lloyd’s coffeehouse negotiating parties had duty of “utmost good faith”
-Applicant had obligation to disclose everything that could conceivably be of interest and not conceal anything
-General Rule now: Don’t ask, don’t tell; if not asked on application, no duty to disclose; if not asked, can assume no duty to reveal
-Utmost good faith rule still applies in marine insurance-covers all transportation/things that can be transported

-In property/casualty, insurance company gives authority to bind on the spot-agent can get info on the phone, give immediate coverage, contract is formed right away
In life/health, there is no underwriting authority in the field—it’s all done at the central office—agent only acts as solicitor—cannot offer/receive acceptance—central office makes the underwriting decision—agent only prepares offer.

In *Ward*, there were some incorrect answers on the application:
1. high blood pressure;
2. DUI conviction

Insured died in car wreck 3 months after policy was issued; wife claimed DUI conviction/blood pressure were “old news”—more than 2 yrs old and irrelevant

The agent filled out the application—why did agent answer questions falsely?

Wife claimed she should not be penalized for agent falsely filling out the application

Most insurance is sold thru intermediaries—must be licensed as an agent to be sponsored by a company;

### Difference between Agent and Broker

**Agent:** Works for the insurance company → anything they do or say is chargeable to company; if agent is paid a premium, the company has been paid

**Broker:** Works for insured → if broker runs off with premium $$, insured is shit outta luck

A broker is deemed to be working for the applicant/insured—deemed to be the agent of the insured

Most agents work for a company, receive salary on commission, only sell from one carrier

A broker has no allegiance to any company—will scout all available co’s for the best deal

A **agent** binds a company; a **broker** binds insured

Also a group called “independent agents” licensed by 4-5 companies—function more as brokers than as an agent

Although brokers are agents of insured, they’re paid by insurers

Companies use this assistance to “check out” the insured

In life insurance, agents are instructed to meet applicant in their home to check out house and see lifestyle and co-habitants

Easier to sell life insurance to somebody with children

*Ward*: negotiation probably took place in insured’s home—agent probably filled out application

Defense argues Inman/McCrimmon:

If applicant told agent the truth, agent lied, and applicant knew the application was false, the applicant would be liable and denied coverage

If agent lied and applicant did not read the application, the applicant still has a duty to read, bound by application/answers and denied coverage

Applicants typically get to review their answers upon receiving the policy

AIDS problem at time of CB printing—belief was that any HIV positive test would lead to fatal AIDS; now medication has improved the situation, people who disclose HIV+ status can still qualify for (costly & limited) life insurance

If insured is not asked specifically about HIV, they’re not liable for failure to disclose (Bernstein likes this result)

Don’t ask, don’t tell approach in providing coverage
-MacKenzie: insured said no hi-blood pressure on life insurance application; discovered the problem the day before policy was issued; did not disclose

Timeline:
Application--------------Acceptance-------------------Delivery-------------------Payment

-No insurance contract until all 4 elements are satisfied
-Option remains with insured to walk away from the deal
-Under Kentucky Law, material risk from misrepresentation or fraudulent misrepresentation are grounds for denying coverage
-Applied to MacKenzie: when insured discovered hi-blood pressure, should have disclosed; the application is a continuous representation-needs to disclose until contract is executed; once 4 elements are satisfied, there’s no duty to disclose
-MacKenzie: decreasing term life insurance
-premiums calculated on basis of age
-As age goes up, the greater the risk of not surviving another year; number of people per 1000 that survive decreases with age
-Expected deaths per 1000 goes up fourfold over 20 years; premiums also go up; aging people in good health are inclined to drop out to avoid the premium; people keeping the premium tend to be in worse health, insurers lose $$
-Whole life insurance: premium remains the same for entire life, starts out too high in the beginning; “overpayment” at the beginning is saved; after a certain point, premium gets “too low”; money saved earlier goes into paying deficiency; unlike pure term (premiums go up with age)
-Main attractiveness of decreasing term is to cover mortgage/debt; coverage decreases along with debt
-Insured can also buy a level term policy-can pay premiums (overpay) for a finite time and receive lifetime coverage, or even pay a single premium for lifetime coverage
-With exception of decreasing term insurance, if any other plan is bought and insured person dies early, the payout is the same

Chapter 2: Insurance Contract Formation & Meaning

Standardization
Life insurance coverage is easy b/c of predictable mortality rate data; knowledge is not hard to obtain
-Prior to Civil War, life insurance was considered immoral, but then the concept of setting aside $$ for dependents became more popular
1. Early forms of life insurance put roughly 20 people in a pool, each put in equal share of $S with understanding that last person alive gets the pool; greed/murder problems could arise when only a few left.

2. Establishment of mutual insurance companies broke the ice
   - Marine insurance was mostly out of UK, not much in US
   - Insurance developed in the area of fire coverage
   - First fire insurance company was chartered by Ben Franklin
   - A lot of people entered business who knew nothing about fire probability/premium cost; “blindly” collected premiums; when fires occurred, often could not pay out and went under
   - People created “fire underwriting bureaus” and obtained basic data (that gov’t provided in life insurance context) by pooling their experience and used rated determined by bureaus
   - Legislation was passed that mandated every insurer had to charge the bureau rate
   - Statistics had to be calculated consistently
   - The only way property insurance could be sold was by a company using standard policy language and using a standard rate-still the law for most policies-New York 1943 language
   - In 1950’s, companies with fixed rates realized they were making huge profits; could lower rates and still make $S; regulators allowed deviation from standard rates; however, fire insurance bureaus continued to survive; were merged into ISO (Insurance Service Office) owned by insurance industry
   - Insurers developed standardized forms for all kinds of property/casualty insurance; calculated standard rates and filed the rates with state insurance regulators

- More recent development has been consumerism attack on ISO-b/c rates and data are owned by insurers, it’s perceived to be unfair to consumers
- This led to 1986 anti-trust suit against insurers
- Commercial General Liability (CGL) policy was revised in the 1980’s-consumers alleged a conspiracy
- Settlement of antitrust suit resulted in revision of ISO
- Still should pool data to determine amount of $S needed to recoup losses, BUT ISO should not determine rates
- ISO has stock; different classes of stock shares have different requirements
- ISO no longer owned/controlled by insurance industry and advisory is no longer industry only-less tilted fashion than before
- Consequences of ISO: **Standardized Policies**
  1. Insurance Companies have a take it or leave it approach-individuals cannot re-negotiate
  2. Much of the language is incomprehensible

**Ambiguities**
- *Rusthoven*, p. 37 (Minn. 1986)
- Auto insurance had uninsured motorist provision
- Commercial truck driver was injured in accident
- Nobody ever found the other vehicle in the accident
- Trucker lost control and the truck overturned
- Trucker Π claimed other car crossed the center line
- Π claimed he had to make a choice-either hit the car or swerve off the road; “mystery car” problem-can’t be identified; significance of the “mystery car claim”
  1. Π convinces ER he’s a safe driver
(2) Π was severely injured and wants uninsured motorist coverage
- Uninsured coverage is primarily designed to pay the insured if injured by (1) uninsured driver or (2) unidentified driver presumed to be uninsured
- Insurer has complete defense if insured caused this kind of accident
- What kind of coverage was involved here: (1) personal policy; (2) company policy
- Π had 3 cars; stacked limits insured pays certain amount for different kinds of coverage on each car; since Π paid for uninsured on 3 cars, personal provider paid out $75 K didn’t object
- Auto insurance policy is combination of: (1) Medical; (2) Liability; (3) Property Damage; (4) Uninsured/Underinsured motorist protection
- Premium charge for each vehicle covered by the policy
- Unique feature: Auto insurance covers both people and vehicles; coverage is both personal and vehicle related
- Coverage of Mr. Rusthoven: seriously injured while driving ER’s vehicle
- Claims accident was caused by “mystery uninsured vehicle” who forced him off the road then vanished; nobody can dispute the claim

**Issue of how much coverage**: To what extent under each policy?

1. **Western Policy**: 3 vehicles, pays combination of 3 premiums; on each vehicle there is a charge, there is no dispute that insurer (Δ) acknowledges coverage; Rusthoven is entitled to maximum amount on each of the 3 vehicles: $25K/vehicle and $50K/accident
2. **Problem with commercial policy**: based on insured gross receipts; ability to combine policies is called “stacking”

Endorsements in commercial policy are ambiguous

1. Caps uninsured payout to single vehicle coverage ($25K)
2. Can get “sum of the limits” (67 vehicles * $25K/vehicle = $1.675 million)

Was it reasonable to believe that insured had $1.675 million in coverage? Π gets no more than they can prove as actual damages; if injuries not worth $1.675 million, Π shouldn’t get that much

- **There is no basis for the court’s decision—they made the expected decision of deciding ambiguity in favor of the insured**
- Court did not worry very much about whether payout amount is reasonable
- Here the coverage arose from precise language that conflicted with other parts of the policy

*Vargas*, p.40 (CA 2 1981)
- Dispute over whether coverage applied in territorial waters around Puerto Rico
- Ambiguity: “Only to accidents which happen within USA, its territories or possessions”
- Plane was traveling from Haiti to Puerto Rico; had started in NYC; presumably the most direct route
- Can be construed to mean such places and areas that must be crossed en route
- Should have provided for express exclusions
- Insured’s Argument: Insured had denied additional coverage for only $50 more
- What significance of low cost additional coverage? If additional cost is so low, then there are very few substantial additional risks involved, so why not automatically include the whole Caribbean? Court rejects this argument
- Court stretches a great deal to find ambiguity
- Keeton: courts aren’t construing ambiguities, but rather honoring reasonable expectations of insured

p.52: “objectively reasonable expectations of applicants and intended beneficiaries regarding terms of insurance contracts will be honored even though painstaking study of those policy provisions would have negated those expectations.”
Electrician makes a repair; child dies sometime in 24 hours following repair
- Insured has Commercial General Liability (CGL) Policy
- 2 situations: (1) Slip n’ fall on the premises; (2) worker causes injury while performing job duties (i.e. knocking over a ladder)
- Question as to defective product coverage not really an issue until late 50s/early 60s; used to be a privity requirement, i.e. no liability for defective car bought from dealer, b/c of multiple transactions
- p.406 N.16: “Products Completed Operations Hazard” now a standard part of CGL policy, but at the time of Atwood this coverage was not standard
- Atwood had completed his work already when the child died, so insurer tried to deny coverage
- Court finds it unreasonable to expect insured to weed through the whole policy; also the language on the 1st page appears to give coverage
- Agent also thought that Atwood was covered-hard to believe that agent w/ 20 yrs experience did not understand the policy; probably the agent didn’t think the insured needed “products completed” coverage b/c an electrician doesn’t really sell any products.

Atwater p. 49, (Minn. 1985)
- Property insurance includes coverage for burglary: “taking of property from inside the described premises by a person as evidenced by visible marks of forcible entry.”
- In Atwater, there was no forcible entry-property was missing-disappeared over the weekend
- Police concluded that it was not an inside job
- Insured makes a claim-claim denied b/c of no visible marks of forcible entry
- Consensus is that it was locked and not an inside job
- There’s no question that this was a burglary, even if unknown how people entered/exited
- What else could have enabled finding for the insured?
  (1) Court rejects the ambiguity argument
  (2) Court applies doctrine of reasonable expectations, holds that insured is entitled to payment
- Atwater is one of the purest applications of the reasonable expectations doctrine-the technical policy definition is different from a lay person’s understanding
  **Reasonable expectation is not the majority rule by a long shot**
- Very few states have ignored policy language in favor of reasonable belief standard
- Most courts use ambiguity rule and find in favor of the insured, or use the hidden exclusion rule: if the exclusion relied upon was hidden, the insurer had an obligation to explain or else is found liable
- Academics prefer reasonable expectations more than courts.

Intermediaries
- Tallant p. 58 (Ala. 1979)
  - Plaintiff sought declaratory jgmt
  - If coverage is being denied, common tactic is to sue both the agent and the insurance company
  - Plaintiff joins 2 Δs, lets them fight against each other, tries to get coverage from one or the other
  - Difference between exclusive and independent agents applies here-Tallant was authorized to represent a number of clients
  - Issue of reliance on apparent authority: even though Tallant said nothing to Bailey, Tallant selected Zurich and prepared an application
- Zurich was thus bound; had Tallant not physically done anything, Zurich would not have been bound
- Court holds Tallant is not liable to Bailey, but where Tallant breached his limitation, Zurich can go after Tallant for indemnification
- Why have this 2-step indemnification process?
- What difference to Bailey whether he can go after agent or insurer?
- There is a BIG difference between suing & getting judgment and COLLECTING A JUDGMENT
- There is no doubt that Zurich has $$ to pay, but some doubt that Tallant has $$ to pay
- Paces the onus on Zurich to get $ from its agent (Tallant)-doesn’t make this Bailey’s problem

Principle: Insurer should have some accountability for choosing a crappy agent
- One of Bailey’s operations, Brantley Gin, was offered an assigned risk pool
- People who can’t get worker’s comp as an individual can get a policy in the name of an assigned risk pool
- Sometimes assigned risk premiums are higher priced than other policies; other times the cost comes out of the policies; this is involuntary coverage
- Basis for assigned risk: often, insured has no assets to cover, but still needs assets to cover victims

Waiver and Estoppel

Waiver: Intentional relinquishment of a known right, i.e. not having to pay premiums on time. Insurer cannot waive the right for on-time payment of premiums, then later reject a claim of insured who makes a late premium payment b/c of the course of dealing prevents this, even if it says so in the policy.
- Must prove that the waiving party knew they could insist upon something, but chose not to.
- Intent is basis for waiver question

Estoppel: Doesn’t concern intent; instead relates to a change of position by the insured as a consequence of some representation/act by the insurer; no known right.

Roseth, p.63 (South Dakota 1985)
- Confusion over whether insurance covered only dead livestock or sick/injured livestock as well
- There was no clear assurance from insurer that sick/injured livestock were covered
- Is this an issue of waiver or estoppel? Estoppel
- Actual coverage provided that animals that can walk away are excluded from coverage
- Issue: Is insurer estopped to deny b/c of exchange between Π and claims adjuster?
- Court holds: Estoppel is not applicable under the facts
- Rationale: Waiver/estoppel are only arguable regarding something in the policy (Majority Rule)
- Minority Rule: Waiver/estoppel only apply to representations made at outset of coverage—that’s the only time to expand coverage
- Courts are reluctant to use waiver/estoppel to give additional coverage

Group Insurance
- Concept of group insurance: It’s almost impossible to lose $$ as a life insurer unless you suffer from adverse selection
- Early 20th Century: Insurers got ideas that policy risks could reduce costs of collecting info for a small group of people
- Initial proposal: Insure a whole group of employees—they’re in better health than the gen’l population, including people too sick to work
- Proposal for Montgomery Ward to offer life insurance to its EEs—they could name anyone as their beneficiary
- Policies would be for a limited amount; ER would “administer” all of the EE policies, paperwork, fee collection, more efficient with expenses this way
- Qualification: Unless 80% of EEs signed up, policy wouldn’t go into effect; no need to show proof of insurance
- Group insurance was formerly available to big companies only—created tremendous opposition
  1. Life insurance companies not offered insurance and their agents took a big hit
  2. Labor Unions/Smaller ERs—this would make it impossible for EEs to leave big Ers
- Eventually coverage was expanded, so all kinds of groups could get coverage
- Sometimes they were contributory, where EE paid; other times they were non-contributory—ER paid
  1. Need the law of large numbers to apply
  2. Needs to be a fluid group with a constant new group (young & good risk) of people entering the pool
  3. Amount of insurance per person has to be limited
- Hypo: someone decides all students at a school are eligible for group insurance; everyone in the group on effective date can join within 30-60 days w/o proof of insurability; if someone decides to join later, they must provide proof of insurability
- Group insurance has been successful w/ life insurance
- Takes on a different form with health insurance
- Has almost no use in property/liability insurance b/c insurers want to do individual underwriting

-Paulson, p. 67 (Ore. 1981)
- EE had just started working for ER
- Group policy was in effect: new EE can get into the policy w/o proof of insurability for self/family, provided he signs up within 31 days
- EE still had prior policy; was told by ER (wrongly) that he had 6 months to join
- When old policy ran out, EE tried to join, was beyond no proof period, daughter got sick, EE got shafted by insurer b/c he didn’t join within 31 days on account of bad info from ER

-Issue: Who has underlying insurance contract? ER and Insurer
- EE is a 3rd party beneficiary; insurer is not bound
- Historically/traditionally: 3rd party beneficiary did not enter into a contract; they would always lose (b/c they’re not a contracting party)
- Court sez Paulson wins b/c of reliance on information from employer—so why does insurer get railed? To a certain extent, ER was acting as an insurance agent and had duties to distribute applications/collect fees—so was ER also the agent in terms of telling EE the wrong thing?
- Even though EE has no 3rd party rights, agency principles allow courts to hold insurer liable for misrepresentation by ER to EE
- The one area where group insurance is a godsend is where someone close to the group is uninsurable—then someone can get into the group w/o proof of insurability

Public Policy Restrictions on Contract Terms
-Insurer had duty to defend suits arising under the policy
-Exclusion: intentional harm
-Policy: “To pay all sums which any insured thereunder becomes legally obligated to pay as damages” does not specify between compensatory and punitive damages
-Insurer’s Argument: It would defeat the whole purpose of awarding punitive damages to allow insurance to cover punitive damages
-Even if the policy explicitly covers punitive damages, the insurer can make a public policy argument against coverage.
-Courts always allow insurer to pay compensatory damage, even if compensatory damages are caused by intentional harm

-First Bank, p. 81 (Mont. 1984)
-More modern view-bases for awarding punitive damages have expanded from the old line view
-Policy should cover unless there is an express exclusion
-BUT the policy language “all amounts due as damages” should cover punitive (probably majority)

-Strickland, p. 88 (Ga. 1978)
-Cestui Qui Vie (CQV) means “insured” in Latin
-Double indemnity policy: if CQV dies of accident, insurer pays double
-Life accident insurance: benefits only arise if accident occurs
-Insured lost a leg and was denied coverage-insurer claimed policy provides leg must have been severed within 90 days of accident-this creates causation concerns
-Insured lost leg within 118 days-insured claimed he was in the middle of treatment and the efforts were kept up for more than 90 days
-90 day rule should be avoided as a matter of public policy-the policy should not force insured to choose between severing leg and losing coverage

Chapter 4: Fire & Property Insurance

-Property insurance: aspect that most strongly applies the principle of indemnity-purpose is to reimburse for a loss that somebody has suffered
-Great similarity between insurance and gambling-both work on the law of large numbers-payout of settlement/casino winnings is OK if lots of other people don’t make claims/lose $ at casinos
-Gambling has been frowned upon in Anglo-American Society-this is further basis for the indemnity principle
-Homeowner’s policy contains both Property and Liability Coverage
-2 basic formats of property insurance coverage:
  (1) All risk policy (a misnomer) – coverage for any damage except specified exclusions
  (2) Specified Risk-only for specifically listed damages

All risk case: Pan Am v. Aetna
-Terrorists hijacked a plane and destroyed it
-2nd Circuit held all-risk covers terrorism damage
-After 9/11, Pan Am was precedent authority, but policies have been subsequently rewritten
Sample Homeowner’s Policy

- Valuation difficulties
- P 178 #4: “Loss to a pair or set”–customarily, wife was supposed to bring a good set of china as a dowry – matching set of 12 place settings – so for insurance purposed, what would happen if one was damaged and the plates are not made anymore?
- Insurance company, under those circumstances, has obligation to make insured whole – the only real way to do this is to replace the whole set, BUT insured doesn’t get to keep the old set.
- P 178 #6: appraisal–either party can ask for an appraisal in the event of a dispute–some people serve as public adjusters to settle disputes between insurance cos/insureds

Requirement of an Insurable Interest
*Requirement of an insurable interest is a fundamental concept of insurance law*

-Gossett, p.186, (Wash. 1997)
-Π had bankruptcy problems/formerly accused of arson
-Trusty Deed acquired title, served as broker to protect somebody who made the short term loan
-Property kept in Trusty’s name
-Loan was made to Trusty, not Gossets
-What sort of insurance coverage for Gossetts? @ time of fire, son had moved in and Gossetts intended to move in the next day.
-Gossett fell out of a ladder, kicked over a kerosene lamp, and burned down the house
-Gossetts had done some work on the house
-Sellers had been paid off; Gossetts were hoping to buy, were fixing up, prepared to move in

Issue: Is Gossetts’ interest in the house insurable?
-Only for improvements made to the property, but not for full value
-@ time of fire, Gossetts had no legal right to the property and Trusty Deed had no legal obligation to convey the property to Gossett.
-Gossetts had no legal right to be there
-Loan was supposed to have been paid off 1 month before the fire; the short term financing period was over and the long term financing had not yet been received.

Important point: Gossetts DID NOT have title to the property, BUT were not total strangers–somewhere in the intermediate area.

-House of Lords defined insurable interest by factual expectancy test
-To prevent absurd results, other opinions sought to limit factual expectancy–better to have interest cognizable at law or equity

Hypo 1: X conveys house “To A for life, then to the heirs of his body, but if A should die without issue, then to B”
-If A is 90 yrs old in a coma with 450 heirs surrounding him, can B take out an insurance policy on A’s home? YES–there’s no chance in hell that B would get it, but there is a legally recognizable interest.

Hypo 2: A owns in fee simple, B is only living heir, A is in a coma and 90 yrs old.
-B does not have an insurable interest b/c no legal interest despite a high probability of receiving the property when A dies
(1) Property Interest  
(2) Contract Right  
(3) Legal Liability-a little more tenuous where somebody has an agreement that if property is damaged, they will contribute to its repair

-Legal test was the prevailing historical test in the U.S.  
-Issue: what was legal relationship that claimant had to the property-the test used in Gossett

-Convent case: convent had been condemned, no longer inhabitable when it burned down, coverage denied b/c factual expectancy (or lack thereof) overrode the fact that an Order of Nuns held the legal title

-The property test for insurable interest looks to the interest at time of loss; one can take out a policy before acquiring title, but loss is only covered if in possession at time of loss

-Property is insured for actual cash value (ACV) @ time of loss  
-What about the space shuttle Columbia? 30 yrs old, hard to determine ACV-rough measure could be replacement value minus depreciation  
-1st Problem: Trying to determine the replacement cost; it’s put together with an obsolete technology; what about depreciation/prior use  
-ACV could be quite low, almost zero  
-Owner could also get “replacement cost”, but on space shuttle, the premium would be outrageous

Hypo: somebody buys a used car from a dealer, appears to have good title, gets auto insurance against collision, crashes the car, takes to repair shop, and car is discovered to be stolen with falsified serial #  
-What is the legal result? Original owner’s car was stolen, new owner is BFP w/o notice; who wins? BFP w/o notice has good title against everyone except original owner; BFP may have cause of action against the dealer.  
-The old debate about legal or economic interest arises here  
-The weight of the law is probably in favor of allowing BFP to collect under collision coverage out of compassion-probably can’t get $$ back from used car dealer  
-Time for measuring interest in insured property is @ time of loss, not the time the policy was taken on

Subrogation

-Refers to an equitable doctrine-assignment by operation of law  
-B loans A $$; C agrees to guarantee repayment  
-The loan comes due, the debt’s in default, B goes to C  
-C pays the debt to B, then A gets $$, C wants to be reimbursed  
-Original debtor challenges this obligation-at no time was there an agreement to this effect

-Similar principle with insurance subrogation

Hypo: Tortfeasor (TF) burns down house of insured  
(1) Don’t want TF off the hook for burning down house of insured
(2) Don’t want insured getting payments from TF and insurer
(3) Don’t want insurer off the hook b/c it received premiums
-Once insured is fully compensated, they should stop collecting
-Corrolary: if insured collects form insurer, any additional amount goes to insurer—this is subrogation of insured’s rights against TF

-Difference between equitable (as a matter of law) and conventional (by contract) subrogation
-Exceptions to subrogation:
  (1) Insurer cannot be subrogated against insured
  (2) No subrogation in favor of a volunteer who comes to the aid of insured-if insurer pays as a matter of accommodation, no right of subrogation; BUT if it’s arguably in the policy and they want to avoid hassle, then they are subrogated
  (3) Life insurance: If beneficiaries collect in wrongful death action, the life insurer is not subrogated
  (4) Health insurance: If insurer pays for med coverage, there is no right of subrogation absent an express provision

-Majority rule: Subrogation does not arise until insured is fully reimbursed
-Substantial Minority: Split the amount on basis of the interest of the 2 parties (based on % of coverage)
-Small minority: Assignment to insurer by operation of law once payout has occurred

Hypo: TF burns down a building and offers $20K in exchange for a full release; insured takes the $20K then goes after an insurance claim.
Law: once insured takes a full release, the insurer is also bound-then if insurer pays the rest of $ to insured, it cannot go after TF b/c full release binds insurer-if insured impairs rights of insurer in this way, they can’t collect.

-Great Northern Oil, p.194, (Minn. 1971)
-Subrogation clause in the policy; insured hired the contractor and released contractor from liability; when damage occurred, insurer refused to pay b/c of impaired subrogation right
-This is different from hypo above where release occurs after the loss here it occurs before the loss
-Court finds equity lies with Π b/c insurer could have made express provision in policy re: cannot release contractors from liability ahead of time

FN2 p. 198: People are frequently in situations like this, i.e. parking garage tickets release garage from liability; storage facility contracts release facility from liability

-Gossett found an insurable interest, but only covered to the extent of that interest
-Many situations where multiple people have an insurable interest in the same property, i.e. landlord& tenant, mechanics lien, future interest, etc.
-It’s also not unusual (Great Northern) for a number of parties with insurable interests to work out an understanding that it will take out a policy to protect everybody

-Subrogation: When insurer has paid insured and becomes subrogated, and the insured decides they don’t want to chase the tortfeasor, the insurer can sue the tortfeasor in insured’s name (playing the odds w/ jury sympathy)
-This can create a number of procedural problems
  (1) There are other damages involved besides what insurer has paid (i.e. deductible); if insurance co sues in the name of insured, what happens if insured doesn’t join that suit but sues in another procedure? This would be splitting the cause of action—it’s incumbent upon the insurer to join.
  (2) Even messier when there’s counterclaims/compulsory counterclaims
  (3) If insurer is subrogated and filing suit in insured’s name, problems can arise—real party in interest rule can be violated—Δ would like jury to know their $$ is going to a rich insurance company.
-Where insurer has been subrogated, they run into difficulty where Α invokes real party interest rule—to avoid this result, what insurers do is loan receipts—insurer does not pay the claim but rather gives a “loan to the insured”, with the understanding that the loan is to be repaid only out of recovery from the tortfeasor—without recovery, the loan is forgiven.
-Insurers can sue for repayment of “loans”—courts know it’s not really a loan, but still allow this legal fiction—Other courts disallow this loan receipt rule

-Mortgage Situation: Difference between secured and unsecured creditors—unsecured does not have an insurable interest in the property.
-secured creditor could get a policy on property, but they don’t like to do this—they prefer to require mortgagor to take out a policy on creditor’s behalf—something banks sell thru their subsidiaries
-mortgagor must get a policy that covers themselves and the secured creditor

2 Ways to do this
  (1) Policy issued in owner’s name w/ bank as a loss payee—satisfactory to the owner, but not acceptable to the bank b/c if insured misses a premium payment, bank loses coverage
  (2) Standard Mortgage Clause: Even of owner defaults or there is a good defense against owner, the insurer will still pay the bank
  -“If premium payment not made on time, mortgagee will be given notice/opportunity to pay premium and only if notice is given will non-payment be a valid defense against mortgagee”-Mortgagee has opportunity to pay when mortgagor defaults

Limited Interests: Mortgages
-Insured has standard mortgage clause
-Homeowner made material misrepresentation in the claim they filed
-Standard subrogation situation: Insurer paid bank, now going after the insured
-Insured claims insurer can’t come after a named insured
-Court rejects this claim b/c insured made misrepresentation and voided their policy

Limited Interests: Leaseholds
  (1) Issue of whether tenants thought they were covered—court holds they were
  (2) Insurer cannot exclude tenant/subrogate
-Notion of “implied” coverage prevails—lease provision obligates one party to protect both parties
- Is implied co-insured entitled to proceeds? Insurer pays for full loss amount or face amount of policy, then assume landlord has discretion

**Holding:** If commercial landlord covenants to maintain fire insurance on leased premises, lease does not clearly establish tenant’s liability for fire loss caused by its own negligence, by reserving to landlord’s insurer the right to subrogate against the tenant, for the limited purpose of defeating the insurer’s subrogation claim, the tenant is implied co-insured of its landlord.

*There is no subrogation against an insured
(1) Insurer cannot recover $$ from an insured
(2) If there’s more than one insured, each of whom is listed, and one is at fault, if insurer pays off owner, cannot then go after contractor

*Where there is a situation that landlord promised lessee to provide insurance to protect both, then fails to comply → lessee becomes an implied insured and becomes immune from subrogation b/c of their implied status

- Insurer is only obligated to pay replacement or ACV at time of loss
- If insurer buys liability insurance, there is diminishing marginal premium cost ($500K of coverage costs more than ½ of $1 million of coverage) b/c occurrences of higher value are less likely to occur
- Property insurance has direct linear relationship between premium cost and policy coverage
- There is a strong temptation to overinsure—an insurer can increase revenue by selling “over insurance” while never having to pay out more than the value of the house
- Insureds can also opt to underinsure property, banking on minor accidents being much more likely than total destruction

**Multiple Interests**

*Paramount v. Aetna, p.209
- Parties executed a land sale contract—there were 15 days to complete the sale between the buyers
- No question that seller has an insurable interest and has a policy
- Buyer has also taken out a policy (regardless of possession/improvements)
- Where is the risk of loss during executory period?
- At time contract is entered, risk of loss typically passes to buyer
- In this case, the executory period lasted 1 year—even though the title was still seller’s, the risk of loss was with the buyer (Equitable title passed to buyer)
- Seller still has legal title
- What happened with the fire? Insurers settled w/ Πs, then sued each other over who has to pay for coverage

**Issue of whether buyers, sellers, or both pro-rata pay for the fire damage**—trial held pro-rata
- Seller’s insurance argues: buyer’s insurer should pay for all damages
- What can be done to avoid unjust enrichment?
  General Rule: Seller collects on seller’s policy, however, to avoid unjust enrichment, use a constructive buyer’s trust: $ has to be paid to seller as a named insured, but the payout to seller comes out of buyer’s price (avoids unjust enrichment)
- Why doesn’t court apply the general rule here? Don’t need a constructive trust if buyer has insurance—“unwitting risk bearer”—principle does not apply here—it’s fairer to put entire risk of
loss on the buyer’s insurer when both have policies than to put it on the seller or split the difference.

-Ye Olde English approach: @ time of loss, seller had legal title w/ value despite being under contract of sale—Therefore, legal title holder is entitled to collect
BUT from economic standpoint, no injury to seller so no recovery
-Courts are divided, but general rule is the constructive trust doctrine
-Vogel (CA3) addressed assignment of Seller’s right to buyer-purchaser has already recovered from seller’s assignment; Erie doctrine required applying state law, allowed double recovery in 3rd Circuit; then PA supreme court had the same problem and disallowed economic recovery by applying the economic test

Other Limited Interests

-Adler, p.215, (Md. 1973)
-When a life tenant takes out a policy, courts require insurer to pay full value of policy; life tenant has no obligation to subsequent remaindermen
-Holding is in accord with majority rule: Life tenant is entitled to full compensation for the value of property; when this takes place, life tenant has no obligation to remainder to rebuild property

-Frequent situation: wealthy man dies, leaving rich widow and several spoiled children
-Under late hubby’s will, everything left to wife, children not concerned
-But then the mother re-marries man w/ less $-children worry about their property, convince mother to promise only a life estate to new hubby, remainder to children
-Then mother dies, children are on bad terms with 2nd hubby, want to force him out of property to get house back.
-All 2nd hubby needs to do is get insurance, burn the place down and take cash w/o obligation to remainder.

-Folgers, p. 219, (W.D. Mo. 1971)
-Fire takes place; property is destroyed, some belonged to insured (Ar-Ka-Mo); other property belonged to Folgers
-Folgers makes claims against Ar-Ka-Mo’s insurer; would have to show Ar-Ka-Mo was negligent to make a claim under traditional rule

-Rule: In bailment situations, bailee is legally responsible to return property to bailor in good condition, unless property is damaged for reasons beyond bailee’s control.
-Issue: Does the phrase “for which the insured is liable” mean legally liable or responsible?
-Court held for broad definition and insurer had to pay
This is still the standard form language issued to bailees-insurers almost always lose despite not changing language-BUT bad languge may deter enough lawsuits to justify the cost of being sued sometimes

Policy Exceptions

-All insurance is peril-specific
-Difference between friendly and hostile fire: fires are used in normal course of activity (i.e. cannot recover for loss on firewood that’s burnt); can only recover for a hostile fire; friendly fire sits where it’s supposed to (fireplace) and does what’s intended
-Hypo: Expensive jewelry is accidentally thrown in garbage, garbage is burned in fireplace, then jewelry is not covered b/c of friendly fire; BUT id cinder from the fireplace escapes and burns the house, then it’s a hostile fire.
-Question of Causation: When is property covered by a peril?

-Bongen, p.223, (Alaska 1996)
-Policy excluded earth movement including mudslides, regardless of cause
-Was mudslide caused by construction?
-There were probably 2 causes of damage:
  (1) Electric company had negligently repaired house next to insured
  (2) Heavy rains onto neighbor’s house weakened the property
-As a result, the ground slid and the mudslide occurred
-Insured argued that negligence of construction company was a covered loss, not an exclusion
-Insured argues for “efficient proximate cause” test, the majority rule: for every bad thing that happens, one of the preceding events is efficient proximate cause; if efficient cause is covered, then insurer is liable; insured argued faulty construction is efficient proximate cause.
-Insured makes a public policy argument; court disagrees and enforces
-Multiple cause situations are fairly common
-Efficient proximate cause: judges believe there’s one cause for everything

3 other tests
(1) Immediate Cause test: What was the last thing in the chain of events that led to the loss?
(2) As long as one of the causes is a covered peril, insured can recover.
(3) If anything not covered was a cause, insured cannot recover.

-Increased Risk: Traditional fire insurance policy had 5 moral hazard exclusions; when one of those occurred, the risk of deliberate destruction was greater i.e. insured no longer the sole owner or there’s a mortgage on the bldg.

-What clause @ issue? Increase in hazard clause: “hazard increased by any means within control or knowledge of insured”
-An employee had turned off the sprinkler system due to leakage
-Court construed this clause to mean “control and knowledge”-insured did not have knowledge despite having control b/c EE didn’t tell his boss about the sprinkler system.
-There must be a long term increase in hazard, i.e. not just smoking a cigarette; insured must have known about it and not done anything about the risk

-Damage occurred during gap btw seller/buyer occupying b/c seller had turned off heat and pipes froze
-Issue of construing policy to mean: vacant or unoccupied?
-If there’s furniture, it’s occupied; if people not around, it’s vacant
-In this case it’s vacant, but occupied
-When dealing with residences, they’re often vacant, i.e. 2 month vacation
-Most of these cases function on estoppel-insurer knew about change in ownership/possession, cannot make vacancy claim.
When property is damaged, insurer can:
   1. Declare a total loss and pay the value of property @ time of loss
   2. Pay for repair/replacement
   3. Pay the difference between actual cash value immediately before the loss and immediately after the loss
   4. Repair on its own

The Measure of Recovery

-Zochert, p.236, (South Dakota 1998)
-Cost of repairing silos = $15K
-Insured wanted full payment; insurer claimed there was depreciation, silos were 20 yrs old, did not want to make full payout
-If insured rec’d 2 brand new silos, it would be unjust enrichment; therefore insurer argues they should deduct depreciation
-B/c insured did not buy replacement value insurance, depreciation had to be taken into account

3 Tests Used By Courts to Measure Recovery

1. Market value
2. Replacement cost less depreciation
3. “Broad Evidence Rule”-uses all evidence given to jury to let them come up with a number for value-this is the foggiest measure, but it has the widest acceptance; used widely for cases like buildings
   -Objective of Broad Evidence Rule is to put insured in the same position they were immediately before the loss.
   -The broad evidence rule is easy to use with brand new items (cars)
   -Broad evidence also easy to do with things that are fungible like crops (i.e. 10 bushels of wheat destroyed by a fire)
   -Moving away creates difficulties (used cars have different valuations)
   -Houses create problems b/c they involve a piece of land and a house
   -Actual cash value of personal property is also rough (i.e. a used business suit could be bought from Goodwill for less than replacement cost less depreciation)
   -Rebuilding houses is also complicated b/c construction methods change over time
   -Courts like broad evidence rule/leaving it to the jury

-P. 240-41: A lot of states (incl MO) have value policy statutes-if property is insured for $500K and it suffers a total loss, then it is conclusive that value of property = value of policy
-This puts pressure on insurers to insure property honestly
-Statutes were enacted in 20 states after WWI, but have been repealed in all but 2-3 states
-Have not accomplished intended purpose: (1) insurers don’t work hard to determine valuation and still overpay; (2) temptation for fraud.

-FAIR (Fair Allocation of Insured Residents): Used to enable people who had nice homes in bad neighborhoods to obtain insurance through a voluntary assignment policy
-This led to overinsurance of property and arson problems

-Co-Insurance p.242: Matter of arithmetic
-Purpose of co-insurance provision, b/c of fact that property insurance is uniform/linear, there is a temptation to overinsure or underinsure
To avoid this, the standard for property insurance is to have a co-insurance clause: if property not insured to at least 80% of full replacement, then the amount of coverage is reduced proportionately to the amount that should have been covered.

Hypo: Insured should have $80K of insurance to cover $100K of property, but only purchase $60K of insurance—When insured suffers $30K loss, they try to claim $30K payout, but co-insurance denies full coverage b/c insured did not cover 80%-insurer will only pay out ratio of actual coverage: 80% of property value—therefore, payout = ($60K/$80K)*$30K loss = $22.5K

Business Interruption Insurance

-When business is damaged, in addition to property damaged, insured suffers a lost profit
-Business interruption insurance reimburses insured for revenues lost from insured-against event

This insurance is property specific
-Sold most frequently as an addition to a property insurance policy
-There must be an actual interruption of business; loss of business b/c fire had occurred and store is less desirable for shoppers is not covered.

Exceptions to gen’l rule about business interruption insurance:

1. Ice Cream parlor across street from movie theater might be able to get business interruption insurance on the theater b/c moviegoers are its main patrons
2. Patent holder could get business interruption insurance on the manufacturer building its patented product

*Omaha Paper*, p.243, (CA 8 1979)

-Difficulties assessing revenues for bus interruption insurance
-Need to estimate revenues
-Need to adjust gross revenues for expenses saved
-Issue of what must be done with workforce while business is not operating
-These policies cover keeping EE’s on the payroll while a factory is burned down
-If no valuation in policy, then calculation of amount to be paid is difficult
-To avoid that argument, this policy was a valued policy to reimburse @ $3,260 per day lost.
-This was a problem in *Omaha Paper* b/c Pi owned a 2nd plant that could pick up some of the slack from the plant that burned down

Rule: Coverage is location specific—use of idle capacity at other plant is irrelevant
-Court is miffed about Δ’s argument—the whole point of a valued policy is to avoid duking it out in court about using idle capacity, etc.
-What is the period of time in *Omaha* that Δ was obligated to reimburse? 152 days
-Issue of actual versus good faith coverage for business interruption insurance— to the extent business interruption is the fault of the insured, Δ does not have to pay—only 130 days covered under the policy
-W/ more explicit language, there could be an offset but that’s not the case here

Chapter 5: Life & Disability Insurance

-Many variations of term & whole life insurance

1. Pure term
   -Lots of variations
   -Only insures on an age basis
   -Mortality tables are used to calculate what premium would be
Term policy for 35 yr old male

1.4: Incontestability-insurer will not contest policy after 2 years from issue date (based on application info)

1.5: Suicide Exception

1.7: Mistreatment of age/sex exception

Section 2: Ownership-life insurance could be taken out on somebody else-used to be the only kind taken out.

(1) Beneficiaries need more $$ than deceased

(2) Moral issues w/ making $$ from death

-Aetna life allowed slave owners to take out life insurance on their slaves; insurable interest existed, but demeaning; less likely b/c of replacement availability

-Uniqueness would allow this, i.e. a celebrity restaurant owner could get insurance on a celebrity’s life.

Section 3: Premiums (3.4 requires a 31 day grace period by law in all states)

Section 4: Allows reinstatement with evidence of insurability

Section 5: Dividends

Section 7: Beneficiaries (7.2 allows insured to name and change beneficiaries)

(2) Declining Value

-Premium is the same each year, but amount of insurance coverage declines

(3) Level Premium

-Same premium each year

-Insured overpays in early years and additional amounts of premium are invested by insurer to gather interest;

-In later years when premiums paid are less than the amount requires, insurer draws on invested funds to make up the difference

(4) Cash Surrender Account (for whole life insurance)

-$ is invested

-Insured can borrow from $$ in that account

(5) Single Premium

-Insured makes one payment for life insurance

(6) Variable Life Insurance

-Amount of premium decided by insured

-Insurer invests the premium $$

-If investment is successful, insured can stop paying

-Regulated by SEC/Insurance regulations to prevent fraud

Unlike property insurance where an agent can authorize on the spot, life insurance coverage must be approved by the central office

-If insurance company accepts insured’s application (offer to contract), it’s a binding contract on insurer upon premium payment, BUT not binding on insured-they can change their mind.

-Conditional receipt (a binder) is given to insured when they complete application/pay 1st Premium, BUT does not provide instant coverage
- In property insurance, measure insured’s interest in item at time of loss
- In life insurance determine if policy owner has interest in life of CQV at time of inception when policy is taken out
- If CQV takes out insurance on own life, they can name anyone as a beneficiary
- If A borrows from Bank and Bank takes out insurance on A’s life, and A dies in debt, then B only gets the outstanding amount of debt; the rest goes to contingent beneficiaries or A’s estate (creditor cannot get insurance proceeds > debt)
- But if B is a friend of A, B can keep all insurance proceeds as B is not a pure creditor of A

_Rubenstein_, p.282: if a policyowner takes out a lot of insurance of a useless employee so as to be grossly disproportionate to the economic worth of CQV’s life, the policy will be voided if EE dies suspiciously
- An insurable interest is conclusively presumed among family (parent-child, spouses)
- Rule broadened to include siblings
- An insurable interest can be shown in other family relationships
- Some state have passed legislations that charities have an insurable interest in anyone’s life

**Limitations on Recovery By Beneficiaries**

**Change of Beneficiary**
- Usually can only be brought about by complying with procedure in policy
- Courts have loosely applied this rule
- Change of beneficiary can be important in a divorce stipulation (i.e. insured named spouse as beneficiary)
  1. Parties get divorced; insured never changes beneficiary, dies 10 years later; should ex-spouse get $$? Under common law, ex is still beneficiary
     - This situation comes up frequently
     - Other courts hold a divorce decree to automatically terminate ex-spouse being the beneficiary (specific statutes)
     - This can create problems for insurers who do not keep track of marital status of beneficiaries
     - When there’s a divorce, it’s best to check state statutes
     - Sometimes insured will still keep ex as beneficiary
  2. Divorce settlement, parties renounce rights they may have in property of ex-spouse, including insurance, however nothing is done to change beneficiaries.
     - Does mere renunciation amount to automatic change of beneficiary?
     - MO Law: Whenever there’s any renunciation of interest in a divorce settlement, that acts as removal of name of main beneficiary, absent CQV re-naming.
- What if the husband is induced to change beneficiary in violation of the settlement agreement?
- If just simply a settlement, it has no legal significance and husband can change beneficiary; it can be stopped in two ways:
  1. Ex-wife can take assignment of insurance policy, including the right to change beneficiary (cleaner way)
  2. Settlement agreement can be incorporated into the divorce decree → if divorce decree is binding, the change of beneficiary is void (this is not as clean)
- If primary beneficiaries are removed, contingent beneficiaries become first in line
- A policy can be assigned; frequently assigned as security for a loan
-The assignee then becomes the named beneficiary-this does not mean that the original named beneficiary has no rights
-If beneficiary is a pure creditor, it only gets the amount of loan → if loan is paid off, creditor doesn’t get payoff

-Grigsby v. Russell, p.291 (Supreme Court Case)
-Insured assigns policy to his doctor
-Issue of whether policy can be assigned to someone w/o insurable interest
-Moral hazars issue; prevents making $ by killing
-Justice Holmes is not concerned about moral hazard in Grigsby b/c:
  (1) Doctor did not take out policy on patient but patient assigned policy to doctor on his own free will.
  (2) Similar to ordinary characteristics of property-life insurance is not a contract of indemnity, but also an investment
-Where the policy has been in effect for anything more than a negligible period of time, it is freely assignable to anyone with or without an insurable interest.

-Insurers: allowed cancellation in exchange for 50-60% of proceeds
-Viaticals: Purchased policy in exchange for assignment; also has potential investors

**More regulations are now in place**

-Is CQV consent necessary for life insurance?
-At common law, no consent was necessary-often life insurance was bought for slaves and no consent was required
-A number of statutes today require CQV consent
-Scandal during Korean War-policies were sold to parents on lives of children in the military-insurers tried to defend with consent rule but lost
-Spousal or parent/child relationship is exception to CQV consent

-Grigsby: vast majority rule that life insurance is assignable to someone without an insurable interest
-Difference between Grigsby and Null? In Grigsby, the policy assigned was in existence for several years → immediately assigned in Null
-The taking out by CQV and the assignment were pre-determined at the outset in Null

-II represents Null’s estate and wanted trial court to fins that Null took out life insurance for himself so she can get proceeds
-Trial Court: N took out life insurance b/c of C’s plan to get N to name C’s dad as a beneficiary, then have N murdered

-RULE: Courts void life insurance policies when it’s shown that beneficiary procured insurance then played some role in death of CQV
-Victor Null claims to have invented an auto engine that got 200 mpg; tired to sell it to auto cos., but they didn’t want b/c of oil interests; was trying to set up a company to sell as after market.
-Null had a workshop on the Eastside; investors were behind killing/convicted of crime
-What happened with policy taken out by Null that was assigned to Calvert? It was voided
-What argument does widow make? Where insurer is perfectly aware of all facts/circumstances, it can’t show it was defrauded when its eagerness to sell the policy created the moral hazard
-A number of courts follow this rule
-Null disagreed with widow b/c insurance policies here created an incentive to kill Null, contrary to public policy-no case has permitted the estate of an insured to recover on a policy on the grounds that the insurer negligently issued the policy
-What was the other issue? District Court concluded that Calvert, not Null was the real party in interest
-Did Null have any personal interest in taking out this policy? Court basically concludes that the lower court has determined that Null took out policy to accommodate Calvert, therefore was void

**Assignment at Outset**

**Majority Rule** (*Null*): Where policy is taken out with immediate intent to assign to 3rd party without insurable interest, it is void.

**Minority Rule** (*Warnock* p.292): CQV assigned 90% of policy at outset to trust who paid premiums/10% went to CQV’s widow; executor of CQV’s estate sues trust, court holds that policy was assigned as security for a loan to pay premiums, but trust is only entitled to the amount of premiums it paid (insurable interest) → the rest of the $$ to the estate

-The way to distinguish *Null* from *Warnock* is that in *Null*, insurer refused to pay anybody; in *Warnock* insurer has already paid $$, estate is bringing suit against the assignee

**Majority**: *Null* rule that policy is void when there’s a pre-arranged agreement to assign at outset to assignee with no insurable interest.

-*Hampton*, p.299 (Okla. 1995)
-Not sure who gets the bacon
-Insurer files interpleader
-Specific Slayer Statute: wife has been acquitted of murdering her husband
-Who wants $$ instead of widow? Children think widow should be disqualified b/c of "felonious" killing

**Incontestability**

-Prevailing Incontestability theory is → discoverability → was the particular provision something that was discoverable at the outset?

-*Amex*, p.306 (Cal. 1997)
(1) Application not filled out truthfully; (2) CQV sent a wringer to take physical
-Impostor defense asserted by insurer
-How many contacts did insurer have with Morales?
-When did insurer first meet someone claiming to be Morales?
-Meeting of minds argument no valid b/c the right person did not fill out the application
-Viattical allowed to collect proceeds; insurer could have been more diligent in determining that wringer sent in for HIV test was not the insured

-Legal construction of incontestability clause started with *Met Life v. Conway*, 169 N.E.2d 642
Conway was N.Y. Superintendent of insurance
-“Policy shall be incontestable after it has been in force for two years during lifetime of insured except for his payment of premiums.”
-Conway argued incontestability meant if insured was alive for two years, all defenses eliminated except non-payment of premiums

**Limitation versus condition**

1. Limitation: survives running of period
2. Condition: invalidates the policy

*Simpson v. Phoenix Mutual Life*: any defense relating to cause of death survives the period

**The essence of distinction between condition and limitation is discoverability**

-For anything that is discoverable → the defense is barred after running of the period
- Courts apply *Simpson* thinking they’re applying *Conway*
- MO follows *Simpson* discoverability rule

**Limitations of Risk**

*Silverstein*, p.311 (N.Y. 1930)

-Policy did not “cover accident, injury, disability, death or other loss caused wholly or partly by disease of bodily or mental infirmity or medical or surgical treatment therefore”
- In this case, insured fell, aggravating a small unknown stomach ulcer that later led to his death
- Court holds only open and notorious diseases are covered
- Court holds any little infirmity contributing to death by an external force is NOT a defense
- There are a lot of stipulations in insurance law where qualification as “accident” is crucial
- A condition (small stomach ulcer) that if left dormant would be harmless and incapable of becoming harmful is not a disease or infirmity within the policy meaning.
- “The infinite interplay of causes makes it impossible to segregate any single cause as operative at any time and place to the exclusion of all others if the cause is to be viewed as a concept of science or philosophy”

**Suicide Coverage Exclusion**

*Charney*, p.314 (CA11 1985)

-Suicide exception construed in favor of insurer if insured commits suicide within 2 yrs of policy date

- Application: 11/6/81
- Issue: 2/4/82
- Suicide: 1/13/84
- 92 days of delay btw application and issue caused by insurer
- Widow argued insurer was negligent in delay of issuance
- Trial court ran date of issue back to application date
- Appellate court denies retroactive coverage, but widow can recover on negligence grounds for full amount of policy

- Offer remains open for a reasonable time, then it expires
- Under contract law, insurer has no obligation to do anything when insured applies → except in insurance where some jurisdictions hold non-action by an insurer to be an acceptance
-Most adopt the approach that insurer has a duty to act upon an application within a reasonable time AND if insured can show damages from not acting within reasonable time, then insured can collect
-Classic example is when insurer delays and CQV dies or develops a disease making him/her uninsurable and blocking the application

-Insurer negligence: insuring party without insurable interest – can be liable for damages to the estate or issuing insurance to wife w/o husband’s consent; wife mistook husband for burglar and killed him; statute was amended to prevent insurance w/o CQV consent

-Bacon: Negligent processing of change of beneficiary

Disability Insurance

-Not very popular anymore b/c most people suffer disabling injuries at work and those lost wages are covered (somewhat) by workers comp
-Only needed for non-work accident/illness; policies are expensive
Health Insurance: Indemnifies insured for hospital/medical charges
Disability: Compensates for lost income

-Mossa, p.360 (E.D.NY 1999)
-Insured had Economics degree but worked as HVAC contractor
-Injured on the job, collected for 2 yrs
-Is there ever a duty to get a new job?
-Insurer argued occupational disability was covered for 2 years then no gainful occupation coverage
-Court applies this language how? “gainful” accounts for salary
-Insurers don’t like disability insurance b/c it’s difficult to determine extent of disability and other available employment opportunities
-Even with occupational disability, it’s tough to determine
-A trial lawyer was able to collect, despite having a JD degree and ability to practice non-trial law
-Gynecologist lost license b/c of molesting patients, brought “sex addiction” disability claim
-For a long time female disability premiums were higher than male b/c perception that injured men are quicker to get back to work while injured women are more comfortable at home

-P.366, N3: Social Disability (physical ability, but legally prohibited-not recognized as much)
(A) 2 levels of disability: occupational and total
(B) Both are difficult to assess with any degree of certainty
(C) With disability, insured is either disabled or not-no such thing as partial disability

-Heller, p.367 (CA7 1987)
-Surgeon was unable to continue practice b/c of carpal tunnel syndrome-he could have had surgery to fix this problem; insurer wants surgeon to have this surgery
-Court holds: b/c no clear policy language requiring surgery, injured did not have to undergo surgery; BUT refusal to take medicine is not valid, but declining risk of surgery is valid

Liability for Bad Faith Breach
Silberg, p.372 (Cal. 1974)
- Injured foot, filed workers comp and health insurance claim; workers comp claim was settled; health insurer refused to pay on account of settlement
- Insurer relied on exclusion of workers comp settlement-found settlement to be full satisfaction of medical damages
  (1) Refused to pay while workers comp liability was being determined
  (2) Once workers comp was settled, insurance company denied any further liability
- Insured sued for: (1) Declaration that insurer was liable; (2) Damages resulting from failure to pay
- Insurer wants both payment of bills and compensatory/punitive damages for failure to pay and resulting stress

**General Rule from Contracts: Only get Hadley v. Baxendale** damages (does not include pain/suffering/punitive damages)
- Insurer wants to limit damages to amount of medical bills

**Court recognizes bad faith breach of contract as a tort**
- Why did court believe insurer acted in bad faith? Policy language was ambiguous, but insurer’s handling of the situation was in bad faith.
- Insurer could have paid the medical bills, then put a lien on the workers’ comp
- Insurer made the argument that any workers’ comp payment relieved insurer of all liability
- This was a policy ambiguity to be found in favor of the insured
- Where insurer could have paid, refusal to pay was bad faith → insurer could be liable for additional damages on a tort basis
- Court had no difficulty concluding that b/c insurer has control of defense, when they did not act in interest of beneficiary, they can be liable for breach of trust
- Insurer has duty to: (1) Defend with vigor; (2) Pay claims to minimize harm done to insured
- Half of states allow compensatory claims for this breach
- Punitive damages are almost never available unless there’s a showing of malice

**Silberg** is slightly out of order
- Courts have dragged the concept into 1st party insurance area
- Not the same justification for finding fiduciary obligation → nut in traumatic situations, a failure to provide coverage can be held to the same standard → this is a minority holding in first party insurance, unlike liability insurance
- Insurer can be liable for extra-contractual damages if refusal to pay is in bad faith

**Chapter 6: Liability Insurance**

**CGL Policy**
- Basic policy for businesses to protect against liability claims
- Policy itself was originally designed/created in 1940 by predecessor of ISO
- Prior to this, there were various specialty packages
- This was thought to be too cumbersome → better to provide basic package than allow cos with special needs to add a supplement
- The last total revision made in 1986-caused considerable confusion
- Persistent rumor that ISO will come out with new revision, but has not happened-basically dealing with 1986 revision
Pollution exclusion, p.396(f)

Prior to 1966, pollution was never mentioned
Industry began to see a lot of claims for pollution damages
Began to cause considerable unanticipated claims
1973 revision included a limited pollution exclusion
This did not work—replaced with total exclusion in 1986
Companies with pollution problems need separate insurance—same thing is happening today with terrorism

Broad form (special policy to include product liability)—became part of 1986 policy; package that everyone wanted to buy—policy has expanded/contracted with marketplace needs
Name changed from “comprehensive” to “commercial”
Idea that documents should be readable—readability index
CGL is said to be in “readable format”
Instead of 3rd person, uses we/you
Certain words are quoted

Coverage A: Standard Coverage, source of most litigation (bodily injury/property damage); this covers tangible injuries
Coverage BL: Personal and advertising coverage; damage to reputation, IP rights, etc.; used to be more trivial, now more important
Coverage A: Will pay sums insured becomes legally obligated to pay as damages b/c of “bodily injury” or “property damage” to which this insurance applies
Have right/duty to defend insured against any suit seeking those damages
However, no duty to defend against suit seeking damages for injury/damage to which insurance does not apply
(a)(1): Amount paid for damages is limited BUT cost of defending is not limited
Limits coverage to damage/injury caused by an “occurrence”
Confusion over single event or series of events
Word changed from “accident” to “occurrence”
“occurrence” can take place over a long period of time
Businesses often switch carriers for CGL—issue can arise over who covered insured when damage/injury occurred
This is known as the “tail” of the policy where there can be many years between when insurer collects premium and when they pay out the $$
Exclusions:
(a) Expected/Intended injury (intentional torts)
Exclusion does not apply to injury resulting from reasonable force used to protect persons/property
(b) Contractual Liability
(c) Liquor
(j) Damage to property of insured not covered—only property of others
(k) Damage to product
(l) Damage to your work
(m) Damage to Impaired property or property not physically injured
Recall of products/work/impaired property

- Pollutants have broad definition
- Property damage means (a) Physical injury to property; (b) Loss of use of property (i.e. car breaks down blocking entry to business)

- *McDonald*, p.409 (Iowa 1991)
- Firm made brass valves, used molding/sand
- Left over sand was dumped on the property-had lead in it
- EPA took administrative proceeding to have land cleaned up
- McDonald agreed to clean up & monitor groundwater for 30 years
- Tried to file claim w/ insurer (INA)
- Issue of whether expenses are covered by CGL

-Issue (1): Does the language “all sums which the insured shall become legally obligated to pay as damages b/c of property damage” include coverage for $ expended/paid by II to comply with terms of consent order?
- Injunctive relief is not traditionally considered damages-there used to be a split of law and equity courts
- Insurer tried to make argument that “damages” are only what a court of law would have awarded in the 19th century, but II’s costs in this case are not damages
- Under CERCLA statute, government could have fixed the property itself, then held II liable for costs
- Another measure of damages is diminution in property value
- Court favors a broader reading of “damages”
- This issue has been litigated with mixed results
- Most states agree with Iowa and favor a broad reading
- Federal courts favor a narrower reading, using the old school “court of law” damaged definition, citing NEPACCO case

-Issue (2):
Hypo (A): When administrative action is begun, no leakage has occurred, but EPA says it will leak and has the right to require action → Policy does not cover expenses to avoid future damage-there must actually be an injury to actual property-otherwise no recover possible
Hypo (B): There has been leakage and insured’s property has been contaminated → insurance does not cover this b/c there must be (1) Actual contamination; (2) On property other than insured’s to have CGL coverage.
- BUT, Federal government is deemed to be protector of air/water including property of insured, so this could be counted as damages
- Once necessary property damage has been established, what cleanup costs are covered?
- “All sums to which insured shall be legally obligated to pay as property damages because of damages”
- This means any cost to remedy, including cleanup of its own property-this comes within definition of property damages
- BUT if cost was strictly for protection of owner, then they’re not covered
- All incidental damages are covered, but first must find “property damage or bodily injury” then anything related, including cleanup to protect against further damage to adjoining property are covered
- *McDonald* made easier b/c it only involved one insurer
- AHP p.419 (SDNY 1983)
  - Cannot say a person has bodily injury upon ingestion of medicine → ix-nayed the exposure tule
  - **Manifestation Test: When were there recognizable symptoms**
  - Manifestation test is not a true gauge of bodily injury—a person could have suffered injury long before any manifestation

- What triggers CGL coverage?
  - Under traditional policy, when does bodily injury/property damage take place?
  - True as a general matter that a company that took on a risk is responsible for all subsequent injury

- **AHP decides in favor of injury rule**

  Three Tests (in a pharmaceutical CGL context)
  (1) Exposure test: bodily injury took place when pill swallowed
  (2) Manifestation theory: once symptoms become diagnosed, bodily injury took place, insurer responsible
  (3) Injury in fact: When did victim **actually suffer** injury?

  **Exposure Problems**
  *Logical*: In a typical fact pattern only a small % of pill takers develop some sort of disease—assumes an immediate problem with pills
  *Practical*: The further one goes back, the lower the value of the policy

  - Using manifestation, likely not to have much insured coverage → very costly and conjectural to determine onset of symptoms.
  - Most courts have adopted the triple trigger → all insurance companies that assumed risk with exposure/manifestation/injury are liable
  - Having decided insurers are liable, need to determine who must actually pay

- NSP, p.430 (Minn. 1994)
  - Electricity plants burned coal; contaminated ground water
  - Utility started using coal in 1910; stopped in 1933; got rid of property in 1978
  - NSP was sued by government for clean up costs → ultimately agreed to pay $1.6 million

  **Issue: What must insurer contribute to cost?**
  - What about Fidelity and St. Paul?
  - All insurers settled exc. St. Paul—Fidelity remained in the case name
  - Self-Insured Retainer
  - How to determine St. Paul liability?
  - Allocate damages as proven by expert testimony—court does not buy this approach b/c of complications
  - Court assumes that damages were continuous, so imposes liability pro-rata by time on the risk
  - Court limits itself to period from 1946-1985
  - Now there’s a whole flock of insurers, so how to divide $1.6 million between all insurers → Divide pro-rata by time on risk.

  **What other alternatives**
  (1) Determine division based on policy limits
  (2) Joint and Several Liability → each insurer liable for entire amount; II can decide they will collect from any insurer the full amount from each insurer is obligated to pay, then
insurers can chase each other for pro-rata shares → this maximizes by allowing insured to pursue the most coverage first
- Joint/Several is an attractive choice for courts
- Issue of how many occurrences given coverage of $25K/occurrence
  - There must have been something that happened
  - Amount of deductible is one per policy period
  - II wanted each claim filed to be an occurrence
  - What fact pattern gave rise to this issue? Improper shipping of the wrong products; toxic flame retardant shipped in lieu of animal feed

**Ambiguity: mistake could have happened in 2 different ways**
1. Bags could have been mislabeled
2. Bags were correctly labeled, but sent to the wrong place and nobody caught the mistake
- One shipment of mislabeled bags went to the Farm Bureau Service → wrong feed was mixed with other feed and sold to thousands of farmers and fed to millions of animals who had to be destroyed
- How are occurrences broken down here? How many occurred?
- Insured argued every time an animal suffered was an occurrence
- Court finds for insurance company; holds only one occurrence/accidental shipment
- Not necessarily a $28 mln cap on liability b/c one cause can have disparate impacts
- Occurrence: For all practical purposes, “occurrence” is a substitute for the word “accident”
- Somebody did something that caused harm → the occurrence is not the harm but the improper act.
- In *Michigan Chemical*, the only evidence of wrongdoing in the shipping – no collection of mislabeling incidents
- Therefore, only one occurrence in terms of shipping mishaps
- Who won the case? Assuming only 1 shipment, insurers only had to pay for 1 occurrence
- Does this mean they’re only “out $28 million”?
BUT, 2 years of coverage were in question: 1973-74
- Even though there’s only one occurrence, in every year that there’s damage, the insurer could be liable for up to the full amount
- **Even though liability (occurrences) are invoked by cause, coverage is triggered by effect**
- Concept of liability coverage is difficult/hard to determine

**Exclusions**

*Stonewall v. Asbestos Claims*, p.444 (CA2 1995)
- **Rejected the known loss defense**
  - Expected/Intended Injury defense → subjective standard
  - Element of probability for harm
  - Must also be a high degree of certainty—mere fact that companies put out dangerous products does not trigger expected/intended damage exclusion
  - One of the purposes of buying insurance is to protect against consequences of negligent behavior
  - Must be a deliberate intent to harm or a gross negligence
It is not unacceptable for there to be insurance on a known loss—A Hotel burned down in the 1970s; insurer collected the premium after the fire then covered the loss → insurer lost its shirt on this deal.

*Unigard*, p.451 (Wash App. 1978)
Kid sets a school on fire
As a matter of law, no way the jgmt could result in a negligent setting of the fire
-The kid could not be indemnified, but the parents could be

**Intentional exclusions are strictly construed against insurer**—even if insured acts like a jackass, i.e. giving a little boy cocaine → boy dies → still not excluded b/c death was not intended.

-Same goes for passing on an STD → coverage unless intent to infect is proven
-HOWEVER, rape of a minor is excluded
-Same with drinking/drugs → if ingestion was deliberate, then harm is considered intentional
-Insanity would preclude exclusion

*Weedo*, p.462 (NJ 1979)
One of the more heavily litigates CGL terms
-Coverage was for injury sustained from work, not for poor craftsmanship
-Could create moral hazard – too many claims
-Poor workmanship deemed to be a normal risk of doing business
-Applying *Weedo* rule liberally, there’s no coverage of work performed
-Often times, replacement of poor work adds additional costs
-The claim in *Weedo* is strictly for the cost of replacing bad stucco with good stucco
-This is an uninsurable business risk
-To the extent that customer spent $$ to replace bad stucco, probably no insurance;
BUT to the extent it can be established that there were incidental repair costs, those costs are insurable
-The only thing covered by business risks is actual service or product supplied
-What is Stone-E-Brick’s argument? 2 exclusions read jointly have an ambiguity
-P.469(a): excludes liability assumed by insured under contract; does not apply to warranty of fitness or quality

*Negating one situation from an exclusion does not mean that situation is excluded b/c one must read all other exclusions*

*Koloms*, p.472 (Ill. 1997)
-Definition of Pollutant
-Difference btw environmental cleanup costs and malfunctioning furnace
-From 1973 to 1986, “sudden and accidental” pollution costs were covered
-Problem came about when ongoing practice occurred for a long time before it was discovered to be pollution causing
-“accidental” was satisfied but “sudden” was not
-In spite of the fact that the exclusion is written so broadly, it **only covers environmental damages**

-Pollution Exclusion: The reason old cases are still important → many cases arise today, especially in pollution/products liability areas where claims are made that can be covered by old policies
-There still is vigorous litigation on the meaning of old policy definitions (1973/1986)

Doctrine of Regulatory Estoppel, p.483: Prior to 1973, CGLs had nothing about pollution; then in 1973, the sudden and accidental exception to the pollution exclusion was submitted by ISO
-ISO sent policy to all state regulatory bodies → policy cannot be used until states have a change to sign off/reject
-ISO anticipated that exclusion exception would only exclude intentional pollution
-Then there was the problem of gradual but unintentional pollution being excluded
-Doctrine of regulatory estoppel still exists in NJ on pollution exclusion → bars literal application of sudden/accidental policy terms

-Mighty Midgets, p.483 (N.Y. 1979)
-There is a duty on the part of insured to give prompt notice to insurer about any occurrence that can lead to a claim against the policy
-Originally, the family of an injured child only wanted medical compensation
-When this was turned down, the family went to a lawyer → this raises a claim of more than just a doctor’s bill
-Some states have voluntary no-fault arrangement to pay medical bills immediately to save grief down the road
-A number of policies don’t have “as soon as practicable” notice provisions but have 30 or 60 days instead
-Courts hold that language should be construed to require insured to give notice within reasonable amount of time considering the facts and circumstances.

-New York is stricter-BUT if insured has an excuse for not giving notice upon the event, they may still have coverage.
-Theoretical possibility that injured party may have trouble collecting b/c of failure to give timely notice-notice need not be given by insured
-It is prudent for injured party’s attorney to (1) find out if tortfeasor has insurance and (2) give notice to insurer

-West Bay, p.488 (CA6 1980)
-Portion of opinion is omitted; regulatory authorities contacted insured that they had to do corrective action; after getting this notice in 1986, insured told intermediary they thought they could have coverage, but intermediary told insured to not file a claim in order to keep premiums down
-By the time insured finished cleanup and realized heavy expenditures, they decided to file a claim
-Delay of almost 2 years b/c of info from intermediary that damage was not covered

Insured had 2 arguments
(1) Notice was timely under the circumstances
(2) Notice to intermediary was notice to insurer

-2nd argument doesn’t fly b/c intermediary was broker, not agent
-What must insurer show? Where there is issue with respect to timely notice, insurer must show prejudice b/c of not getting timely notice
-What does court say about prejudice? B/c cleanup was done, insurer had no opportunity to defend their claim

-Duty to Cooperate: Can be tricky-does not require denial of liability
-Cannot “butter up” the facts in order to stick it to the insurer
- Must be available for depositions at behest of insurer

  - "Claims Made" policy
  - Insured sued for negligence in 1985
  - Policy was canceled, so claims made after cancellation for negligence before cancellation are not covered
  - Under occurrence policy, there must be bodily injury or property damage within the policy period
  - All that matters under occurrence is when the injury took place
  - For a pure claims made policy, all that matters is when the claims were made-times and dates do not matter
  - If coverage stops under claims made policy, claim cannot be made once premium payments stop
  - The beauty of claims made policies to insurers is that when the year ends, insurer knows all of the claims it will have to defend/indemnify
  - Also gives an early warning of problems, BUT forces a lot of risk back onto insureds and makes re-insurance difficult
  - For CGL policies when insurance industry did revision in 1980s, the first re-iteration was claims-made only
  - Insureds got upset, so did the regulators
  - 1983 revision was withdrawn – replaced with 1986 version – ISO created alternatives for both (1) Occurrence and (2) Claims Made
  - Claims made policy has not been very popular except in malpractice area
  - All policies come with a retroactive date-dates can be tailored to cover differences in liability
  - Once professional is with a company with claims made policy, then it is difficult for them to switch employers unless the new ER has a claims made policy with a retroactivity date
  - *Thoracic* involves a double claims made policy: (1) 3rd Party claim against insured; (2) Insured claim against insurer
  - Claim must be made within policy period and then reported to insurer within 3 months
  - In this case, notice was not given until after expiration of the period
  - With claims made policies, courts are very strict about notice requirements
  - Insurers have complete defense against late notice b/c they must know what all claims are by the end of the reporting period → to allow deviation from these rules would defeat the whole purpose of claims made policies
  - The claim is made on the date there is a specific demand for relief
  - Extended coverage is available for people retiring from professional service

*American Causalty*, p.503 (DC Mass 1994)
- D&O liability insurance
  - (1) Intends to cover lawsuits against directors/officers in their official capacity
  - (2) Policy covers corporation but only to the extent it indemnifies directors & officers
- As a matter of public policy, it doesn’t make sense to insure against indemnification it won’t give
- D&O covers legal expenses differently than CGL; insurer has duty to defend
- Main issue is when the reimbursement for legal defense takes place-most D&O call for rolling reimbursement
- Insured versed Insured exclusion → no indemnification when one director sues another to prevent conspiracy
-Regulatory Exclusion: 1980’s S&L collapses – insurers wanted no part of regulators suing D&O’s

Chapter 7: Liability Insurance Defense and Settlement

Duty to Defend
Common law rule: under common law, it was contrary to public policy for one party to agree to cover the legal expenses of another party
-Common law sought to block amount of litigation-discouraged people from suing
-Insurance companies were allowed to defend b/c they had agreed to indemnify – they wanted to provide defense if their $$ was on the table
-Traditionally, practice was for sued insured to turn the claim over to insurer and have insurer control the defense
-The duty to defend is still co-extensive with the duty to indemnify in theory BUT some significant differences
-Duty to defend exists even if allegations are groundless, false, baseless
-Allegations still indicate a possibility of liability
-Insurer has duty to make the case go away

-Beckwith, p.511 (WD Penn 1986)
-Insurer started to defend on compensatory damages but not punitive damages
-Insured hires his own attorney for punitive damages
-Abruptly, two years after case started, insurer’s attorney changed their mind, withdrew from representing
-The law firm obtained by insured now has to defend entire litigation
-Parties reach settlement for $ 100K
-Beckwith then sues Travelers for failure to defend
-When must insurer indemnify?
-Duty to defend is broader → determination of insurer’s duty to indemnify is only at the end of the road
-Decision re: defense must be made up front
-What test to use @ outset to determine duty to defend?
-Court holds insurer must provide a defense until it is decided that complaint is patently outside of coverage
-Duty to defend until it is established that there is nothing that is covered → if it takes a long time, tough shiznit

-Duty to defend is a subsidiary of the duty to indemnify
-Difficulty arises b/c of timing disparity
-Insurer must make duty to defend decision at the outset-much earlier than indemnification decision
-N1, p.518: Four Corners of the complaint rule → insurer determines if there’s any possibility of being obligated to pay
-If policy indicates there is an obligation to defend but extrinsic evidence indicates falsehood of claim, insurer still has duty to defend
-Beckwith deals with question of when some claims invoke duty to defend and others do not
-Insurer in Beckwith said it would defend, then retracted its offer →because of this initial offer to defend, insurer becomes responsible for the cost of defense and the amount of claim
- Bad idea for insurer to unconditionally offer to defend; what can insurer do?
- Reservation of Rights Letter → insurer says there is questionable coverage – will defend but reserves right to indemnify
- Non-waiver agreement → bi-lateral reservation of rights where insurer offers to defend but insured agrees to insurer’s right to not indemnify
- Insurer could also file a declaratory judgment as to whether it is obligated to defend or indemnify
- The main disadvantage is that it results in two lawsuits at a higher cost
- Insurer is obligated @ outset to make a determination and is stuck to their choice
- Anything insurer fails to mention in reservation of rights letter it loses
- Must give exact picture of what liability is accepted
- Insurance is never mentioned in the trial, but where insured gets their own lawyer and both appear in court there are two Λ lawyers fighting each other and nobody tells the jury why

- Gray v. Zurich, p.520 (Cal. 1966)
- Jones sues Gray for battery; Gray claims self-defense, tenders compliant to insurer – insurer says they won’t defend against intentional tort claim – the only defense offered is self-defense
- Court finds insurer was obligated to defend for 2 reasons
  (1) To a reasonable person, exclusion for intentional torts would only apply where it could be shown that it was pre-meditation, not where insured was defending himself
  (2) It would be possible to wind up with a finding of negligence
- If court had gotten rid of any potential for a negligence claim, insurer could have walked away
- 200 years ago, if П pleaded an intentional tort and found negligence they lost
- Under modern pleading rules, П can amend their complaint
- Possibility of bringing a declaratory judgment

What if П (Jones) starts trial with only a battery claim, then later adds a negligence claim?
- Insurer can seek declaratory judgment action to cover Jones and Gray
- Some states block declaratory judgment alternative- this is only a limited remedy
- In ultimate outcome, Gray gets his own lawyer, loses $6K; basis for decision was self-defense;
  no punitive damages were awarded; doesn’t say basis of claim
- Gray then sues Zurich for $6000 judgment plus fees
- Insurer claims they’re only liable for fees, not the compensatory damages claim
- Court holds that if insurer had met its obligation to defend, it could have prevailed on $6K claim → if insurer refuses to defend, it’s liable for (1) cost of defense; (2) ultimate outcome
- Insurance company that wrongly refuses to defend can be stuck for the whole bill, even if it includes shiznit that’s not covered.
- Insurer’s last argument: conflict of interest → although both are unified in wanting jury to decide for Gray, insurer wants Gray to lose on intentional tort grounds while Gray wants to lose on negligence grounds → court holds if rights are properly reserved, the issue between Gray and insurer is de novo

- Gray v. Zurich: conflict of interest between insured, insurer and attorney
- In most cases attorney is selected, hired, controlled by insurer; most 🤷‍♂️ of defense go through insurer
- In Gray, insurer wants to lose on intentional tort theory; insured wants to lose on negligence theory → how do you deal with this at trial?
- Gray says not to focus on this when 3rd party sues insured, but have a 2nd trial if 3rd party wins first trial
- This makes the operation more expensive (2 trials instead of 1)
The strategy element in the 1st trial becomes crucial—this is not a comfortable result.

Other Alternatives

1. Retain the same jury after Jones v. Gray, then get decision re: intentional or negligent harm
2. Ask jury for special interrogatories
3. Have 2 juries sitting on trial, one for liability, the other for coverage

Alternatives Given By Book

1. Gray could have his own lawyer
2. Byrd case from New Jersey; where there is potential conflict, insured may not provide a defense
- If insurer pays for the defense, but insurer not found liable, then insurer gets a free ride
- There is some authority giving insurer the right @ the start of litigation when there’s a mixed complaint (some parts not covered) to notify insured that they will collect for defense costs if insured not held liable for covered risks-only one case found by Bernstein that this actually happened.

-Cumis, p. 527
- Insured has the right to select independent counsel paid by insurer
- Collusion between independent counsel and Insurers lawyers to keep the cane coming from the insurer in the form of attorney’s fees

-Parsons, p.528
- Use of info obtained in defending battery claim against insured in denying coverage
- What happened at trial? Jury found against Δ for $50K, double the amount of insurance coverage
- Suit was brought by Π against insurer, not against Δ
- The same lawyer who handled the defense of Δ (insured) also handled claim by Π against insurer
- This was an ethical violation

-Majority Rule: Under these circumstances, attorney owes full zealous advocacy/fidelity to the insured
- Although attorney is selected/appointed by insurer atty owes a primary fidelity to the insured
- Attorney in this case should have withdrawn (extreme answer relied on by Ethics Committees)
- Problem: if attorney told insurer he could no longer represent them, but couldn’t say why (insured committed intentional tort), that’s almost as bad as spilling the beans as atty did in the Parsons case
- The other possibility is for attorney to not tell anything to insurer
- Basically speaking, when attys are put in this position, they can condition their loyalty to insurer by limiting the extent that the insurer is informed
- There have been challenges to the right of the insurer to control the litigation other than appointing a lawyer
- Some cases have held insurer has no right to control litigation b/c that’s engaging in unlicensed practice of law.

Duty to Settle

-Crisci, p.536 (Cal. 1967)
-Π suffered mental problem by falling down staircase (and physical problems also)
- Victim sues insured; insurer agrees to defend
- Insurer’s coverage limit was $10K
- Insured offered to settle for $10K limit
- Insurer was willing to settle for $10K, but insurer refused
- Jury awarded $101K verdict to Insured
- Insurer based conclusion on assumptions that:
  1. All Insured’s evidence would be believed and
  2. Insured would be awarded less than $10K
- Jury went along with Insured’s witnesses, damages would be substantial – no big surprise here
- Insured paid the $10K limit, but refused to pay then other $91K

Most important thing in this case: insured assigned the claim proceeds (all of them) to Insured from first trial
- Fully assignable “chose in action”
- Assignment was in exchange for full release
- Also had to throw in $22K and 40% interest in insured’s property

Basis for lawsuit? Insurer had opportunity to settle the case within the policy, but failed to do this, and because of this failure Mrs. Crisci was also subject to substantial consequential damages

- There was no duty to settle in the policy itself, BUT policy says “insurer can settle within its own discretion”
- No contractual obligation to settle, but question of whether court will find an implied duty
- Implied covenant of good faith and fair dealing → does this mean insurer should always settle within policy limits? Always obligated? No
- BUT if insurer reaps benefits of determining not to settle, it should also suffer the detriments of this decision.

**TEST: Whether a prudent insurer without policy limits would accept the offer**
- If insurer does not accept a reasonable settlement, it breaches implied duty of good faith and fair dealing.
- In Crisci it was foreseeable that rejection of settlement could lead to liability
- Insured also awarded another $25K for mental suffering damages
- Most states limit recovery more than in Crisci-by applying “prudent insurer without limits” approach, it’s hard to know without concrete terms
- Issue could be the opinion of insurer’s attorney whether or not to settle – good faith standard
- Some courts thus do not penalize insurance defense attorney’s lack of hindsight

When a person has minimal assets/modest insurance

1. File suit
2. Make offer to settle within limits
3. Offer is rejected
4. Jury verdict awarded
5. Injured party can then go after insurer on behalf of insured for bad faith refusal to settle

When insurer receives offer to settle within policy limits and rejects, they must inform the insured.
- Important for insurer to keep insured advised of settlement opportunities
- There’s also case law where no settlement offer was made, but insurer still obligated to make the offer

- When injured party sues in the shoes of the insured, lying to the injured party is breach of good faith/fair dealing.
- *Crisci* indicates that insured had assigned her claim to the injured party
- This is a common practice when insurance company turns down an offer to settle
- When insurer denied coverage/refuses to defend, insured party can go to insured, threaten to sue, and have their claim satisfied by insured’s claim against insurer
  → If insurer refuses to defend claim when it should have, it is bound to pay settlement
- Missouri Law: claims against insurer for bad faith are non-assignable

- *State Farm v. Campbell* (US Supreme Ct 4/7/03)
- Fatal auto accident, Δ tried to pass 6 vans in oncoming lane of traffic and ran another car off the road; Δ had no injury at all and was clearly at fault
- IIs sued for wrongful death/tort had $50K policy limit
- IIs offered to settle for limit; insurer offered to defend, had $186K jgmt from jury awarded to IIs
- Insurer paid $50K limit, then left Δ hung out to dry
- Insured (Δ) brought bad faith claim against State Farm, even though State Farm paid the rest of $186K
- Utah trial court awarded $2.6 mln comp damages/$145 mln punitive damages
- Utah Supreme Court awarded $1 mln comp/$145 mln punitive damages
- US Supreme Court dropped the punitive damages award as unconstitutional
- Insured brought lawsuit in his name, but IIs lawyers controlled the lawsuit and insured was a party in interest, gave 90% of $$ to IIs; technically did not assign but effectively did assign
  - Ginsburg, Scalia, Thomas dissented
  - Court held that punitive damages are not limited outright, but are limited to a single digit multiplier

**Chapter 3: Insurance Regulation**

- There have always been state regulations
- Legislatures would put conditions on insurance companies, but most state approved insurers could freely sell insurance
- Around the time of the Civil War, states specifically regulated domestic companies
- As laws got in place, they were challenged in *Paul v. Virginia*
- VA passed a law making it illegal for out of state insurers to sell in VA
- Paul tried to sell from out of state, was cockblocked and argued the VA law was obstructing interstate commerce → Supreme Court upheld the state law on the grounds that an insurance contract is not commerce
  - Pattern then developed
- Feds had no power over insurance industry and states were happy
- Insurance was regulated in almost every state (not in TX until after WWII)
- Everyone was happy with this arrangement until late 1930’s
- Thurman Arnold was appointed by FDR to be head of antitrust division; went after *Paul* decision to try to get it reversed
- Problems with solvency in fire insurance industry → this was always a concern
- Southeastern Underwriters Ass’n → precursor to ISO
- Provided a specimen insurance policy with a set of rates that was distributed to all association members
- Really sought to get rid of all companies that did not use the preferred rates
-Made covenant to “cockblock” or secondary boycott anyone not in association and anyone doing business with them
-Arnold filed antitrust claim

**Insurers argued:**

1. Insurance not interstate commerce (*Paul v. Virginia*)
2. Legislative intent of Sherman Act excludes insurance

-Went all the way to the Supreme Court
-Southeastern reversed and overruled *Paul v. Virginia*
-Nothing in Sherman Act explicitly excepting insurance; also insurance clearly is a part of interstate commerce

This threw industry into chaos for several reasons

1. Old established network of state regulations was out of business
2. Big source of state tax revenue
3. Underwriters Association structure was demolished

-Industry was split on whether to use state or federal regulation
-Congress passed the McCarran Ferguson Act

-Supreme Court held:

1. McCarran Ferguson relieved applicability of statutes
2. Did not relieve applicability of Constitution

-Therefore, states could not have discriminatory tax on out of state insurers
-To unilaterally discriminate is not allowed, BUT retaliatory discrimination is allowed

1. Congress has authority to overrule any state insurance law if it “applies to business of insurance”
2. For statutes not “applying to business of insurance” it still applies, provided it doesn’t trump a state law relating to “business of insurance”

-Recent Supreme Court Case: *Forsyth* (1999)
-Fed gov’t brought RICO action with practice of health insurance
-Practice was outlawed by state but had stricter RICO penalties, so RICO could apply
-McCarran §1013(a) blocked application of Sherman until 6/30/48
§1013(b) Sherman act prohibits coercion/intimidation

**SUMMARY**

1. Feds can jump in at anytime
2. States still try to block fed regulation

-In addition to all state regulators, there is the National Assn of Insurance Commissioners (NAIC) → has no official authority
-NAIC has certification process to strengthen its role by inducing states to pass legislation that it likes

-State Regulations: relate to character, fitness, competency and financial resources of company seeking to insure.
-The minimum to enter the business = $5 million in assets → must be in approved assets
-Approved assets definition includes: fed/state/local securities, private securities, real estate/equity securities, computer equipment
-In addition, every year, every insurance company must file an annual report based on NAIC criteria
- Annual reports verified for solvency → check assets and liabilities; liabilities determined based on what is sold and what are expected losses
- With property/casualty insurance, much harder to determine solvency b/c of unknown claims (IBNR – Incurred but not reported)
- Also loss expenses, fees, lawyers, etc.
- After loss expenses and IBNR are estimated, a company must have a sufficient surplus to meet the standard

**State Insurance Commissioners**

- Appointed by governor in 30 states
- Elected in 20 states

In order to preserve/monitor solvency of insurance cos

1. Required to file annual reports
2. Reports are checked for problems; NAIC has established methods to examine for early warnings
- All insurers are periodically audited
- All must be at least every 5 years
- Troubled companies are audited much more often; what happens if audits turn up problems? If it looks like insurer is in danger of insolvency, regulators can take over the company
  1. **Conservatorship**: Insurer can send in a representative to monitor all company expenditures
  2. **Receivership**: All states allow instant ex parte receiverhsip of insurers by the state

**Bankruptcy is not allowed for insurers**

- Once in receivership, state insurance director decides whether to (1) Rehabilitate or (2) liquidate
- Guaranty funds are statewide: will only pay claims of MO residents/property and only up to $300K per claim
- $ for guaranty finds comes from other licensed insurers
- Contributed after company is found insolvent
- Assessment made against all eligible companies based on premiums written in the prior year
- Insurers get to take guaranty fund payments as a credit against premium tax

**Regulation of Rates**

- No rate regulation of life insurance rates b/c:
  1. Availability of mortality tables
  2. Ease of entry into life insurance market
- The one exception is “credit life insurance” to cover payment of mortgage-subject to abuse
- Property & Casualty are heavily regulated
- Historic rate regulations of fire insurance → inadequacy problems

**Rubric:** Rates should not be

1. Excessive
2. Inadequate
3. Unfairly discriminatory

1. Most regulatory problems re: inadequacy
   - Traditionally, rating bureaus made this determination
2. Insurers could change rates if they filed a request and received no notice for 30 days
Prior disapproval: can change until state stops you
File and Use → this is now the norm and prior approval is the exception
Mass, N.C. still require prior approval
N.J. has disapproval schedule
Still some rate regulations for auto industry, but property/casualty still unregulated
Main concern of insurance department is to protect solvency of company

State Rate case from North Carolina, p.110
Instructive only for showing the complicated steps an insurance department must take to determine reasonableness of rates

_Calfarm_, p.116 (Cal. 1989)
California Proposition 103
(1) Insurance Commissioner elected, not appointed
(2) 20% rollback in rates from first date of public attention, UNLESS insurer could show the lowered rate threatened insolvency
(3) After this, insurers could only raise their rates with prior approval from department of insurance
(4) Also requires minimum 20% good drivers discount
(5) Prevented cancellations without nonpayment of premium, fraud or increased risk of hazard
(6) Could not base rates on age/location etc. only personal info about driver
The proposition was challenged; Cal supreme court upheld except for rate freeze w/o insolvency provision
Insurers had a Constitutional right to get rates that gave them a fair return

Consumer Protection
Prior to Mc-F Act, insurers paid little attention to consumer protection
Mc-F also has a provision that rates cannot be unfairly discriminatory
Almost universal to have gender based rates, esp. in auto insurance
Men age 16-25 pay higher rates than women based on actuarial justification
This practice was challenged on Title 7 grounds
Equally immoral to discriminate based on gender as on race
PA Supreme court held gender based rates were unconstitutional → Then PA legislature amended the law to provide for gender based rates that were actuarially justified
What about when insurance rates are location based, but are higher in minority neighborhoods?
Another problem is availability
Issue of indirect versus direct → Indirect discrimination is still tolerated

Consumer protection is still a relatively new area for insurance commissioners
Began in 1950’s when FTC investigated, b/c of Mc-F blocking anti-trust regulation of insurance
Unfair trade acts were passed in all states
Then FTC investigates claim settlement
NAIC issued amendment to Fair Trade Practice Acts
Model Acts provide for enforcement only by insurance commissioners
In most states, there is no private right available for unfair claims/underwriting
Federal Government Activities

- Whenever problems arise in insurance industry, federal government amends McCarran Act to allow more federal regulations → States get excited and start to enforce more vigorously
- “Business of Insurance” is exempt from general laws to the extent they invalidate/supersede a state regulation

-Humana, p.135:
- Supreme Court held that a RICO action did not invalidate/impair/supersede state laws regulating insurance
- Read Mc-F in a way that there is still considerable scope of application of federal laws

-Pireno, p.135 (Supreme Court 1982)
- Distinguished between “business of insurance” and “business of insurance companies”
- Problem with chiropractors: they do a good job of giving short-term relief (1-2 days)
- This can go on and on
- Insurers are always concerned about abuse; some chiropractors submit outrageous bills
- Chiropractors had a peer review committee → insurer had an arrangement with review committee to submit questions re: reasonableness of bills
- Dr. Pireno has his own approach/fees; thought the traditional approach was wrong
- Claimed arrangement between peer review and insurer meant his charges would be reviewed by traditional chiropractors and rejected, thus driving him out of business
- Court found that the peer review is not within “business of insurance” and cited 3-Part test from Royal Drug:
  (1) Effect of transferring or spreading of risk
  (2) Part of policy relationship between insurer and insured
  (3) Limited to entities within the insurance industry
- Royal Drug held that variable life insurance was not the “business of insurance” because the first criteria failed

Federal Regulation of Insurance:
(1) Business of Insurance
(2) To the extent not regulated by state law
- Bernstein doesn’t like the 3-prong test for “business of insurance” → doesn’t apply to everything insurers do; the only way to read this is that if any one of the 3 criteria is satisfied, then it’s the business of insurance
- Some courts have required satisfying all 3 criteria
- Having decided that business of insurance relates to the 3 criteria, the next question is: what constitutes regulation by the states?
- Mere existence of a state regulation satisfied second prong of Mc-F test (unless it’s a sham)
- Low threshold for showing state regulation
- Antitrust action has been with overriding boycott, coercion or intimidation

-Barry, p.147 (1978)
- Customers of insurer brought lawsuit challenging insurer’s decision to only give a claims made policy AND and agreement between other insurers to not insure at all
- II: Agreement constituted boycott under Mc-F
- Δ: “Boycott, inteimidation, coercion” was inserted in McF to prohibit conduct in Southeastern case (ramrodding of Assn forms/rates and refusal to do business with non members) → the boycott exception was specifically designed to prohibit unfair competition among insurers
- Supreme Court Disagreed → held a competitive relationship was not required to trigger the boycott provision
- Not only an agreement to sell one type of insurance → also an absolute refusal by other insurers to sell any kind of insurance made this a boycott

- Large group of consumers/customers challenged 1986 revision of CGL policy
- Claim was that 4 major insurers got together and conspired to force ISO to come out with a CGL revision that met insurers’ criteria:
  1. Eliminate all occurrence policies and claims made would have retroactive limitations
  2. Have absolute provision on pollution, even for sudden and accidental
  3. With duty to defend, insurers wanted a provision that defense costs counted toward policy limit
- ISO compromised by allowing both occurrence and claims made policies
- II allegation was that insurers’ actions constituted a boycott
  1. Not business of insurance b/c their lobbying of ISO was supported by re-insurance companies
  2. Adding foreign re-insurers took it out of re-insurance classification
Holdings
  1. Supreme Court decided 5-4 that foreign re-insurers were in business of insurance → Mc-F does not apply
  2. Could not get agreement among majority/dissent; Souter wrote majority on business of insurance; Scalia wrote majority on boycott
Scalia
  1. Boycott usually involves multiple parties – cannot be unilateral – must be at least 2 people
  2. Can expand to related transactions
  3. Doesn’t necessarily entail unequal treatment
  4. Must be something more than concerted action
- Souter dissent on boycott → 4 primary insurers dragged re-insurers into the fray – the addition of re-insurers made it a boycott
- Scalia did not buy this argument → says the carryover to other transactions besides the contested issues → bringing in the collateral issues and refusing to do any business with ISO makes it a boycott → analogous to situation with Captain Boycott

Health Insurance Overview

- Not much need prior to WWII b/c of modest medical bills
Hospital stays were short, scope of care limited
Original health ins sold on an individual basis
1st big change in 1930’s w/ BCBS-intended to raise $$ for payment of med bills to protect docs/hospitals – structured as a charitable enterprise
-Notion of community rating: everyone who joined paid the same premium, regardless of age/health
-b/c of community ratings, BCBS established under state law w. very favorable tax provisions that allowed them to keep prices down
-During WWII, U.S. had wage/price freezes-there were limits on what ERs paid EEs –were allowed to provide EEs with health insurance as a fringe benefit to attract EEs
-Until 1960’s-1970’s, amount paid by ERs to provide coverage was very small, rec’d little attention
-This system created a tendency for overuse
-Some commercial insurers began providing group insurance on a “retro rated” basis –each group has its own price structure, i.e. if Wash U wants insurance, it goes to the insurer, gets estimated premium for 1st year, then for each year the premium is adjusted for prior year’s experience
-This is still dominant form of private sector health insurance; community ratings became less popular-group insurance become more dominant
-HMOs: basic philosophy limits doctors that can be used
-Managed care: docs compensated by # of people that agree to serve (capitation rates)
-Cheapest way for doctors to deal with large patient group is by keeping them healthy/avoiding sickness → lost money for overtreatment
-For a while, managed care was the answer to all of our problems

Problems with Managed Care
(1) Limited to doctors within the plan
(2) Lots of denials of coverage-people felt they weren’t receiving treatment they wanted
2 alternatives
(1) Fee for service arrangement → high rates
(2) Managed care arrangement → lower rates
-System cannot operate on arrangement that all medical treatment (i.e. cosmetic) is indemnified
-Must be some criteria for limiting coverage
-“Medically necessary” – must be something wrong with patient and treatment must have good potential to cure
-What is definition of “necessary”? Fertility treatment? Hearing Aid?
-What about experimental treatments (bone marrow for breast cancer)? Costly w/ poor track record
-Federal/state legislatures are now mandating coverage of certain treatments-policies are getting overloaded.