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CONNECTICUT INSURANCE LAW JOURNAL

VOLUME 19 2012-2013 NUMBER 1

CONTENTS

ARTICLES

LIABILITY FOR BAD FAITH
AND THE PRINCIPLE
WITHOUT A NAME (YET) *Kenneth S. Abraham* 1

BAD FAITH AT MIDDLE AGE:
COMMENTS ON “THE PRINCIPLE
WITHOUT A NAME (YET),”
INSURANCE LAW, CONTRACT LAW,
SPECIALNESS, DISTINCTIVENESS,
AND DIFFERENCE *Robert H. Jerry, II* 13

THE ECONOMICS OF INSURANCE
LAW—A PRIMER *Ronen Avraham* 29

STRANGER-INITIATED ANNUITY
TRANSACTIONS AND THE CASE
FOR INSURABLE INTEREST *Kendall J. Burr*
Thomas F.A. Hetherington
David T. McDowell 113

NOTES

SUPERVISORY COLLEGES:
IMPROVING INTERNATIONAL
SUPERVISORY COORDINATION *Kelly Kirby* 149

THE EVOLUTION OF THE
ADVERTISING INJURY
EXCLUSION IN THE INSURANCE
SERVICE OFFICE, INC.'S
COMPREHENSIVE GENERAL
LIABILITY INSURANCE POLICY
FORMS

Kyle Lambrecht

185

MEDICALLY UNNECESSARY:
HOW THE LAWS IN MEDICARE
PART D'S COVERAGE OF OFF-
LABEL MEDICINES WITH
DEMONSTRABLE MEDICAL
NECESSITY PREVENTS BETTER
HEALTHCARE OUTCOMES,
INCLUDING FOR BENEFICIARIES
WITH PSYCHIATRIC DISORDERS

Alexander W. Wing

209

LIABILITY FOR BAD FAITH AND THE PRINCIPLE WITHOUT A NAME (YET)

KENNETH S. ABRAHAM*

In this article, Kenneth Abraham examines the concept of liability for bad faith practices on the part of insurers. Abraham asserts that liability for bad faith is a concept that has existed for roughly half a century despite its inability, as of yet, to be recognized as part of the formal body of insurance law. Abraham details what has been, to some extent, a transmutation with respect to the bad faith claim handling practices of the insurance industry. What once could be dismissed as nothing more than the occasional isolated incident, or “screw up,” can now be characterized by incidences of systemic bad faith. Abraham provides four examples, each one highlighting some form of systemic bad faith practice undertaken by an insurer. Abraham closes with a discussion of the uniqueness of the insurer-consumer relationship and how that relationship creates obligations of fair dealing for insurers which simply do not exist for other private enterprises.

In 1994 the TEXAS LAW REVIEW devoted an entire Symposium issue to the developing law governing insurers’ liability for bad faith.¹ My contribution to that Symposium was called “The Natural History of the Insurer’s Liability for Bad Faith.”² The organizers of this Conference have asked me to revisit my piece, and to make some observations about the

*David and Mary Harrison Distinguished Professor of Law, University of Virginia School of Law. This Article is a slightly revised version of my presentation at “Bad Faith and Beyond: A Conference on the Law of Claims Practices,” held at Rutgers-Camden Law School on February 29, 2012.

¹Symposium, *Law of Bad Faith in Contract and Insurance*, 72 TEX. L. REV. 1203 (1994).

² Kenneth S. Abraham, *The Natural History of the Insurer's Liability for Bad Faith*, 72 TEX. L. REV. 1295 (1994). Robert H. Jerry, II, wrote a piece for that Symposium commenting on my Article, entitled *The Wrong Side of the Mountain: A Comment on Bad Faith's Unnatural History*, 72 TEX. L. REV. 1317 (1994). Dean Jerry has been generous in preparing a piece commenting on this Article as well. See Robert H. Jerry, II, *Bad Faith at Middle Age: Comments on Abraham, “Liability for Bad Faith and the Principle without a Name (Yet),”* 19 CONN. INS. L.J. 13 (2012).

development of liability for bad faith in the eighteen years since then.

I will do exactly that. But I also want to try to situate the developments in bad faith law over the past two decades within a larger context. I want to suggest that liability for bad faith reflects a broader principle. This is a principle that, as my title suggests, does not yet have a name, but that treats insurers as having obligations that are more demanding than those imposed on ordinary contracting parties, though not as demanding as those we impose on governments. An obligation to handle claims fairly is one of the obligations that flows from this principle, though it is not the only one.

In the modern state, insurance often falls in between these two poles of private contract and governmentally-provided entitlement. Insurance is brought into being by private contract, but our political system relies on insurance to promote economic well-being and to serve as a social safety net. In a series of separate doctrines and practices insurance law recognizes this, but it has not yet articulated a single principle that reflects what connects them.

I. THE RISE OF SYSTEMIC BAD FAITH CLAIMS

In my 1994 Article I argued that liability for bad faith had by then become a mature field. I suggested that, whereas the field had been much in the flux of early development during the preceding several decades, it was by then becoming stable. I cited a number of reasons for this conclusion, in addition of course to the fact that the field was at that point over thirty years old, and arguably older.³ Thirty or more years seemed to me to be about the amount of time it takes most sub-fields of law to reach at least the beginning of maturity.

In an Article published a decade later, Douglas Richmond chastised me in the opening sentence of his piece for what he took to be my implication that liability for bad-faith was not a severe threat for insurers.⁴ To that charge I would reply here that there is a difference between an unstable threat and a stable one. My point was that the field had matured from early instability to the point where it was now merely posing a stable threat to insurers. After all, insurers are in the business of dealing with stable problems. In fact, they sell protection against stable, predictable problems. So what I took to be increasing stability in the field of liability

³ See Abraham, *supra* note 2, at 1295-1308.

⁴ Douglas R. Richmond, *Bad Insurance Bad Faith Law*, 39 TORT TRIAL & INS. PRAC. L.J. 1, 1 (2003).

for bad faith seemed to me to be a salutary development for insurers.

To continue the metaphor, I would say that the field is now in middle age, and like many who are at that stage of development, unanticipated difficulties have arisen, some of one's own doing and some the fault of others. From the vantage point of 2012, the most striking feature of the field as it stood in 1994 was that it was almost entirely concerned with claims for what I would call "sporadic" or "isolated" bad faith. A single claim person or group of claim personnel had allegedly misbehaved. Sometimes it was alleged that this misbehavior had violated the standards of the insurer in question, and sometimes it was not. And it may well be that at trial the plaintiff made an effort to blame not only the individual claims personnel who had misbehaved, but also to blame their employer, the insurer. But the unstated premise that hung over the majority of bad faith claims in the years running up to 1994 was that these were isolated incidents; that they departed from what ordinarily occurred; and that they reflected a divergence between what the insurer as an entity intended to occur and what had actually occurred. In short, these cases involved, or were thought to involve, screwups.

There still are a lot of these cases. To draw an analogy to products liability, most of the reported cases involved allegations of what appeared to be something like "manufacturing defects." Long ago the law of torts decided that there should be liability for injuries caused by manufacturing defects—departures of an individual product unit from the manufacturer's intended design. Claims for sporadic bad-faith handling of a claim are analogous. It is true that in many instances manufacturers' design specifications are more precise and more detailed than an insurer's prescribed claims handling practices. But the logical structure of manufacturing defect suits and of sporadic bad-faith claims is parallel.

A new type of claim, however, has emerged in the last two decades. These claims have been based on what some observers have called institutional, or systemic, bad faith.⁵ These are more like design defect claims in products liability. They do not involve allegations that there was a single screwup in the handling of a particular claim. Rather, these are cases in which the insurer is alleged to have adopted a company-wide policy of handling claims in a manner that the plaintiff argued constituted bad-faith, even if there was only one actual plaintiff in the bad-

⁵ See, e.g., Douglas R. Richmond, *Defining and Confining Institutional Bad Faith in Insurance*, 46 TORT & INS. PRAC. L.J. 1 (2010); James A. Varner, Tiffany R. Drust & Debra T. Herron, *Institutional Bad Faith: The Darth Vader of Extra-Contractual Litigation*, 57 FED'N DEF. & CORP. COUNS. Q. 163 (2007).

faith suit.

II. FOUR EXAMPLES

I want now to give you four examples. Several, but not all, involve claims for bad-faith claims handling, and one does not involve claims handling at all. But each of them involve what might be called bad faith, and help to make the point that I will develop after I describe them.

In *State Farm v. Campbell*, the nation's largest auto insurer was alleged to have had a national scheme of taking cases to trial in order to meet the corporate fiscal goal of capping payouts on claims, nationwide.⁶ This scheme was referred to as State Farm's Performance, Planning and Review or "PP& R" policy. The suit alleged bad faith against a State Farm liability insurance policyholder after State Farm refused to settle a tort suit against him and the jury returned a verdict in excess of his policy limits.⁷ He sued State Farm, and the jury in his bad-faith case returned a verdict of \$2.6 million in compensatory damages and \$145 million in punitive damages.⁸ These verdicts were reduced, in part by a decision of the U.S. Supreme Court, but in the end they were still substantial.

Based on my conversations with them, I can say that the people at State Farm continue to deny that the company had the particular policy that was found to have led to the bad faith claims handling in that case. They have engaged in at least one retreat that I know of in which they brainstormed about how to ensure that the actions that took place in that case do not happen again. They think of what happened as a screwup, as a misapplication of company policy rather than as an application of policy. That will often be the insurer's perception in these institutional, or systemic bad-faith cases. But what makes these cases different from sporadic bad-faith cases is that the institutional bad-faith cases are not litigated only about whether an acceptable policy was misapplied in a particular claimant's case. They are litigated, at least in part, over the question whether there was a company-wide policy that was rotten to the core.

My second example comes from the first-party side and involves UNUM Provident, a disability insurer. UNUM apparently, or at least allegedly, had a policy of what can plausibly be called cheating in the handling of what it referred to as "subjective" disability claims.⁹ These are

⁶ *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 415 (2003).

⁷ *See id.* at 414.

⁸ *Id.* at 415.

⁹ For an account, see *Merrick v. Paul Revere Life Ins. Co.*, 594 F. Supp. 2d

claims based on mental or emotional disorders whose existence cannot be proved by concrete medical evidence. Basically, UNUM allegedly decided not to pay these claims but instead to require insureds to provide objective medical evidence that they had a disability, which they ordinarily could not do. UNUM set targets for resolving these claims based on its own profit goals and regardless of the merits of the claims themselves. They allegedly did this, among other things, by setting claim closure targets that were endorsed by high level management and the Board of the company.

A third example hasn't resulted in any damages claims that I know of, although there may have been a few. This is the contingent commission controversy of 2003 and 2004. As you will recall, certain insurers, AIG among them, were revealed to have been secretly paying brokers commissions that were contingent on the subsequent claim and loss experience of the brokers' clients – the policyholders to which the insurers issued policies. There is now a literature addressing whether contingent commissions should or should not be permitted, but no one that I know of has argued that it was okay to keep them secret.¹⁰ The issue is whether an obligation on the part of brokers to disclose the existence of a contingent commission arrangement is sufficient, or whether, instead, such commissions ought to be prohibited outright, at least for the consumer segment of the market, or for all applicants, whether consumer or commercial.

This is not an example of bad-faith claims handling. But it is an example of a practice that at least arguably was in bad faith. It was a secret deal between the broker and the insurer to whom the broker was steering applicants for insurance. I have cited this example, not because I necessarily want to argue that there should be a cause of action of some sort against either the broker or the insurer for damages caused by the wrong, but to suggest that there is a broader principle underlying bad-faith claims than may appear. Liability for bad-faith claims handling is about more than bad-faith claims handling. But first, on to my fourth example.

In the early 1990s, Allstate Insurance Company became concerned about its profit levels. It hired McKinsey & Co., and (to oversimplify a bit) these consulting geniuses had the deep insight that Allstate could increase its profits if it paid less for claims. McKinsey recommended the redesign of

1168 (D. Nev. 2008).

¹⁰ See, e.g., J. David Cummins & Neil A. Doherty, *The Economics of Insurance Intermediaries*, 73 J. RISK & INS. 359 (2006); Daniel Schwarcz, *Differential Compensation and the "Race to the Bottom" in Consumer Insurance Markets*, 15 CONN. INS. L.J. 723 (2009).

a number of different claim processes. Jay Feinman described this whole process and the different redesigns very effectively in his book, *DELAY, DENY, DEFEND*.¹¹ One of the claim process redesigns, with the acronym “MIST,” standing for “minor impact soft tissue”¹² – mostly whiplash – had as its purpose cutting down on payments for this kind of claim, and taking cases to trial if a satisfactory settlement could not be negotiated. This policy applied to both Allstate’s own policyholders making Uninsured Motorists claims, and to third-party suits against Allstate’s own liability insurance policyholders. Some of the guidelines for claim valuation were computerized and some claims personnel allegedly adhered slavishly to what the computer told them to do.

Now there is nothing necessarily wrong with using computer programs to guide claim valuation, and nothing wrong with trying to cut back on claim payments if they are too high. It certainly is unwise, and it might even be bad faith, to rely only on what a computer tells you a claim is worth. But that was not what was fundamentally wrong with what Allstate is alleged to have done. If you have an acceptable metric for deciding whether you are currently paying too much for a given category of claims, then that metric might appropriately be used to guide claim valuation. I’m not sure what an acceptable metric would be, since it is not as if there is some objective, freestanding value to a tort claim. But let’s suppose hypothetically that in principle there could be such a metric. For example, if Allstate could have gotten the data, the average of what GEICO and Nationwide paid for these claims in analogous cases *might* have been an appropriate metric for Allstate.

But that’s not what Allstate allegedly did. It didn’t use some acceptable metric for valuing claims. Its metric allegedly was how much less it needed to pay in order to make its desired profit. An insurer can certainly set premium rates on this basis. It can decide how much to charge you for coverage based in part on how much it needs to charge in order to make an acceptable profit. Once you have paid for coverage, however, you’re entitled to have the Uninsured Motorist claims you make, and lawsuits that are brought against you, settled based on some kind of principle other than how much profit your insurer wants to make.

Now I’m well aware that many of the victims of this practice by Allstate were not its own policyholders, but people who brought suit against Allstate’s policyholders. And we know that the question whether a

¹¹ JAY M. FEINMAN, *DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON’T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT* 56-103 (2010).

¹² *Id.* at 31.

liability insurer is liable for bad faith to a party who brings suit against the insurer's policyholder is largely settled. This is what is sometimes referred to as the *Royal Globe* problem, after the 1979 California case holding that there is such a duty.¹³ But the *Royal Globe* rule is dead, and with the exception of a very few isolated cases, that is not the law. It might be that conduct like Allstate's violates a state's Unfair Claim Practices Act and warrants a regulatory fine, but it would be a stretch to imagine that there could be a cause of action by a non-policyholder against Allstate for damages resulting from its practices.

III. A BROADER PRINCIPLE?

Those are my four examples. Now let's take stock. All involve institutional, or systemic bad faith. One case – *State Farm v. Campbell*, is a third-party bad-faith case in which the conventional bad faith remedy was available. A second, UNUM Provident, was a set of first-party bad faith cases in which the conventional bad-faith remedy was available. A third, the contingent commission controversy, did not directly involve claims at all, and while the conduct in question might generate civil liability, it is more likely to be restitutionary liability than the kind of liability for extracontractual damages that is threatening enough to deter misconduct. An insurer or a broker won't be deterred from capturing an undeserved gain through a contingent commission if the only remedy for doing so is that it has to refund the commission or pay it to the policyholder. So fines were necessary in that situation. My last example did involve misbehavior in the claims process, by Allstate, but many of the victims were third parties who did not have a cause of action for any damages they may have suffered as a result of the misbehavior.

What links these examples together, I think, is not merely that each involved something that we would be willing to describe as "bad faith." There are two additional links. First, the bad-faith behavior in all these examples involved, or allegedly involved, something systematic or institutional rather than being an isolated screwup. And second, the bad-faith behavior in each instance is something that we probably would tolerate, and have the common law tolerate, if it were a different sort of business enterprise that engaged in this behavior. If a building contractor adopted a systematic policy of charging for every minor change from an architect's working drawings, because it had decided that its profits were insufficient, we would not consider this an occasion for legal intervention.

¹³ *Royal Globe Ins. Co. v. Superior Court*, 592 P.2d 329 (Cal. 1979).

If an auto parts retailer had a secret deal with some manufacturers that it would be paid an annual rebate that increased if products liability suits against the manufacturer decreased, we would consider this no business of those who purchased the auto parts in question, even if this affected which customers were influenced to buy which kinds of parts. These would be examples of harsh, slightly unsavory dealing, but that's about it.

On the other hand, suppose that the government engaged in these kinds of behaviors. Then we would probably consider them to be constitutional violations. Suppose the government decided to adopt a more stringent test for disability under the Social Security Act, not because it had been misapplying the statute, but because it concluded that it was paying too much out in benefits. That would almost certainly violate beneficiaries' right to due process of law. Or suppose that the U.S. Army secretly paid its own recruiters higher bonuses for recruits who signed up for the Corps of Engineers rather than for Artillery training, because the costs of providing medical care for the former were lower than for the latter. We would think that the due process rights of the recruits had been violated, because they had a right to know whether they were being steered to the Corps of Engineers by the recruiters' financial interest in the particular enlistment choice they made.

If some of you disagree with my admittedly shallow constitutional analysis, I hope that at least you agree that we would find the government's actions in these hypotheticals far more blameworthy than the analogous behavior in the hypotheticals involving private enterprise. We expect far less of most private enterprises in the way of fair dealing and fair process than we expect of government. Customers deal with private enterprises in arms-length transactions where self-interest is expected to be operative. People deal with government as constituents or citizens where government is expected to be concerned with the welfare and fair treatment of those whom its actions and decisions affect.

By now it should be obvious where I am headed. Insurance companies do not fit into either of the categories we have for determining how much fairness we expect from an enterprise or institution. We expect more of insurers than we expect of ordinary private enterprises, though we may not expect as much of insurers as we expect of government. That is what links the four different examples of bad faith that I offered earlier, even though some are governed by the law of bad faith and some are not. In each instance our sense of what makes an insurer's behavior wrongful turns in part on the core nature of insurance and insurance companies. Insurers owe, or ought to owe those with whom they deal, a higher obligation of fair dealing than ordinary private enterprises typically owe

those with whom they deal. As critical legal theory taught us decades ago, the public-private distinction tends to break down in such instances.¹⁴

This notion is already reflected, though somewhat selectively and only partly expressly, at various places in the law governing insurance. First and foremost, of course, the law of bad faith is a reflection of the notion that insurers owe their policyholders higher duties than ordinary contracting parties owe their customers. There is also the occasional judicial assertion, which typically doesn't go very far or is rejected on appeal, that insurers are fiduciaries or quasi-fiduciaries. And of course there is the very practice of administrative regulation of the terms of insurance policies. In my view the justification for insurance regulation must not only be the typical one that is given for economic regulation – market failure or market imperfections. In addition, I think that we regulate insurance, and that there is support for regulation, so that regulators will have the opportunity to ensure that the requisite level of fair dealing occurs, whether or not it would be provided by a perfectly operating market.

For example, we place limits on the characteristics that insurers can use in creating premium classifications,¹⁵ and to me that looks for all the world like a version of equal protection's prohibition of legislation that employs suspect categories. In fact, that kind of insurance regulation actually goes farther than constitutional equal protection would require. Similarly, in at least a few cases, the courts may be on the lookout for coverage defenses that insurers assert as subterfuges, when the insurers cannot prove their actual basis for denying the claim. For example, defenses based on exclusions or conditions that obviously do not apply, but which the insurers assert anyway when they suspect but cannot prove fraud in the application for coverage or deliberate wrongdoing such as arson.¹⁶

¹⁴ See, e.g., Duncan Kennedy, *The Stages of the Decline of the Public/Private Distinction*, 130 U. PA. L. REV. 1349 (1982).

¹⁵ See KENNETH S. ABRAHAM, *INSURANCE LAW & REGULATION* 144-56 (5th ed. 2010).

¹⁶ That may well be what happened in *Heller v. Equitable Life Assurance Society of U.S.*, 833 F.2d 1253 (7th Cir. 1987), where a disability insurance policy covered lost income resulting from the “complete inability of the Insured, because of injury or sickness, to engage in the Insured’s regular occupation.” *Id.* at 1255. The policyholder was a cardiologist who specialized in invasive procedures and contracted carpal tunnel syndrome, a condition affecting the dexterity of his hand and fingers, nine months after he purchased the policy. *Id.* The insurer denied coverage on the ground that, because the insured refused to consent to have surgery for the condition, he had violated the policy requirement that he be under the “regular” care of a physician. *Id.* at 1257. But it might just as easily have

This looks to me to be an awful lot like a common law version of a due process requirement.

If I am correct, then the law governing liability for bad-faith handling of insurance claims is not an isolated exception to the law of insurance contracts, but just one manifestation of a broader and deeper principle that runs through this entire body of law: the notion, partly embodied in legal doctrine, partly in administrative regulation, and partly in a more general legal ethos, that more in the way of regularized and consistent treatment of applicants and insureds, and more in the way of fair process, can be expected of insurers than we have a right to expect of most other private enterprises.

Admittedly, this is only an underlying principle or value, what I have elsewhere called a “regulative ideal.”¹⁷ There is not a body of legal doctrine that systematically reflects the principle. Indeed, I would have to say that at present the principle is only selectively reflected in legal doctrine. For example, we don’t have a body of legal doctrine that protects all those who were disadvantaged by Allstate’s conduct, and administrative regulation doesn’t completely fill the gap either. Some might say that I am therefore misidentifying a principle, or seeing a principle where it doesn’t exist. Fair enough. I am not trying to close debate about this, but to open up debate by offering a conceptual insight to be tested against our intuitions and against the law as it stands. If I am capturing our intuitions correctly but I am not accurately describing the law as it stands, then we can either adjust our intuitions or we can consider changing the law.

Moreover, I have been painting with a very broad brush. It seems pretty clear that we should expect the law governing the two forms of insurance that are most essential to individual well-being, health insurance and consumer auto insurance, to more systematically reflect the principle than the law governing other, less essential forms of insurance. There is also room for distinguishing generally between consumer and commercial insurance. Sizable corporate policyholders’ dealings with their insurers are in many respects identical to their dealings with other private enterprises, and do not need as much legal regulation of the sort that I have been

denied coverage on the ground that the insured was still able to “engage” in his “regular occupation”. The insurer’s stated basis for denying coverage was so likely to fail that the alternative of suspected fraud is a far more plausible explanation for the insurer’s fighting the claim all the way to its unsuccessful appeal to the Seventh Circuit.

¹⁷ Kenneth S. Abraham, *The Expectations Principle as a Regulative Ideal*, 5 CONN. INS. L.J. 59, 63 (1998).

describing. If insurance law could manage, predictably and inexpensively, to distinguish between individuals and small businesses, on the one hand, and large enterprises, on the other hand, that might make sense. But that's an issue for another day.

IV. CONCLUSION

To sum up, I think that we should more frequently be thinking about insurers as distinctive enterprises with a set of obligations that are neither those of private parties nor those of government. Some scholars have called this conception, or something like this, “insurance as governance.”¹⁸ That is not right, however, among other reasons because it implies an element of democratic or participatory control – as in labor unions or homeowners associations – that is not present in insurance and that we probably don't want to be present in insurance. I'm not talking about turning stock insurance companies into mutuals. Nor am I talking about the coercive power of insurers, their capacity to “govern” the behavior of their policyholders. I am not talking about negative rights against insurers, but positive rights. Not freedom from something, but freedom for something. And also I don't think that conceiving of insurance as a product gets us very far on this score, though it may be a useful construct for some purposes.¹⁹ The fair process that we expect from insurers we don't expect and should not expect from the makers of chain saws.

The character of the principle I discern in insurance law is one of obligation resting on the nature and contemporary importance of insurance, not resting on the consent and trust that are part of governance. Few individuals trust their insurers or consent to anything meaningful in connection with their purchase of insurance. What might we call the obligations reflected in this principle? *Quasi-constitutional*? *Good faith*? *Fair treatment*? I don't think that any of these names fit, but I don't have a better one. Maybe we should have a naming contest. In any event, I do know this: although the principle may not have a name yet, the principle is lurking in our law, and recognition of the principle's existence will enhance

¹⁸ See, e.g., RICHARD V. ERICSON, AARON DOYLE, & DEAN BARRY, *INSURANCE AS GOVERNANCE* (2003).

¹⁹ See Daniel B. Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389 (2007); Jeffery W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813 (2009).

our understanding of what insurance law is, and what insurance does.

**BAD FAITH AT MIDDLE AGE: COMMENTS ON “THE
PRINCIPLE WITHOUT A NAME (YET),” INSURANCE LAW,
CONTRACT LAW, SPECIALNESS, DISTINCTIVENESS, AND
DIFFERENCE**

ROBERT H. JERRY, II*

In this article, Robert Jerry expounds on Professor Abraham’s article on insurer liability for bad faith by pointing out that the concept of institutional bad faith is not a new phenomenon, but rather, one that is as old as the insurance industry itself. Jerry focuses on Abraham’s depiction of the “specialness” and “distinctiveness” of insurance, while exploring additional instances of “rotten to the core” systemic bad faith dating as far back as the nineteenth-century. Much like Abraham did in his article on bad faith, Jerry uses these examples of systemic bad faith to further his assertion that the insurance industry, due to its “specialness,” is held to higher standards of care than other realms of “ordinary business.”

In “Liability for Bad Faith and The Principle Without a Name (Yet),” Professor Kenneth Abraham discerns an original and compelling way to express one of the core insights upon which much of the modern law of insurance is built: that insurance has special characteristics not found in the other things, services, information, etc. which individuals and institutions value and acquire, and that the law governing insurance transactions is itself special, distinctive, and different.¹ Through the decades, this insight has been expressed, if not always entirely accurately, in a number of different ways: insurance is a special kind of chattel or

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¹ See Kenneth S. Abraham, *Liability for Bad Faith and the Principle without a Name (Yet)*, 19 CONN. INS. L.J. 1 (2012).

quasi-chattel;² insurance, as an aleatory contract instead of a commutative contract, involves an uneven exchange of values that leads to the “peculiar legal aspects” of the contract;³ the relationship between insurer and insured is fiduciary, or quasi-fiduciary, in nature;⁴ an insurance contract is more than an “ordinary contract” and insurance law is more than “ordinary contract law”;⁵ insurance contracts are imbued with heightened obligations of good faith and fair dealing;⁶ in insurance contracts the duty of good faith is a “one way street,” unlike general contracts where the duty runs both directions;⁷ and so on.

² 7 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 900, at 34 (3d ed. Jaeger 1963). See *Estrin Constr. Co. v. Aetna Cas. & Sur. Co.*, 612 S.W.2d 413, 424 n.10 (Mo. Ct. App. 1981) (describing “equally valid” analysis that treats insurance policy as “in the nature of a special chattel rather than a contract”). Imagining insurance as a chattel leads to the argument that insurance policies contain an implied warranty of fitness for an intended purpose, but implied warranty analysis has not gained traction in the insurance cases.

³ EDWIN M. PATTERSON, ESSENTIALS OF INSURANCE LAW 62 (2d ed. 1957).

⁴ See *PolSELLI v. Nationwide Mut. Fire Ins. Co.*, 126 F.3d 524, 531 (3d Cir. 1997) (insurer’s duty of good faith toward insured is predicated on fiduciary relationship created when the contract is formed); *Rawlings v. Apodaca*, 726 P.2d 565, 571 (Ariz. 1986) (relationship between insurer and insured is not fiduciary relationship, but has some elements of a fiduciary relationship). Cf. *Lyerla v. AMCO Ins. Co.*, 536 F.3d 684, 694 (7th Cir. 2008) (applying Illinois law, no fiduciary relationship exists between insurers and insureds). For more discussion, see Douglas R. Richmond, *Trust Me: Insurers Are Not Fiduciaries to Their Insureds*, 88 KY. L.J. 1 (2000).

⁵ See, e.g., *Victor v. Turner*, 496 N.Y.S.2d 761, 764 (N.Y. App. Div. 1985) (“[I]nsurance industry transactions with consumers are not governed by ordinary contract law.”); Jay M. Feinman, *Relational Contract Theory in Context*, 94 NW. U. L. REV. 737, 744 (2000) (“Insurance is a contractual relationship, but courts and legislatures have developed a body of insurance law that is distinct from the mainstream of contract.”); Dudi Schwartz, *Interpretation and Disclosure in Insurance Contracts*, 21 LOY. CONSUMER L. REV. 105, 113 (“[I]nsurance law’s rules, including interpretive rules, were designed to distinguish the insurance industry from other fields of contract law.”) (citation omitted).

⁶ See, e.g., *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246, 251-52 (Cal. Ct. App. 1990) (“[B]ecause of the ‘special relationship’ inherent in the unique nature of an insurance contract, the insurer’s obligations attendant to its duty of good faith are heightened.”); *Nugent v. Unum Life Ins. Co. of Am.*, 752 F. Supp. 2d 46, 56 (D.D.C. 2010) (insurance contracts have special characteristics that “warrant heightened liability” for breach of the duty of good faith) (citation omitted).

⁷ See, e.g., *Johnson v. Farm Bureau Mut. Ins. Co.*, 533 N.W. 2d 203 (Iowa 1995) (Iowa does not recognize tort action for “reverse” bad faith by insurer

The common theme running through the foregoing expressions emerges from the unique characteristics of insurance itself. All contracts involve transfers of risk in some way, typically at the margin of some other sale or exchange, but what distinguishes insurance contracts is the fact that they exist for the *purpose* of transferring risk. Courts have sought to capture this idea, usually when deciding the boundaries of state regulatory authority over transactions that have the look and feel of insurance but may be something else, in the principle that to constitute an insurance contract, the transfer and distribution of risk must be the “principal object and purpose” of the contract,⁸ the very essence of the exchange that gives the contract its “distinctive character.”⁹ Because the party casting off risk through an insurance contract has such an extreme amount of reliance on the presumed enforceability of the contract and puts so much financial and emotional well-being at stake in the transaction, all in circumstances where the insurer knows from the beginning of the magnitude and importance of this investment (indeed, the insurer markets the product through assurances of security to the insureds), the protections afforded by law to this party must be safeguarded with utmost rigor. Through the years, these ideas have presented themselves in insurance law through pro-insured results and outcomes that would ordinarily not be predicted if the laws of contract, tort, agency, equity, or remedies were applied in their expected ways.

Working in ground well plowed by others for decades, Professor Abraham finds a new and creative way to describe insurance law’s “specialness.” He invites us to visualize placing insurance law on a continuum: insurance law puts obligations on insurers that are more rigorous than what are placed on ordinary contracting parties, but less rigorous than the principles under which we test the actions of governments and state actors. The lens that Professor Abraham uses to capture this insight is systemic or institutional bad faith.

The law of bad faith is the thread in insurance law where insurers can be held liable in tort for bad faith performance of the contractual duties they owe insureds; “[t]he tort duty contemplates that insurers must deal fairly with insureds and conduct their affairs in good faith.”¹⁰ As Professor

against insured who brings frivolous bad faith claim against insurer); Douglas R. Richmond, *The Two-Way Street of Insurance Good Faith: Under Construction, But Not Yet Open*, 28 LOY. U. CHI. L.J. 95 (1996).

⁸ See *Jordan v. Group Health Ass’n*, 107 F.2d 239 (D.C. Cir. 1939).

⁹ See *GAF Corp. v. Cnty. School Bd.*, 629 F.2d 981 (4th Cir. 1980).

¹⁰ ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 156 (5th ed. 2012).

Abraham explains, systemic, institutional bad faith is the most recent evolution in this thread. The cases in which the law of bad faith was routinely applied after the doctrine's emergence and development in the 1970s and 1980s typically involved an individual insured's claim that the insurer in the specific claims processing sequence in which the insured and insurer were involved committed breaches in claims handling that caused damage to the insured, and this damage can be remedied adequately only under the remedial regime of tort law.

In contrast, the institutional or systemic bad faith claim involves a situation where an insured takes a dispute over a single loss and challenges the insurer's practices and procedures as those occurred in claims processing for all similarly situated claimants, essentially arguing that the insurer's practices were designed to reduce, or perhaps even eliminate, fair payments to all claimants.¹¹ Thus, the notion is that institutional bad faith is a new kind of bad faith claim that has emerged in the past couple of decades, and policing these questioned systemic practices under the law of bad faith represents an expansion of the territory in which bad faith law operates.¹²

Although the bad faith cases of recent years in which plaintiffs allege systemic or institutional insurer bad faith conduct are departures from the circumstances in which bad faith was alleged in the past, this does not mean that claims against insurers for institutional, systemic misconduct are new. Professor Abraham refers to these alleged systemic practices as ones that are "rotten to the core";¹³ I would suggest that allegations of

¹¹ See Douglas R. Richmond, *Defining and Confining Institutional Bad Faith in Insurance*, 46 TORT TRIAL & INS. PRAC. L.J. 1, 1 (2010) ("Essentially, the theory of institutional bad faith allows a plaintiff to expand a dispute over a single loss into a widespread attack on an insurance company's practices and procedures"; citing MICHAEL R. NELSON ET AL., EXTRA-CONTRACTUAL LITIGATION AGAINST INSURERS § 2.11, at 2-59 (2009)); James A. Varner, Tiffany R. Drust & Debra T. Herron, *Institutional Bad Faith: The Darth Vader of Extra-Contractual Litigation*, 57 FED'N DEF. & CORP. COUNS. Q. 163, 163 (2007) ("Institutional bad faith is the 'Ebola' virus of extra contractual litigation [I]t can . . . grow explosively and wreck not only litigation management budgets, but can also seriously deplete corporate equity and shareholder value.").

¹² Richmond observes that "[t]here is a surprising lack of case law on institutional bad faith given the frequency with which such allegations are made. This disparity is probably attributable to the fact that carriers settle many institutional bad faith cases to avoid discovery costs and potentially severe damage exposure." Richmond, *supra* note 11, at 4 n.8.

¹³ See Abraham, *supra* note 1, at 12.

systemic, “rotten to the core” insurer practices have been made for decades, with the major and important difference between those older allegations and the more modern ones is that the earlier claims did not have a law of bad faith in which the allegations could be packaged and presented. If these practices existed today and were being challenged today, they would be packaged in the same wrapping in which the modern systemic, institutional bad faith claims are alleged.

If the amount of litigation and commentary in the literature in the early twentieth century are reliable guides, one of the prominent early examples of systemic, institutional bad faith conduct by insurers involved insurers’ delay in action on applications. Like today, insurers took the first premium payment with the application, but did not issue the policy until a period of time passed during which the insurer evaluated whether to accept the risk. During this period the insurer would have use of the insured’s money, but, in the absence of a binder providing temporary coverage, the applicant had no protection. Even with a temporary written binding receipt, the coverage was often so conditional that the applicant who suffered a loss during the period the binder was in force received no compensation. Many binders by their terms purported to eliminate coverage if the application would be unacceptable to the insurer’s underwriting department. The frequency of *ex poste* determinations of ineligibility was itself a matter of concern for insureds, and the longer the insurer could delay acting on applications, the less exposure the insurer would have on the risk. Yet if no loss occurred during the period between application and policy issuance, the policy’s coverage upon issuance would be backdated to the time of the application, so the insurer engaged in this practice essentially received a payment for nothing. Delaying action on the application lengthened the period during which this imbalance existed. Like a number of other insurer practices that caught the attention of the public, legislators, regulators, and the Armstrong Commission, this practice was one of those that was “rotten to the core,” and it was one that, apparently, was institutional and systemic.

Courts confronting this practice in the early twentieth century had considerable trouble regulating insurers’ delay in acting on applications because the legal doctrines of that time were inapplicable.¹⁴ Unless a temporary binder was issued, there was no contract between applicant and insurer to which contract law principles could be applied; furthermore,

¹⁴ For examples of cases declining to hold the insurer liable for delay in acting on an application, see *Savage v. Prudential Life Ins. Co. of Am.*, 121 So. 487, 489 (Miss. 1929) (fact that insurer is granted franchise to do business in the state does not impose upon them a duty to consider promptly all who apply).

there was no basis for finding that the insurer had taken action that would create a contractual obligation. The applicant made the offer to form the contract with the application; if the application was not accepted, no contract was formed. Courts correctly described the insurer's inaction on the application as "silence," but under the rules of contract law, silence did not constitute acceptance absent special circumstances,¹⁵ none of which existed in the typical fact pattern. Construing the insurer's retention of the premium as a promise to be bound was not a plausible interpretation of the usual circumstances. Estoppel, as it was understood both then and now under the label "equitable estoppel," did not fit because there was no false or misleading statement inducing reliance.¹⁶ Promissory estoppel as a basis for recognizing the existence of a contract was a doctrine in its infancy; yet the insurer made no promise that might induce detrimental reliance, which was essential from the beginning of the doctrine's history to finding an enforceable promise in the absence of offer, acceptance, and a consideration that was the object of a bargained-for exchange.¹⁷

As we now know, many courts attempted to regulate the insurer misbehavior, and these courts, looking for ways to extend the established doctrines of that era, approved the principle of imposed responsibility grounded in the recognition of a duty to act.¹⁸ The circularity of this

¹⁵ See RESTATEMENT (SECOND) OF CONTRACTS § 69 cmt. a (1981) ("Acceptance by silence is exceptional. Ordinarily offeror does not have power to cause the silence of the offeree to operate as acceptance. . . . The exceptional cases where silence can be acceptance . . . [are] those where the offeree silently takes offered benefits, and those where one party relies on the other party's manifestation of intention that silence may operate as acceptance.").

¹⁶ The elements of equitable estoppel are generally described as: (1) belief and reliance on a representation; (2) a change of position because of the representation; (3) detriment or prejudice caused by the change of position. See, e.g., *Cothorn v. Vickers, Inc.*, 759 So.2d 1241, 1249 (Miss. 2000) (discussing elements in context of former supervisor's action against employer); *Lybbert v. Grant Cnty.*, 1 P.3d 1124, 1128 (Wash. 2000) (discussing elements of equitable estoppel in context of county's effort to assert insufficient service of process as affirmative defense).

¹⁷ See RESTATEMENT (SECOND) OF CONTRACTS § 90 (1981) (elements of promissory estoppel are a promise and substantial reliance that is actual and reasonably foreseeable, in circumstances where enforcing the promise is necessary in the interests of justice).

¹⁸ See, e.g., *Boyer v. State Farmers' Mut. Hail Ins. Co.*, 121 P. 329, 331 (Kan. 1912) (hail insurance policy that issued policy day after crop was destroyed by hailstorm is liable in damages due to unreasonable delay by its soliciting agent in forwarding the application); *Wilken v. Capital Fire Ins. Co. of Lincoln*, 157 N.W. 1021, 1022-23 (Neb. 1916) (bank's delay in returning application was act of agent

reasoning begs the question of exactly where this duty came from. Some courts found it in the idea that a company doing business under a franchise assumes a duty toward the public,¹⁹ but why this would be so is not obvious. Presumably the intended logic underlying this conclusion is that the protection afforded the franchise through its enforcement by the state created a reciprocal obligation – essentially, a *quid pro quo* – on the part of the franchise holder to serve the state, i.e., the public, with prompt action on the public’s requests, applications, etc. Failure to do so breached the duty, and damages caused by the breach could be remedied in tort.

This reasoning sounded plausible and authoritative, and, expressed as a rationale for a decision, seemed to have its anchor in other more familiar legal principles with which we are comfortable. But as frequently illustrated during the centuries in which the common law has evolved, new reasoning when applied to other similar situations can cause extreme havoc. For example, if the existence of the insurance franchise is what establishes the duty, the duty to act must presumably exist in the business activities of other kinds of corporations and business organizations operating under franchises. An obvious example is a bank; thus, does it follow that a bank which receives an application for a loan and delays acting upon it breaches the duty to act and thereby commits a tort?²⁰

Of course, if we sense that this goes too far and that a bank should not be liable for delay in acting on an application for a loan, we are challenged to explain why a franchise to engage in the insurance business imposes a more robust duty to act without delay. Taking up the challenge, we would argue that “ordinary business” is not the same as the insurance business. Banks and other lenders acting on applications for loans are engaged in “ordinary business,” like those who sell products, services, licenses, information, and so forth. These products, services, etc. are not the

of insurer, and insurer is responsible for damage caused by delay in acting on application); *Behnke v. Standard Acc. Ins. Co.*, 41 F.2d 696, 699 (7th Cir. 1930) (under Wisconsin law, insurance company may be liable for delay in passing upon application).

¹⁹ See *Duffy v. Bankers’ Life Ass’n*, 139 N.W. 1087, 1090 (Iowa 1913) (insurance company “holds and is acting under a franchise from the state”).

²⁰ See, e.g., *Mfrs. Hanover Trust Co. v. Yanakas*, 7 F.3d 310, 315 (2d Cir. 1993) (affirming district court’s finding that “the Bank had no fiduciary duty to accept or respond promptly”); *Armstrong Bus. Servs., Inc. v. AmSouth Bank*, 817 So. 2d 665, 681 (Ala. 2001) (““There is . . . no tort liability for nonfeasance for failing to do what one has promised to do in the absence of a duty to act apart from the promise made.” (quoting *Morgan v. S. Cent. Bell Tel. Co.*, 466 So. 2d 107, 114 (Ala. 1985))).

same as insurance -- which is special, distinctive, and different. Because insurance is special, the duties that attach to the corporation or business organization engaging in the insurance business are greater. If the principle we use to justify finding a duty to act would also make those engaged in “ordinary business” liable, then we must be applying the wrong principle to the problem arising in the “ordinary business.” Insurance is special; it is distinctive; it is different. The insurance business is imbued with the public interest in a way that “ordinary business,” such as the business of banks making loans) is not.

Interestingly, the framework just described is exactly where the law is landing in the early twenty-first century. On the issue of whether lenders ought to have liability in tort for negligent delay in processing an application for a loan, it is easy to see that an applicant for a loan could be harmed with the loss of favorable financing terms due to the passage of time during which the lender delays. Yet the consensus, at least thus far, from cases that date back to shortly after the explosion in insurance bad faith litigation, is that recognizing tort liability for lenders in the financial industries is problematic, and, except for rare exceptions that have not garnered a strong following,²¹ courts have not embraced the idea.²² It appears that the insurance business is special, but the lending business is not, and the more rigorous analysis applied to insurance industry practices by insurance law is not something that is or will be applied in similar fashion in the lending industry.

Thus, perhaps the decisive reason for recognizing an insurer’s tort duty to act promptly on an application for insurance is not the existence of the franchise but is instead the existence of a relationship imbued with the public interest. To what other analogous situations might this principle apply? Consider markets for employment: it is certainly in the public interest that those who are able to work have jobs that enable them to earn salaries or wages sufficient to support themselves and their dependents. But are we willing to use public interest analysis to create a rule that employers, many of whom obviously do not operate under franchises, are obligated to act promptly on applications for employment? The answer is, apparently, no. So here, as with lending, we conclude that employment, notwithstanding its obvious importance, is “ordinary business” -- or it is

²¹ See *Jacques v. First Nat. Bank of Md.*, 515 A.2d 756, 762 (1986) (bank that agrees to process application for loan owes customer duty of reasonable care in processing and determination of the application).

²² See Nan S. Ellis & John A. Gray, *Lender Liability for Negligently Processing Loan Applications*, 92 DICK. L. REV. 363, 366-68 (1988).

not “business” at all under some kind of conclusory rule that “employment is labor, and business is business.” As we keep delay in acting upon applications for employment out of the realm where courts will provide a remedy, we embrace the idea that insurance is somehow special, distinctive, different, and in need of a different legal framework than what applies to other “ordinary” business practices in other markets, notwithstanding the obvious importance of the transactions that occur in those other markets.

The foregoing, of course, is exactly Professor Abraham’s point. Upon a close look, the decades-old recognition of the insurer’s tort duty to act promptly on applications comes from the legal system’s negative reaction to institutional, systemic, rotten-to-the-core bad faith practices that compromise the value of seeking and securing insurance protection. In other words, insurers have a responsibility to act promptly on applications; this obligation is embedded in the nature of the insurance business, where security from the risks of loss is the subject of the bargain; damage is foreseeable in the absence of the insurer’s reasonably diligent action on the application; negligent retention of the application without prompt action sounds like a tort; and courts are comfortable finding a tort-based duty to act promptly on an insurance application, with damages flowing from the breach of this duty. If the delay in acting on the application cases had arisen in the late twentieth and early twentieth-first century, they surely would have been pleaded as bad faith cases, consistently with the other examples referenced by Professor Abraham and other commentators. Reduced to its essence, the practice of insurer delay in responding to applications appears to have been a systemic, institutional practice sharing the “rotten to the core” characteristics of the practices that have produced the bad faith claims processing litigation of recent years. The law’s response to the older practices reveals the specialness and distinctiveness of insurance as profoundly as the modern responses continue to demonstrate.

In addition to the duty to act on applications, there are other examples in the past of what we would today label institutional, systemic bad faith. Of the four modern examples of institutional, systemic bad faith discussed by Professor Abraham, the one involving contingent commissions does not involve bad faith claims processing. How much is wrong with contingent commission arrangements and the manner in which such secret commission deals should be regulated are unresolved questions today; the regulatory options range from disclosure of the arrangements on

the one hand to outright prohibition on the other.²³ This controversy is reminiscent of a past widespread industry practice – premium and commission rebating -- where the question was whether to regulate and, if so, how. Early in the twentieth century, the question of whether premium and commission rebating was valid was settled in the legislative arenas with the answer “no.”²⁴ This history is revealing on the subject of insurance law’s specialness, distinctiveness, and difference.

The anti-rebate statutes have their roots in the rapid expansion of the life insurance industry in the late nineteenth century, and it is fair to characterize that period of expansion as endemic with high pressure sales tactics, deceptive trade practices, and very high agent commissions.²⁵ In this wild-west market, agents created a variety of ways to refund portions of their commissions to customers, and rebating gradually became perceived as an evil that led to inequality and discrimination among applicants, with the privileged getting good deals unavailable to the general public. Rebating came to be considered a threat to the integrity of the insurance business, and insurance regulators acting in the public interest sought to prohibit it. That rebating of commissions in the insurance setting is an untoward business practice remains the prevailing view today.

Yet, interestingly enough, rebates of commissions, payments, or other consideration through renegotiated business arrangements are met with less hostility when they occur outside the insurance business. In real estate transactions, for example, it is common for a person represented by a broker during negotiations with a prospective buyer over price to simultaneously renegotiate the commission to be paid her agent in the transaction. Similarly, cash-back rebates when a consumer buys a product and meets certain eligibility conditions are not seriously questioned as unfair price discrimination, and cash-back rebates for making purchases with a credit card are virtually the norm. By analogy to these practices, one can legitimately wonder what would be wrong with negotiating an

²³ See generally, Hazel Beh & Amanda M. Willis, *Insurance Intermediaries*, 15 CONN. INS. L.J. 571, 591-94 (2009); Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, 25 YALE L. & POL’Y REV. 289, 321-23 (2007).

²⁴ For discussion of the history of this practice, see Robert H. Jerry, II & Reginald Robinson, *Statutory Prohibitions on the Negotiation of Insurance Agent Commissions: Substantive Due Process Review Under State Constitutions*, 51 OHIO ST. L.J. 773, 776-80 (1990).

²⁵ See Constitutionality of Ins. Anti-Rebate Law, 1996 Alaska Op. Att’y Gen. (Apr. 22).

individualized commission with an insurance agent based on the value of the agent’s services and the prospective insured’s interest in using them.

Yet as a matter of statutory law, the insurance agent is required to decline summarily any such request for a refund of a portion of the commission on the grounds that doing so would be illegal.²⁶ Whether this regulatory framework is wise is a question for another day (and if contingent commissions are declared illegal, the wisdom of that prohibition will also continue to be debated). The fact remains, however, that a practice tolerated in other contexts is prohibited in insurance, reminding us that insurance is special, distinctive, and different. What we tolerate in other business settings with regard to commission splitting, rebating, etc. is not tolerated in insurance under the reasoning that this would create impermissible inequities among classes of purchasers and might even threaten the solvency of insurers if premium rebates became too common. This has the effect of treating insurance as a quasi-public good; just as similarly situated consumers should pay the same rates for water, electricity, or fire protection, similarly situated consumers should not be able to strike back-room deals that change the price paid for the same product, and insurers should not be able to engage in systemic, institutional practices that advantage a privileged few at the expense of the many. This, again, is precisely the point made by Professor Abraham:

[T]he bad faith behavior in each instance is something that we probably would tolerate, and have the law tolerate, if it were a different sort of business enterprise that engaged in this behavior. . . . *If an auto parts retailer had a secret deal with some manufacturers that it would be paid an*

²⁶ See *Chicago Title Ins. Co. v. Butler*, 770 So. 2d 1210, 1221 (Fla. 2000) (declaring anti-rebate statutes unconstitutional “to the extent they prohibit title insurance agents from rebating a portion of their risk premium”); *Dep’t of Ins. v. Dade Cnty. Consumer Advocate’s Office*, 492 So. 2d 1032, 1033 (Fla. 1986) (holding the Florida statute unconstitutional “to the extent they prohibit rebates of insurance agents’ commissions”). The California rebate law was repealed by Proposition 103 in 1988. See, *The McCarran-Ferguson Act Before the Antitrust Modernization Comm’n* (Oct. 18, 2006) (statement of Jay Angoff, Of Counsel, Roger Brown & Associates), available at http://govinfo.library.unt.edu/amc/commission_hearings/pdf/Statement_Angoff.pdf (last visited July 22, 2012). Despite the invalidity of the statutes in those two states, there are no readily available indications that consumers are seeking to negotiate rebates or commission returns with agents, brokers, or insurers.

annual rebate that increased if products liability suits against the manufacturer decreased, we would consider this no business of those who purchased the auto parts in question, even if this affected which customers were influenced to buy which kinds of parts. These would be examples of harsh, slightly unsavory dealing, but that's about it.²⁷

This point is correct not only with respect to the examples discussed by Professor Abraham but also with respect, in the insurance setting, to the act of rebating itself.

Another example of institutional, systemic bad faith from the past is found in claims processing regulations created in the early twentieth century. Insurers' use of the defense of misrepresentation has a long and interesting history, but the portion of the narrative relevant here involves the late nineteenth and early twentieth century practice where life insurers frequently alleged misrepresentation by the applicant when a claim for proceeds was filed many years after the policy had been issued. In these circumstances, the beneficiaries had great difficulty refuting, and would perhaps be unable to refute, the insurer's assertion of the defense. Aware of the mismatch between beneficiaries and the insurer in this setting, many insurers took advantage and pressed the disparity to their financial advantage, or at least so the common wisdom ran. This systemic, institutional, "rotten-to-the-core" practice led to the widespread enactment of incontestability statutes early in the twentieth century. If a similar kind of regulation exists in another contracting context, it is obscure. Once again, this systemic, institutional insurer practice, and the regulatory response to it, illustrates that insurance has a special, distinctive status among the relationships, products, and services that consumers purchase and acquire. Not surprisingly, the law governing insurance recognizes this specialness and assumes the characteristics and dimensions of a body of law operating in its own field with its own principles and rules.

I like the statement "[l]ife is uncertain"²⁸ because it expresses in three words the basic truth upon which all of the business and law of insurance, not to mention most human behavior, is based. I also like Professor Leonard Moldinow's observation that "our clear visions of

²⁷ See Abraham, *supra* note 1, at 13.

²⁸ Robert H. Jerry, II, UNDERSTANDING INSURANCE LAW 9 (1st ed. 1987).

inevitability are often only illusions.”²⁹ Blending these two insights yields a third: In life and in law, one can always look back and say “there are many different ways this could have unfolded.” Just as the core insight that insurance law is special, distinct, and different can be articulated in different ways,³⁰ the path through which this core insight is manifested in the law could have evolved differently than it did, and there are multiple paths that its future evolution might take. Looking backwards, we might observe that the core insight has been in the middle of some jurisprudential currents that flowed parallel to those of insurance law during most of the twentieth century. A notable example is the analysis of Friedrich Kessler presented in his 1943 article in the *Columbia Law Review* on standardized forms,³¹ arguably the most prominent of the early explorations of the challenges standardization poses to the principles of contract law. Kessler used insurance policies as his principal example, discussed the problem of insurers’ delay in acting on applications, and presented what was probably the first articulation of the doctrine of reasonable expectations.³² Early in the article, Kessler explained how courts had succeeded in reaching just decisions in construing ambiguous claims against the policies’ drafters – even in cases where there was no ambiguity. He then observed that these techniques, however, were unable to address a problem arising in contract formation – delay in acting on an application. He observed that courts

²⁹ LEONARD MLODINOW, *THE DRUNKARD’S WALK: HOW RANDOMNESS RULES OUR LIVES* 218 (2008).

³⁰ *See supra* pp. 1-2.

³¹ Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 *COLUM. L. REV.* 629 (1943).

³² Kessler plainly recognized “reasonable expectations” permeates “our whole law of contracts,” and embraced the notion that contract terms should be rewritten to fulfill reasonable expectations. *Id.* at 629, 637. However, credit for recognizing the doctrine of reasonable expectations is given to Professor Robert Keeton, who while a professor at Harvard Law School wrote a seminal article titled *Insurance Law Rights at Variance With Policy Provisions*. Robert Keeton, *Insurance Law Rights at Variance With Policy Provisions*, 83 *HARV. L. REV.* 961, 967 (1970). Professor Keeton’s thesis was that many courts had applied familiar rules to the end of not enforcing clear contract language based on one of the parties’ “reasonable expectations” of coverage. *Id.* This two-part article is a remarkable work that brought together a large number of related principles, all of which serve to demonstrate why insurance and the law governing it are special. Kessler, however, put squarely on the table the notion that with standardized contracts, “[i]t can hardly be objected that the resulting task of *rewriting, if necessary*, the contents of a contract of adhesion is foreign to the function of common law courts.” Kessler, *supra* note 31, at 637 (emphasis added).

seeking to solve this problem had invoked a tort law duty to act promptly on an application as the solution.

Kessler's broader point was essentially to advocate, like some other scholars of that era, that contract law be divided into dual frameworks: one for negotiated contracts between parties with roughly equal information and bargaining power, and one for contracts created through the use of standardized forms. He wrote:

[Here is the] basic issue with which the courts in the insurance cases are confronted. It is: *can the unity of the law of contracts be maintained* in the face of the increasing use of contracts of adhesion? The few courts which allow recovery in contract and the many which allow recovery in tort feel more or less clearly that insurance contracts are contracts of adhesion, and try to protect the weaker contracting party against the harshness of the common law and against what they think are abuses of freedom of contract. The courts denying recovery, on the other hand, cling to the belief that an application for insurance is not different from any other offer, and they are convinced that efforts to build up by trial and error *a dual system of contract law* must inevitably undermine the security function of all law, particularly since courts are ill equipped to decide whether and to what extent an insurance contract has compulsory features.³³

Kessler favored a dual system where standardized contracts received heightened regulation. Importantly, a major reason he came to that conclusion was because he understood that insurance involved a different kind of contract, where the subject of exchange was more important than the ordinary commodities exchanged in other contracts. To preserve and promote this value, he proposed that the law of torts be used to “nullify those parts of the law of contracts *which in the public interest* are regarded as inapplicable.”³⁴

Professor Abraham's continuum, where insurance law rests in the middle between ordinary contract law on the one hand and government regulation on the other, is entirely consistent with Professor Kessler's observation that contract law's unity was not sustainable, and that

³³ Kessler, *supra* note 31, at 636 (emphasis added).

³⁴ *Id.*

standardized contracts (e.g., insurance contracts) needed a different system of governance than ordinary contracts freely negotiated between parties of roughly equivalent bargaining power. Kessler’s embrace of tort principles to deal with the problem of an insurer’s delay in acting on applications was essentially the equivalent of putting the tort-driven new principles of the “new contract law” in the center of the continuum.

Later in the twentieth century, Professor Robert Keeton addressed the question of the insurers’ delay in acting on an application in his 1971 *Basic Text on Insurance*.³⁵ He began with an overview of the limitations of existing estoppel, contract, and tort doctrines to address the harm caused by insurers’ delay.³⁶ Having catalogued various reasons these doctrines were inadequate to address the issue, he advanced arguments for “a somewhat broader liability than that imposed in tort.”³⁷ His initial argument was essentially an economic efficiency rationale without the dressing of the vocabulary of law and economics; he essentially suggested that insurers could spread the risk of delay’s harm across premium-paying insured more efficiently.³⁸ His second argument came back to the fundamental premise that insurance law is different, distinctive, and special. Invoking and citing Kessler, he observed that insurance transactions almost always involve “the standardized mass contract” and “courts should develop a different set of doctrines for such cases, rather than allowing technical doctrines of contract law to defeat liability when public interest would be served by imposing it.”³⁹ Moreover, just as “railroad companies have been required to furnish transportation to all qualified passengers and shippers, . . . an insurance company might similarly be regarded as a public service company, under a legal duty to insure upon reasonable terms all properly qualified applicants.”⁴⁰ Keeton wrote that the case law as of 1971 had not yet reached the ‘insurance as public service company’ principle, but he believed a ‘different kind of contract law’ was already being applied, even if courts “seldom expressed [it] in this way.”⁴¹

Bad faith has now reached middle age. With the helpful insights of Professor Abraham, we can now see in bad faith’s evolution additional evidence that insurance law is special, distinctive, and different, and we

³⁵ ROBERT E. KEETON, *BASIC TEXT ON INSURANCE LAW* (1971).

³⁶ *Id.* at 45-48.

³⁷ *Id.* at 48.

³⁸ *Id.* at 48-49.

³⁹ *Id.* at 49.

⁴⁰ *Id.*

⁴¹ *Id.* at 50.

have another way to express it. As a result, “our understanding of what insurance law is, and what insurance does” is, in fact, now deeper.⁴²

⁴² See Abraham, *supra* note 1, at 13.

THE ECONOMICS OF INSURANCE LAW—A PRIMER

RONEN AVRAHAM¹

This article presents a law and economics perspective on the topic of insurance law as a whole. In doing so it provides both an overview major topics in insurance law as well as a discussion on the major themes of the economic analysis of insurance law and its leading cases. The paper also presents a theoretical framework—the two islands functional approach—that can help solve insurance law puzzles. Ultimately, this paper could help any insurance law judge, lawyer, or student as well as any legislature to correctly conceptualize and solve the legal problems facing courts and insurance lawyers alike.

Imagine two islands.

These two islands are identical in almost every way—from their white sand beaches, to their elaborate hotels, to their coconut oil powered insurance text book printing facilities. The only difference between the islands is the insurance regime for automobile accidents. On the first island, everyone buys first-party insurance. This means that if you are involved in a car accident you file a claim with your own automobile insurance company which will pay for your damages. On the second island, however, everyone is required to buy third-party liability insurance, and first-party insurance is not available. This means that if you are involved in car accident you file a claim with the insurance company of the person who hit you. Which island would you prefer to live on?

On the first island, you enjoy the benefit of choosing your own insurance. You can ensure that you buy from a company that is reliable and will pay for any harm you incur in the case of an accident. You can also guarantee you have as much coverage as you want, so driving your Bentley around town is a less harrowing prospect. But not everything is great about this island. You may, in fact, not drive carefully enough, knowing that after all you are fully insured, or almost so. And what about the fact that being a

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victim of an accident—even one that is not your fault—may raise your premiums because it is your insurance company that is paying for the damage? A first-party insurance regime may also penalize the poor, whose cars may be less inwardly safe, since insurance premiums would reflect not only the likelihood of the insured being harmed in an accident but also the magnitude of the harm, and unsafe cars do not adequately protect drivers. A first-party insurance regime could also incentivize drivers to buy more outwardly dangerous cars—cars with ramming guards, or behemoth trucks that would do grave damage to another car in an accident—but would leave the driver and her vehicle relatively unharmed, resulting in lower premiums.

Now let's look at the second island. Since third-party liability insurance premiums reflect not the potential of harm to you, but the potential for you to negligently harm others, they only penalize you for being *negligent* in an accident, not for simply being in an accident. This incentivizes drivers to not drive negligently and might lead to a safer driving environment. Third-party liability insurance may also incentivize cars that are more outwardly safe. However, it also puts the insured at the mercy of other drivers—who may be incentivized to buy minimum coverage from less than reliable operators—potentially becoming judgment-proof for large-scale accidents. If you are hit by a driver without enough coverage, you may have to bear a large portion of your harm yourself.

There is a lot more to be said, but for now let us pause and think: can you tell which island is better? Without a more nuanced theoretical analysis and a wealth of empirical evidence it is difficult, if not impossible, to decide. The purpose of this article, in fact, is not so much to answer this question – which has been discussed by Guido Calabresi almost three decades ago² – but rather to provide a *theoretical framework* helpful to answering this and similar questions. This framework can provide judges and policy makers a first approximation to determine the best normative solution, from a law and economics perspective, for many *different* insurance law disputes. Since insurance law is heavily embedded in insurance theory, the latter being primarily the economics of insurance, my hope is that by explaining the foundations of insurance theory readers will find it easier to understand insurance law. More precisely, this article

² See Guido Calabresi, *First Party, Third Party, and Product Liability Systems: Can Economic Analysis of Law Tell Us Anything About Them?*, 69 IOWA L. REV. 833 (1984).

intends to present the theoretical and practical difficulties posed by insurance law and to propose a conceptual framework—the two islands approach—as a way to better conceptualize the shortcomings and inefficiencies of insurance law’s various doctrines.

The theoretical framework presented here should help transform the way courts interpret insurance contracts (in short, subjective and objective interpretation of the parties’ intentions) to a simple thinking tool which allows courts first, to identify the relevant variables and second, to determine the optimal solution. Even when the framework cannot provide a definite answer, it at least provides a road map for asking the relevant questions to focus the analyst’s attention on the relevant missing empirical data.³

The standard insurance dispute arises because the insurer denied coverage, relying on the language of the contract, or a general principle of insurance law, such as lack of insurable interest. How can we know whether the denial is justified? The tension in such situations is between the ex-post and the ex-ante, between providing coverage to the insured who had suffered a loss, and not distorting the insured’s (and the insurer’s) incentives to minimize loss.

If the denial of coverage serves a sound function in the insurance market, then it should be upheld. For example, if the denial of coverage eliminates *insureds*’ strategic behavior while not creating a larger problem of *insurers*’ strategic behavior, then it is probably justified. Such is the exclusion, for example, on coverage of liability for intentional torts. Another example would be the exclusions of coverage for automobile accidents from homeowners insurance which could be justified in that insurers ensure the pool of homeowner insureds contains similar risks, eliminating cross subsidization of those without cars of those with cars, which, as we will see below, might lead to inefficient risk classification. If the administrative costs in determining the validity of an exclusion are too high, a bright-line rule might be appropriate. Other times, when administrative costs are not a problem, a case-by-case approach which evaluates a specific exclusion is ideal.

³ Others have previously argued American courts should use a more normative approach when deciding insurance law issues. See Daniel Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389 (2007) (arguing courts should treat insurance litigation similar to how products liability litigation is treated, and do so by looking to the value of a given policy term).

I call the approach proposed here “the two islands functional approach” because it requires the analyst to focus on the *function* of the coverage denial. The analyst ought to compare two states of the world—two islands—one where the relevant exclusion exists and one where it does not. Much like in the opening example for this paper, on these islands, everything else is the same except for whether or not the denial of coverage exists. Sometimes, one island is clearly superior to the other. On other occasions, the superiority of any given solution depends on (sometimes missing) empirical evidence.

The rest of this article is organized as follows. Section 1 begins with an overview of insurance and the relationship between the contracting parties, discusses some historical and conceptual background to insurance, and then explains why we need insurance at all. Section 2 starts dealing with impediments to the efficient insurance contract. It discusses the most important impediments—those evolving from the double-sided asymmetric information between the parties. Section 3 discusses other impediments to efficient contracting such as transaction costs and externalities. It highlights more complicated factors which differentiate the sale of insurance and the sale of other goods—such as the existence of agents and the conflict of interest it brings about. At measured intervals throughout Sections 2 and 3 I use the Two Islands Functional Approach to evaluate one of the solutions to insurance impediments. These illustrations are not meant to be exhaustive, as that would be impossible, but rather to demonstrate how the approach can be used to assist a judge or other decision maker. Section 4 concludes.

I. INTRODUCTION TO INSURANCE

A. THE RELATIONSHIP BETWEEN INSURER AND INSURED

Insurance is a legal mechanism by which the insured pays a premium to purchase from an insurer some financial protection against a future potential loss. The goal of this transaction is to provide the insured protection from financial risks to her assets, health, and life, or from third party claims, while incentivizing her to guard against those risks.

In many ways, insureds, purchasers of insurance, are like other types of consumers in their need for some type of legal protection against sellers, in this case insurance companies, or insurers. However, insureds may even be in a worse position than other consumers because insureds do not buy anything tangible that they can use immediately and return to the store if they do not like it. An insured cannot return his health insurance and begin

comparison-shopping once he is in a hospital. Rather, insureds purchase a promise for future financial protection in the case of a covered occurrence. The problem is that the product sold, insurance coverage, is not usually well defined in the minds of insureds. What exactly is covered under the policy? What type of “protection” will be delivered? What constitutes an “occurrence” which triggers coverage? Not only are all of these left undefined in the minds of insureds, but they are all widely litigated questions. That there are so many hidden characteristics in the product of insurance compared with other goods and services, and that as a result there is a lot of room for insurers’ strategic behavior, suggests that insureds require even *more* protection than other consumers.

But that is just part of what is unique about insurance. Perhaps unlike other types of consumer contracts, the *sellers/insurers* deserve some protection as well.

Sellers in other industries usually price their product or service based primarily on the cost of its production and the seller’s market power. While the market equilibrium price is determined by the supply and demand for the product, the seller’s costs of production are almost never correlated with consumers’ demand for the product. Consumers’ demand, in turn, is a function of their preferences, available substitutes, and a host of other factors. But in insurance markets, things are different. An individual’s risk type— her hidden characteristics or level of engagement in strategic behavior—determine not only the demand but also directly affect the *cost* of the product.⁴ While sellers in other consumer contracts may be exposed to some small financial risk if a consumer’s check bounces, or to some legal risk if their product is defective, that risk is limited. In contrast, the cost of production of insurance coverage crucially depends on the insured’s strategic behavior and hidden characteristics. In the health insurance market, for example, it is the insured’s lifestyle and dietary choices, and in the automobile insurance market, the insureds driving decisions. Thus, insurers are not only exposed to the risks regular sellers are exposed to, but also to a much greater risk of systematically under-pricing their product due to asymmetry of information between them and their insureds regarding their insureds’ strategic behavior or hidden characteristics. However, one has to remember that unlike insureds, insurers are well aware of the asymmetric information problem and the risks it carries and they

⁴ Liran Einav & Amy Finkelstein, *Selection in Insurance Markets: Theory and Empirics in Pictures*, 25 J. ECON. PERSPECTIVES 115 (2011).

have developed various means, to be detailed below, to combat this problem.

But that is still not the entire story.

The reason why insurers deserve some protection goes deeper. In regular goods and services industries a financial collapse of a seller will lead to losses only for the various entities it contracted with, such as its employees, shareholders, suppliers, etc. It will not lead to a great loss to its existing customers. Existing customers might be harmed if they need to replace, upgrade, or repair their goods, but they usually do not lose the money they initially spent on the product. In contrast, when an insurance company cannot deliver on its promise, some customers will be left with large uncompensated losses while others will lose the money paid for the covered period. Many of them will no longer be able to find coverage elsewhere, and those who would might have to pay a much higher premium. While this may be a problem in other industries where money is paid in advance, ordinarily it is not as pronounced as in insurance, where contracts may last for decades. This suggests that in addition to the normal social welfare reason to ensure contracts are efficient (more on this below), there is a strong *consumerist* reason to ensure insurance contracts are sustainable—therefore guaranteeing that insurance companies do not collapse and cause insureds to forfeit their premiums. This, in turn, means that there is a consumerist reason for the contracts to be efficient. Efficient contracts—those made with perfect information and low transaction costs—are those that maximize social welfare while still sustaining the company providing the contract.

Hidden characteristics and strategic behavior are much greater risks in the insurance industry than in most other sales industries. Both the seller and the consumer may have hidden characteristics or engage in strategic behavior. But because of the abstract nature of the good, the negative effect of the characteristics is much more pronounced in an insurance contract. The risk of double-sided hidden characteristics and strategic behavior is that the contract between the parties will not be efficient and the costs of these unknown risks will not be properly allocated. In particular, as will be explained below, these informational impediments give rise to problems of adverse selection, reverse adverse selection, moral hazard, and reverse moral hazard.

The economic analysis approach to insurance law employs the efficient insurance contract paradigm. According to this paradigm, insurance law should be viewed as doing not much more than protecting insureds and insurers from contracting inefficiently due to transaction costs primarily in the form of each other's strategic behavior and hidden

characteristics. That is, at least, the approach this article takes in addressing the problems posed by these informational asymmetries and destructive incentives, as well as other economic inefficiencies such as administrative costs, negative externalities, correlated risks, non-competitive pricing and irrational behavior.

This article adopts an *ex ante* outlook toward the evaluation of insurance disputes, refocusing the discussion from the facts of a particular case—where tragic events can often cloud a court’s judgment—to how a ruling would affect the overall pool of insureds and society at large. This can be seen in the applications of the Two Islands Functional Approach throughout the paper.

B. SOME HISTORICAL AND CONCEPTUAL BACKGROUND

In the historical record, the first instances of insurance date back to the Babylonians in the fourth millennium B.C. Insurance plans and the law have interacted since at least the time of Hammurabi’s Code, which included references to primitive private insurance contracts. Public insurance policies first appeared during the time of ancient Rome, including the government’s underwriting of merchants’ losses due to storms or capture at sea. Private risk spreading was common from ancient times to the post middle-ages through friendly societies that spread the cost of some risks among their members. Such societies existed in what is currently China, India, Greece, Israel, Italy and other countries in medieval Europe, providing insurance against illness, death, marine and fire risk, and even legal liabilities. And of course, rudimentary risk-sharing arrangements such as share-cropping have been common throughout history. While not a formal insurance, these arrangements served many of the same purposes.⁵ Today’s modern insurance industry provides a wide variety of products. These products can be classified in multiple ways. First, the classification may focus on who bears a loss. For example, first-party insurance covers losses sustained by the actual holder of the insurance policy. Health-care insurance is an example. If an insured gets sick and has to pay for care, thus bearing the loss, the insured herself is reimbursed. Third-party insurance, on the other hand, covers losses caused by the holder onto others, when the holder could be exposed to legal liability for causing that

⁵ DAVID A. MOSS, WHEN ALL ELSE FAILS: GOVERNMENT AS THE ULTIMATE RISK MANAGER 27-28 (2002). For ancient Israel, see *Babylonian Talmud, Baba Kama* 117.

loss. Malpractice liability insurance is an example. If a lawyer makes a mistake and causes his client a loss, the lawyer's insurer pays the client who actually had to bear the loss.⁶

Another way to categorize insurance is by the type of loss insured. Health insurance protects against costs associated with health care. Malpractice liability insurance protects against costs associated with malpractice. Likewise, life insurance covers costs associated with the loss of life and property insurance covers damage to property.

The modern industry is also surrounded by a broad institutional infrastructure. The institutions are those common to all areas of the law: legislatures, regulators, and courts. In the United States, insurance is largely governed by state rather than federal law.⁷ While laws may prescribe or prohibit certain behavior by insureds or insurers—such as requiring people to have coverage, or requiring insurers to provide coverage—mostly legislatures create regulatory schemes and delegate rulemaking authority to agencies and commissioners. The role insurance commissioners or agencies perform varies widely by jurisdiction. Generally, the administrative function is divided into rulemaking—such as creating requirements for certain types of coverage—and enforcement—ensuring insurers follow the rules. Courts also participate in the policing. They have a large role in defining the contractual relationship between insureds and insurers and between the insurance companies and the regulators.⁸

C. SOME FUNCTIONS OF INSURANCE

⁶ It is possible to see liability insurance as first party insurance. The lawyer is forced to pay for the harms she caused, and the liability insurer is merely repaying the lawyer for this personal loss. Nonetheless, it is common practice to classify liability insurance as third-party insurance, and treat the loss being insured against as that of the outside party.

⁷ Though the Employee Retirement Income Security Act of 1974 and the Patient Protection and Affordable Care Act of 2010 are major exceptions.

⁸ Michelle Boardman, *Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1107 (2006) (contending that most policy language, specifically boilerplate language so prevalent in policies, is targeted at courts, not the insureds); see also Schwarcz, *supra* note 1 (arguing there is a role for courts in the regulation of insurance, and that role should mirror products liability law).

The underlying theme to all these historical developments and theoretical principles is that individuals have a natural tendency to recognize and be concerned about risk, whether to themselves, others, or their property.⁹

Indeed, the vast majority of individuals, at least in the context of possible large future losses, tend to respond to risk with risk aversion—the preference for certainty over uncertainty with regard to future losses. Risk aversion, a concept developed by the Swiss mathematician Daniel Bernoulli, explains why an individual would rather pay \$10,000 for an insurance premium than \$1,000,000 for a loss that occurs with a one in hundred chance. More generally, a risk-averse individual will pay a small premium now to protect against potentially large, but uncertain losses in the future, when in all likelihood the total premiums paid will be more than the eventual loss. While risk aversion has been traditionally considered a near universal condition, risk neutrality (indifference to certainty or uncertainty with regard to future losses) and risk-affinity (preferring uncertainty over certainty) are also possible preferences.¹⁰

One of the most important developments in modern insurance came in the formalizing of the basic principle of insurance in 1713 by Jacob Bernoulli, who was Daniel Bernoulli's uncle. The idea was that the sample mean for a probabilistic set nears the expected mean for an occurrence or process in

⁹ Though recent work has looked at the fact that insureds do a relatively poor job of buying insurance they should buy, and refraining from buying insurance they should not buy. See Howard Kunreuther & Mark Pauly, *Insurance Decision-Making and Market Behavior*, 1 FOUNDATIONS AND TRENDS IN MICROECONOMICS 64 (2005); see also Kyle D. Louge, *The Current Life Insurance Crisis: How The Law Should Respond*, 32 CUMB. L. REV. 1, 6-8 (2001-2002) (identifying reasons for under-insuring in the life insurance context and suggesting the best legal response).

¹⁰ Some like to root risk aversion on the observation that people have diminishing marginal utility from money. But that is not a very helpful observation, because, among other things, people demonstrate great heterogeneity in levels of risk aversion in different contexts; A simpler approach is to consider risk aversion part of people's preferences, which determine their demand for insurance. *But see* Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decision Under Risk*, 47 ECONOMETRICA 263 (1979) (advocating an alternative approach to the risk aversion hypothesis); Kahneman and Tversky's work was later incorporated into legal theory. See Christine Jolls, Cass R. Sunstein & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471 (1998).

the population as the sample size increases. For example, if the average risk of an insured getting a certain type of cancer is 5%, then the larger the pool, the closer the pool's cancer rate will be to 5%. This is known as the law of large numbers. The obvious extrapolation to be made is that pooling of risks reduces the risk per insured, as long as these risks are not perfectly correlated. This principle is apparent in all the instances of insurance practices described below.

Insurance policies utilize the law of large numbers to reduce uncertainty for risk-averse individuals. The first step in that process is risk transfer, by which the risk of a certain event is shifted from one party to another.¹¹ The law of large numbers, discussed above, allows an insurer to predict with reasonable certainty the aggregate losses it will pay in a given year—assuming that neither adverse selection nor moral hazard, both discussed below, bias the analysis—and to adjust its premiums accordingly. Thus premiums offered by an insurer equal the value of the risk of loss, plus administrative fees and profit to the insurer. Insureds are willing to pay the excess over the value of the risk due to their risk aversion.¹² Risk aversion by itself, however, cannot fully explain the existence of the entire insurance industry. For example, even companies which may be large enough to not be considered risk averse at all, indeed large enough to be able to buy the insurance company, purchase insurance coverage. These large companies do not need insurance to transfer risk as they are large enough to remain exposed to many of their dissimilar, independent risks

¹¹ Nearly every contract or transaction transfers risk in some way, such as the risk that a seller's costs will go up and make the transaction unprofitable for her. If a buyer contracted for the right of specific performance—by explicitly or implicitly paying a premium—then she is insured against any increase in the seller's costs because the buyer has already paid for the right to receive the goods. See Ronen Avraham & Zhiyong Liu, *Incomplete Contracts with Asymmetric Information: Exclusive Versus Optional Remedies*, 8 AM. L. ECON. REV. 523 (2006). Insurance arrangements are somewhat unique in that the risk to be transferred is explicitly recognized by the arrangement—i.e. the risk that the policy-holder will fall ill or that her home will be flooded. Of course, this is true of other forms of insurance. For example, derivative financial instruments are tied to particular risks, such as changes in value of securities or commodities or even weather events.

¹² Premiums are also determined based on expected and incurred investment profits or losses, and the competitiveness of the markets. The expected rate of return for investments affects the premium that an insurance company needs to charge to maintain its margins. For simplicity I ignore that fact.

and cancel them out on their own—a strategy called risk diversification.¹³ These large companies are considered more risk-neutral and capable of self-insurance than individuals, yet those companies typically carry very large insurance policies.¹⁴ So there must be another explanation besides risk-aversion for the existence of insurance and, in fact, there are many of them.¹⁵

One of the simplest and most fundamental functions served by an insurer is the process of information gathering and knowledge production. In a way, all other functions of the insurer rely on its ability to gather data about the risks it intends to insure, including the frequency, severity, and variance thereof, and to translate that data into policies and premiums. This is why, as will be discussed below, the insurance industry is given some immunity from federal antitrust laws.

Another explanation for why corporate entities purchase insurance policies is the cheap claim-handling service provided by insurers, particularly with regard to legal liability of corporations and health-insurance coverage for their employees. The insurance company saves the corporation administrative costs associated with receiving, processing, negotiating, and paying out claims.¹⁶

Insurance also lowers negotiation costs between transacting parties as it allows them to not have to worry about detailing various risks in the contract between them. Insurance policies are thus an implicit party of nearly all commercial interactions because parties can rely on insurance to cover innumerable risks that would, if they had to be hedged in each and every contract, add tremendous negotiation costs to every contract. In addition, the existence of insurance reduces the need for and the cost of litigation in the commercial context, which also reduces the costs parties

¹³ If the company is publicly held, then the true bearers of the risk, the stockholders, have also spread out their own risk by owning a diversified portfolio. See SCOTT E. HARRINGTON & GREGORY R. NIEHAUS, *RISK MANAGEMENT & INSURANCE* 171 (2d ed. 2004) (discussing reasons why companies purchase insurance even though shareholder risks are already diversified).

¹⁴ Though the plans often have large deductibles that represent the share of the risk the company feels comfortable bearing.

¹⁵ Victor Goldberg, *The Devil Made Me Do It: The Corporate Purchase of Insurance*, 5 *REV. L. & ECON.* 541, 543-44 (2009) (discussing various benefits that insurers provide to companies).

¹⁶ Göran Skogh, *Mandatory Insurance: Transaction Costs Analysis of Insurance*, in *ENCYCLOPEDIA OF LAW AND ECONOMICS, VOLUME II: CIVIL LAW AND ECONOMICS* 521, 526 (Boudewijn Bouckaert & Gerrit de Geest eds., 2000).

must account for in creating a transaction in the first place. By reducing these costs, insurance plays an essential role in facilitating trade and commerce.

Other explanations for carrying insurance include lowering the expected transaction costs of bankruptcy, lowering the corporation's expected tax liability, reducing regulatory constraints on firms, and shielding them from class actions filed against them.¹⁷

Beyond these benefits, insurance companies also provide another important function - that of loss prevention or minimization. Insurance companies have the institutional expertise and knowledge to suggest and implement cost-effective preventative measures.¹⁸ Consider, for example, fire insurance on a commercial property worth \$1 million. The chance of a fire destroying the property in a given year is 1%, which means the expected loss for that year is \$10,000 and the insurance premium must be at least slightly more than that amount. Now, assume that by installing a sprinkler system, the risk of a fire destroying the property is cut in half, meaning the premium to be paid is likely to be reduced to (slightly more than) \$5,000. If installing and maintaining the sprinkler system will cost less than \$5,000 per year, and its installation can be easily verified by the insurer, the property owner has every incentive to invest in the sprinkler system—a “loss control”—which reduces the risk of the loss in return for a discounted premium.¹⁹ It is true that an uninsured person, generally, has an even stronger incentive to prevent losses. The problem, however, is knowing which steps to take, something that insurance companies are often experts at. Furthermore, as will be explained below, in some contexts an entity on the verge of bankruptcy, without insurance, may have only minimal incentive to take care, as it has nothing to lose. However, the

¹⁷ See David Mayers & Clifford W. Smith, Jr., *On the Corporate Demand for Insurance*, 55 J. BUS. 281 (1982) (conducting extensive work on why public corporations purchase insurance); see also TOM BAKER & SEAN J. GRIFFITH, *ENSURING CORPORATE MISCONDUCT: HOW LIABILITY INSURANCE UNDERMINES SHAREHOLDER LITIGATION* 42 (2010) (documenting how Directors and Officers liability insurance shields corporations from losses due to securities class actions filed against them); Goldberg, *supra* note 14, at 543 (providing numerous reasons why insurance is value enhancing despite arguably being inefficient for a risk neutral company).

¹⁸ Goldberg, *supra* note 14, at 543-44.

¹⁹ KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 11 (1986). How deductions incentivize loss prevention will be explained below.

possibility of a reduced premium restores the incentive of even that entity to, for example, install the sprinkler system.

Insurance has some socially beneficial functions which go beyond benefiting the direct parties to the insurance contract. One such function served by compulsory insurance companies is gatekeeping, which is accomplished in many of the most important sectors of modern economies. Automobile insurance is required to drive a car; homeowners insurance is often required to obtain a mortgage; and business owners insurance is often required to take out a commercial loan. Insurers provide a way to screen and filter individuals before they are permitted to undertake important, but potentially socially harmful activities, thus serving effectively as quasi-regulators. For instance, if a person has been in too many accidents for any insurance company to offer him an automobile policy, the result is that he cannot buy insurance and thus legally cannot drive a car. This keeps society safer, at least as long as he does not drive without carrying insurance. The gatekeeping function, however, may not be a social benefit if the insurance industry acts inefficiently or considers factors—such as race, gender, or nationality—that society views as inappropriate for determining insurability.²⁰

Another positive externality of a functioning insurance market is that private insurance provides fast compensation to victims of disasters, accidents, and torts, easing the burden on tax-funded social insurance programs like Social Security disability benefits or FEMA's Disaster Aid Programs. For example, as of August 2006, only a year after the disaster, insurers had already paid \$17.6 billion for wind damage from Hurricane Katrina.²¹ Without these payments, many more homeowners would likely have been forced to turn to the government for assistance.

On the other hand, insurance affects social stratification in significant, meaningful ways. The ability to obtain (and to afford continuously) various types of insurance can be a serious and disconcerting divide between the well-off and the lower classes, leading many states, and recently the US Federal government, to provide national insurance, especially health insurance, to lessen stratification.

Over all, insurance has many positive elements, and plays a necessary role in nearly all commercial transactions. However, insurance

²⁰ See Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517 (1983).

²¹ Joseph B. Treaster, *Judge Rules for Insurers in Katrina*, N.Y. TIMES, Aug. 16, 2006 at C.

can create negative externalities as well. For example, it is possible that health insurance may encourage insureds to take less than optimal precautions to avoid sickness, or doctors to perform unnecessary procedures, or the medical device and drug industries to excessively innovate, since insureds are sheltered from the true costs of these actions.

A policy makers committed to a well-functioning market should seek to minimize these adverse consequences of insurance. These impediments to efficient insurance contracts, and some potential solutions, are the core of this article and are discussed in the following sections.

II. INFORMATIONAL IMPEDIMENTS TO EFFICIENT INSURANCE CONTRACTS

According to the economic analysis of law, rational parties operating in a perfectly competitive market (without transaction costs) where everyone has complete information will voluntarily contract efficiently to maximize their joint welfare. Absent externalities, these contracts will also increase overall social welfare. That parties, especially insureds, are not always rational has been widely documented will be discussed in section 3 below,²². This section focuses on other impediments to efficient insurance contracts—informational impediments and strategic behavior. I discuss these impediments and offer possible contractual and doctrinal solutions to them.

A. INFORMATIONAL IMPEDIMENTS IN GENERAL

Information impediments result from the existence of *imperfect information* with respect to the probability of the risk materializing and/or its scope. Information impediments also arise from the existence of *information asymmetry* between the insurer and the insured with respect to these factors. It is the second reason for information impediments—those stemming from asymmetric information—that is at the center of our discussions. Why? Because when the information held by the insurer (and the insured for that matter) is not perfect, but there is no problem of information asymmetry, the risk the insurer is facing is small. For example, an insurer who charges a premium equal to two percent of the total value of

²² See Jolls, Sunstein & Thaler, *supra* note 8; Daniel Schwarcz, *Regulating Consumer Demand in Insurance Markets*, 3 ERASMUS L. REV. 23 (2010).

the property instead of three percent increased its risk by one percent of the value of the property, an increase which usually is not destructive for him.²³ More serious problems arise when information asymmetry exists between the insurer and the insured. Such asymmetry can exist at the pre-contractual stage; after the contract begins, but before the insured event occurs; or after the occurrence. Four problems which arise from the information asymmetry between the parties will be discussed in this section. When the insured has more information at the pre-contractual stage, which is relevant to the contracting itself, an *adverse selection* problem may occur. On the other hand, when the insurer has more information relevant to the contract itself, a *reverse adverse selection* problem may occur. After parties have entered the contract, whether before or after the insured event occurred, an informational gap about the insured's behavior can lead to the problem of *moral hazard*, while informational gaps about the behavior of the insurer may lead to the problem of *reverse moral hazard*. At the end of each of these discussions I will use the Two Islands Approach laid out in the preface to demonstrate how one can go about analyzing potential solutions to these problems.

Before we turn to the analysis of these four problems it is worth mentioning that regulation of the insurance industry by the executive branch also has an important role in dealing with these problems. For example, the monitoring of insurance policies by the insurance commissioners ensures both that consumers are burdened with efficient disclosure duties, thus reducing the risk of adverse selection, and that the policies match the consumer's reasonable expectations regarding the scope of coverage, thus reducing the risk of reverse adverse selection. Further, capital and liquidity requirements enforced by the commissioners ensure that insurance companies meet their financial commitments to the insureds, preventing reverse moral hazard. And so on and so forth. Of course regulation is not a magic solution. Insurance commissioners often lack the necessary resources to monitor effectively, are vulnerable to political pressures, and some argue are often captured by market players or for various other reasons do not maximize social welfare. In this paper I do not focus on the functions of insurance commissioners, but rather on the available solutions that courts and the parties to an insurance contract have

²³ The picture may be different of course if the error is systematic and was done for many uninsured, or if without the mistake the insurer would not have agreed to insure the property at all, and there is no possibility of reinsurance.

for dealing with the two pairs of problems resulting from asymmetric information.

B. ADVERSE SELECTION

Foremost, information that insurers and insureds possess will inevitably end up being imperfect or asymmetric. Asymmetry of information leads to the problem of adverse selection. A theoretical concept first appearing in the late nineteenth century, adverse selection describes the phenomenon of high-risk parties who, knowing their ‘type’, seek more insurance coverage than low-risk parties. For example, a person with a personal or family history of certain medical problems will be more likely to purchase health insurance than a person who does not have such a history. This result follows from insurers charging one premium rate to all (or at least many) insureds. The insureds, though, have varying degrees of risk and are personally better able to determine their own risk than the insurers, who only know the average risk for a pool of observationally similar, but in fact heterogeneous, insureds. This informational asymmetry allows high risk parties to obtain insurance at a premium that is lower than they would actually be otherwise willing to pay. For low-risk parties, however, the premium charged to the entire pool is too expensive. Low-risk parties might object to *cross subsidizing* the high-risk parties—with insurers using the excess premiums of the low-risk parties to defray the costs of offering cheaper insurance to high-risk parties—and might therefore drop their coverage and leave the insurance pool. Consequently, the average risk faced by the insurer increases, the premium must increase, and this cycle of adverse selection repeats itself and theoretically might lead to the risk pool unraveling completely—a classic death spiral.²⁴

In general, the risk of the total market unraveling increases along with the following factors: the heterogeneity of the insureds (whether both high and low risk insureds exist), the certainty of the insureds’ knowledge of their own risk level (otherwise, high risk insureds might not be excessively attracted to the pool), and the competitiveness of the market (when there is a greater chance that another insurance company will offer lower premium for low-risk insureds).

²⁴ For a case study which explores a death spiral in the context of a health-insurance plan see David M. Cutler & Sarah J. Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q. J. ECON. 433 (1998).

Of course, this is all known to the insurance companies which try to design their contracts in a way that will address this problem. Unfortunately, this is not a simple task because the asymmetric information brings with it strategic behavior such as when high-risk insureds pretend to be low-risk (for example by not reporting that they smoke). The following subsection provides some possible solution.

1. Theoretical solutions to the adverse selection problem

There are several possible solutions on the theoretical level. The first and most basic is requiring disclosure by the insureds. More accurate information regarding the characteristics and behaviors of the insured parties allows better assessment and pricing of the overall insurance pool. This is why insurance companies ask insureds to fill out long forms describing and bringing to light the potential risks the insureds bring to the pool.

The information collected is used to differentiate premiums for insureds in a way that reflects their varying levels of risk, a process known as risk classification. By dividing insureds according to their risk classifications in this way, an insurer may mitigate to some extent the problem of adverse selection, because similar risks pay the same premium. However, risk classification does not come free of disadvantages. By decreasing the extent of cross subsidization between insureds, insurers reduce the degree at which they spread risk among their risk-averse insureds. This tradeoff between increasing ex-post coverage while eliminating the ex-ante incentive for strategic behavior on the part of the insured is *fundamental* to insurance and characterizes it more broadly. In reducing the problem of adverse selection, risk classification allows the insurer to reduce the average cost of insuring its pool while at same time, to the extent high-risk insureds leave its pool to be admitted elsewhere where the degree of cross subsidization is larger, it increases the average costs of its rivals.

One may think there should be no limit to pursuing risk classification if one wants to combat adverse selection. In practice, besides the harm to the risk-spreading function of insurance, an attempt at too detailed a classification will often cost more than the benefit derived from it due to the costs involved in collecting, analyzing and utilizing the data. Thus, in life insurance it may be of no use to distinguish between female smokers and females non-smokers because the gap in life expectancy is not substantial enough or because the proportion of women who smoke is low and the extra cost of distinguishing between them is

high. Hence, a certain amount of cross subsidization, and therefore of adverse selection, will always remain.

In some cases the insurer can afford not to invest resources at the contracting stage to ensure that the insured met its disclosure obligations, despite being of vital significance, because after the occurrence it might be able, perhaps more easily, to check whether the insured breached her duty of disclosure. When the information is easily discoverable after the occurrence and can serve as grounds for canceling the insurance contract or paying reduced benefits—both are self-help measures the insurer can take without a court—the insurer can make do with collecting information only *after* the occurrence. A simple example involves the question of whether an insured who died of lung cancer was a smoker. Instead of investigating the condition of the lungs of all insured persons who stated they were not smoking the insurer can only investigate those who died from lung cancer, thus saving resources across the entire pool.

Classifying risk based on information collected from the insured, either by way of filling out questionnaires or by medical examinations, as a way to combat adverse selection, has many obvious limitations. The insured has an incentive to hide negative information from insurers, either because he is afraid the insurance company would refuse to insure him or because he wants to pay a lower premium. Insurance law, as we will see below, has developed various legal doctrines which punish insureds for material false representations, but it seems that despite this insureds do not always disclose private information, a fact that might lead to adverse selection.

Is there a way insurance companies can get policyholders to disclose *voluntarily* whether they are high risk? The answer, as first shown by Rothschild and Stiglitz, is positive.²⁵ By offering policies with diverse deductibles insurance companies incentivize the insureds to sort themselves into different risk pools based on a self-estimation of their own risk. High-risk insureds will tend to purchase more insurance coverage and therefore will choose a lower deductible for a higher premium, while low-risk insureds will prefer higher deductibles for a lower premium. Rothschild and Stiglitz famously showed that under some distribution of insureds' risk

²⁵ Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON 629 (1976). Their paper is the canonical insurance application of George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488 (1970).

types what is called a ‘separating equilibrium’ may be reached where high-risk types are fully covered but low-risk types are only partially insured.²⁶ In other words, self-selection by insureds may lead to an equilibrium where high-risk and low-risk insureds choose different policies (in terms of scope of coverage and the premium they pay for the scope of coverage they choose) so that effectively they voluntarily self-classify themselves into two separate pools without providing any further information about the risks they bring to the pool.

On the other hand, if the proportion of high-risk insureds in the pool is small and low-risk individuals are sufficiently risk averse, then the economic justification for offering lower price and narrower coverage to the low-risk insureds diminishes and the equilibrium that will be created is a ‘pooling equilibrium,’ where both types of insureds are pooled together, paying the same premium for the same scope of coverage.

Another way that insurance companies are encouraging self-selection is by offering multiple-period contracts. For example, consider a commercial by Allstate, a leading insurance company in the U.S, where it guarantees that automobile insurance premium will not go up for those involved in a car accident. Allstate markets this insurance by claiming it does not leave its policyholders in the lurch. In practice, this scheme may serve as a marketing device to create long-term relationships with the insureds allowing Allstate to gather information on the risk level of its policyholders. Moreover, the promise that the premium will not go up after an accident is especially tempting to drivers with private information as being at high risk of getting involved in multiple accidents. Those drivers will self-select into this program, allowing Allstate to classify them into their own special pool.²⁷

A few problems arise, however, when insurers risk classify their insureds. First, because classification is never perfect, certain insureds (the less risky) essentially cross subsidize others (the more risky) when they pay a premium higher than the risk they actually present. That creates not only problems of efficiency as insurance pools might unravel, or some low risk insureds will be driven out of the market, or get less coverage than they desired—problems which were discussed above—but also of distributive justice. Insurers—private or public—have the ability to redistribute resources between the classes they have separated by overcharging,

²⁶ Rothschild & Stiglitz, *supra* note 24, at 648.

²⁷ *Allstate - Accident Forgiveness*, YOUTUBE (Jun. 30, 2010), <http://www.youtube.com/watch?v=J2nJYflRdM>.

intentionally or otherwise, the less risky and undercharging the more risky.²⁸ In health insurance, for example, the healthy subsidize the chronically sick.

A related potentially troubling issue with risk classification logically stems from the nature of classification which often raises sensitive matters of discrimination. The reason is that the most obvious (and least expensive) way to divide a large group of individuals, with the goal of assigning them to different risk levels, is by observable characteristics like age, sex, and race. Any parent of a male teenage driver feels the effect of this practice when he or she pays a much higher car-insurance premium for his or her son.

Is it discriminatory to force those people who have a lower risk-level, like women who drive on average less than men—although not necessarily more carefully—to subsidize the relatively more risky by having them pay the same premiums?²⁹

On pure welfare grounds the analysis is (at least theoretically) clear: in the implausible case where the correlation between risk and gender, race, or age is perfect, that is, when insureds have no residual private information about their own risk not captured by the classification, then allowing such classification is welfare enhancing as it eliminates the adverse selection that otherwise would exist. In all other cases, the social welfare implications of allowing such classification is an empirical question which requires comparing the ex-ante costs of strategic behavior with the ex-post costs of reduced coverage. More specifically, one would need to compare the loss caused by adverse selection in a pool without the classification to the loss caused by classifying risk pools when the correlation is less than one, thereby making insurance both over and under expensive to some people.³⁰

Obviously, whether a policy is discriminatory or distributively unjust is not necessarily uniquely determined, although might well be informed, by economic analysis. To what extent society is willing to

²⁸ For an analysis of the tension between risk distribution and risk classification see Kenneth S. Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403 (1985).

²⁹ See *City of Los Angeles, Dep't of Water & Power v. Manhart*, 435 U.S. 702 (1978) (banning gender based annuities provided by an employer under Title VII); Cour Constitutionnelle [CC] [Constitutional Court] Case C-236/09, para 47, Sept. 30, 2010 (Belg.) (European Union Court of Justice actually banned insurers from even considering gender in determining insurance premiums).

³⁰ Einav & Finkelstein, *supra* note 3, at 121.

tolerate classifications such as race, gender, religion, or age varies greatly with the groups affected, but the process remains in many ways discriminatory nonetheless.³¹

An interesting, controversial matter on the forefront of the insurance and adverse selection problem involves genetic testing and its value in predicting disease. In one sense, the tremendous information advantage presented by genetic knowledge could lead to better loss prevention (for example people testing positive for HIV can be treated before they actually develop AIDS) and to more efficient risk classification.³² But the intensely private nature of that information, the risks of errors, the fear that it would leak to third parties or be used against relatives of the insureds, as well as the invasive means required sometimes (at least to date) to obtain it cheaply, may speak against permitting insurers to use genetic testing. Another argument against such testing is that it is not “fair” to punish a person for things that were determined before his or her birth. From a law and economics perspective an argument against the usage of genetic testing for insurance purposes can be expressed in the claim that using information obtained from genetic testing might lead to a welfare loss stemming from the fact that realized risks might no longer be insured, the so-called Hirshleifer Effect.³³ Imagine a test which predicts that a particular individual has a probability of 99% of developing cancer in the next five years. Once the information is revealed, insurance companies might not want to insure those who tested positive. That is a social loss, as most risk averse people would be willing to pay a premium *before* they take the test to make certain that they were still insurable even if they tested positively.

On the other hand, suppressing this information might deny the individuals access to preventative medical care, or to at least planning more optimally for their shorter expected life span. This creates a difficult dilemma, and jurisdictions, including the United States, have weighed in against the use of genetic testing by insurers for that very reason.³⁴

³¹ See Kyle Logue & Ronen Avraham, *Redistributing Optimally: Of Tax Rules, Legal Rules, and Insurance*, 56 TAX L. REV. 157, 207-27 (2003).

³² Alexander Tabarrok, *Genetic Testing: an Economic and Contractarian Analysis*, 13 J. HEALTH ECON. 75 (1994).

³³ Jack Hirshleifer, *The Private and Social Value of Information and the Reward to Inventive Activity*, 61 AM. ECON. REV. 561 (1971).

³⁴ Michael Hoy & Michael Ruse, *Regulating Genetic Information in Insurance Markets*, 8 RISK MGMT. & INS. REV. 211 (2005) (analyzing the economic efficiency aspect of allowing the use of genetic test results for risk classification).

A sensible compromise might be to allow insureds to know about their genetic makeup but prevent insurers from using it in their underwriting procedures. Unfortunately, the legal prohibition against using genetic testing has the potential to lead to further exaggeration of the adverse selection problem because of the asymmetry it creates. Given that some individuals will undertake genetic testing for their personal knowledge or will infer their genetic makeup from their family history, those who know that they are high risk will view insurance as a worthwhile investment and will over-insure. The opposite is true for those with knowledge of their own clean genetic make-up.

This adverse selection effect of banning genetic testing was shown in a recent study of individuals at risk for Huntington Disease, a terminal genetic illness, and their propensity to purchase long-term care insurance—insurance that covers the costs of nursing care later in life.³⁵ The rates of Huntington Disease are extremely low among the general population, but if one parent has the disease you have a 50% chance of also having it and there is no cure.³⁶ Those with the genetic mutation are guaranteed to require some sort of nursing care during their lives, making long-term care insurance very valuable.³⁷ Not surprisingly then, those individuals who are at risk (have a parent with the disease) are two and half times more likely to own long-term care insurance, and those who have tested positive (100% chance of having the disease) are five times more likely to have the coverage when compared with the general population and controlling for various factors like age.³⁸ While long-term care underwriters screen for those who have been diagnosed with the disease (and would reject an applicant who had previously tested positive), they do not ask whether a parent has Huntington Disease.³⁹ Insurers can also not force the potential insured to undergo genetic testing to screen for Huntington or other diseases. This illustrates the adverse selection issues that arise when one party (the insureds) can use genetic testing to gain private information but the other party (the insurer) cannot.⁴⁰

³⁵ Emily Oster et al., *Genetic Adverse Selection: Evidence from Long-Term Care Insurance and Huntington Disease*, UNIV. CHI. BOOTH SCH. BUS. (June 8, 2010), <http://faculty.chicagobooth.edu/emily.oster/papers/geneticadverse.pdf>.

³⁶ *Id.* at 2.

³⁷ *Id.* at 3.

³⁸ *Id.* at 18.

³⁹ *Id.* at 7.

⁴⁰ In fact, the death spiral for the long-term-care insurance market may have already begun. See Anne Tergesen & Leslie Scism, *Long-Term-Care Premiums*

A totally different solution for adverse selection is group-based insurance where insurance is offered to a group of people united by characteristics other than the risk insured against. All members of the group are automatically admitted without individual underwriting. Health insurance offered through employers, as in the U.S., life insurance offered through one's bank, and automobile insurance offered through a trade organization are such examples. Because the risk insured against is randomly distributed in the group, the risk of the pool should not be excessively high. The benefits to the insureds from groups insurance stem from three sources. First, as was just mentioned the risk for adverse selection is null and therefore premiums can be kept low. Second, the administrative costs associated with group-based insurance are much lower than the costs associated with individual underwriting, and, third, the group often has market power that enables it to negotiate even lower prices. As a result, the premium offered in group-based insurance is appealing even to low-risk insureds. Those low-risk insureds prefer the group insurance coverage even though they cross subsidize the high-risk insureds, further eliminating the problem of adverse selection, because the premium is lower than in a homogeneous risk pool but one where underwriting is done individually.

Another possible solution for adverse selection is eliminating coverage for preexisting conditions or a delayed coverage for these conditions. If a patient has cancer and knows that he would have to wait two years before he can get coverage in a new insurance company he would not adversely select into that pool, if only because he might die before the coverage would begin. But denying coverage for preexisting conditions creates terrible ex-post problems as the sickest people in society are left without care. Indeed, in the recent Healthcare reform (the Patient Protection and Affordable Care Act, known as the ACA) insurance companies are prohibited from denying coverage for preexisting conditions. In other countries, health insurance plans have always been mandated to accept every applicant for health-care coverage regardless of any preexisting conditions the insureds may have. The societal value of this exclusion is discussed under the Two Islands Approach later in this section.

Soar, WALL ST. J. (Oct. 16, 2010), <http://online.wsj.com/article/SB20001424052748703298504575534513798604500.html> (reporting that rate increases of up to 40% were submitted to state regulators for approval to cover unexpected increases in insurer costs).

While it sounds noble, accepting every applicant who self-selects into the pool may restore the adverse selection problem. Ordinarily at least, it would. To prevent this from happening the prohibition of the preexisting condition exclusion is usually accompanied, as it is in the ACA, with a mandate requiring that everyone, including the young and healthy who might not otherwise apply for insurance, purchase coverage.⁴¹ If everyone is required to purchase insurance, then more healthy people will be in the pool to subsidize the sick people. While a greater number of sick people in the pool may put upward pressure on premiums, the increased number of healthy people, who might have been previously priced out of the pool by adverse selection, will likely keep premiums close to their original level, or lower. Furthermore, the cycle of adverse selection where relatively healthy people are priced out by sick people, and then the moderately sick people are priced out by the very sick people, and so on, cannot happen because everyone is required by law to be included in the pool. Essentially, mandatory insurance is tantamount to a one single group-based insurance pool, which, as we saw above, is a way to combat adverse selection.⁴²

A less extreme solution is to provide a lump sum subsidy toward the price of the policy, especially to the low risk individuals. This will lead to fewer low risk individuals remaining without insurance.

In any case, uniform subsidies or mandatory insurance do not solve the distributive justice and discrimination concerns raised before. Charging every driver the same premium entails that good drivers subsidize bad drivers, that drivers who drive less subsidize drivers who drive more, and less directly, that the old subsidize the young and that women subsidize men. More generally, there is an inherent question with insurance as to how much the able and lucky should subsidize the unable and unlucky; with car insurance it is the safe drivers against the unsafe, with health insurance it is the healthy against the sick, and with liability insurance it is the non-negligent-prone against the negligent-prone. These questions are a bit easier to resolve when those subsidizing today will inevitably become those

⁴¹ Such mandate was recently held constitutional by the U.S Supreme Court in *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

⁴² If the administrative costs of processing claims are too high, it might be socially optimal to leave some low risk individuals outside of the pool, as the cost of providing them coverage might outweigh the benefits to them. In such cases, mandatory coverage might not be welfare enhancing. Einav & Finkelstein, *supra* note 2, at 123.

being subsidized tomorrow like when the young subsidize the old. In contrast, these questions become starker in situations when the relatively risky classification coincides with other social disadvantages, such as poverty.⁴³

2. Doctrinal solutions for the adverse selection problem

Insurance law has found ways to facilitate the practice of some of these theoretical solutions in order to alleviate or prevent the effects of adverse selection. Laws establishing a mandatory insurance framework—such as in automobile insurance—are an obvious example. But other legal doctrines, which pertain more closely to disclosure and risk classification, are more intricate and arguably more significant in that they expose private information about insured parties to investigation by insurers.

One such doctrine concerns the “warranties” proffered by the insureds prior to the conclusion of the insurance contract. This practice engages the warranty doctrine, and according to its terms in the U.S., the insured party is permitted, prior to insurance contract formation, to make any truthful statement about itself that would lower its perceived risk and, consequently, its premium.⁴⁴ If the insured party later makes a claim, though, and the insurer can prove any of those statements, however inconsequential, to have been false, the claim may be rejected. Because of the high cost of a false statement, the warranty doctrine presents a fairly effective means to encourage accurate disclosure. The associated frequent, costly investigations into pre-contractual statements and the potential for a penalty being imposed on the insured for simple pre-contractual carelessness, however, are substantial detriments to the warranty doctrine. A similar doctrine is that of misrepresentation. Here, an insured party also makes pre-contractual representations to the insurer regarding the risk of the insured. Under this doctrine, instead of being liable for any

⁴³ Mandatory insurance may also increase the risk of moral hazard, to be discussed further below. See Alma Cohen & Rajeev Dehejia, *The Effect of Automobile Insurance and Accident Liability Laws on Traffic Fatalities*, 47 J.L. & ECON. 357 (2004). Same holds for state mandates requiring health insurance plans to cover medical treatment. See Jonathan Klick & Thomas Stratmann, *Diabetes Treatments and Moral Hazard*, 50 J.L. & ECON. 519 (2007) (finding that mandates generate a moral hazard problem, with diabetics exhibiting higher BMIs after the adoption of these mandates).

⁴⁴ Seth Chandler, *Insurance Regulation*, 3 INT’L ENCYCLOPEDIA OF L. & ECON. 837, 845 (2000).

misstatement, a future claim may only be denied if the insured *knowingly* made a misrepresentation which is *material* to the insured's risk. Thus courts ask whether the insurer would have agreed to cover the risk at all, or whether the premium the insured has paid for the policy covering the event that actually occurred would have been *materially* higher if an accurate representation had been made. Over time, the law in the U.S. has generally shifted from the stricter liability associated with warranties to a negligence-based system of representations, whether through statutory action or common law.⁴⁵

Given a finding of breach of warranty or misrepresentation, the penalty for the insured party is typically voiding or reducing the insurance policy. If the penalty is reduction, the amount owed to the insured is usually reduced to the amount that would have been available had no misrepresentation occurred prior to contract formation. The rationale for reduction is that, because it puts the insured in the same position as if her representations were correct, there is no incentive for the insured to be dishonest up front. The problem, however, is that not all misrepresentations will be caught, and if the only penalty is reduction, insureds might gamble that they can get away with the misrepresentation. Voiding the policy outright provides an affirmative penalty, creating a stronger incentive for the insured to be honest at the outset.

In some scenarios, like when an insured has been paying premiums for several years, certain statements and representations may not be challenged under the doctrines of warranty or misrepresentation, because after that much time has lapsed there is a high risk of erroneously determining either the validity, or falsity, of pre-contractual statements. This is the doctrine of incontestability.⁴⁶ The purpose of incontestability is to prevent an insurer from opportunistically issuing policies to insureds and accepting years of premiums, all the while knowingly concealing a technicality with the application that would allow the insurer to later deny coverage should it so choose.⁴⁷ Incontestability acts as de facto statute of

⁴⁵ Particular attention has been recently paid to the requirement that a materially higher premium would have been charged for insurance covering *the particular event that actually occurred*. In other words while some require that the misrepresentation contributed to the loss actually occurred, others require that it contributed to the risk of loss. *Id.* at 846.

⁴⁶ *Id.* at 846.

⁴⁷ See John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV.

limitations insulating insured parties from “post-occurrence underwriting”, a practice which is profitable for the insurer but places large risks of forfeiture on a potentially innocent policy holder, who has presumably paid years of premiums up to that point. Life insurance, health insurance, and disability insurance policies often contain an incontestability clause or are subject to an incontestability statute.⁴⁸

Incontestability clauses, however, do not strip insurers of all defenses. Fraud is a common exception where insurers are allowed to challenge the validity of a policy, though what type of fraud avoids an incontestability clause is not always clear. The California Supreme Court, for example, has differentiated between the insured sending an imposter to take his life insurance medical examination and a healthy person giving the name of someone else as the insured, but taking the medical examination herself: the former is subject to incontestability, while the latter is not. The rationale given by the court for this discrepancy is that in the former case there was a valid contract between the parties, even though it was procured by fraud, and therefore the dispute was governed by the contract itself, including its incontestability clause.⁴⁹ In the latter case there was no meeting of the minds between the insurer and the deceased person, as the deceased person was obviously not a party to the contract. The policy insured, if anyone, the person who completed the application and took the medical examination.⁵⁰

Another related doctrine is concealment, which punishes the intentional nondisclosure of information by the insured either when asked during the application process, or in the period that follows it.⁵¹ Given how easy it is for insurers to ask relevant questions and to collect relevant information, it is not clear that the doctrine of concealment should apply to incomplete application forms. Rather, the doctrine of concealment seems more relevant in the period after the insured filled out the applications but before the insurance company issued the policy, as well as in the period after the policy was issued and before the occurrence, because in these

1315 (2007) (documenting how Unum/Provident knowingly took on policies with minor errors in them and then denied coverage on the basis of these technicalities).

⁴⁸ See, e.g., *Halstead Consultants, Inc. v. Cont'l Cas. Co.*, 891 P.2d 926, 928 (Ariz. Ct. App. 1994); *Equitable Life Assurance Soc'y of U.S. v. Bell*, 27 F.3d 1274 (7th Cir. 1994).

⁴⁹ *Amex Life Assurance Co. v. Superior Court*, 930 P.2d 1264, 1266 (1997).

⁵⁰ *Id.*

⁵¹ 1 JEFFREY W. STEMPEL, *LAW OF INSURANCE CONTRACT DISPUTES* § 3.08(d) (2d ed. Supp. 2000).

periods insureds are not usually asked about changes in their risks, and therefore it makes sense to require them to initiate a disclosure of any new changes in their risk profile. Indeed, courts have ruled that insureds may remain silent unless specifically asked by the insurer or the insured knows that the withheld information is material to the insurer's decision to grant a policy. In that sense concealment is not as far-reaching as the misrepresentation or warranty doctrines. As with misrepresentation, however, the penalty for concealment is usually reduction of the scope of coverage or voiding of the insurance policy all together.⁵²

3. Returning to the Two Islands Approach

The value of the two island approach can be seen clearly in the debate over coverage of preexisting conditions in health insurance, discussed earlier in this section as a theoretical solution to the problem of adverse selection.⁵³ The Third Circuit addressed the preexisting medical condition exclusion in *Lawson ex rel. Lawson v. Fortis Insurance Co.*⁵⁴ The question in that case was whether a child, treated for symptoms of leukemia two days before the issuance of a policy but not diagnosed with leukemia until after, was excluded from coverage by a preexisting condition exclusion.⁵⁵ Judge Alito found the policy language ambiguous as to whether the exclusion required treatment or diagnosis, and found for the insureds per *contra proferentem*.⁵⁶ That decision merely limits the scope of the preexisting condition exclusion in those situations where a condition has not yet been diagnosed. The court's decision can be explained by the distaste anyone would have denying insurance to a child with leukemia. But that is an ex-post approach which focuses on the parties at bar, whereas

⁵² Compare *Mut. Benefit Life Ins. Co. v. Higginbotham*, 95 U.S. 380 (1877), with *Stipcich v. Metro. Life Ins. Co.*, 277 U.S. 311 (1928). In *Stipcich* the U.S. Supreme Court voided a policy where the insured did not disclose changes in its health that occurred between the date of application and the date of the issuance of a policy, where as in *Higginbotham* it did not.

⁵³ The exclusion has since been prohibited by the Patient Protection and Affordable Care Act. 42 U.S.C.A. § 300gg-3 (West Supp. 2012).

⁵⁴ *Lawson ex rel. Lawson v. Fortis Ins. Co.*, 301 F.3d 159 (3d Cir. 2002).

⁵⁵ *Id.*

⁵⁶ *Id.* at 167. *Contra proferentem* is a doctrine which dictates that an ambiguous provision in a contract should be construed against the drafter. As will be shown below, this doctrine combats reverse moral hazard.

the correct approach, as we saw, is the ex-ante which focuses on the function of insurance and the future implications a decision would carry.

All else being equal, an island with an exclusion for preexisting conditions or illnesses will have far cheaper insurance premium than an island without the exclusion. Indeed, an island without the exclusion could potentially have the adverse selection cycle discussed above, pricing out all but the sickest from the insurance market. Without the exclusion, there would be little reason to buy insurance until you know you are sick. Premiums would go up dramatically, causing fewer healthy people to buy insurance, causing premiums to increase, and so on.

On an island with the exclusion, just as insureds know they cannot purchase fire insurance after their houses burn down, they would know they cannot purchase health insurance after they are diagnosed with a disease. In a well-functioning market that knowledge should incentivize everyone to purchase coverage in advance. Thus, healthy and sick people are jointly members of the insurance pool, and once sick people are diagnosed, their care costs are subsidized by the healthy people's premium. It is clear, therefore, as a general theoretical matter, the preexisting condition exclusion is important, at least when insurance coverage is not mandatory.⁵⁷ However, to make a judgment about the *Lawson* case specifically, the discussion must be sharpened.

In the *Lawson* opinion the issue was not the overall value of the preexisting condition exclusion, but whether it should be applied when symptoms have been treated without a diagnosis of the actual condition.⁵⁸ Adding the court's chosen "island" to the above analysis, the issue becomes close. That "island" would only void the exclusion for people treated without being diagnosed with a specific illness. This is a relatively small group of claims, limited further by excluding instances where there is an indication of bad faith or fraud. The adverse selection issue would be

⁵⁷ If individuals are mandated to purchase insurance then they cannot wait until after they discover they are sick to purchase insurance, and thus the problems preexisting decision exclusion are designed to prevent never come to be.

⁵⁸ In the *Lawson* case, there was some circumstantial evidence that the condition, or at least a serious condition, was suspected by the daughter's family prior to the issuance of the insurance policy. Specifically, the grandmother was a registered nurse, and the health insurance was applied for on the same day the daughter was originally taken to the doctor. *Lawson*, 301 F.3d at 161. But the court thought differently. To quote then Judge Alito, "[h]ere, there is no evidence that the possibility that Elena's condition was actually leukemia ever entered the minds of Elena's parents or Dr. Parikh." *Id.* at 166.

vastly smaller than if there was no preexisting condition exclusion at all. There would still be some adverse selection, however, if the patients themselves suspect they have a serious disease even before they are officially diagnosed, leading to some increase in premiums.⁵⁹ Additionally, there will be higher administrative costs due the required case-by-case analysis as to whether a condition has actually been diagnosed, or if symptoms have merely been treated, and if there is any indication of bad faith or fraud. The higher administrative costs will also lead to an increase in premiums. The higher premiums associated with more coverage could well be preferable to cheaper premium and no coverage, but to identify the pool's welfare maximizing "island", further information is needed about the frequency and costs of such circumstances. If such empirical information exists, it should be presented to the courts. Otherwise, the court needs to "guesstimate" it itself.

Here we have seen that while the Two Islands Approach does not provide a definitive answer, it does allow us to look at the situation objectively. The court in *Lawson* probably got it right but only because of the overall effect of its decision on insurance pools, rather than any sympathy for a plaintiff with leukemia.

4. Adverse Selection—The Empirical Evidence

Although a formidable problem theoretically, there is only little evidence that in certain insurance markets adverse selection exists and almost no evidence to suggest that adverse selection is actually a major problem for the insurance industry at large.⁶⁰ Alma Cohen and Peter Siegleman provide several explanations for the disconnect between theory and practice. One is that it is hard to measure adverse selection

⁵⁹ This would be further reduced by implementing some type of waiting period, where new insureds do not receive full coverage until a certain period of time has elapsed since they purchased coverage, unless they were previously covered, as is currently the case with most United States health insurance policies.

⁶⁰ Alma Cohen & Peter Siegelman, *Testing for Adverse Selection in Insurance Markets*, 77 J. RISK & INS. 39 (2010) (surveying a wide-ranging literature and concluding that whether adverse selection exists varies across insurance markets and pools of insurance policies); Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004). For a study finding adverse selection see Amy Finkelstein & James Poterba, *Selection Effects in the United Kingdom Individual Annuities Market*, 112 ECON. J. 28, 47 (2002) (showing significant adverse selection in the United Kingdom annuity market).

empirically. Many empirical papers attempt to estimate adverse selection by comparing the insurance costs of those with ample insurance coverage with the costs of those with less. But that, as Liran Einav and Amy Finkelstein show, is problematic on various grounds, as any difference could equally be attributed to moral hazard.⁶¹ There are also theoretical explanations for why adverse selection is not detected. As was discussed above, some forms of insurance, such as car insurance, are mandatory. Mandatory insurance prevents adverse selection because low risk insureds cannot opt out of the pool. Another explanation might be that insureds' informational advantage vis-à-vis insurers is not really that large, and that insureds fail to use whatever private information they do have, so at the end of the day insurers' superior predictive ability offsets whatever informational advantage insureds might use. Adverse selection might also not be prevalent because, as was explained above, insurance companies have developed various underwriting practices (such as deductibles, waiting periods, or group-based insurance), and because courts have developed various doctrines, all of which encourage disclosure of private information to combat the problem. Lastly, adverse selection might not be detected because it is offset by another phenomenon called "propitious" or "advantageous" selection. This stems from the fact that in the real world there is heterogeneity in risk-aversion. Whereas the early models of adverse selection, such as Rothschild and Stiglitz from 1976, conveniently assumed people have the same preferences when it comes to risk, there is substantial literature documenting heterogeneity of risk preferences between different individuals and different insurance markets. Specifically, to the extent that those who are more risk-averse (and therefore more likely to carry

⁶¹ For an excellent explanation of the methodological difficulties in measuring adverse selection see Einav & Finkelstein, *supra* note 2, at 126-36. One way to separate the two effects is to test the impact of an exogenous change in an insurance contract on existing versus new insureds. If existing insureds change their behavior, or if reported losses increase, that would be a sign of a moral hazard effect. If, in contrast, the chance of accidents differs between new and old policy holders, that would be a sign of an adverse selection effect. See Jaap H. Abbring et al., *Adverse Selection and Moral Hazard in Insurance: Can Dynamic Data Help to Distinguish?*, 1 J. EUR. ECON. ASS'N, PAPERS & PROC. 512 (2003) (using dynamic insurance data to distinguish moral hazard from adverse selection); Patrick Bajari, Han Hong & Ahmed Khwaja, *Moral Hazard, Adverse Selection and Health Expenditures: A Semiparametric Analysis* (Nat'l Bureau of Econ. Research, Working Paper No. 12445, 2006) (arguing that the two inefficiencies can be separated through regression analysis).

insurance policies) are also low risk individuals, that is, they are more likely to pursue safe (non-risky) behavior, then a phenomenon known as “propitious” or “advantageous” selection may emerge. These low-risk individuals who propitiously select into the pool may well offset the cost of the high-risk insured who adversely select into the pool.⁶² While in theory insurance markets can face both adverse selection and propitious selection, current empirical methods do not allow separating their effects.

It is worth mentioning that “propitious” or “advantageous” selection, while not necessarily welfare enhancing, is usually beneficial to the insurer.⁶³ Accordingly, insurers seek to bring about propitious selection by rigging the incentive structure of the policy to only entice low-risk individuals. Offering a free health club membership as an incentive to purchase life insurance selects for healthy individuals—who else would

⁶² See David Hemenway, *Propitious Selection*, 105 Q.J. Econ. 1063 (1990); see also David de Meza & David C. Webb, *Advantageous Selection in Insurance Markets*, 32 RAND J. ECON. 249 (2001).

⁶³ The usual underinsurance result in adverse selection models arises because insurance companies anticipate self-selection of high-risks into their pool and therefore set high premiums, making it unattractive for low-risks to join the pool, even though the low-risk individuals would be more than willing to pay the actuarially fair price for their coverage. In “propitious” or “advantageous” selection, the presence of risk-averse yet cautious types causes insurers to lower premiums and thus draws into the market less risk-averse people (who do not place a high value on coverage), but which are high-costs types. These people value the insurance at less than their expected costs and therefore on efficiency grounds should not have been insured. Put differently, whereas adverse selection entails that some people who should have been insured will not get insurance because they were priced out, “propitious” or “advantageous” selection entails that some people who should *not* have been insured (because the administrative costs of providing them insurance are higher than their expected loss), will nonetheless get coverage. See John Cawley & Tomas Philipson, *An Empirical Examination of Information Barriers to Trade in Insurance*, 89 AM. ECON. REV. 827, 829-30 (1999) (finding that the mortality rate of U.S. males purchasing life insurance is below that of the uninsured); Amy Finkelstein & Kathleen McGarry, *Multiple Dimensions of Private Information: Evidence from the Long-Term Care Insurance Market*, 96 AM. ECON. REV. 938 (2006) (providing evidence that more cautious individuals are more likely to purchase long-term care insurance and also invest more in precautionary behavior but are less likely to eventually use a nursing home); Hanming Fang, Michael Keane & Dan Silverman, *Sources of Advantageous Selection: Evidence from the Medigap Insurance Market*, 116 J. POL. ECON. 303 (2008) (documenting advantageous selection in the market for Medigap coverage).

want the membership? In a novel example of this “cream-skimming,” one insurer was rumored to have offered applications for health insurance to the elderly only on the third-floor of its office, which was only reachable by stairs. The assumption was that if an elderly individual was able to traverse the stairs, then she was likely a lower-risk individual.⁶⁴ A more common method is to market to the risk-averse under the assumption that they might be those who will take more care than necessary. This may explain the scary advertisement one sees on T.V. where one’s happy family life is financially destroyed because he did not have life insurance, or where an uninsured driver gets into a violent accident. Use of such high-pressure sales tactics to induce people into buying life and other forms of insurance is in a way an insurer-induced selection device: you don’t want to sell the product to anyone who actually needs to buy it; only to those who really want it but do not really need it.

C. REVERSE ADVERSE SELECTION

Adverse selection occurs not only among the insureds—insurers themselves are also susceptible to its effects. “Insurer-side adverse selection” results when there is a disparity in the quality of policies offered by insurers and an information barrier that prevents insureds from accurately separating those policies into high and low quality. The lower quality policies will be offered at lower premiums, attracting more insureds yet driving out of the market other insurers which offer higher quality coverage (but which high quality the insureds cannot observe) at a more expensive price, the so called “market for lemons”.⁶⁵

Eventually, a race-to-the-bottom leads to either low quality of coverage, costing much more than the benefits it actually provides, or non-payment of claims by insurance companies who priced their premiums below the necessary levels required to stay solvent. Both effects result in negative public attitudes toward insurance as the externalities associated with non-paying or under-paying insurers build up.

A famous example of the market of lemons in insurance policies is the fire insurance industry in the late nineteenth century where insurance companies offering property/casualty insurance policies sought to save

⁶⁴ Siegelman, *supra* note 59, at 1253.

⁶⁵ Akerlof, *supra* note 24.

money by ratcheting back coverage without informing consumers.⁶⁶ In response, New York promulgated a mandatory policy form for fire insurance that was widely copied by other states.⁶⁷

A recent study looked at homeowners' insurance policies in six states and found some of the same problems in the modern insurance market as in nineteenth century New York.⁶⁸ One variation of the study compared sixteen homeowners insurance policy types found in North Dakota and Pennsylvania to the HO3 standard policy provided by the ISO.⁶⁹ Of the sixteen, five had substantially less generous coverage than the HO3 policy, eight had slightly less coverage but were consistent with HO3 terms, and three had more generous coverage. Generally speaking, the negative deviations exceeded the positive deviations. Following his analysis, Daniel Schwarcz expresses concern that some insurance carriers may be exploiting consumer ignorance by ratcheting back coverage while seeking to hide differences between their policies.⁷⁰ He refers to this as the "exploitation hypothesis,"⁷¹ and it is a perfect example of reverse adverse selection.

Policy differences are not inherently bad though. In fact, offering insureds different coverage levels for different prices is one of the ways to get insureds to self-identify their risk level, as discussed in the previous section on theoretical solutions to adverse selection. A problem arises, however, when heterogeneity in coverage is combined with a lack of transparency. The lack of information in many insurance markets occurs at two stages. For example, homeowners cannot access policy forms prior to purchasing the insurance. Second, even when insureds receive policy forms

⁶⁶ See Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, U. CHI. L. REV. 1263, 1268-70 nn.9-11 (2011) (citing various studies of early insurance policies and the standardization of fire insurance forms around the New York form).

⁶⁷ See George W. Goble, *The Moral Hazard Clauses of the Standard Fire Insurance Policy*, 37 COLUM. L. REV. 410, 410 (1937). As Goble explains, "[b]efore the advent of the standard fire insurance policy there were in use in the United States almost as many policy forms as there were companies." *Id.*

⁶⁸ See Schwarcz, *supra* note 65, at 1277-1308.

⁶⁹ ISO, Insurance Services Office, is a provider of legal and regulatory services to insurers including homeowners' insurance forms portfolio. See *generally id.* at 1308-17, for a discussion on why the policies were chosen and how they were analyzed.

⁷⁰ *Id.* at 1315.

⁷¹ *Id.*

after payment the terms are “virtually indecipherable.”⁷² This lack of information makes it impossible for consumers to select insurance based upon coverage terms, and creates an environment where consumers can be exploited by insurers offering an inferior product at a higher price.

There are a number of possible solutions to the problem of reverse adverse selection. The foremost solution to this problem is regulation. For example, by limiting the prices at which policies may be offered and by requiring insurers to maintain sufficient assets to pay out on claims, the government prevents the race-to-the-bottom and non-payment problems directly.

One of the major themes of regulatory reform to combat this problem is transparency. Transparency could be achieved by making policy forms and terms available online and requiring insurers to compare their policies to a standard form baseline, like the HO3 form. Regulators could also require simplified policy language that is comprehensible by the average insured. These two reforms would prevent insurers from hiding policy differences and allow consumers to make educated choices about their coverage options.⁷³

However, transparency alone may not be enough to combat this serious problem. Other options include creating a standard form or at least a default policy that consumers would have to opt out of.⁷⁴ In this way it would be impossible for insurers to secretly ratchet down coverage. Mandatory floors provide similar protections, and, as the 19th century fire insurance example teaches us, legislation mandating minimum standards is already used in many states to ensure policies meet minimum quality standards.⁷⁵

1. Returning to the Two Islands Approach

One way courts can combat reverse adverse selection is to not strictly enforce an “increased risk” exclusion against an unsuspecting

⁷² *Id.* at 1318.

⁷³ *Id.*

⁷⁴ As will be discussed in Section 3 (e) *infra*, the vast majority of insureds will not make any changes to the standard form, so it is important that these protections are adequate.

⁷⁵ See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 63-64 (1999) (arguing mandated policy provisions are an efficient way to battle the reverse adverse selection problem).

insured. As mentioned above, one place we see reverse adverse selection is when insurance companies sell policies with specific coverage exclusions, but because of various information impediments the insured is not aware of the clause. An “increased risk” clause eliminates from coverage any incident that was caused by an increased hazard within the control of the insured.⁷⁶ A fire caused by the insured smoking in bed is a perfect example of an action that, under a strict reading of such an exclusion, would not be covered under the insured’s policy. In deciding these cases, courts have often held that such a loss is covered by insurance policies even though the incident is specifically excluded.⁷⁷ The question becomes whether we want courts to enforce increased risk clauses under these circumstances, and in our analysis we again set up two islands. Remember that each two-islands exercise starts anew to allow us to focus on the ex-ante effects of the proposed rule. Therefore the two islands we have created are identical in every way except for the enforcement of increased risk clauses.

On the first island, the increased risk exclusion is fully enforced, and so any actions by the insured that increase the risk of an incident will lead to a finding of no coverage. Even common actions such as smoking in bed would not be covered on this island.⁷⁸ As a result, insureds have stronger incentives to refrain from smoking in bed and policy premiums should be lower because fewer events are covered. The costs of reduced coverage, however, are that insureds will not be able to obtain insurance for these accidents because such coverage would not be available.⁷⁹

On the second island, the increased risk clause is not strictly enforced by courts, so a fire caused by smoking in bed will still receive coverage. Insureds’ incentives to refrain from smoking in bed are diluted and more events will be covered, which means that policy premiums will be higher. However, insureds now have less risk of remaining homeless after losing their house to a fire accidentally caused by them, thus avoiding a cost that is potentially very high.

⁷⁶ See Schwarcz, *supra* note 65, at 1283-84 (discussing increased risk clauses and quoting several examples).

⁷⁷ ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 376 (2d ed. 1996).

⁷⁸ Although smoking inside may be less prevalent now than it was in previous generations, smoking is still the cause of around 15,000 residential fires each year, many of which originate in the bedroom late at night. FEMA, Smoking Causes Nearly 15,000 Residential Fires in United States (2005), *available at* <http://www.fema.gov/news-release/smoking-causes-nearly-15000-residential-fires-united-states>.

⁷⁹ It is hard to imagine a secondary market for smokers insurance.

Looking at these two islands and adopting the perspective of the entire pool of insureds, we can attempt to determine which they would prefer: higher premiums for increased coverage yet diluted incentives to take care, or lower premiums for less coverage and increased incentives to take care.

One reason for preferring the second island is that people may reasonably expect, even if they do not actually expect, that they will be covered for their own clumsy actions. Both homeowners and liability insurance capture this point. Specifically, people may want to be able to smoke in bed and, on the small chance a fire begins, have these costs covered by insurance. The insured already has other strong incentives to not burn down his or her home without this exclusion – his own safety is at stake – so not enforcing the exclusion is not expected to dilute their incentives to take care.⁸⁰ While people in the insurance pool who do not smoke may oppose having to cross subsidize those who want to smoke in bed, they could still benefit from this clause if they, for example, like to burn scented candles in their bedroom, or otherwise engage in activities that carry increased risk of loss.

Moreover, it may be the situation that on both islands the insured *actually* expects that the event will be covered. If this is the case, then the insurance companies may be able to charge the same amount of premiums on both islands because insureds are not aware they should be demanding lower premiums on the first island (without coverage). The risk of insurance companies exploiting the ignorance of insureds by charging the same premium regardless of the exclusion provides another reason for courts to mandate coverage, even when it is specifically excluded by an increased risks clause.

In this analysis we have seen an example where, unlike the child with leukemia, a judge or jury might be unsympathetic to the plight of the insured because it is well known that smoking in bed can cause fires. However, by viewing the effects on the insurance pool as a whole, and seeing that the risk of diluted incentives is not large and that the corresponding benefit (lower premiums) may not be present, it seems clear

⁸⁰ See Saul Levmore, *Obligation or Restitution For Best Efforts*, 67 S. CAL. L. REV. 1411, 1424 (1994).

that in many circumstances the increased risks clause should not be strictly enforced.⁸¹

D. MORAL HAZARD

Another systemic risk insurers face is known as “moral hazard.” Moral hazard consists of the risk of three distinct kinds of behavior by insureds, all of which are hidden from the insurer. The first is when insureds take less than optimal care in protecting themselves against the insured risk. The second behavior categorized as moral hazard is when insureds make less of an effort to minimize their loss should the risk occur. The third action, somewhat more controversially defined as moral hazard because it can also be plain fraud, is the exaggeration of losses by insureds to get higher reimbursements. The first behavior is considered *ex-ante* moral hazard, while the second is considered *ex-post* moral hazard. The third behavior, depending on its magnitude, is sometimes considered *ex-post* moral hazard, but sometimes is considered fraud. In all these cases the insureds externalize costs onto the pool. Why? Because the insurer cannot distinguish between insureds who do and those who do not behave in a moral hazard way, the insurer charges the same premium to all insureds, leading to cross subsidization. The risk for such “immoral” behavior by the insureds was dubbed by insurance companies in the nineteenth century “moral hazard”.⁸²

Take, for example, a property owner with a piece of real estate worth \$1 million. She is concerned with fire damage, which at a 10% likelihood each year will destroy the entire value of the property. Thus, her expected cost from fire damage is \$100,000 per year. The property owner also knows that with a janitor properly maintaining the property, the probability of a fire is reduced to 1% and therefore the expected cost falls to \$10,000. She can hire a janitor for \$30,000 per year, bringing the total expected cost of fire damage, plus a janitor, to \$40,000. Therefore, investing in care is efficient for an uninsured property owner—she has invested \$30,000 in care and has saved \$90,000 in expected costs.

⁸¹ Other actions that are intentionally dangerous, like making explosives in the basement, would undergo a different analysis and likely lead to a different conclusion.

⁸² Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 250-51 (1996).

The problem begins when the property owner purchases insurance. Fire insurance could serve as a substitute or as a complementary solution to the property owner's concerns. If an insurer has no way of monitoring the property or the janitor's work, it will charge an annual premium of \$100,000 plus the insurer's administrative costs and profit. The insured who knows she is fully insured and cannot be monitored will have no incentives to optimally invest in prevention. She has no incentive to hire a janitor because it would not reduce her premium at all. This hazard of "morally" inappropriate behavior by insureds—of not taking what would ordinarily be cost-effective precautions—is "moral hazard."

Moral hazard is often a problem also in the third-party liability insurance context. Take, for example, automobile liability insurance. Beginning in the 1970s, most American states adopted a requirement that drivers be covered by automobile liability insurance.⁸³ In theory at least, drivers covered by liability insurance would take less care than those not covered. Without insurance, a negligent driver causing an accident would bear the cost of the harm the accident caused. With insurance, the driver no longer bears that cost, thus her *financial* incentive to take care to avoid an accident is diluted.⁸⁴

A necessary but insufficient condition to the characterization of moral hazard is that the suboptimal behavior of the insured is *the result of* the insurance coverage. Thus, the insured's behavior must be examined in relation to her conduct in the state of the world where she was not covered. An insured who never arms the alarm in her house (even in states of the world where she was not insured) is a higher-risk insured and may pose a problem of adverse selection to the pool, but does not pose a moral hazard problem to the pool because her inefficient behavior is not *as a result of* the insurance coverage. In contrast, if an insured does not activate the alarm before she leaves the house—an inefficient behavior that is hidden from the insurer—as *a result of* the insurance coverage she is acting in a moral hazard way.

And why is such an action still an insufficient condition for the characterization of moral hazard? Because not every behavior of the insured—even if it is *because* he is covered—is necessarily suboptimal or poses a disturbing moral hazard problem. For example, there is a concern that health insurance brings about *ex-post* moral hazard because insured

⁸³ Cohen & Dehejia, *supra* note 42, at 358.

⁸⁴ Whether or not this theoretical prediction holds in practice will be discussed below.

people consume more health services as a result of being insured. But not every over-consumption (relative to consumption in the absence of insurance) is problematic since the very purpose of insurance coverage is to ensure that when the insured person gets sick, she can afford expensive medical treatments that otherwise could not be provided to her. Although insureds may demand plastic surgery on the grounds that they have a medical need, may replace their eye glasses too often, or may visit the dental hygienist beyond what is reasonably necessary because they do not bear the full economic costs of these treatments, it is hard to believe that people will seek a heart transplant or brain surgery solely because they are insured.⁸⁵

How can one tell when the insured's decision to get medical care is a legitimate and efficient, and when it is a moral hazard behavior which creates a social loss?

Here is a mental exercise that may help resolve this issue, at least theoretically. Suppose an insured needs a kidney transplant, which costs \$50,000, and he is insured under a policy which enables him to choose one of two options. Option one: the insured undergoes the kidney transplant and the insurer will indemnify him for its \$50,000 costs. Option two: the insurer would send him a check for \$50,000 for his personal use. Now let's assume that Insured A tells the insurer that he is indifferent between the two options while Insured B says he prefers the check. What can we learn about A and B from their answers? An insured who really needed a kidney transplant will be indifferent between the two possibilities, since in each case he will undergo a transplant and remain financially neutral. This is our Insured A, and we can deduce therefore that A's decision to undergo a transplantation is efficient. The interesting point here is that A's decision is efficient even though it is quite possible that without the insurance money A might have chosen to not undergo the transplant. In other words, even though A's decision to undergo a kidney transplant *is a result of* the fact that he has insurance, his behavior is not considered a disturbing moral hazard. In fact, A's choice fulfills the very purpose of insurance.

In contrast, an insured who would prefer the check, B in our example, is signaling that undergoing a kidney transplant is not his preferred use of the money and therefore that is probably not an efficient option. Therefore, if the insurer offered Insured B only the option to be

⁸⁵ JOHN A. NYMAN, THE THEORY OF DEMAND FOR HEALTH INSURANCE 104 (2003); John A. Nyman, *Is Moral Hazard Inefficient? The Policy Implications Of A New Theory*, 23 HEALTH AFF. 194, 195 (2004).

reimbursed for the costs for the surgery (option one above) and Insured B chooses to undergo the kidney transplant, it is clear that Insured B's decision to undergo the transplant is not only as a result of having an insurance coverage, but it is also inefficient. This situation reflects an inefficient allocation of resources and thus a disturbing moral hazard.

Another way to look at this is to notice that providing insurance coverage creates two effects. The first is an "income effect" that allows the insured to consume medical care he could not otherwise afford. Under the "income effect" the insured would have undergone these treatments under either of our options above. Over-consumption of medical treatments in such a case does not create a distortion in the efficient allocation of resources and is therefore not problematic. The second effect is a "substitution effect," whereby the insured will consume medical treatments he would not have consumed had he received cash in advance (just like insured B above). Only the "substitution effect" is problematic from a social welfare perspective because it *does* create a distortion in the efficient allocation of resources. As we shall see, the distinction between over-consumption due to income effect and substitution effect is important for empirical studies attempting to measure the social welfare costs of moral hazard.

Over-consumption due to income effect is one example of how what looks like moral hazard can actually increase social welfare. Another example engages the "theory of the second best."⁸⁶ For example, where medical services are provided in a non-competitive or monopolistic market the quantity offered is too low relative to the efficient outcome (known as the "first best"). In such a market, the excessive consumption of medical services due to (*ex-post*) moral hazard may offset some of the social loss due to smaller supply of medical services and bring on an increase in social welfare because it corrects the market failure stemming from the monopolistic market. In effect, the "excess" caused by moral hazard may bring the level of consumption closer to a socially desirable level, the "first best." The same holds when as a result of budget constraints, lack of information, or various cognitive biases, insureds do not consume enough medical services, for example preventative medicine. With preventative medicine, a certain level of consumption is required to prevent disease and save on future costs, so again moral hazard may lead to an increase in social welfare because it offsets a market failure. While these examples of

⁸⁶ R.G. Lipsey & R.K. Lancaster, *The General Theory of Second Best*, 24 REV. OF ECON. STUD. 11, 11 (1956-57).

the potential *benefits* of moral hazard are interesting from a theoretical standpoint, it is clear that, with few exceptions, moral hazard remains a problem that needs to be combated. The next sections discuss various contractual and doctrinal solutions to the moral hazard problem.

1. Contractual Solutions for the Moral Hazard Problem

On a theoretical level, solving moral hazard requires disincentivizing the deviations from the optimal level of care. Such a solution can be approached from multiple angles. The first approach involves the stick—punishing carelessness by denying coverage when the insured was negligent in preventing the loss, in minimizing the loss, or in exaggerating its scope. The second approach is the carrot—rewarding carefulness. Third, we can more closely align the insured’s incentives with the insurer’s, for example, by forcing the insured to bear some of the risk.

Let’s start with the carrot. Essentially, moral hazard is a paradigmatic principal–agent problem where the agent (the insured) exercises at least some control over the level of risk that the principal (the insurer) incurs. One way to ameliorate this problem is to have the parties “contract on care” by coming to a mutually beneficial agreement where the insured agrees to take certain precautions in return for lower premiums. This approach requires insurers to first determine what people should do to lower the likelihood of an occurrence. With that information, the insurer then requires the insureds to take those measures as a condition of an insurance policy. Costly problems may arise for the insurer, however, in both ascertaining that information and in monitoring insureds, whether on a continuing basis or in retrospect.

In the example above if an insurer can monitor the property and know that the janitor in fact is doing his job, the insurer can reward the insured a “carrot” by lowering the premium to just over \$10,000.⁸⁷ Alternatively, if the insurer discovers after the occurrence that the insured violated his obligation according to the policy to hire a janitor, the insurer can deny coverage (the stick). These methods align the incentives of the insured and the insurer and motivate the insured to do the socially optimal thing by hiring the janitor.

⁸⁷ Another example of this contracting on care is the common practice of Israeli insurers to condition automobile insurance on the installation of electronic anti-theft devices.

While the carrot and stick approach would seem to solve the moral hazard problem, in many cases the insurer cannot effectively monitor the insured's care-taking behavior, nor can it cheaply investigate the reasons for the loss. Like in the case of adverse selection, carefully designing the policy contract may help. Deductibles and co-insurance clauses in the policy force insureds to bear some specified amount or percentage of harm (respectively), thereby forcing the insured to internalize some of the cost of an occurrence and incentivizing careful behavior. Policy limits, or caps on the total amount payable under the policy, similarly provide a strong incentive to avoid risky behavior and to minimize total harm. The higher the deductibles and co-insurance payments are, the lower the premiums are. Similarly, the lower the policy limits are, the lower the premiums are. While not a perfect solution—because it dilutes the ex-post coverage for the insured—this is another way of at least partially aligning the *ex-ante* interests of the insurer and the insured.

To better appreciate the way deductibles and co-insurance clauses magically align parties' incentives, let us return to our property owner and her \$1 million property. This time, she has an insurance policy which contains a co-insurance clause of 35%, in this case \$350,000, to be borne by the insured in the event she files a claim for a total loss of her property, leaving the insurer to bear a risk of \$650,000. With no janitor and a 10% probability of an accident, the owner's premium is \$65,000, her personal expected uninsured cost of fire damage is \$35,000, and therefore her total expected costs are \$100,000.⁸⁸ But, if she hires a janitor and the probability of an accident falls to 1%, her expected uninsured cost is now \$3,500—one percent of the deductible—plus the \$30,000 for the janitor's salary, totaling \$33,500. Add to this the \$65,000 premium charged and the total is \$98,500, which is lower than without a janitor. Thus, with the deductible, an insured has a monetary incentive to hire the janitor, and thus reduce risk, even if doing that cannot be verified by the insurer. (Furthermore, that reduced risk can result in a lower premium because the risk is now only 1%, meaning premiums should really be only \$6,500. With the lower premiums, overall

⁸⁸ The owner's premium is \$65,000, because it equals the damage the insurer bears multiplied by the 10% chance of harm. Here, I am ignoring the administrative fees and profits also charged by the insurer. Her personal expected uninsured cost of fire damage is \$35,000 because it equals the deductible multiplied by 10%.

expected costs for the insured are only \$40,000.⁸⁹) The result is that the insured, acting self-interestedly, decided to hire a janitor, even though that decision is not observable to the insurer, which is the socially efficient outcome. This is the way a well-planned co-insurance clause can solve a moral hazard problem in a way that is beneficial to all.

By and large, moral hazard is combated by deductibles in cases of small losses, co-insurance in cases of medium losses, and caps (or policy limits) in cases of large losses. Deductibles are fixed dollar amounts borne by insureds, say \$1,000 for car insurance. They provide incentives to keep small claims out of the administratively expensive insurance system. This is especially important because including small claims in the system would mean a larger portion of premiums would go towards administrative costs. Co-insurance clauses are fixed percentages of the loss borne by the insured, say 35% of any claim as seen in the previous paragraph. They combat strategic behavior for medium claims because the dollar amount insureds have to bear increases with the claim. Lastly, caps, or policy limits, combat strategic behavior for large claims by forcing any costs above the cap onto the insured.

Unfortunately, deductibles and co-insurance are not perfect solutions for all lines of insurance. In the health insurance market, for example, the insured generally has to cover all expenses up to the deductible, then pays a portion (10–20%) of his care up to the out-of-pocket maximum, and then has no costs associated with additional insurance until he reaches his policy maximum. Therefore if the insured is conscious not just of the price of each item of care he consumes (like an MRI), but focuses on his expected expenditures for the entire year, then varying the deductible or the co-pay might not change the behavior of the insured as expected.⁹⁰ A recent paper by researchers at MIT and Stanford

⁸⁹\$30,000 cost of janitor plus \$6,500 premium plus \$3,500 expected loss borne by insured. The insured will find it worthwhile to hire a janitor even when he initially misleads the insurer to believe he has a janitor (when in fact he does not) and in return is being charged only \$6,500 as premium. Without a janitor his costs will be \$41,500 (\$6,500 premium plus \$35,000 expected losses), whereas with a janitor his costs will be \$40,000.

⁹⁰ For example, assume a deductible of \$3,000, co-insurance of 20%, an out-of-pocket maximum of \$5,000, and total expected medical costs of \$20,000 for the year. Our hypothetical insured's co-insurance would be \$3,400 (.20*17,000) and so his total costs (\$6,400) would exceed the out-of-pocket max. If the deductible is lowered to \$2,000 or raised to \$4,000, his co-insurance costs still cause him to exceed his out-of-pocket maximum for the year and so will not change his

University found that insureds did in fact “look forward” to the future costs of medicine.⁹¹ In other words, insureds take into account the actual price and the future price when making medical care decisions.⁹² These results must be considered when an insurer is trying to influence consumer behavior through co-pay, deductibles, and co-insurance.

Another way the insurer can protect itself from moral hazard without exerting control over the insured is by classifying insureds according to their experience with the loss to be insured—called *experience rating*.⁹³ In other words, insurers threaten higher premiums for those insureds with the highest losses, incentivizing the insureds to invest in minimizing their losses (as well as reducing cross subsidization of high-risk insureds by low-risk insureds). Some insurers offer policies that are experience rated retrospectively, meaning that the premium is set after the loss experience is known. Insureds with lower losses receive refunds for part of their premiums, while a surcharge is levied on those with higher losses.

An interesting question is when experience rating, as opposed to deductibles or co-insurance, should be used to combat moral hazard. Experience rating is more often used for third-party rather than for first-party insurance, whereas deductibles and co-insurance clauses usually apply to first-party but not to third-party insurance. The reason is two-fold: First, deductibles better reduce the administrative costs associated with the processing of small claims, which are more prevalent in the first-party insurance context. Second, experience rating works better for repeat players, which are more often found in the third-party liability insurance context.⁹⁴

consumption. If co-pays for each doctor’s visit count towards the out-of-pocket total, then they too will not influence a forward looking insured with high expected yearly costs.

⁹¹ Aviva Aron-Dine et al., *Moral Hazard in Health Insurance: How Important Is Forward Looking Behavior?* 26-27 (Nat’l Bureau of Econ. Research, Working Paper No. 17802, 2012), available at <http://www.nber.org/papers/w17802>.

⁹² *Id.*

⁹³ ABRAHAM, *supra* note 18, at 15.

⁹⁴ Patricia Danzon argued that liability insurance policies do not have deductibles because of the problem of reverse moral hazard, which will be discussed below. Specifically, the insured is exposed to moral hazard with respect to the insurer’s legal defense efforts. Not having deductibles makes insurers bear the full costs of coverage in case they do not defend vigorously, and thus dilutes

However, in automobile insurance, which has a strong first party component to it, experience rating *is* prevalent (in addition to deductibles), whereas it does not exist in third-party medical malpractice coverage. The reason for that is primarily because automobile accidents are frequent enough and fault is often not hard to determine, whereas medical malpractice claims are too infrequent to allow estimating risk components for individual physicians and because it is widely believed that apparent differences in number of lawsuits among physicians are the result of chance or misinformation, not negligence. This stems from a belief that the legal system is incompetent in accurately determining doctors' fault.⁹⁵

Lastly, as was mentioned above, sticks are also a possible means to control moral hazard. One stick that can mitigate moral hazard is to limit the types of occurrences for which the insurer will compensate the insured. Such *exclusions* typically include high-risk behavior or, in the case of liability insurance, intentional torts such as battery.⁹⁶ In an obvious way, exclusions pressure the insured party to avoid the proscribed behavior.

As was mentioned above, in addition to the *ex-ante* moral hazard, there is also an *ex-post* moral hazard, i.e. moral hazard that happens after the occurrence. One of the general concerns in this context is that in indemnity policies, the insured will not take sufficient measures to minimize the damage stemming from the realization of risk, or would file a claim for excessive losses. Here, transferring part of the risk to the insured (for example, by having deductibles) would not help because the covered event had already happened and the deductible is a sunk cost (In fact, there is a concern that the higher the deductible is, the greater the incentive the insured has to exaggerate a claim in order to recover the deductible amount).⁹⁷

the reverse moral hazard problem. Patricia M. Danzon, *Liability and Liability Insurance for Medical Malpractice*, 4 J. HEALTH ECON. 309, 319-20 (1985).

⁹⁵ However, this traditional explanation for insurers' failure to utilize experience ratings in medical malpractice insurance has been brought into doubt in recent years. See D. M. Studdert et al., Special Article, *Claims, Errors, and Compensation Payment in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031(2006) (saying that the malpractice liability system is relatively accurate in sorting claims and that most insurance dollars are spent on valid claims).

⁹⁶ Samuel A. Rea, Jr., *Insurance Law*, in 2 THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 346 (Peter Newman ed., 1998) (discussing intentional acts in regard to insurance law).

⁹⁷ Georges Dionne & Robert Gagné, *Deductible Contracts Against Fraudulent Claims: Evidence From Automobile Insurance*, 83 REV. ECON. & STAT. 290, 298

Insurance companies deal with ex-post moral hazard in several ways. First, they refuse to insure non-pecuniary losses because proving their scope is hard and sometimes impossible.⁹⁸ Second, insurance companies audit claims that, due to different characteristics, are suspected to involve *ex-post* moral hazard. In such claims, insurers will involve private investigators, appraisers, and doctors to investigate the claim on their behalf. But because these investigations are expensive, insurers find it hard to commit to investigating all claims or even only those that are suspected. Thus, in many cases a random investigation of claims actually deters better than non-random investigations.⁹⁹ Moreover, false or exaggerated claims often lack external characteristics known to insurers to be highly correlated with false or exaggerated claims. In such situations post-occurrence investigations may be inefficient. Therefore, a better strategy is for insurance companies to design the policies so that insureds have fewer incentives to engage in ex-post moral hazard to begin with.

Indeed, one way to deal with such an ex-post moral hazard is by designing insurance contracts so that the incentives of the insured to exaggerate a claim are small. A simple way to do that is by substituting indemnity policies for stated-value policies, which require the insurer to pay the value stated in the contract regardless of the actual value of the loss.¹⁰⁰ In the jurisdictions that recognize stated-value policies, if the insured property is completely destroyed the insurer cannot look beyond the policy to determine the actual value of the property. Instead, the full

(2001) (finding that in automobile insurance, the larger the deductible is, the larger the loss reported, especially in accidents with not witnesses).

⁹⁸ There is a debate in the literature whether the lack of insurance for non-pecuniary losses stem from insureds' lack of demand, or from lack of supply due to market failures. See Steven P. Croley & Jon D. Hanson, *The Non-Pecuniary Costs of Accidents: Pain-and-Suffering Damages in Tort Law*, 108 HARV. L. REV. 1785, 1789-99 (1995); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1546-47, 1553 (1987); Ronen Avraham, *Should Pain-And-Suffering Damages Be Abolished from Tort Law? More Experimental Evidence*, 55 U. TORONTO L.J. 941, 945-46 (2005).

⁹⁹ Dilip Mookherjee & Ivan Png, *Optimal Auditing, Insurance and Redistribution*, 104 Q.J. ECON. 399, 413 (1989). Obviously, relying on third parties' investigations raises issues of collusion and fraud. See Ingela Algar & Ching-to Alberta Ma, *Moral Hazard, Insurance and Some Collusion*, 50 J. ECON. BEHAVIOR & ORG. 225, 226 (2003).

¹⁰⁰ See, e.g., *Bd. of Trs. of First Congregational Church of Austin v. Cream City Mut. Ins. Co. of Milwaukee, Wis.*, 96 N.W.2d 690, 695 (Minn. 1959).

value stated in the policy must be paid. The principle here is “caveat venditor”—insurers have to make sure at the contracting stage that the asset is properly valued. On the other hand, such contracts prevent a false representation as to the magnitude of the loss. Stated-value contracts provide certainty to both parties and reduce post-occurrence investigation costs. Insurance of jewelry is a common example of stated-value policies.

As we have seen before, there is always a tradeoff between providing coverage ex-post and not distorting incentives for proper behavior. While stated-value policies reduce the incentives for ex-post moral hazard they may under-indemnify a risk-averse insured, thereby creating a welfare loss. Insurance companies can, therefore, offer a hybrid between an indemnity contract (which fully compensates the insured but creates incentives for ex-post moral hazard) and a stated-value contract (where such incentives do not exist but the insured may find himself under-compensated). Such hybrid policies will be partially dependent on the size of the damage and will therefore induce weaker incentives for ex-post moral hazard. An example of this is a policy which under-compensates types of losses where false representations are relatively prevalent, such as back pain with no clinical markers, and generously compensates types of losses where false representations are extremely difficult, such as losses of limbs¹⁰¹

2. Doctrinal Solutions for the Problem of Moral Hazard

Moral hazard presents the greatest risk when the insured party has no personal stake in the property or person covered by the insurance policy. Thus, a simple method of countering that problem is to require the insured to have an *insurable interest* in the covered item. An insurable interest exists where the relationship between the beneficiary of the insurance contract and the thing to be covered are such that it is reasonable to assume the beneficiary has a significant benefit or advantage from the continued existence of the insured item. Thus, in life insurance an insurable interest exists where the relationship of the parties are such that there are

¹⁰¹ Keith J. Crocker & John Morgan, *Is Honesty the Best Policy? Curtailing Insurance Fraud through Optimal Incentive Contracts*, 106 J. POL. ECON. 355, 355 (1998). See also Alan O. Sykes, “Bad Faith” Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405, 429 (1996); Keith J. Crocker & Sharon Tennyson, *Insurance Fraud and Optimal Claims Settlement Strategies*, 45 J.L. ECON. 469, 470 (2002).

reasonable grounds, either pecuniary or contractual or by blood or affinity, to expect a significant benefit or advantage to the beneficiary from the continuance of the life of the insured.

In the early days of insurance, an insurable interested was not required. For example, in 1743 insurers offered 3:1 odds on the survival of George II when he personally led his army in the Battle of Dettingen.¹⁰² Anyone could have purchased those contracts. Only in 1774 Britain enacted the Life Assurance Act which required the beneficiary to have an insurable interest. Since then more legislatures followed suit. However, courts have also played a role in shaping this practice by refusing to enforce insurance contracts that do not have an insurable interest. One pointed example is “murder policies.” These are life insurance policies that de facto incentivize the murder of the insured by the beneficiaries of such policies. Courts typically void these policies and cut off the payment to the beneficiary in order to undermine their criminal incentive.¹⁰³ Moreover, courts have even shown a willingness to recognize wrongful death suits filed by insureds’ families against the issuers of such policies. In this way courts have diluted the incentives of both murderous beneficiaries and irresponsible insurers to engage in life insurance policies where the beneficiaries have no insurable interest.¹⁰⁴

Despite the obvious benefit of requiring an insurable interest, it is important not to over-void policies for formalistically lacking this requirement. Indeed courts have found insurable interests in various forms, including a legal or equitable interest in the property; a factual expectancy; a contractual right; and a legal liability. The most common insurable

¹⁰² Yoni Appelbaum, *Have Insurance Companies Forgotten the Meaning of Insurance?*, THE ATLANTIC, May 7th, 2012, available at <http://www.theatlantic.com/business/archive/2012/05/have-insurance-companies-forgotten-the-meaning-of-insurance/256677/>.

¹⁰³ See Saul Levmore & Kyle D. Logue, *Insuring Against Terrorism—and Crime*, 102 MICH. L. REV. 268, 315 (2003).

¹⁰⁴ Many states have statutorily imposed and defined insurable interest requirements. See 44 C.J.S. *Insurance* § 359 (2007). For example in California, Section 10110 of the Insurance Code, reads: “Insurable interest. Every person has an insurable interest in the life and health of: (a) Himself. (b) Any person on whom he depends wholly or in part for education or support. (c) Any person under a legal obligation to him for the payment of money or respecting property or services, of which death or illness might delay or prevent the performance. (d) Any person upon whose life any estate or interest vested in him depends.” Cal. Ins. Code § 10110 (West 2005).

interest is a legal or equitable interest in property. Thus, a person has an insurable interest in the house she owns. The factual expectancy doctrine, however, makes clear that legal title to property is not a requirement for an insurable interest. Instead, an insured need only have a reasonably certain expectation for a gain or other pecuniary interest in the subject property. Thus, if there is a factual expectation that property will soon pass to a putative insured, that insured has an insurable interest. A contractual right to property can also create an insurable interest. This doctrine allows secured creditors, such as mortgagees, to obtain insurance for property securing a debt. Lastly, a legal liability gives rise to an insurable interest. If a putative insured is legally liable in the event of the destruction of certain property, but that insured does not have actual title to the property, an insurable interest still exists up to the value of the liability.

The common thread through all types of insurable interest is a direct and reasonably certain pecuniary interest in the object being insured. A merely speculative interest is not sufficient.¹⁰⁵ The exception to the general rule that pecuniary interest is enough to establish an insurable interest is life insurance, where a strong emotional interest between the beneficiary and the insured is also an avenue to an insurable interest.¹⁰⁶ Without the insurable interest requirement, insurance could be used to *create* risky situations instead of removing risk, as it is intended to do.

Another feature of most, especially first-party, insurance contracts that protects against moral hazard, and which is closely related to the insurable interest requirement, is the *indemnity principle*—an insured may only recover compensation up to the smaller of the amount covered and the amount lost. This principle mitigates the incentive of the insured to acquire too much coverage and then to cause the loss to her property when insurance coverage is greater than the value of the property covered. But, “value of the property” must be understood appropriately, as it typically reflects replacement cost and not actual cash value. For example, most goods have a lower cash value after they become used than when

¹⁰⁵ See, e.g., *Gossett v. Farmers Ins. Co. of Wash.*, 948 P.2d 1264, 1272-73 (Wash. 1997).

¹⁰⁶ While often the beneficiary of a life insurance policy does have a pecuniary interest in the life of the insured, specifically the beneficiary has an interest in the continued stream of income from the insured, it is not a requirement. There is nothing that would prevent the purchase of life insurance benefitting a loved one when the beneficiary has no possible expectation of monetary gain from the insured’s continued life.

purchased new, but insurance will typically cover the cost of replacement of a new warehouse, provided the moral hazard is not too great.

Whether the value to be paid is actual cash value or replacement value is an issue that can be contracted on. Many homeowners' insurance policies provide for replacement value in the event of total destruction of the property. The risk of moral hazard created when the actual cash value is significantly lower than the replacement value can be mitigated by only providing the replacement value if the recovery is actually used to replace the property.¹⁰⁷

Although the indemnity principle applies to most insurance contracts, accident and health insurance are not fully included and life insurance is usually not at all included in that category. The reason for this is one of valuation; courts are reluctant to value a person's life or limbs. In the health and accident insurance contexts, courts do not want to engage in the evaluation of the medical treatment insureds have received and determine whether it is excessive or not. In the life insurance context, for instance, if it cannot first be determined what the actual value of a person's life is, it is impossible to determine if the amount of the policy exceeds that value. However, when the purpose of life insurance is strictly financial, say insuring the life of a debtor to guarantee recovery of the debt, the indemnity principle will dictate that the recovery will be limited to the amount of the financial interest, here the amount of the debt.

Another solution stemming from the indemnity principle is to prohibit over-insurance and under-insurance. As we saw, improper levels of first-party insurance potentially increase moral hazard by creating incentives for careless behavior that could result in windfall recoveries. One may wonder why states have to regulate the prohibition over-insurance and under-insurance. After all, the negative incentives created for insureds by over-insurance would be handled by the principle of indemnity which would prevent recovery which is too high. However, the administrative costs and information-gathering problems associated with fully enforcing the indemnity principle create a chance that over-insurance could lead to windfall recoveries despite the protections the indemnity principle provides. Stated-value policies, which were discussed above, may further enhance the problem if the value is not correctly established.

Moreover, over-insurance does not emerge solely due to the insured's strategic behavior. Often *insurers* have incentives to sell too

¹⁰⁷ See, e.g., *Rhodes v. Farmers Ins. Co.*, 86 S.W.3d 401, 401-03 (Ark. Ct. App. 2002).

much coverage with the knowledge that the principle of indemnity will prevent courts from forcing them to ever pay the full value of the policy. This means that the insurance company can charge a premium that is higher than their actual risk associated with an occurrence. As a result, many states have solved the over-insurance problem by explicitly prohibiting in their codes over-insuring, thus reducing *both* parties' strategic behavior.

Under-insurance creates different, but potentially severe, negative incentives. In fire and property coverage, for instance, small losses are far more frequent than large losses. Yet, policy prices are determined linearly, increasing at a set rate as the value of the policy increases. Thus, \$50,000 of coverage costs half as much as \$100,000 of coverage, even if the value of the house is \$100,000. The likelihood that any loss will only be partial creates a strong incentive to only purchase the \$50,000 of coverage, and still be covered for the most likely losses. This incentive would distort the insurance market, diluting the incentives to purchase coverage for large losses, which is one of the fundamentals functions of insurance.

One can dilute the insureds' incentive to under-insure by setting the premiums based on the lower probability of a larger loss instead of a purely linear pricing system. However, a more common approach to address the problem of under-insurance is through coinsurance pegged to the value of the property. If an insured covers only a small portion of her property, her co-insurance will be higher. If, on the other hand, a policy is valued at the actual value of the property, little or no co-insurance will be required. For example, a homeowners policy may contain a clause that, in the event of a loss, and if the coverage is less than 80% of the replacement value, the insurer will pay only the proportion of the loss which the total coverage bears to 80% of the replacement cost.¹⁰⁸ Under such a clause, if a house is worth \$100,000, but coverage is only \$60,000, then the insurer will only pay 75% of any claim (\$60,000 over \$80,000 equals 75%). If, on the other hand, the insured purchases coverage of at least 80% of the value of the house, the insurer will pay 100% of any loss (\$80,000 over \$80,000 equals 100%). In this way, coinsurance provisions provide an incentive for insureds to purchase coverage for most of the value of their property.¹⁰⁹

¹⁰⁸ See KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 272 (5th ed. 2010).

¹⁰⁹ *Id.* Some companies no longer price their policies using the linear approach described above but rather use a more complicated pricing method which allows them to abandon coinsurance terms. As early as 1981 some scholars had suggested

From the doctrine of indemnity follows the doctrine of *subrogation*, which allows a first-party insurer to step in for the insured and pursue his or her legal rights against tortfeasors after compensating for a loss. For example, suppose a water pipe bursts near an insured's house, and that insured makes a proper claim to her homeowner's insurance carrier. If that carrier pays the claim, it then has a right of subrogation to exercise the insured's legal rights. If the water pipe bursting resulted from a tort, the insurer has a legal right of action against the tortfeasor.¹¹⁰ Subrogation keeps premiums lower in that it permits the insurers to recover part of their expenses from tortfeasors and by reducing insureds' moral hazard in that it avoids the potential problem of double-recovery which would exist if subrogation were not part of the insurance contract. Thus, subrogation is overall an efficient arrangement.

Extending the doctrine of subrogation, one could also argue that an insured should be prohibited from settling a tort case regarding a loss for which it carried insurance. Take for instance an insured who was tortiously injured in a car accident, and who is also covered by health insurance. The insurer, through its right of subrogation, is entitled to any recovery related to the medical expenses. The insured, therefore, has a strong incentive to structure any settlement in a way that none of the recovery is attributable to medical costs. In that way, the insured will have her medical costs paid for by the insurer, and keep the whole of the settlement. However, in doing so, the insured externalizes costs to the entire insurance pool. For this reason, it could be advantageous to allow first-party insurance companies to exert some control over settlements, or their structure, in these situations. Indeed, in practice there is often a three-way split among the plaintiff, her attorney and the insurer.¹¹¹

Similar negative incentives exist in the context of third-party liability insurance. There, a tortfeasor covered by liability insurance may wish to avoid the burdens of litigation because any liability attributed to her would be paid by the insurer. To avoid litigation, the insured could therefore settle up-front for the policy maximum, even if the actual harm

coinsurance was becoming obsolete. See Michael L. Smith & David L. Bickelhaupt, *Is Coinsurance Becoming Obsolete?*, 48 J. RISK INS. 95, 95 (1981).

¹¹⁰ See *State Farm Fire & Cas. Co. v. E. Bay Mun. Util. Dist.*, 62 Cal. Rptr. 2d 72, 74 (Cal. Ct. App. 1997) (quoting *Self-Insurers' Sec. Fund v. ESIS, Inc.*, 251 Cal. Rptr. 693 (1988)).

¹¹¹ Tom Baker, *Blood Money, New Money, and The Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275, 304-08 (2001).

was less than the settlement amount. This behavior too externalizes costs to the pool and decreases the efficiency of the insurance market.

To prevent insureds from settling too often, or, more generally, from not defending the claim against them very vigorously, general liability policies impose on the insurer the duty to defend the claim. The idea is that it would be advantageous to allow the insurer to act on the insured's behalf, presumably with better resources and stronger incentives than the insured. But that creates a new problem as now the insurer is the agent of the insured, acting on his behalf. These agency relationships create the problem of "reverse moral hazard," which will be discussed below.

As mentioned above, there is also the danger of ex-post moral hazard where the insured exaggerates its losses in order to get monies he does not deserve. We saw that insurance companies have a number of contractual tools to deal with this problem.

One of them is the stated-value policy. These policies are common in lines of insurance where the principle of indemnity does not necessarily apply such as life insurance, health insurance and accident or disability insurance. Once the indemnity principle does not apply, the justification for subrogation falls as well.

Courts handle the problem of ex-post moral hazard in the same manner they dealt with misrepresentations that occur before the issuance of contract. When the insured does not cooperate with the insurer after the occurrence so that the insurer can determine its liability, or when the insured submits fraudulent claims, courts generally approve a reduction in the insurance benefits and often allow insurers to not pay them at all, even in cases where but for the insured's post-occurrence behavior (exaggerating his loss) the insured would have been entitled to reduced benefits. One may even argue that such situations justify damages paid to the insurer from the insured to further deter these misrepresentations.

3. Returning to the Two Islands Approach

As discussed above, one way to combat moral hazard is to use deductibles and caps on losses to align the incentives of the insurer and the insured. One common exclusion along these lines is the "loss of market" exclusion for business interruption insurance coverage. Business interruption insurance provides coverage for lost profits due to the interruption of business after a covered peril occurs, such as fire, flood, or wind. Business interruption insurance is typically added, by endorsement, to an insurance policy covering damage to an insured's property. The loss of market exclusion excludes from that coverage any lost profits due to the

business's market disappearing. The loss of market could be due to economic decline, competition, or shifts in demand that happened after the occurrence. The loss of market exclusion has been a source of increasing debate in recent years due to catastrophic events such as the 9/11 terrorist attacks on the World Trade Center and Hurricane Katrina, which have destroyed entire markets. The general question, as usual, is whether that exclusion should be honored.

To analyze whether the exclusion is desirable, we once again create two identical islands except that one island has the exclusion and one does not. On the island that ignores the loss-of-market exclusion, business owners can purchase insurance which essentially guarantees they make a profit even when the demand for their product will never bounce back after an occurrence. This might lead to a large moral hazard problem. After an occurrence, if it is guaranteed that a company will be covered up to its previous level of profitability, what incentive does that company have to strive to restore its earlier business efforts? After a fire, for instance, an owner of a restaurant with lost profits coverage would have no incentive to work hard to get back some business when she is guaranteed to make at least as much money as she was making before. That restaurant owner could take that lazy attitude until customers return on their own.

On the island that enforces the loss-of-market exclusion, however, there is no such moral hazard problem; the company must do everything it can to earn business back after a disaster. While this is an advantage, the disadvantage of the island is that there is less coverage. Due to an occurrence, a business may not be able to survive until the market returns. The reason for insurance in the first place is protecting the business in the event of a covered peril, so it is likely a reasonable insured would be willing to pay the higher premiums in exchange for the protection of her business.

The question becomes one of incentives. Economic analysis suggests that policies should not exclude loss of market (that is the policy should provide coverage) when the risk of moral hazard is relatively small. Consider for example *Duane Reade*, which dealt with business interruption insurance in the context of the 2001 attack on the World Trade Center.¹¹² The court decided that the destruction of the World Trade Center where Duane Reade ran a store, and Duane Reade's resulting lost profits, were clearly a covered peril, and that the "loss of market" provision did *not*

¹¹² See *Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co.*, 279 F. Supp. 2d 235, 238 (S.D.N.Y. 2003).

encompass the destruction a market due to terrorist attack.¹¹³ In other words, because the market loss was due to a covered peril—the destruction of the business—the resulting lost profits were covered.

The court got it right, only for the wrong reasons. As the example with the fire in the restaurant above suggests, we want to provide incentives to business owners to work hard to restore customer traffic after an occurrence. Therefore the court is wrong to provide coverage for loss-of-market only because it was originally initiated by a covered peril. However, when it comes to catastrophic events, where there is nothing the business owner can do to bring customers back to his store (think about ground zero in the years post 9/11), there is no risk of distorting incentives. The interest in providing coverage should therefore prevail, and the market exclusion should not be honored.

However, it is unlikely a reasonable insured would want to pay for coverage to keep a business around in perpetuity even though there is no demand for the business. Thus, even in catastrophic events the coverage could not be unlimited. The *Duane Reade* court took this approach to the timing issue. It ruled lost profits were to be covered and the loss market exclusion should not be honored—in other words, coverage should last—only for the time it would reasonably take “to rebuild, repair, or replace” the specific store at issue.¹¹⁴

4. Moral Hazard—The Empirical Evidence

As discussed above in the section on empirical evidence for adverse selection, one problem with empirically measuring either moral hazard or adverse selection is distinguishing one’s effects from the other. For example, an unhealthy person would be more likely to buy health insurance (adverse selection), while a person with insurance may be more likely to adopt unhealthy habits, knowing that he has insurance in case he became sick (moral hazard). In both cases the empiricist observes a correlation between high-risk individuals and scope of coverage. In other words, it is easy to observe a positive correlation between the demand for coverage and the number or scope of insurance claims, but it is difficult to determine whether this correlation is the result of adverse selection, moral hazard, or some combination of the two. This inability to separate the two problems poses policy consequences as well, since ameliorating either the

¹¹³ *Id.* at 239-40.

¹¹⁴ *Id.* at 239.

potential welfare losses of moral hazard or adverse selection requires separate policy tools. To curtail moral hazard, insurers would increase deductibles to encourage healthful activities and discourage waste by exposing consumers to the true cost of their medical care.¹¹⁵ To reduce the potential problem of adverse selection, on the other hand, requires stricter disclosure laws for potential insureds to allow insurers to better screen for pre-existing conditions, or alternatively, a health-insurance mandate as discussed above.

But not being able to distinguish between moral hazard and adverse selection is not the only problem with the empirical literature. Potentially a more worrisome problem is that the empirical literature fails to distinguish between the moral hazard which stems from the “substitution effect,” and that which stems from the “income effect.” As discussed above, the former is welfare decreasing and the latter is welfare increasing.¹¹⁶ Thus, that people consume more healthcare because they have insurance is not worrisome from a policy making perspective as long as the excess consumption is due to the income effect. Similarly, the fact that people search for a job for a longer period of time because they have unemployment insurance is not necessarily worrisome, as long as the excess search period is only due to the impact of the insurance on their liquidity constraints.¹¹⁷

For several decades health economists have been finding evidence interpreted as ex-post moral hazard in health insurance. The most important study is the Rand Health Insurance Experiment, which randomized people into different insurance plans, thus eliminating adverse selection effects stemming from the insured’s ability to choose the type of coverage she wishes. The Rand Experiment, as well as other studies, found that demand for medical care is elastic with respect to its out-of-pocket costs. In other

¹¹⁵ However, “cost-sharing” is a blunt and not necessarily efficient way of reducing over-consumption of health insurance. Empirical evidence shows that when consumers have to bear a higher proportion of their health costs, they do cut back on spending, but they do so on both frivolous and beneficial procedures. See Mary Reed et. al., *High-Deductible Health Insurance Plans: Efforts to Sharpen a Blunt Instrument*, 28 HEALTH AFF. 1145, 1145 (2009).

¹¹⁶ See *supra* p. 69.

¹¹⁷ Raj Chetty, *Moral Hazard Versus Liquidity and Optimal Unemployment Insurance*, 116 J. POL. ECON. 173, 173-75 (2008) (separating moral hazard effect and liquidity constraints effect in unemployment insurance).

words, people carrying health insurance *are* responsive to the personal cost of healthcare and therefore ex-post moral hazard exists.¹¹⁸

The Rand Experiment approach (as well as other studies) presents several empirical challenges to analyzing people's utilization of medical care as a function of their scope of insurance coverage. First, the scope of the plan coverage might be endogenous. Generous health insurance plans might boost utilization of medical services, or, areas where people need or demand more medical services will be areas where people demand more generous health insurance coverage, without these studies being able to isolate which one is operating in practice. Second, as was just discussed, not every variation in consumption that follows a variation in insurance coverage can be tied to ex-post moral hazard. It is conceivable that when insurance coverage expands, the consumption of medical services, especially by budget-constrained people, will increase since the price will become affordable. This is the income effect discussed above. It is only the increase in demand due to the substitution effect which is worrying, but such type of increase in demand is much harder to empirically identify.

So far I have dealt with ex-post moral hazard. An equally interesting question is the extent to which one would expect to see *ex-ante* moral hazard. It is worth mentioning that even a small effect is important because even if the chances the individual's moral hazard behavior has an impact on her probability of being involved, say, in a fatal accident is small, it may still cause a large social problem at the aggregate. Thus, for a population of 100 million people, a one percentage-point increase in the probability of a fatal accident creates a million more deaths.

In general, the empirical literature fails to establish ex-ante moral hazard in health care.¹¹⁹ In the context of automobile insurance, one would think that an insured driver is not going to drive more recklessly than he otherwise would, as there are plenty of uncompensated losses associated with an accident (including uncompensated bodily injuries) besides the cost of repairs. Yet, using an instrumental-variables approach, Cohen and Dehejla find evidence that automobile insurance does have moral hazard

¹¹⁸ The Rand study found an overall medical-care price elasticity of about -0.2, which means that as the personal costs increases by say, 10%, the demand for medical care decreases by 2%. See Peter Zweifel & Willard G. Manning, *Moral Hazard and Consumer Incentives in Health Care*, in HANDBOOK OF HEALTH ECONOMICS 410, 454. (A.J. Culyer & J.P. Newhouse eds., Elsevier Science B.V. 2000).

¹¹⁹ *Id.* at 446.

costs, leading to an increase in traffic fatalities.¹²⁰ Because they cannot distinguish between the income effect (careful drivers drive more miles which might be optimal despite the increase in fatalities) and the substitution effect (careful drivers no longer take care, which is always not optimal) caused by automobile insurance, Cohen and Dehejla cannot identify the net welfare effect of automobile insurance.¹²¹

E. REVERSE MORAL HAZARD

Just like there is reverse adverse selection, there is arguably also reverse moral hazard. It is not insured parties alone that behave strategically once the insurance contract is in place—insurers are similarly the perpetrators of opportunistic behavior, finding it easy and advantageous to mistreat their insureds once they are locked in a contract.¹²² This is especially true because barriers to litigation can prevent insureds from challenging insurer abuse.

While insurers and policyholders have similar interests at the ex-ante contractual stage, a fundamental conflict of interests arises in the post-occurrence stage. At the contractual stage they will agree to a policy that minimizes total loss-related costs, including defense costs, because that will be efficient and will keep the premiums low. But ex-post (after insurance is purchased and claims arise) the insurance company might have different incentives than the insured about whether the loss should be covered and—

¹²⁰ Alma Cohen & Rajeev Dehejia, *The Effect of Automobile Insurance and Accident Liability Laws on Traffic Fatalities*, 47 J.L. & ECON. 357, 357 (2004). See also Sarit Weisburd, *Identifying Moral Hazard in Car Insurance Contracts* 27 (Hebrew Univ., Working Paper, 2010), available at http://pluto.mssc.huji.ac.il/~saritw/moralhazard_sep12.pdf.

¹²¹ Similarly, Bernard Fortin and Paul Lanoie have documented an increase in work injuries correlated to the implementation of North American workers' compensation programs, which provide employees with fast access to damages for work related injuries. Bernard Fortin & Paul Lanoie, *Incentive Effects of Workers Compensation: A Survey*, in HANDBOOK OF INSURANCE 421, 421 . (Georges Dionne ed., Kluwer Academic Publishers 2000).

¹²² As far as I know, the idea of reverse moral hazard was first mentioned by Patricia Danzon. See Danzon, *supra* note 93. See also Eric D. Beal, *Posner and Moral Hazard*, 7 CONN. INS. L.J. 81, 97 (2000); William Choi & Lan Liang, *Reverse Moral Hazard of Liability Insurers: Evidence from Medical Malpractice Claims*, 39 APPLIED ECON. 2331, 2331-32 (2007). .

in liability insurance contract—how defense of the claim should be exercised.

Take for example, the insurer's decision whether to cover a claim. After the occurrence, insurers have the dual role of both deciding whether a certain claim is covered under the policy, and paying the damages associated with that claim if it is determined to be covered. As one would expect, insurers often have the economic incentive to decide coverage exists in as few situations as possible, knowing that they are often effectively insulated (or "insured") from being sued due to insureds' lack of sophistication, knowledge, and resources. This is a reverse moral hazard. (While one could imagine a system where insurers are not the judge and financier of a claim, and instead these decisions are made by separate entities, that is not the world we live in.)

As with ordinary moral hazard, there are multiple ways to counter reverse moral hazard on a theoretical level. First, full and detailed disclosure of the coverage decisions insurers make could be required, whether to potential customers (thus harnessing market forces to eliminate unethical insurers) or complaining insureds (thus exposing the unethical practices). Second, such disclosure could be used to punish opportunistic behavior by insurers. Insurance regulators, for instance, could analyze the disclosures and impose fines on, or revoke the licenses of, the worst behaving insurance companies. Third, individual insureds could have a legal claim for damages resulting from bad faith denial by insurers. Fourth, independent and simplified alternative dispute resolution mechanisms could make it easier to challenge insurers' decisions.¹²³

Doctrinally, there are several principles of contract law which serve to mitigate the effects of reverse moral hazard. One is the interpretive principle of *contra proferentem*—that ambiguities in any contract will be construed against its drafter. For insurance contracts, the drafter of course is the insurer. Thus, the doctrine of *contra proferentem* prevents insurers from taking advantage of gray areas of policy coverage and instead incentivizes clear, unambiguous policy writing. However, whether or not that incentive outweighs the incentive to maintain ambiguous, boilerplate policy terms, is a very complicated question.¹²⁴

¹²³ See Daniel Schwarcz, *Redesigning Consumer Dispute Resolution: A Case Study of the British and American Approaches to Insurance Claims Conflict*, 83 TUL. L. REV. 735, 810-11 (2009).

¹²⁴ Bad boilerplate is often perversely incentivized by the very rulings that would seem to cut against it in that a term that has an established, known cost may

Ambiguities come in multiple forms. A policy can be ambiguous because it is vague in and of itself.¹²⁵ A policy can also be considered ambiguous if it does not address a certain situation. An example of this is litigation arising out of the attack on the World Trade Center where it was unclear, based on the language of a policy, whether each plane strike was an “occurrence,” or the entire event was an “occurrence.”¹²⁶ Lastly, a policy can be ambiguous if two or more of its provisions conflict. For example, a Second Circuit case found a policy ambiguous when one of its provisions seemed to extend airplane insurance to trips between the United States and the Caribbean, and another provisions indicated the policy only applied to flights over the continental United States.¹²⁷ To generalize, a policy is ambiguous if “it is reasonably susceptible to two meanings.”¹²⁸ Even if the policy writing is clear, it can still be opportunistic when an insurer includes unambiguous, but still self-advantageous, provisions. This is an issue because insureds may be unaware of the provision and its impact on the insurance coverage, and may think they are covered for an occurrence when under the stated policy terms they are not. To counteract that problem, courts have applied what have been called “allied” doctrines with *contra proferentem*, including waiver, estoppel, and the “insured’s reasonable expectations” doctrine.¹²⁹

be more valuable than one whose cost or benefit is unknown. For more on the complex relationship of policy drafters and the courts, see Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1111 (2006).

¹²⁵ See, *Columbia Heights Motors, Inc. v. Allstate Ins. Co.*, 275 N.W.2d 32, 34 (Minn. 1979).

¹²⁶ See *World Trade Center Props., L.L.C. v. Hartford Fire Ins. Co.*, 345 F.3d 154, 158 (2d Cir. 2003). The policy limited recovery to \$3.5 billion per occurrence. *Id.* If each plane strike was an occurrence, the insured could collect a total of \$7 billion, whereas if the entire event was an occurrence, the insured could only collect \$3.5 billion. *Id.*

¹²⁷ *Vargas v. Ins. Co. of N. Am.*, 651 F.2d 838, 840 (2d Cir. 1981) (involving a trip from New York to Puerto Rico, with stops in Miami and Haiti to refuel, where the airplane crashed before it reached Puerto Rico). The court found, because the policy was ambiguous, the policy covered the incident. *Id.* at 842.

¹²⁸ Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 537 (1996).

¹²⁹ See Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970). The term “insured’s reasonable expectations” was coined by Professor Robert Keeton in 1970 when he recognized that courts provide coverage even when the exclusion is not ambiguous.

Though recognized in only a minority of jurisdictions, the reasonable expectations doctrine allows courts to enforce an insurance contract despite an unambiguous exclusion contained therein if the exclusion goes against the reasonable expectations of the insured. Some jurisdictions distinguish between sophisticated and unsophisticated insureds, recognizing that sophisticated parties may contract for such exclusions in exchange for lower premiums.¹³⁰ Waiver and estoppel are heavily fact-dependent doctrines, with courts relying on the particulars of the policy and the relationship between the insured and insurer to determine whether coverage should be granted despite a policy term indicating otherwise.¹³¹ The societal value of the reasonable expectations doctrine is examined in more detail, via an application of the Two Islands Functional Approach, in the next subsection.

As mentioned previously, a special type of reverse moral hazard exists in liability insurance policies around the decisions regarding the defense of a claim. Problems of reverse moral hazards arise because the insurer acts as an agent of the insured, but might maximize its own interests rather than the insured's interests. For example, because insurers often care only about their financial exposure in a specific case, they may prefer to settle a lawsuit instead of litigating. But the insureds, whose reputation and livelihood depend on the outcome, might prefer to defend against such suit in court to clear their name. Another example is when an insured's potential liability to its victims is higher than the policy limit, but any potential settlement would be at or close to the policy limit. The insurer has incentives to pursue the litigation because the payout would be the same, while the insured might be happy to settle for the amount of the policy limit, because this will ensure he or she bears no personal liability.¹³²

Parties combat reverse moral hazard through the design of the insurance policy. As was mentioned above, many liability insurance contracts include provisions requiring the insurer to defend a suit unless the insured consents in writing to a settlement. Over time, courts have also found ways to deal with reverse moral hazard in the context of defense decisions. For example, courts have often penalized insurance companies

¹³⁰ See Hazel Glenn Beh, *Reassessing the Sophisticated Insured Exception*, 39 TORT TRIAL & INS. PRAC. L.J. 85, 85-86 (2003).

¹³¹ See ABRAHAM, *supra* note 107, at 70-71.

¹³² See Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255, 266 (1995) (discussing these problems and many other conflicts of interest arising in such situations).

who subordinate the insureds' interests to their own.¹³³ That helps solve the first problem mentioned above, where insurers settle and consequently harm the insureds. With respect to the second problem, where insurers *refuse* to settle and harm the insureds, several states' supreme courts have affirmed judgments against insurance companies for bad faith refusal to settle where they gambled with their insureds' money. In *Crisci*, for example, an insurer refused to settle a claim by a tenant against the landlord (the insured).¹³⁴ The insured's policy limit was \$10,000; the lowest settlement demand by the plaintiff-tenant was also \$10,000. As a test for whether an insurer has liability above a policy limit after it refused to settle, the court relied on whether a prudent insurer *without* policy limits would have accepted a settlement offer. In that case, the court believed such an insurer would have settled and therefore awarded the insured damages in the amount she had to pay to her tenant.¹³⁵ This rule prevents insurers from gambling with insured's money.¹³⁶

Interestingly, and somewhat counter-intuitively, insurers' power to strategically refuse to settle which seems to harm the insured when viewed from an ex-post perspective, may in fact benefit the insured when viewed from the ex-ante perspective. Such strategic behavior by the insurer functions as a commitment device that the insurer would reject victims' excessive settlement offers.¹³⁷ Thus, insurers may extract better settlements from the insureds' victims, which will lead to lower premiums to the class of insureds. Still, if settlement negotiations fail, the insured might discover she has to pay judgment way beyond the policy limit, a risk she might not want to bear.

In more extreme scenarios, it is even possible to get punitive damages if the insurer denied coverage while violating the covenant of good faith and fair dealing. Insurers who attempt to take advantage of an insured in an improper manner may be required nonetheless to pay out on

¹³³ Kent Syverud, *The Duty to Settle*, 75 VA. L. REV. 1113, 1116 (1990).

¹³⁴ See, e.g., *Crisci v. The Sec. Ins. Co. of New Haven*, 426 P.2d 173, 175 (Cal. 1967).

¹³⁵ *Id.* at 177.

¹³⁶ See also Alan O. Sykes, *Judicial Limitations on the Discretion of Liability Insurers to Settle or Litigate: An Economic Critique*, 72 TEX. L. REV. 1345, 1373-74 (1994) (using an economic analysis of bad faith claims for refusal to settle to suggest courts should not interfere with contracts between insureds and insurers).

¹³⁷ Michael J. Meurer, *The Gains from Faith in an Unfaithful Agent: Settlement Conflicts between Defendants and Liability Insurers*, 8 J.L. ECON. & ORG. 502, 502-22 (1992).

an insurance policy where a repudiation of the insurance contract or a denial of coverage is made in bad faith.¹³⁸ *State Farm Mutual Auto Insurance Co. v. Campbell* showed punitive damages against insurance companies for bad faith denial of coverage are available, even if there are due process limits to the size of the punitive damages award.¹³⁹ In *State Farm*, the liability insurer refused to settle a car accident case even though “a consensus was reached early on by the investigators and witnesses that Mr. Campbell’s [the insured’s] unsafe pass had indeed caused the crash.”¹⁴⁰ Rejecting the at-policy-limit settlement offer, State Farm told Campbell he need not worry as he would not be held liable for the accident. The jury returned a verdict three times the limit of Campbell’s policy, and, at first, State Farm refused to cover the excess, or the cost of appealing the judgment. At one point State Farm even told the Campbells they would have to sell their house. After the Campbells lost the appeal State Farm did pay it in full, but that was too little too late as in a separate lawsuit against State Farm the court awarded punitive damages for its treatment of Campbell.¹⁴¹ While this case sends a clear message to insurers to not deny coverage in bad faith, it has been argued that claims against insurers for bad faith denials of coverage cause more harm than good due to courts’ limited abilities to accurately identify opportunistic behavior by insurers.¹⁴² In sum, insurers in third-party liability policies usually assume the duty to defend the insured. This gives insurers control over the case and thus works to prevent insureds from failing to defend a claim vigorously or settling with the insurers’ funds too easily.¹⁴³ At the same time, requiring an insurer to receive the insured’s consent on any settlement agreement and imposing liability for a bad-faith refusal to settle by the insurance company lowers the agency costs associated with the fact that insurers act on behalf of the insureds.

¹³⁸ *Silberg v. Cal. Life Ins. Co.*, 521 P.2d 1103, 1108-09 (Cal. 1974); Chandler, *supra* note 44, at 850-52.

¹³⁹ *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 429 (2003).

¹⁴⁰ *Id.* at 413.

¹⁴¹ *Id.* at 413-14.

¹⁴² See Alan O. Sykes, “Bad Faith” Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405, 443 (1996).

¹⁴³ In contrast, Directors and Officers insurance policies state that it is the insured’s responsibility to defend a claim when one occurs. Yet, these policies still prohibit the insured from settling without the insurer’s consent.

1. Returning to the Two Islands Approach

An excellent candidate for the Two Islands analysis for this section is the reasonable expectations doctrine. Take for instance a Minnesota Supreme Court decision from 1985. In *Atwater Creamery*, the issue was whether an insurance policy covered a break-in where there was no visible evidence of forcible entry.¹⁴⁴ The policy quite clearly excluded coverage where there is no physical evidence of *forcible entry*. Yet, the court decided that despite the language of the policy, where it is clear that a burglary happened by unrelated parties, there should be coverage. In ignoring the language of the policy the court relied on the reasonable expectations doctrine, with a focus on the ex-post bargaining power of the parties, not the future effects of its decision.¹⁴⁵

Under the two islands functional approach, the question in that case should have been, all else being equal, whether an island that allows the physical-evidence exclusion is better than an island that does not allow the exclusion. To answer that one needs to inquire about the function of the exclusion. The exclusion is designed to screen out coverage for burglaries by someone associated with the insured—inside jobs. The island that allows the exclusion places the costs of burglaries without physical evidence on insureds, yielding two effects on insureds: insureds are motivated to monitor their property against an inside job, and they will be more likely to take precautions to prevent clean “out-side” burglaries by locking their property or using alarm systems. In other words, the exclusion reduces moral hazard associated with insurance burglary policies by incentivizing the insured to take optimal care. One could expect there will be fewer burglaries as a result of the exclusion, and premiums will be lower, both social benefits.

On the other island, where the exclusion is not enforced, insureds will have less incentive to secure valuables, and may even be incentivized to defraud insurers by burglarizing their own property. Either way premiums and social loss would be higher.

¹⁴⁴*Atwater Creamery Co. v. W. Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 274 (Minn. 1985).

¹⁴⁵*See id.* at 277-79. The Iowa Supreme Court in *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, cited by the Minnesota Supreme Court in *Atwater*, also relies on fairness to the insured to apply the reasonable expectations doctrine to ignore a similar definition of burglary. *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 274 N.W.2d 169, 177 (Iowa 1975).

It seems therefore that as a general matter excluding burglaries where there is no sign of forcible entry is desirable because “inside jobs” are hard to detect by the insurer and relatively easier to prevent by the insured. The exclusion therefore maximizes social welfare for the entire pool of insureds. Between providing more coverage (for clean outside jobs) and not distorting the incentives to take care against inside jobs, the latter seems a better option.¹⁴⁶

But, in the *Atwater Creamery* case there was no suggestion that anyone associated with the insureds was involved in the burglary. Furthermore, it was clear that proper precautions were taken to secure the property.¹⁴⁷ The Minnesota Supreme Court decided to provide coverage in this case. Was that a good decision? In this situation, the island the Minnesota Supreme Court chose would still fight the moral hazard problem because by conditioning its decision on the finding that no insider was involved the court did not dilute the incentives insureds have to not participate in self-burglaries and to take adequate precaution. At the same time, in those situations where the insured acted in a socially beneficial way, that is, when she took optimal precautions, providing coverage (by ignoring the language of the contract) would distribute the risk of clean “outside jobs” across the entire pool of insureds. Most likely a welfare gain.

While the court’s opinion in *Atwater Creamery* might well maximize the pool’s welfare, one needs to remember that the down-side of the decision is that it opens the door for costly, case by case analyses of every similar situation. For this reason, and because it provides coverage in cases such as clean outside jobs, the island the Minnesota court chose would have higher premiums than an island with the full exclusion enforced. Insureds, however, might prefer higher premium in exchange for the additional coverage.

The result in this case is not unambiguous, and to determine the best island empirical data comparing the increased risk of extending

¹⁴⁶ Daniel Schwarcz comes to the opposite conclusion about these clauses, arguing that the potential moral hazard benefits of the exclusions are low because there is little that can be done to prevent against internal thefts, and if insurers do have evidence of fraud then they can deny the claim on that basis. *See* Schwarcz, *supra* note 65, at 1288. Schwarcz also notes that many of these clauses were rejected by courts decades ago, but have since returned to homeowners policies. *Id.*

¹⁴⁷ *Atwater Creamery*, 366 N.W.2d at 274.

coverage to clean inside jobs (which should be excluded) against the net benefit of covering clean outside jobs (which should be covered) is needed. Selectively ignoring the exclusion would certainly combat moral hazard more than always ignoring the exclusion, and would likely be less effective at combating moral hazard than always honoring the exclusion, but where in that spectrum the Minnesota court's decision would fall is unclear. Furthermore, the administrative cost of selectively ignoring the exclusion is also hard to determine, although it is certainly more costly to selectively ignore the exclusion than always honoring it or always ignoring it: a bright-line rule will almost always be cheaper to enforce than a case-by-case analysis. Thus, the Minnesota court's decision can be justified if clean outside jobs is such a prevalent phenomenon that covering them provides more benefit than covering only dirty, or forced-entry, outside jobs creates costs in forgone coverage, and if the administrative costs associated with proving an incident were not an inside job are not too large.¹⁴⁸

As this example has demonstrated, the two islands analysis will not always provide the answer, but it does give us a good, basic framework for answering the question.

F. SUMMARY

This section discussed the major impediments to the efficient insurance contract—hidden characteristics and strategic behavior. These problems manifest themselves in adverse (and reverse adverse) selection and moral (and reverse moral) hazard. According to the economic analysis of law, one of the main roles of insurance law is to protect the parties from strategically exploiting hidden information. Indeed, the contractual and doctrinal solutions discussed in this section do just that. These solutions, however, do not come without a price tag. For both adverse selection and moral hazard the challenge is to strike a balance between diluting both parties' strategic behavior while providing maximum coverage, and the two islands approach can often help courts and other decision makers strike that balance.

¹⁴⁸ One may still wonder why insurers did not find a simple way to design language that supplements the forced entry requirement. Their failure to do so suggests that insuring clean outside jobs is hard to do without also creating a big loophole into which many inside jobs will fit.

III. OTHER IMPEDIMENTS TO EFFICIENT INSURANCE CONTRACTS

The previous section discussed informational problems and the strategic behavior they create as impediments to an efficient insurance contract. However, there are many other systemic factors that impede the creation of efficient insurance contracts including transaction costs, externalities, correlated risks, non-competitive pricing and insurers' irrational behavior. In this section I briefly discuss them. At the end of the discussion of these five additional impediments I will use the two islands approach to analyze a solution to one of them- the problem of correlated risks.

A. TRANSACTION COSTS

One systemic impediment to insurance contracts is transaction costs, part of the larger administrative costs category.¹⁴⁹ Such costs arise in the arranging and executing of a transaction, and in extreme cases may exceed the value that the transaction itself would create. Thus, the transaction, which would otherwise be efficient, is not pursued by the parties.¹⁵⁰ In the insurance world, one common solution to the transaction cost problem has been the standard form. Standard forms have long been thought to present several advantages for the parties to an insurance contract: (1) creation of economies of scale in drafting which may lower premiums; (2) greater likelihood of terms with predictable meanings; (3) facilitation of price competition; and (4) facilitation of the collection and aggregation of claim and loss data for use in rate-setting. This subsection evaluates the current usage of standard forms as a way of combating transaction costs.

Addressing the first potential advantage, the economies of scale for insurance contracts were once especially valuable because insurance contracts must be filed and approved by state regulators. This gave insurers a strong incentive to collectively draft their contracts and submit a single contract for approval, rather than having each one approved

¹⁴⁹ Administrative costs include any extra cost incurred in the business of insurance. They include transaction costs, but also the costs necessary for any insurance company to run, the costs to market policies to consumers, the costs in adjudicating disputes, etc.

¹⁵⁰ ABRAHAM, *supra* note 18, at 14.

individually.¹⁵¹ Recently though, new changes have reduced these regulatory burdens. As of today, all fifty states and the District of Columbia utilize an electronic platform called the System for Electronic Rate and Form Filing (SERFF), which provides for easier approval of policy forms.¹⁵² Indeed, a study of homeowners insurance policies, finds anecdotal evidence suggesting that the vast majority of insurance policies submitted to state regulators are approved.¹⁵³ If new contract forms are easily approved, then regulatory transaction costs may now be almost nonexistent, and the benefit from economies of scale from collective policy drafting lessened.

Moving on to the second advantage, insurers may rationally prefer the predictability of complicated terms which courts have already interpreted over the clarity of untested terms.¹⁵⁴ The stability of standard forms is further increased due to path dependency where insurers fear that deviation from the traditional language of the contract might be perceived as an attempt to mislead insureds. Yet, the actual benefit of predictability of meaning is difficult to ascertain, as courts have often diverged on the meaning of even common terms such as “sudden.”¹⁵⁵ Thus, this benefit of the standard form may also be overstated.

Third, many scholars have argued that standardized forms allow for competition because consumers can more easily compare coverage and pricing details.¹⁵⁶ On the other hand, when the standard forms are drafted collectively and every insurer uses the same form, the forms eliminate competition over the substance of the coverage provided and discourage innovation in the formulation of terms. Indeed, in the early 1900s a standard insurance form and pricing schedule were proposed specifically to prevent “ruinous competition” between insurers.¹⁵⁷ More recently, an entity called the Insurance Services Organization (ISO) has produced

¹⁵¹ Schwarcz, *supra* note 65, at 1272.

¹⁵² See Nat’l Assoc. of Ins. Comm’rs, *About SERFF*, SERFF, <http://www.serff.com/about.htm> (last visited Aug. 27, 2012).

¹⁵³ Schwarcz, *supra* note 65, at 1276.

¹⁵⁴ See *id.* at 1273 (arguing that “network effects” are created by a wealth of case law applying contract language, especially in the property and casualty insurance lines where policies attempt to categorize a large number of potential future scenarios, and that insurers will use specific language to “tap into this pool of precedent”).

¹⁵⁵ See *Just v. Land Reclamation, Ltd.*, 456 N.W.2d 570, 573 (Wis. 1990).

¹⁵⁶ Schwarcz, *supra* note 65, at 1272.

¹⁵⁷ *Id.* at 1270.

standard forms and aggregated data in the property and casualty lines. Until the late 1980s, the ISO also published advisory rates with its standard forms, a practice which dampened competition between insurers.¹⁵⁸ While these rates could not be mandatory due to antitrust laws, they did provide a potential vehicle for price-fixing or collusion within the insurance industry. This history suggests that standard forms may actually reduce competition rather than facilitating it, although the jury is still out on this benefit. Indeed, the life and health insurance business have survived and thrived without the existence of an ISO-like entity.

The last benefit of the standard form to be analyzed is that it allows the aggregation of loss data, which can only be done when companies utilize the same coverage. While this was once important for insurance companies, most modern insurers are very large, and are able to collect enormous amounts of information that is specific to their company—specific information that is more relevant to their risk calculations than what would be collected from all insureds under a standard form.¹⁵⁹ Technological advances have also helped in this area, reducing its importance.

To sum up, the standard form may still reduce transaction costs, but its actual benefit to insurers and insureds could be overstated. In practice, however, the insurance industry may actually be moving away from the standard form. This is evidenced by recent finding that there is now “substantial heterogeneity” in homeowner’s insurance policies. Rather than solving problems related to transaction costs and competition, however, this change may just create a whole new set of problems as consumers lack the ability to comparison shop between policies.¹⁶⁰

B. EXTERNALITIES

Another impediment to efficient insurance contracts is the externality problem. Externalities, or more particularly negative externalities, are costs of an action or transaction that are projected onto

¹⁵⁸ ABRAHAM, *supra* note 107, at 34.

¹⁵⁹ Schwarcz, *supra* note 65, at 1275.

¹⁶⁰ *See id.* at 1318 (finding that in practice the variety between insurance forms can make it impossible for consumers to comparison shop because they lack access to policy information and many of the contract details are extremely complex). While Schwarcz only investigated homeowners policies, this trend may also hold true for other types of insurance coverage.

non-parties or society as a whole, rather than being borne by the parties to the transaction. One of the principle justifications of the American tort system is to force wrongdoers to pay for the harm they cause. In other words the tort system forces tortfeasors to internalize their externalities. Liability insurance helps insulate tortfeasors from paying for their actions, thus it makes negative actions cheaper, and externalizes some of the costs onto society—or at least onto the tortfeasors' insurers.¹⁶¹ On this view, liability insurance is a welfare reducing institution.

Interestingly, liability insurance also prevents externalities. Some individuals and companies are judgment proof, meaning they do not have enough assets to pay for harm they may cause. Because a judgment proof entity will not have to compensate victims in the event of a loss, it has a lower incentive to take care than a non-judgment-proof entity. In contrast, insured entities are not judgment-proof, thus they may have more incentive to take care than non-insured entities, as long as the insurance company can provide them incentives to take care.¹⁶² Requiring an otherwise judgment-proof driver to carry insurance leaves him or her to bear the cost of dangerous driving (via higher premiums) rather than leaving the victim or society (via the tax and transfer system) to pay.

If liability insurance both externalize costs and prevents cost externalization at the same time, is it a welfare decreasing or welfare increasing institution? The insurance industry has developed ways to deal with negative externalities, mainly through experience rating, and refusing to insure certain high-risk entities or activities. Knowing that their premium might go up if they are in a car accident, drivers take more care thus at least partially internalizing the social costs of driving with insurance coverage. But not all is so rosy with liability insurance. Historically, liability insurers tried to limit their exposure by writing in the insurance contract clauses—called diminution clauses—which allowed them to reduce their own liability on account of the insolvency of the insured (the wrongdoer), in essence restoring the judgment-proof problem.¹⁶³ The diminution clauses

¹⁶¹ See Steven Shavell, *On the Social Function and the Regulation of Liability Insurance*, 25 GENEVA PAPERS ON RISK & INS. 166, 175 (2000).

¹⁶² See Steven Shavell, *Minimum Asset Requirements and Compulsory Liability Insurance as Solutions to the Judgment-Proof Problem*, 36 RAND J. ECON. 63, 63 (2005).

¹⁶³ Chandler, *supra* note 43, at 854. The historical reason for this is that in the past liability insurance policies provided true indemnification for losses incurred by policyholders. A condition for true indemnity is that the policyholder pay the

imposed costs on the victims of the insured, who were not fully compensated for the harm they suffer. These clauses exacerbated the moral hazard problem because these potential tortfeasors paid lower premiums that reflected that not all their victims were compensated. As with other problems discussed in this paper, insurance law has developed internal doctrines to remedy many of these more nuanced types of externalities, including this one. Nowadays, anti-diminution laws, also called bankruptcy provisions, prohibit the inclusion of diminution clauses into the policy.¹⁶⁴

Another insurance law doctrine developed to combat externalities arises in the context of subrogation. As we saw above, it is a general principle of subrogation, and a common clause in first-party insurance contracts, that if the insured releases a wrongdoer of liability when, otherwise, the first-party insurer would have had a claim against that wrongdoer through its right of subrogation, then the insured forfeits his claim under the policy.¹⁶⁵ This protects the insurer's ability to exercise its subrogation rights. The general principle prevents insureds from externalizing the cost of harm caused to them onto their first-party insurers. If the rule was not so, insureds could exchange a release of liability for something of benefit from the wrongdoer, and still require the insurer to pay for the harm. However, courts have made an interesting exception for releases of liability of the wrongdoer *prior* to the wrongful action.¹⁶⁶ Such release often comes up in construction contracts where the contractor is released from any liability arising during its performance of the contract. In exchange for the liability release, the hiring company (the insured) receives a discount. The hiring company then has to rely on its first-party coverage.

Despite the potential externalities, courts allowing prior liability releases can be justified in several ways. First, when insureds are unsophisticated, exculpatory clauses are often contained in fine print on standard form contracts that people do not read—such as the common

loss and ask to be reimbursed. In the case of judgment-proof policyholders, insurers benefited automatically from policyholders' inability to pay.

¹⁶⁴ The interplay of mandatory minimum liability coverage with prohibitions on diminution of coverage in bankruptcy works an interesting effect, in that it weakens the protection bankruptcy laws provide for insureds by requiring them to spend prospectively on insurance—a payment that cannot be discharged, since it is in advance—for the benefit of victims whose claims are dischargeable.

¹⁶⁵ See, e.g., *Great N. Oil Co. v. St. Paul Fire & Marine Ins. Co.*, 189 N.W.2d 404, 408 (Minn. 1971).

¹⁶⁶ See *id.* at 406-07.

limitation of liability in parking garages tickets. Even if a driver sees the limited liability notice, it is probably not reasonable to ask drivers to notify their first-party insurers every time they enter a parking garage that they have just agreed to release the parking garage from liability and therefore that the first-party automobile insurer is exposed to higher risk. Second, when insureds are sophisticated, the practice of releasing putative wrongdoers from liability can be justified if first-party insurers can better monitor or risk-classify their insureds than liability insurers of construction contractors can monitor or risk-classify their insureds or insureds' clients. This can happen if first party property insurers know well the value and risks associated with the property they insure whereas the contractor's third party liability insurers may have less information about those whom their insureds may damage in the course of their activities. In any case, it should be remembered that first party insurers can easily deal with this externality by explicitly requiring insureds not to release putative wrongdoers from liability, even prior to the act, in the policy.

Insurance law also proscribes, in many instances, liability coverage for fines incurred from intentional misconduct and for punitive damages. That sort of coverage, if permitted, would remove the deterrent effect of fines by reducing or eliminating the cost to the actor himself; in other words, by allowing him to externalize that cost.¹⁶⁷ For this reason, some countries do not allow indemnity for criminal sanctions. Courts should also be cautious in interpreting too broadly insurance policy clauses providing coverage for civil fines (such as in Directors and Officers policies) and carefully consider any externalities that such policies may create. The more broadly courts construe that fine coverage, the freer insureds are to violate whatever law imposes the fine and force their costs onto society. Such coverage allows insureds to participate in whatever activity the fine provision is intended to curb without bearing the cost of the fine.¹⁶⁸

¹⁶⁷ *But see* George L. Priest, *Insurability and Punitive Damages*, 40 ALA. L. REV. 1009, 1012 (1989) (cautioning that as views change regarding punitive damages, it may become more desirable to allow insurance for them).

¹⁶⁸ *But see* Tom Baker & Sean Griffith, *Predicting Corporate Governance Risk: Evidence from the Directors' and Officers' Liability Insurance Market*, 74 U. CHI. L. REV. 487, 533 (2007) (finding some deterrence effect from directors and liability insurance because the providers seek to factor in the risk of legal violations into the premiums).

C. CORRELATED RISKS

Correlated risks are those risks that, if they come to fruition, will affect a large portion of the insurance pool. Hurricanes, floods, and acts of war are examples of these types of risks.¹⁶⁹ They pose a problem for insurers for two reasons: they affect a large portion of the insurance pool—meaning the insurer will have to have access to a lot of cash to honor claims; and the timing of when the risk will occur is unpredictable. Thus, in a year when a correlated risk occurs, an insurer's loss ratio will be extremely high—meaning the insurer must pay out far more than it takes in. Covering correlated risks therefore would require insurance companies to keep large amounts of capital liquid, something the institutional infrastructure of the capital markets makes very unappealing.¹⁷⁰ Without liquid capital to pay claims, however, an insurance company would become insolvent when correlated risks come to fruition.

Correlated risks are not so much an impediment to efficiency but a category of risks that are generally hard to insure. As discussed above, the insurance market works because risk-averse insureds transfer their risks to the insurer who spreads those risks among all the insured parties. In this way the insurer fills a large pool by charging small premiums to cover the losses of the unfortunate few whose risks come to fruition. The law of large numbers allows an insurer to charge a certain premium which reflects only a small fraction of the actual loss an individual would suffer if the risk materializes. The ratio of the losses paid out over the premiums collected—plus any interest made on capital held—is called the loss ratio.

¹⁷¹ In order to be sustainable, the loss ratio must be under one—or 100%,

¹⁶⁹ An interesting form of correlated risk appears in the liability insurance context and is called "sociolegal risk." See PATRICIA M. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 177-78 (1985). In some situations, for example, one high court ruled all commercial general liability policies within the court's jurisdiction covered expenses incurred due to America's Superfund statute. *A.Y. McDonald Indus., Inc. v. Ins. Co. of N. Am.*, 475 N.W.2d 607, 621 (Iowa 1991). With one court ruling, liability insurers in the jurisdiction were exposed to millions of dollars more liability than they were previously.

¹⁷⁰ Dwight M. Jaffee & Thomas Russell, *Catastrophe Insurance, Capital Markets, and Uninsurable Risks*, 64 J. RISK & INS. 205, 208, 213 (1997).

¹⁷¹ *Id.* at 211.

depending on the scale used—meaning the premiums collected in a given year are greater than the losses paid out.¹⁷²

How can one deal with correlated risks? Sometimes the state takes it upon itself to provide insurance for such risks. Flood insurance created through the National Flood Insurance Act of 1968 is one example. Sometimes the state provides reinsurance for such risks. The Terrorism Risk Insurance Act of 2002 is an example of that. Other times, insurers have to find their own solutions. As is well known, insurers extend their protection through diversification of risk. Diversification of the risks to which the insurer (through the insured parties) is exposed occurs in two ways: diversification with regard to a particular risk and across different types of risks.¹⁷³ For particular risks, the principle is essentially the same as the law of large numbers. More individuals protecting against the same risk reduces the uncertainty faced by any one of them, provided the risks are not perfectly correlated with each other. For different types of risks, the overall chance of loss is reduced by hedging exposure related to the risk of a particular event, such as a tornado, against exposure to other events, such as a fire.

Because insurance is often sold through retail, many policyholders are localized in the same geographic regions—making the hurricane risk correlated between a large bulk of the insureds. That is why diversification—both in covering different types of risk and covering larger geographical areas—is so important to protect against correlated risks. Another way to protect against correlated risks is purchasing reinsurance in local or foreign markets, and when the private market cannot supply it, from the government.¹⁷⁴ Lastly, insurers often exclude those types of risks

¹⁷² *Id.* at 208. The rare exception—loss ratios over 1—could come in sectors where the risk materializes long after premiums are collected such as life insurance. Another possibility is insurance for rare events—like natural disasters—where the premiums collected in a given year are less than the losses paid out if the event happens, but because the event only happens rarely, say an average of every 10 years, the company can still make a profit.

¹⁷³ TOM BAKER, *INSURANCE LAW AND POLICY: CASES, MATERIALS, AND PROBLEMS* 4 (2d ed. 2008).

¹⁷⁴ Government programs—such as the National Flood Insurance Program—can provide insurance for correlated risks, though the value of public sector involvement is up for debate. See Howard Kunreuther & Mark Pauly, *Rules Rather than Discretion: Lessons from Hurricane Katrina*, 33 *J. RISK & UNCERTAINTY* 101, 102-03 (2006). But see J. David Cummins, *Should the*

from their policies—war, pollution and flood exclusions in homeowners’ policies are such examples. Those who want flood or pollution insurance must get it separately. At the end of this section I apply the two-island approach to the problem of correlated risks.

D. NON-COMPETITIVE PRICING

Another obstacle to efficiency to be discussed is non-competitive pricing. Pricing problems arise when there are significant impediments to competition between insurers, whether on account of capital requirements, unfair competition, or regulatory standards.¹⁷⁵ As in any market, such conditions result in inefficiently high prices and lead to a less-than-ideal amount of insurance being purchased. It must be noted, though, that legal interference to correct these pricing problems may create more costs than benefits, for example, where premiums are artificially kept down, which may cause insurers to respond by reducing the quality of their contracts.

The problem of competitive pricing is linked to problems discussed above. Collectively drafted standard form contracts and path-dependency present parallel problems, in that they limit insurers’ flexibility to offer differing, competitive terms to insureds, thus harming overall competition. Offering contracts which deviate from norms might be interpreted as an attempt to mislead consumers. Similarly, it has been argued that both plaintiff and defense lawyers have incentives to keep insurance contracts complicated in order to maintain their role as informed intermediaries between insurers and insureds. Sometimes, the result could be inefficiently restrictive or onerous terms, especially in compulsory insurance regimes where insurers have greater capacity to dictate terms.

Limited competition has long been considered a social negative, and is regulated by federal antitrust law. Insurance, though, was considered a matter of state law under the U.S. Constitution, and the insurance market was therefore traditionally exempt from antitrust law. In 1945, reacting to a U.S. Supreme Court case which subjected insurance companies to federal antitrust laws,¹⁷⁶ Congress enacts the McCarran-

Government Provide Insurance for Catastrophes?, 88 FED. RES. BANK ST. LOUIS REV. 337, 338 (2006).

¹⁷⁵ ABRAHAM, *supra* note 18, at 13.

¹⁷⁶ *United States v. Se. Underwriters Ass’n*, 322 U.S. 533, 552-53 (1944), *superseded by statute*, McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2006), *as recognized in* *U.S. Dep’t. of Treasury v. Fabe*, 508 U.S. 491 (1993).

Ferguson Act, which provided that federal antitrust law would apply to the insurance market in each state beginning in 1948 unless the state had passed its own legislation. Within several years, every state passed its own legislation which preempts the McCarran-Ferguson Act. Today, insurance markets are still largely exempt from federal antitrust laws.

E. RATIONAL (OR IRRATIONAL) BEHAVIOR BY THE INSURED

The final obstacle to be discussed is irrational behavior. Much of the behavior by insureds discussed in this Primer has been assumed to be rational. However, as in many other areas, consumers do not always make the economically efficient decision when it comes to insurance. The field of behavioral economics, which explores and explains how people act in the real world, provides some useful insights into how best to take advantage of a variety of irrational biases held by the majority of insureds. Some of the major decision-making anomalies that affect insurance companies include: loss aversion, status quo bias, choice overload, value of zero, availability bias, and hyperbolic discounting—and the list goes on.¹⁷⁷ The field of behavioral economics is too large to be covered in a paper of this length, but the following discussion provides a taste of how behavioral economics might be helpful in complimenting the theories of insurance law discussed in other sections.

The first bias amongst insured is loss aversion, or the idea that people feel more pain from a loss than they do pleasure from a gain.¹⁷⁸ In other words, the joy and pain in losing twenty dollars and gaining twenty dollars would not cancel each other out (despite the equal but opposite economic outcomes). For insurance purposes, this translates to a preference for steady premiums rather than rates that vary up and down over time. Loss aversion also explains one of the most irrational decisions a consumer can make: purchasing an extended warranty. Under this theory, the insured categorizes the extended warranty as a cost rather than a loss. Therefore the cost of the warranty is weighed less than the expected

¹⁷⁷ Christine Jolls et al., *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471 app. at 1548-50 (1998); Jeffrey Liebman & Richard Zeckhauser, *Simple Humans, Complex Insurance, Subtle Subsidies* 7-8 (Nat'l Bureau of Econ. Research, Working Paper No. 14330, 2008), available at <http://www.nber.org/papers/w14330>.

¹⁷⁸ Jolls et al., *supra* note 177, at 1484.

loss from product failure, and that product-loss calculation is exaggerated because of loss aversion.¹⁷⁹

Status quo bias has also proved to be very powerful in predicting behavior, and basically resonates with the idea of inertia from physics. This translates into people being more likely to accept form contracts (which represent the status quo) rather than making individual choices.¹⁸⁰ Much of this may have its roots in loss aversion, or that people are worried about making a choice that ends up being risky. When faced with a variety of options, discussed below as choice overload, many insureds opt to keep the status quo. A natural quasi-experiment that demonstrates the power of the status quo bias took place couple of decades ago.¹⁸¹ Changes in Pennsylvania and New Jersey automobile insurance laws introduced the option of giving up some of one's right to sue, with a corresponding reduction in insurance rates. In New Jersey, the default was to have a reduced right to sue, and a driver had to opt in to the full right to sue by paying more. In Pennsylvania, the default was retaining the full right to sue, and one could receive a discount for opting out. Since the option is the same and only the default is different, one would expect that insureds would act based on whether the reduction in premiums was worth the lost right to sue, leading to similar results in both states. Instead, only twenty percent of drivers in New Jersey opted into the full right to sue, and seventy-five percent of Pennsylvania drivers retained this right.¹⁸² In other words, about three-fourths of all drivers did nothing.

A related anomaly is choice overload which predicts that when given too much information potential insureds may become overwhelmed and do nothing, even if their actions would be beneficial. Insurers must be aware of the danger of increasingly complex terms as it may serve to confuse buyers and cause them to not make the best choices for their situation.¹⁸³ Health care is a great example of the numerous decisions that must be made by an insured. Even if the employer has made many of the

¹⁷⁹ Tom Baker & Peter Siegelman, *Law and Economics after the Behavioral Turn: Learning from Insurance*, 27 (Oct. 10, 2011), <http://www.law.harvard.edu/programs/petrie-flom/workshop/pdf/baker.pdf>.

¹⁸⁰ See *supra* Part 2.C.

¹⁸¹ Eric. J. Johnson et al., *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK & UNCERTAINTY 35, 48 (1993).

¹⁸² *Id.*

¹⁸³ However, insurers may be intentionally confusing insureds via choice overload. See Schwarcz, *supra* note 66, at 1268 (“[F]irms may be exploiting consumer ignorance to draft inefficiently one-sided contracts.”).

choices for their employees, an employee still must choose a plan (PPO, HMO, etc.), pick a deductible and finally decide when and how much medical care to consume.¹⁸⁴ These decisions can be very difficult, and behavioral studies have shown that human beings are not good at predicting high-consequence, low-probability risks (even though they must do this to choose their efficient level of insurance).¹⁸⁵

A phenomenon that extends well past the insurance world is people's bias towards the value of zero. Individuals are very attracted to free promotions, to the point of acting irrationally. For example, when Amazon.com rolled out its free shipping promotion for all orders above a certain dollar value the Amazon.com operation in every country except for France saw an increase in sales. In France, Amazon.com was charging the equivalent of \$.20 instead of nothing for shipping on large orders, and this tiny amount was enough to prevent the increases in order size seen in other countries.¹⁸⁶ The value of zero applies equally to insurance too, as consumers will appreciate additional services at "no additional cost."¹⁸⁷ Of course the costs of the policy just include these services, but the customer feels like they are getting something for free.

An additional decision making anomaly relevant to insurance is the availability bias. This theory details how people generally assess the chances of an event occurring based upon specific examples in their lives, and can also be thought of as a rule of thumb bias.¹⁸⁸ As was mentioned earlier in the paper, the expected yearly cost of an incident is the probability of the event multiplied by its cost. This means that if people think the probability is higher, they will be more likely to purchase insurance. A great example of the availability bias comes from 1990 when a business consultant and self-proclaimed climatologist predicted there to be a .5% chance that an earthquake would occur in eastern Missouri during an upcoming two day span.¹⁸⁹ This prediction received significant press

¹⁸⁴ Liebman & Zeckhauser, *supra* note 177, at 5–6.

¹⁸⁵ *Id.*

¹⁸⁶ Bridge Strategy Grp. LLC, *Behavioral Economics: A New Frontier for Insurance?*, A VIEW FROM THE BRIDGE (May 2009), http://www.bridgestrategy.com/topics/behavioral_economics.

¹⁸⁷ For example, 21st Century Insurance offers a free Security Advantage Program to all its customers which includes roadside assistance, identity theft restoration, and travel and medical assistance. *21st Roadside Assistance*, 21ST CENTURY INS, <http://www.21st.com/insurance-products/security-advantage.htm>.

¹⁸⁸ Jolls et al., *supra* note 177, at 1477.

¹⁸⁹ Johnson et al., *supra* note 180, at 37.

coverage but was refuted by other earthquake experts. Still, State Farm reported that more than 650,000 policyholders added earthquake insurance to their homeowners policy, mostly in the two months prior to the predicted date.¹⁹⁰ The earthquake never happened, but people were still made more aware of the chances of an earthquake and therefore wrongly calculated the earthquake probability to be higher than it actually was. More broadly speaking, it has been shown that “[p]eople tend to conclude, for example, that the probability of an event (such as a car accident) is greater if they have recently witnessed an occurrence of that event than if they have not.”¹⁹¹

The last bias to be discussed here is hyperbolic discounting. This occurs when individuals use a large discount factor to compare current benefits to future benefits.¹⁹² If you have heard of the time value of money¹⁹³ then this concept should sound familiar. However, most people will use the wrong discount factor when deciding between present consumption and future benefit. This leads to underinvestment in future health care and a lack of preventative medicine. In theory a rational insured would make the correct choice about their health care plan and undergo economically efficient preventative care, but behavioral economics predicts, as indeed was empirically confirmed, that this does not happen in the real world.

This section has discussed the irrationality of insureds, and it adds a few additional layers of complexity to the analysis of efficient insurance contracts. Most importantly, the irrational behavior by insureds must be taken into account when making ex-ante predictions, and many times it can be worked into the models we use to predict behavior. The other important takeaway is that our theoretical solutions to market inefficiencies are not perfect. The full effects of behavioral economics is beyond the scope of any introduction to law and economics, but know that applications of the theoretical and contractual solutions to the impediments to efficient

¹⁹⁰ *Id.* at 38.

¹⁹¹ Jolls et al., *supra* note 177, at 1477.

¹⁹² Liebman & Zeckhauser, *supra* note 176, at 7-8.

¹⁹³ This concept holds that money now is better than money later, and that the exact amount greater it is can be calculated based upon the expected rate of return. If interest rates are 5%, then the “present value” of receiving \$1000 in five years is \$783.53. In other words, if you received that amount and invested it you would have \$1000 in five years. Among many things, this is why the lotto payouts are higher if you opt for the installment plan rather than a lump sum—the lotto organization invests the rest of the money and ends up paying less overall.

insurance contracts are able to account for both the rational and irrational behavior of insureds.

1. Returning to the Two Islands Approach

For brevity's sake I will not apply the two islands approach to every one of the impediment discussed in this section. Instead I will apply it only to the problem of correlated risks. The two island approach shows the utility of exclusions associated with correlated risks. Consider the flood exclusion in homeowner's policies. On one island, floods are excluded, and on another they are covered. If a flood hits each island, the majority of houses on that island are going to be damaged. On the island that does not cover floods, premiums will be lower than the island where floods are covered. Without more, it is a close call—higher premiums with coverage or lower premiums without coverage. The answer depends on the probability of flood, people's risk aversion, the size of the losses, and other factors. However, the analysis must consider that floods are a correlated risk. This fact likely makes the island without coverage more desirable. On the other island, because the flood will hit all of the insureds, the insurer might not have enough cash to pay all of the premiums, leading to insolvency, or will have to charge exceedingly high premiums to cover such an island-wide event. An insolvent insurer is clearly not good for insureds, and therefore flood exclusions, and other catastrophic correlated risk exclusions, are socially useful. Of course, insureds can always purchase flood insurance separately from companies—or public agencies—which specialize in such risks, but that is a different issue from whether a general homeowner's policy should have such coverage.

Two cases demonstrate how courts do, and how they should, use the economic factors discussed above to interpret flood exclusions in homeowners policies. *Kane v. Royal Insurance Company of America* involved a standard flood exclusion clause and a dam failure in Colorado. The court found that because the water damage occurred from a natural body of water invading normally dry land, it was unambiguously a flood under the policy.¹⁹⁴ In *Ferndale Development Co. v. Great American Insurance Co.*, on the other hand, a burst water pipe was found not to be a flood under similar terms in an insurance policy.¹⁹⁵

¹⁹⁴ *Kane v. Royal Ins. Co. of Am.*, 768 P.2d 678, 681 (Colo. 1989).

¹⁹⁵ *Ferndale Dev. Co. v. Great Am. Ins. Co.*, 527 P.2d 939, 940 (Colo. App. 1974).

In each of these cases the respective courts based their decisions on interpretations of the meaning of “flood.” Is there really a difference between a flood caused by a failing dam and a flood caused by a ruptured valve on a city water line? Under the functional approach the relevant question is the purpose of the flood exclusion which, as discussed above, it is to prevent insurers from being exposed to correlated risks. A dam failure will likely lead to the inundation of a large area, possibly an entire town. This is the same type of correlated risk that the flood exclusion is meant to avoid. On the other hand, a burst pipe is likely to only affect a small number of houses around the pipe. This type of occurrence is not likely to lead to correlated losses, thus it should not be interpreted as being under the umbrella of the flood exclusion.

In today’s world of large, national insurance companies, though, correlated risks actually threatening insurers’ solvency are less likely. Most insurers cover insureds across a state, or the entire country. It is unlikely any one flood will affect a large percentage of a given insurer’s insureds. Thus, in our ongoing example, the islands are quite large, and the risk of a flood leading to insolvency is small. If there is no threat to a large portion of the insurance pool, there is actually no correlated risk problem. The question becomes again whether higher premiums for coverage are better than lower premiums for no coverage. This is another example of a situation where more empirical information as to what a rational insured would do behind the veil of ignorance is necessary. That is the proper question behind any insurance dispute. Unfortunately, the needed empirical evidence to answer this question (such as the frequency and distribution of floods, their costs, etc.) is often missing, so courts will have to decide based on other framework. But as long as the question is focused in the right direction, more and more often the right answer is within reach.

F. SUMMARY

As has been shown, there are many additional impediments to the efficiency of the insurance market in addition to moral hazard and adverse selection. Transaction costs, externalities, correlated risks, non-competitive pricing, and irrational behavior all serve as partial barriers to the maximization of social welfare. While various strategies can be employed to battle each of these impediments, none of the strategies are completely effective and they often create additional problems that must be dealt with. Standard forms are an ideal example. While they are useful in lowering transaction costs, they certainly do not eliminate them. Furthermore, the forms may sometimes lower competition and even make it easier for

insurers to collude when fixing their pricing. Consumers' irrational behavior vis-à-vis standard forms is another reason for concern. When courts or legislatures examine a particular legal problem in insurance law, all of the impediments must be kept in mind and the effects on these inefficiencies of any new rule or reform must be considered. Over time, through judicial decision-making, doctrine should be refined so as to consider the function of the exclusion before a court. On the one hand, insurers should not be able to use their greater bargaining power—including greater resources and expertise—to unfairly take advantage of insureds. On the other hand, exclusions generally serve a useful purpose, and if courts do not consider that purpose when ruling whether to uphold or void an exclusion, they risk creating a less efficient insurance market and hurting the entire pool of insureds.

IV. CONCLUSION

The modern insurance market arose from a desire to manage and distribute risks. It is, by definition, a system where customers pay now to receive financial protection later, if they need it. Like many other consumers, purchasers of insurance need protection. Unlike other sales situations, however, there is an inherent need to protect the sellers—insurers—as well. Insurers should be seen as a nexus of insureds. The reason that both parties need protection arises primarily from informational impediments. These main impediments are: adverse selection, reverse adverse selection, moral hazard and reverse moral hazard. In addition, many other impediments to efficiency arise in the insurance context, including: administrative costs, negative externalities, correlated risks, non-competitive pricing and irrational behavioral. Other impediments, such as conflicts of interest, were not discussed in this paper. Most insurance policy clauses, and almost all of the appropriate ones, are designed to address one or more of these impediments.

Any lawyer or judge dealing with the insurance field should keep the impediments in mind. Judges in particular should consider the function an exclusion clause plays in the policy before they decide whether to honor it. In most circumstances insurers have unquestionably more bargaining power, putting them in a better position than insureds to protect themselves. For this reason insurers' actions should be closely policed. That being said, just because a certain exclusion seems to treat an insured harshly in a given case does not mean it should be voided. The question is not so much whether the plaintiff who suffered a loss should recover based on the language of policy, because deciding questions of coverage based

solely on the language of the policy is never simple. Rather, the question should be whether a rational plaintiff behind a veil of ignorance would have been willing to pay for the disputed coverage without knowing whether he would ever need it, given that such coverage might distort parties'—and the entire insurance pool's—incentives. This is exactly the pool of insureds' perspective, and this is the efficient insurance contract paradigm employed here.

The two islands functional approach facilitates a users' ability to determine which side of a dispute maximizes social utility. It relies on the ex-ante perspective to refocus a decision from the (often heart wrenching) effects on a specific insured to the overall impact on the pool of insureds and, if externalities exist, on society. This refocusing is made easier in the insurance context once the view of insurers is appropriately shifted from a faceless company to a pool of similar people who all pay money to the insurance company in exchange for its possible protection later. The two island approach allows the analyst to balance the advantages of extended coverage against the possible incentive distortions such extension carries while considering all of the possible effects of either side of a ruling. The result of this inquiry is often that more information is necessary. While this is not ideal, at least it focuses the decision-maker in the proper direction. In other words, the right question is always the first step towards the right answer. The two island approach offers a way to find the right question and not infrequently even answer it.

STRANGER-INITIATED ANNUITY TRANSACTIONS AND THE CASE FOR INSURABLE INTEREST

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This article addresses the issue of whether insurable interest requirements similar to those which have already been enacted in many states to prohibit the practice of Stranger-Originated Life Insurance policies (STOLIs) should also be made applicable to Stranger-Originated Annuity Transactions, or 'STATs.' The article makes the case that they should by highlighting the inherent similarities that exist between STATs and STOLIs while also analyzing the flawed reasoning behind the lone case to hold that insurable interest requirements are not applicable to STATs. The authors then discuss various state insurance statutes and advance the argument that many of them may already prohibit STAT contracts from being entered into. In other words, the statutory framework for criminalizing STAT schemes may already be in place, in which case, the issue becomes the charge of the courts whose job it will be to interpret these statutes.

I. INTRODUCTION

Variable annuities have traditionally been viewed as long-term investment vehicles that offer a number of desirable benefits, including a guaranteed future income stream, favorable tax treatment, and standard or enhanced death benefits paid to a beneficiary in the event of untimely death. Savvy investors, however, claim to have discovered a “loophole” in these products, exploiting them to invest aggressively in the securities markets with the assurance that any short-term losses will be borne by the insurance company. To implement their strategy, they recruit terminally ill individuals to serve as the measuring lives for annuities with built-in death benefits, which provide a full and prompt refund of the investors’ premiums if their high-risk investments go awry. This predation on sick individuals—who often claim not to have understood that their poor health

was being exploited as a hedge against market losses by a total stranger—raises a significant legal question: should these “Stranger-Originated Annuity Transactions,” or “STATs,”¹ be rescinded as unlawful wagers on human lives, violating the well-established “insurable interest” requirement applied in life insurance cases? Examining the pertinent laws applicable to annuities and life insurance, persuasive arguments can be made that insurable interest laws apply to annuity products, and that stranger investors may not use the products to profit from the deaths of other human beings.

II. THE PRODUCT: VARIABLE ANNUITIES

A variable annuity is a product, primarily sold by life insurance companies, that incorporates certain features of an investment account and life insurance. Fundamentally, an annuity is a contract pursuant to which a purchaser agrees to make one or more premium payments to the issuer up front, during an “accumulation phase,” and the issuer agrees to make a series of payments thereafter, either to the purchaser or to a designated beneficiary, during a “payout phase.” Thus, an annuity is essentially a loan from the purchaser that the insurer pays back over time. An annuity may be “fixed,” meaning the insurance company promises to pay a minimum rate of interest or a set dollar amount for each periodic payment, or “variable,” allowing the premiums to be invested in mutual funds or other options in the bond and equity markets.² Variable annuity products offer a range of benefits that make them appealing to individuals interested in both preparing for retirement and safeguarding against untimely death. Variable annuities typically offer three major categories of benefits: guaranteed income distribution, favorable tax treatment, and death benefits.³

First, variable annuities provide a guaranteed distribution of periodic income. An annuity may be structured so as to make payments for a period certain, but is more commonly structured as a “life annuity,” made payable for the duration of the lifetime of a designated “annuitant.” The

¹ Also sometimes referred to as “Stranger-Originated Annuities” (“STOAs”) or “Stranger Originated Life Annuities” (“STOLAs” or “STOAs”).

² Variable annuities are regulated by the Securities and Exchange Commission, whereas fixed annuities are not considered securities and are therefore not regulated by the SEC. *Annuities*, SEC, <http://www.sec.gov/answers/annuity.htm> (modified Apr. 6, 2011).

³ See *Variable Annuities: What You Should Know*, SEC, <http://www.sec.gov/investor/pubs/varannty.htm#vch> (modified Apr. 18, 2011).

income distribution schedule and amounts are typically fixed at the time of annuitization, the point at which the contract owner agrees to freeze all or some of the funds invested in the accumulation phase and use them to commence distributions in a payout phase. Thus, a fundamental characteristic of a life annuity is its ability to provide a guaranteed source of income lasting as long as the uncertain lifetime of the annuitant. This offers a form of “longevity insurance,” protecting the designated beneficiary against the possibility that the annuitant will outlive the assets available from the accumulated value of the investment at the point of annuitization. Given this framework, a purchaser of a variable annuity will often name the same person as both annuitant and beneficiary, or will designate one person as the annuitant and his or her spouse, child, or other family member as the beneficiary.

The second attractive feature of a variable annuity is its favorable tax treatment. Under the Internal Revenue Code, variable annuities owned by individuals may be invested during the accumulation phase in a tax-deferred manner,⁴ much like a Roth 401(k). As a variable annuity is funded during the accumulation phase with after-tax dollars, any internal accumulation remains tax free. Once annuitized, any amounts withdrawn from the annuity during the payout phase over and above the amounts contributed are taxable. These market profits are taxed at ordinary income tax rates rather than capital gains rates. As such, the utility of the variable annuity is maximized if used as a long-term investment vehicle.

Third, a variable annuity typically includes a “Guaranteed Minimum Death Benefit” (“GMDB”) to be provided to the beneficiary upon the annuitant’s death. Usually, the life insurer offers a standard death benefit provision already built in to the base contract, generally guaranteeing the beneficiary an amount no less than the greater of (1) the total face value of the account, or (2) the total of all premiums paid, minus any adjusted withdrawals from the account. Enhanced or “stepped-up” GMDB options are often available à la carte for additional fees, either as part of the annuity contract or as a contract rider. A stepped-up GMDB option may, for example, allow the customer to “lock in” the account’s face value as of a specified date, if the account’s investments have been performing well. The issuer may also offer a “high water mark” or “anniversary ratchet” option, which looks at the account face value on each contract anniversary date and guarantees a minimum GMDB based on the highest account value as of any of those dates. Or the company might offer a “roll-up” option, guaranteeing a minimum rate of return on the invested

⁴ See generally I.R.C. § 72 (2012).

funds. Various combinations of these enhanced options may also be available.

While other elective features may also be available for additional fees,⁵ these three main advantages—guaranteed income distribution, tax-deferred investment, and death benefits—are frequently the defining features of a variable annuity product. Because these products incorporate death benefits, as well as lifetime benefits whose duration is tied to the date of the annuitant's death, it is often treated as an insurance contract, or as a hybrid product combining features of an investment product and life insurance. Whether a variable annuity is actually *legally* defined as life insurance varies from state to state, as discussed in further detail below.

III. THE BACKDROP: STOLI

Before examining how the death benefit component of variable annuities has been recently exploited to pursue risk-free investment opportunities by third-party investors, it is first necessary to examine recent developments in the life insurance industry.

Over the past decade, investors and agents have developed a gray market in life insurance known as Stranger Originated Life Insurance (“STOLI”).⁶ STOLI refers to any transaction or arrangement by which an investor seeks to purchase a life insurance policy on the life of an individual, typically an elderly insured, even though the investor does not have an insurable interest in the insured's life. The investor typically pays the premiums and structures the transaction so that the investor obtains ownership of the policy, the beneficial interest of a trust holding the policy, or otherwise secures control of the policy through a variety of clandestine transactions, enabling it to re-sell the policy or its controlling interest on the life settlement market. STOLI promoters use various methods to acquire interests in life insurance policies. The investor might agree to buy the

⁵ Insurers may, for example, offer various guaranteed *lifetime* benefits for an additional charge, such as a guaranteed minimum income benefit (“GMIB”), promising a minimum income stream during the payout phase, or a guaranteed minimum accumulation benefit (“GMAB”), which, after a set period of time (usually 10 or 20 years), resets the account's value to a guaranteed accumulation amount. Insurers also sometimes offer “bonus credit” features, such as a promise to add a bonus contribution to the accumulated value based on a specified percentage of purchase payments, typically ranging from 1% to 5%.

⁶ Also referred to as Investor-Owned or Stranger-Owned Life Insurance (“SOLI” or “IOLI”).

policy outright from the insured on a pre-determined date, or purchase a beneficial interest in a trust holding the policy.⁷ Or the policy might be funded by premium financing for a period of two years (the typical statutory contestability period of a life insurance policy), after which the insured is given the option of either paying off the loan, which typically has large administrative fees and a high interest rate, or surrendering the policy to the investor in full satisfaction of the loan.⁸

STOLI practices pose significant problems for the life insurance industry. STOLI often promotes fraud, incentivizing investors and agents to encourage exaggeration of the insured's net worth and income in order to qualify for larger death benefits,⁹ and sometimes takes place even without the knowledge or complicity of the insured.¹⁰

The most significant problem posed by STOLI, however, is its noncompliance with the well-established requirement that a life insurance policy's initial owner, beneficiary, or both must possess an insurable interest in the life of the insured. This requirement is based on public policy and is designed to prevent wagering on human lives, which creates perverse economic incentives to hasten the insured's death.¹¹ As discussed in further detail below, nearly all states impose insurable interest

⁷ See *Life Prod. Clearing LLC v. Angel*, 530 F. Supp. 2d 646, 649 (S.D.N.Y. 2008) (describing STOLI scheme whereby policy was owned by an irrevocable trust and the insured, who had initially named himself as trust beneficiary, sold his beneficial interest to a funding third-party investor shortly after policy issuance).

⁸ See *Lincoln Nat'l Life Ins. Co. v. Calhoun*, 596 F. Supp. 2d 882, 885 (D.N.J. 2009) (describing a "typical STOLI transaction" as involving an up-front cash payment in exchange for a promise of a future sale of the policy, use of a trust to hold the policy, and funding of premiums through non-recourse premium financing).

⁹ See, e.g., *Settlement Funding, LLC v. AXA Equitable Life Ins. Co.*, No. 06 CV 5743(HB), 2010 WL 3825735, at *1 (S.D.N.Y. Sept. 30, 2010) (STOLI policy on life of elderly insured was based on application claiming that she had a net worth in excess of \$12 million, even though she lived in an apartment and had assets of less than \$100,000).

¹⁰ E.g., *id.* (evidence showed that insured's signature was forged on trust agreement, insured was not in the same state as where the agreement was purportedly signed, and notary had never met the insured or notarized the trust agreement).

¹¹ See, *Warnock v. Davis*, 104 U.S. 775, 779 (1881) (insurable interest required as a matter of public policy to avoid the issuance of life insurance "by which the party taking the policy is directly interested in the early death of the assured").

requirements in a life insurance transaction. Due to the proliferation of STOLI practices in the last decade, many states have also recently enacted additional statutes specifically targeting STOLI transactions and clarifying that they violate the insurable interest requirement. For example, the California Insurance Code, as amended in 2009, defines entering into a STOLI arrangement as a “fraudulent life settlement act,”¹² and defines “STOLI” to include any arrangement designed to “initiate the issuance of a life insurance policy in this state for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest, under the laws of this state, in the life of the insured.”¹³ A majority of states have already enacted legislation specifically targeting STOLI practices just in the past few years,¹⁴ with additional legislation in other states likely to follow.

¹² CAL. INS. CODE § 10113.1(g)(1)(B) (West 2012).

¹³ *Id.* § 10113.1(w) (adding, “Trusts that are created to give the appearance of insurable interest and that are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life.”); *see also id.* § 10110.1(e) (same).

¹⁴ At least twenty-seven states thus far have enacted statutes specifically defining and prohibiting STOLI practices, nearly all since 2008, including Arizona, Arkansas, California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Minnesota, New Hampshire, New York, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, Washington, West Virginia, and Wisconsin. *See* ARIZ. REV. STAT. ANN. § 20-443.02 (West 2002 & Supp. 2011-2012) (prohibiting STOLI); ARK. CODE ANN. § 23-81-802(24) (LexisNexis 2005 & Supp. 2011-2012) (defining STOLI as unlawful practice); CAL. INS. CODE § 10113.1(g)(1)(B), (w) (West 2005 & Supp. 2012) (describing STOLI as fraudulent life settlement act); CONN. GEN. STAT. §§ 38a-465 (defining STOLI), -465j (2011) (entry into any practice or plan that involves STOLI constitutes fraud); GA. CODE ANN. § 33-59-2(24) (West 2003 & Supp. 2011) (defining STOLI as unlawful practice); HAW. REV. STAT. §§ 431E-2 (defining STOLI), -24 (2005 & Supp. 2009) (prohibiting entering into any practice or plan that involves STOLI); IDAHO CODE ANN. §§ 41-1951(15) (defining STOLI), 1962(1) (2010) (prohibiting any act that constitutes or promotes STOLI); 215 ILL. COMP. STAT. ANN. 159/5 (defining STOLI), 159/50 (prohibiting entering into STOLI), and 159/72 (West 2008 & Supp. 2011-2012) (crime of life settlement fraud includes entering into any arrangement which involves STOLI); IND. CODE ANN. §§ 27-8-19.8-7.8 (defining STOLI), 27-8-19.8-20.1 (LexisNexis 2008) (prohibiting the issuance, solicitation, or promotion of STOLI); IOWA CODE ANN. § 508E.2(12) (West 2007 & Supp. 2011-2012) (defining STOLI as unlawful practice); KAN. STAT. ANN. § 40-5002(f)(5) (K.S.A 2011 Supp.) (same); KY. REV. STAT. ANN. § 304.15-020(15) (West 2006) (same); ME. REV. STAT. ANN. tit. 24-A, § 6802-A(12-A) (West 2000 & Supp. 2011) (same); MINN. STAT. ANN. §§

Thus, the past few years have witnessed a flurry of legislation and an industry-wide spotlight on the STOLI issue. Legislators and life insurers, focusing their efforts solely on life insurance policies owned by strangers, apparently did not foresee that despite these tightened restrictions, some opportunistic investors would move on to exploit variable annuities in an analogous but unanticipated manner.

IV. STATs

The life insurance industry is now facing a new challenge from brokers and investors orchestrating the purchase of variable annuities offered by life insurance companies, referred to as “Stranger-Originated Annuity Transactions,” or “STATs.” STATs are the subject of a well-publicized lawsuit currently pending in federal court in the District of

60A.0782(12) (defining “STOLI practices”), 60A.0784 (making it “unlawful” to “engage in STOLI practices or otherwise wager on life”), 60A.0786(1) (creating presumption of STOLI practices where, *inter alia*, the premiums are financed by means other than the assets of the insured or someone “closely related to the insured by blood or law”), and 60A.0789 (West 2005 & Supp. 2011-2012) (insurer may bring declaratory judgment action to declare STOLI policies void); N.H. REV. STAT. ANN. 408-D:2(XVI) (defining STOLI), D:12(I) (LexisNexis 2011) (prohibiting the solicitation, promotion, or knowing participation in any STOLI activities); N.Y. INS. LAW § 7815 (McKinney 2000 & Supp. 2012) (defining STOLI as prohibited practice); N.D. CENT. CODE § 26.1-33.4-01(23) (2010) (same); OHIO REV. CODE ANN. §§ 3916.01(W) (defining STOLI), and 3916.171 (any contract, arrangement or transaction entered into in furtherance of STOLI act is “void and unenforceable”), 3916.172 (West 2005 & Supp. 2011-2012) (promoting STOLI constitutes fraud); OKLA. STAT. ANN. tit. 36, § 4055.2(13) (West, Westlaw through 2012) (defining STOLI as unlawful practice); OR. REV. STAT. §§ 744.318(18) (defining STOLI), 744.369 (2011) (prohibiting entering into any practice or plan involving STOLI); R.I. GEN. LAWS ANN. § 27-72-2(26) (West, Westlaw through 2012) (defining STOLI as unlawful practice); TENN. CODE ANN. § 56-50-102(12) (2011) (same); UTAH CODE ANN. §§ 31A-36-102(18) (defining STOLI), 31A-36-113(2)(a)(iii) (LexisNexis 2010) (prohibiting the entering into any practice involving stranger-originated life insurance); VT. STAT. ANN. tit. 8, §§ 3835(18) (defining STOLI), 3844(a)(2) (2009) (prohibiting any activities resulting in or intending to result in the issuance of STOLI); WASH. REV. CODE ANN. § 48.102.006 (West, Westlaw through 2012) (defining STOLI as unlawful practice); W. VA. CODE ANN. § 33-13C-2(18) (LexisNexis 2011) (same); WISC. STAT. ANN. 632.69(w) (West 2004 & Supp. 2011-2012) (same).

Rhode Island,¹⁵ in which two life insurance companies, Transamerica Life Insurance Company and Western Reserve Life Assurance Company of Ohio, claim to have been defrauded by STAT arrangements masterminded by Rhode Island attorney Joseph Caramadre and carried out with the collaboration of investors and brokerage firms.¹⁶

Caramadre, a real-estate specialist, believed he had discovered a “loophole” in the variable annuity product that allowed their use to facilitate aggressive short-term investments.¹⁷ By locating individuals with extremely poor health and a short life expectancy who would be willing to act as “annuitants” for variable annuities with GDMBs, Caramadre realized that one could engage in high-risk, short-term investments with the expectation that any potential losses would be borne by the insurance company upon the individual’s death.

To implement their strategy, STAT originators like Caramadre first seek out potential annuitants with terminal illnesses, recruiting such individuals through a number of unsavory methods that have drawn national attention. Caramadre, for example, published advertisements in the Rhode Island Catholic, an official diocese publication, stating “Terminal Illness? \$2,000 in CASH, Immediately Available.”¹⁸ The ads further promised that the funds were offered by a “compassionate organization” hoping to provide “financial assistance” to those near death.¹⁹ STAT originators also target church patrons and workers and patients in nursing homes, hospices, and hospitals, circulating flyers or through direct solicitation²⁰ and generally offering between \$2,000 and \$5,000 for their participation.²¹

¹⁵ See *W. Reserve Life Assurance Co. of Ohio v. Conreal LLC*, 715 F. Supp. 2d 270 (D.R.I. 2010) *on reconsideration in part sub nom.* *W. Reserve Life Assurance Co. of Ohio v. Caramadre*, 847 F. Supp. 2d 329 (D.R.I. 2012).

¹⁶ See generally *W. Reserve’s Amended Complaint*, *W. Reserve Life Assurance Co. of Ohio v. Conreal LLC*, 715 F. Supp. 2d 270 (D.R.I. 2010) (No. 09-564S).

¹⁷ *Id.* at ¶¶ 12-13, 20; see also Mark Maremont & Leslie Scism, *Investors Recruit Terminally Ill to Outwit Insurers on Annuities*, WALL ST. J., Feb. 16, 2010, <http://online.wsj.com/article/SB10001424052748704479704575061392800740492.html>.

¹⁸ Maremont & Scism, *supra* note 17.

¹⁹ *Id.*

²⁰ See, e.g., *Amended Complaint*, *supra* note 16, at ¶ 17; Jim Connolly, *Senior Recounts Brush with STOA as Commissioners Determine Tools to Fight It*, THE INS. BELLWETHER BLOG (May 21, 2010, 12:57 AM),

Once a terminally ill individual is identified, the STAT originator arranges for a licensed agent of an annuities brokerage firm to provide and sign an application for a variable annuity, designating an investor as the owner and beneficiary and having the terminally ill individual serve as the annuitant. The annuitization date is usually far enough in the future that a terminally ill annuitant will likely never receive an annuity payment. STAT sponsors opt on the application for either a standard or stepped-up GMDB, guaranteeing that the beneficiaries will receive a death benefit totaling at least the amount of premiums paid, and in some cases also purchasing additional enhanced benefits.²² The GMDB acts as a safety net, allowing the investor to make aggressive investments within the variable annuity with the expectation that, if they do not perform well, the insurance company will pay out at least the total of all premiums paid upon the annuitant's death.

V. THE NATIONAL RESPONSE

STATs have been widely criticized since coming to national attention over the past two years, with particular focus on the disturbing manner in which terminally ill annuitants are recruited. Often, the individuals or their families claim to have been misled about the nature of the arrangement, believing that the solicitors were simply offering charity.²³ As one such individual later testified to the National Association of Insurance Commissioners ("NAIC"), "What if I die now? He's going to collect. I don't want to see him get that kind of money. Not for bodies. I'm not going to sell my body."²⁴ Another individual testified to a federal grand jury that Caramadre and his associates never mentioned annuities at

<http://www.theinsurancebellwether.com/2010/05/senior-recounts-brush-with-stoa-as.html>.

²¹ Linda Koco, *Testimony Rips into Stranger-Originated Annuities in Different Ways*, NAT'L UNDERWRITER LIFE & HEALTH (June 14, 2010), <http://www.lifehealthpro.com/2010/06/14/feature-testimony-rips-into-strangeroriginated-ann>.

²² See Amended Complaint, *supra* note 16, at ¶¶ 19, 28, 45, 62.

²³ See Koco, *supra* note 21 (noting testimony from Rhode Island's Superintendent of Insurance that the annuitants "are unclear on their participation in the annuity contract" and believe that they are receiving a charitable gift); see also Olsen Testifies to NAIC: Annuity Transactions Raise Regulatory Questions, ACTUARIAL UPDATE, July, 2010, at 1, available at http://www.actuary.org/files/publications/Actuarial_Update_July_2010.pdf.

²⁴ Connolly, *supra* note 20.

all, and never told him that someone would profit from his wife's death, saying, "They preyed on the sick and the weak at a vulnerable time."²⁵ The plaintiffs in the Rhode Island cases have even alleged that some of the annuitants' signatures may have been forged.²⁶

However unsavory and exploitative STAT tactics may appear, questions still remain regarding their legality. The similarities between STATs and STOLI practices are obvious, particularly their exploitation of elderly or ill individuals for the profit of investors with no genuine interest in the continued life of those individuals. But despite the flurry of recent statutory enactments relating to STOLI, legislatures have yet to expressly tackle STATs. The NAIC held hearings in May 2010 at which numerous groups, including the Life Insurance Settlement Association ("LISA"), the National Association of Insurance and Financial Advisors ("NAIFA"), and the American Council of Life Insurers ("ACLI"), testified in condemnation of STATs and described them as sharing many of the same troubling characteristics of STOLI practices, but not all groups were yet prepared to announce their support of implementing new regulation or legislation to directly address STATs.²⁷ Several state insurance departments have issued bulletins regarding the potential harms of STATs, but they have not openly condemned them as illegal *per se*, instead opting to merely warn life insurers and recommend the implementation of safeguards.²⁸

Courts have yet to resolve open questions regarding the legality of STATs. The Securities and Exchange Commission is investigating Caramadre and his associates for possible violations of the securities

²⁵ Katie Mulvaney, *Philanthropist Accused of Profiting from Terminally Ill*, PROVIDENCE J.-BULL. (Mar. 7, 2010).

²⁶ See, e.g., Amended Complaint, *supra* note 16, at ¶ 24.

²⁷ See Gary A. Sanders, Vice President of Securities and State Government Relations, National Association of Insurance and Financial Advisors, Statements before NAIC Life Insurance and Annuities Committee Public Hearing on Stranger Originated/Owned Annuities (May 20, 2010), available at: <http://www.naifa.org/advocacy/documents/naifatestimonyfornaichearing.pdf>; Doug Head on behalf of LISA and the ACLI at the May 20, 2010 NAIC hearing, available at http://www.naic.org/committees_a.htm.

²⁸ See, e.g., *Companies Encouraged to Have Safeguards in Place to Limit Potential Exposure to Stranger Originated Annuity Transactions*, OH. DEPT. OF INS. (Apr. 6, 2009), <http://www.insurance.ohio.gov/Consumer/Documents/Stranger%20Originated%20Annuity%20Transactions.pdf>; *Bulletin No. 2010-02*, LA. DEPT. OF INS. (July 6, 2010), http://www.lidi.state.la.us/docs/CommissionersOffice/legal/Bulletins/Bul2010-02_cur_StrangerOriginatedAn.pdf (bulletins issued by the Departments of Insurance of the states of Ohio and Louisiana).

laws,²⁹ but that investigation is still ongoing. Caramadre and his colleague were also indicted by a grand jury on charges including conspiracy, mail fraud, wire fraud, identity theft, aggravated identity theft, and money laundering.³⁰ Outside of Rhode Island, several other lawsuits have been filed involving disputes regarding the validity and enforceability of stranger-initiated annuities, and whether insurance companies must remain bound to those contracts.³¹ However, only one court, the District of Rhode Island in dealing with Caramadre's scheme, has thus far rendered a substantive decision directly addressing the validity of STATs, *Western Reserve Life Assurance Co. of Ohio v. Conreal LLC* (hereinafter "*Conreal*").³² Moreover, that court's conclusion, that the contracts were *not* voidable for lack of insurable interest nor contestable on fraud grounds, is based on a tenuous interpretation of Rhode Island statutes and, as discussed further below, raises more questions than it answers. Regardless, in at least forty-nine states, the question as to whether STATs should be viewed as analogous to STOLI policies, and potentially subject to rescission under existing insurable interest laws, remains a matter of first impression.

²⁹ See generally *Indictment, Securities and Exchange Commission v. Caramadre et al.*, No. 1:10-mc-00052-S (DLM) (D.R.I. 2010).

³⁰ See Katie Mulvaney, *Two Men Plead Not Guilty to Defrauding Elderly, Dying*, PROVIDENCE J., Dec. 1, 2011, at 5.

³¹ For example, in *MetLife Investors USA Insurance Co. v. Zeidman*, 734 F. Supp. 2d 304 (E.D.N.Y. 2010), a STAT was issued and the terminally ill annuitant, Sherry Pratt, died twelve days later. MetLife later investigated and then rescinded the annuity, and the contract owner, the Zeidman Trust, did not contest rescission; it sought only the return of the \$975,000 purchase price for the annuity. *Id.* at 308. MetLife thereafter interpleaded those funds with the court, citing competing claims to the funds by the Zeidman Trust and the estate of Ms. Pratt. *Id.* The court issued an opinion addressing various claims asserted by Ms. Pratt's estate against the Zeidman Trust and MetLife, ultimately holding that the estate had failed to adequately allege its claims. The only claim by the estate against MetLife was an alleged violation of the Illinois Right of Publicity Act, claiming that MetLife had used Ms. Pratt's identity for an annuity without her consent, but the court dismissed the claim because the statute required a "public" use of one's identity to be actionable. *Id.* at 311-12. The court then granted MetLife's petition for discharge. *Id.* at 316. The decision did not involve any discussion regarding the validity or enforceability of the annuity itself, however, given the Zeidman Trust's concession to rescission.

³² See *W. Reserve Life Assurance Co. of Ohio v. Conreal LLC*, 715 F. Supp. 2d 270 (D.R.I. 2010).

VI. COMPARING AND CONTRASTING STATs AND STOLI

STATs and STOLI arrangements share several key elements. For both types of transactions, a third-party investor is the real party in interest acquiring the product, despite having no familial relationship or other interest in the life of the individual insured or annuitant. Both also involve the exploitation of a product offered by life insurance companies, and both involve products that guarantee a death benefit. But obvious distinctions between life insurance policies and variable annuities are worth consideration before addressing whether STATs should be subject to insurable interest requirements.

First, life insurance policies and variable annuities trigger different financial obligations on the part of the issuing insurer during the named individual's lifetime and after his or her death, and thus implicate different interests for the insurer with respect to that individual's longevity. In the case of life insurance, the insurer hopes to benefit by continuing to receive premium payments for the duration of the insured's life. As such, insurance companies have a clear interest in obtaining more thorough information from applicants seeking life insurance that will enable them to more accurately assess the mortality risk of persons and determine proper risk classes for each policy, so as to maximize average expected profits.

By contrast, issuers of variable life annuities only continue to receive premium payments during the accumulation phase, but not after the contracts are annuitized. Moreover, before STAT exploitation, the only perceived profitable use of variable annuities was for long-term investments. Customers who purchase annuities were therefore viewed as self-selecting, being highly unlikely to commit large proportions of their funds to a long-term investment if their health was poor.³³ Thus, for a typical non-STAT annuity with a GMDB, the initial mortality rate is roughly 1%.³⁴ Based on this risk assessment, most insurers did not see a need to engage in extensive underwriting, and structured their variable annuity applications and contracts accordingly, unaware that the mortality risk for a STAT, by definition, would approach 100%.³⁵ Thus, insurance

³³ See ACLI, *supra* note 27, at 4.

³⁴ Nancy Bennett, Senior Life Fellow, American Academy of Actuaries, Actuarial Considerations of Stranger Initiated Annuity Transactions 5 (July 9, 2010), available at <http://www.actuary.org/pdf/life/AAA%20Comments%20to%20NCOIL%20on%20Stranger%20Originated%20Annuities%20final%207-9-2010.pdf>.

³⁵ *Id.*

companies have historically had comparatively few financial incentives to examine a prospective annuitant's health or life expectancy, and thus do not engage in the same degree of underwriting they ordinarily require of prospective insureds.

These different underwriting requirements may make it more difficult for an insurer to prove fraud in a STAT case than in a STOLI case. STOLI disputes are likely to involve more clear evidence of fraud and misrepresentation, given that an applicant must answer direct questions on the policy applications regarding their medical condition and finances. Annuity applications often do not ask such questions. Of course, the evidence in a particular STAT case may still show express misrepresentations, or a failure to disclose the annuitant's failing health or the fact that the beneficiary and the annuitant are total strangers, despite a duty to do so. The Rhode Island plaintiffs, for example, allege that Caramadre set up a relatively low initial premium on the application, invested conservatively, to avoid arousing the suspicions of the insurer, and then, after issuance, dramatically increased the premium payments and transferred the funds into riskier investment options.³⁶ Caramadre and his associates, however, respond that the insurer does not request medical information or inquire about the relationship between the annuitant and the beneficiary, and argue that the application, contract, or prospectus are silent on such issues.³⁷

Another key difference between life insurance policies and variable annuities relates to the duration of the contract's contestability period. Life insurance policies typically have clauses providing that they are contestable on grounds of material misrepresentation for a period of two years, and most states have enacted statutes requiring insurers to promise no more than two years of contestability in life insurance contracts.³⁸ But although state statutes sometime allow insurers to provide for up to two years of contestability for annuity contracts,³⁹ some insurers still opt for a shorter contestability period and choose to make their annuity contracts

³⁶ See Amended Complaint, *supra* note 16, at ¶ 21.

³⁷ See *generally* Answer and Counterclaim, *Transamerica Life Ins. Co. v. Caramadre*, No. 09-471 S (D.R.I. Apr. 8, 2011).

³⁸ See, e.g., CAL. INS. CODE § 10113.5 (West 2006); 215 ILL. COMP. STAT 5/224(c) (West 2000); N.Y. INS. LAW § 3203(a)(3) (McKinney 2008); FLA. STAT. ANN. § 627.455 (West 2011); TEX. INS. CODE ANN. § 1101.006(a) (West 2009).

³⁹ See, e.g., ALA. CODE § 27-15-18 (LexisNexis 2007); FLA. STAT. ANN. § 627.466 (West 2011).

incontestable from the date of contract issuance.⁴⁰ Again, such business decisions reflect the perceived self-selective nature of annuity applicants, and demonstrate how insurers simply did not foresee how variable annuity products might be exploited by stranger investors.

The *Conreal* opinion shows that such business decisions may come back to haunt the insurer. There, the court determined that the fact that the insurers drafted their annuity contracts as incontestable from the “policy date” foreclosed any argument by the insurers that the policies should be rescinded due to fraud.⁴¹ Notably, the court still allowed the insurers to pursue fraud claims seeking damages from Caramadre and his associated sponsors, agents, and brokers, noting that “unlike Harry Potter’s ‘Invisibility Cloak,’ which could conceal not only Harry, but anyone who wore it,” the incontestability clauses could not be invoked by third parties to the contract.⁴² But as to the owners of the annuities, and the validity of the contracts themselves, the court dismissed all fraud claims as incontestable.⁴³

Still, despite these varied distinctions, a key functional similarity between a life insurance policy and a variable annuity with a GMDB remains: both products provide a death benefit, and if purchased by a stranger investor, can therefore be exploited to provide a significant monetary payout upon the death of an individual in which the purchaser has no insurable interest.

⁴⁰ For example, the Rhode Island STATs cases all appear to have involved contracts providing that they were incontestable from the “policy date.” *See* W. Reserve Life Assurance Co. of Ohio v. Conreal LLC, 715 F. Supp. 2d 270, 279-80 (D.R.I. 2010).

⁴¹ *Id.* at 279-80.

⁴² *Id.* at 281.

⁴³ *Id.* at 280. Insurable interest claims, however, would in most states survive the contract’s contestability period. Most state laws provide, at least in the insurance context, that insurable interest is an issue that goes to contract formation, rendering the contract void *ab initio*, and thus may be raised at any time regardless of any contestability clause therein. *See* 1 LEE R. RUSS, COUCH ON INSURANCE 3D § 240:82 (2009) (“The majority of jurisdictions follow the view that an incontestable clause does not prohibit insurers from resisting payment on the ground that the policy was issued to one having no insurable interest—such a defense may be raised despite the fact that the period of contestability has expired.”).

VII. LEGAL DISTINCTIONS BETWEEN “INSURANCE” AND “ANNUITIES”

Before addressing whether insurable interest rules should apply to annuity products, it must be noted that courts have long recognized various legal similarities and distinctions between life insurance policies and variable annuities in various contexts. Courts have treated the two types of products differently for such varied purposes as to compel issuers of variable annuities to comply with securities laws,⁴⁴ to allow national banks to sell annuities,⁴⁵ or to address their tax treatment.⁴⁶ But as the Seventh Circuit noted after examining numerous cases and treatises addressing the similarities and differences between insurance and annuity products, “The most we can conclude from these long lists of cases and treatises is that annuities are not *exactly* insurance policies, but that the two have multiple similarities. Thus courts and treatise writers have stated that the two products are different in some situations, and the same in others.”⁴⁷ The court then concluded that “none of the cases or treatises authoritatively answers the question that we must decide.”⁴⁸ While the issue before that court is not pertinent here,⁴⁹ it demonstrates that given the numerous

⁴⁴ See *SEC v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65 (1959) (discussing the differences between life insurance and variable annuities and concluding that the latter had to be registered under the Securities Act of 1933). Interestingly, a key reason for the Supreme Court’s conclusion was its understanding that a variable annuity “places all of the investment risk on the annuitant, not on the company. . . . The companies that issue these annuities take the risk of failure. But they guarantee nothing to the annuitant except an interest in a portfolio of common stocks or other equities -- an interest that has a ceiling but no floor.” *Id.* at 71-72. STATs, however, do not follow these conventions; the investor is guaranteed a floor in the form of a GMDB, and the insurer is misled into unwittingly assuming all of the risks in the investment portfolio.

⁴⁵ See *NationsBank of N.C., N.A. v. Variable Annuity Life Ins. Co.*, 513 U.S. 251, 263-64 (1995) (noting various similarities and distinctions between annuities and insurance, and deferring to the Comptroller of the Currency’s decision to treat them as distinct products for purposes of the National Bank Act, noting that his conclusion was “at least reasonable”).

⁴⁶ See *Helvering v. Le Gierse*, 312 U.S. 531 (1941) (focusing on the differences between insurance risks and investment risks in examining estate tax dispute).

⁴⁷ *Am. Deposit Corp. v. Schacht*, 84 F.3d 834, 840 n.4 (7th Cir. 1996).

⁴⁸ *Id.*

⁴⁹ See *id.* (examining the specific question as to whether annuities should be considered to be “insurance” for purposes of the McCarran Ferguson Act).

similarities and differences between the two types of products, any analysis of whether they should be treated similarly or differently depends entirely upon the nature of the legal issue being considered. Here, the salient question is whether insurable interest requirements should apply to both products.

VIII. PUBLIC POLICY REASONS FOR REQUIRING INSURABLE INTEREST FOR VARIABLE ANNUITIES

A review of the historical development of the insurable interest requirement suggests that it should apply equally to variable annuities with GMDBs for the same reasons it applies to life insurance policies. The requirement was first imposed in eighteenth-century Great Britain in an effort to combat the so-called “dead pools” or “death pools” popular at the time, in which aristocratic gamblers wagered on when royals and other celebrities would die first.⁵⁰ Prior to 1750, the common law had only condemned wagers on human life when accompanied by a criminal act, such as murder to collect on a policy.⁵¹ In the third quarter of the eighteenth century, however, gambling on human life began to be seen as an independent moral hazard, a concern plausibly related to growing unease over slavery and the concept of trafficking in the commerce of human lives.⁵² Thus, Parliament enacted the Life Assurance Act in 1774, holding that any insurance policy made to benefit a person who had “no interest” in the life of the person insured would be deemed “null and void.”⁵³

This insurable interest requirement was reinforced in the common law of the United States as a matter of public policy. For example, the United States Supreme Court recognized this public policy requirement in 1881 in *Warnock v. Davis*, explaining that without such an interest, “the contract is a mere wager, by which the party taking the policy is directly interested in the early death of the assured. Such policies have a tendency to create a desire for the event.”⁵⁴ The Supreme Court reiterated the same concerns in *Grigsby v. Russell*, a 1911 opinion rendered by Justice Oliver

⁵⁰ See Timothy Alborn, *A License to Bet: Life Insurance and the Gambling Act in the British Courts*, 14 CONN. INS. L.J. 1, 1 (2007).

⁵¹ *Id.* at 2.

⁵² *Id.* (citing GEOFFREY CLARK, *BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND 1695-1775*, 62-63 (Manchester University Press 1999)).

⁵³ Life Assurance Act 1774, 14 Geo. 3 c. 48, § 1 (1774).

⁵⁴ *Warnock v. Davis*, 104 U.S. 775, 779 (1881).

Wendell Holmes: “A contract of insurance upon a life in which the insured has no interest is a pure wager that gives the insured a sinister counter interest in having the life come to an end.”⁵⁵ The “very meaning” of insurable interest, Justice Holmes explained, “is an interest in having the life continue.”⁵⁶ Recent court decisions addressing STOLI disputes have reiterated these principles in holding that modern statutes imposing insurable interest requirements are based on these fundamental public policy concerns.⁵⁷

Thus, although the insurable interest requirement has since been incorporated into the insurance codes of nearly every state,⁵⁸ the

⁵⁵ *Grigsby v. Russell*, 222 U.S. 149, 154-55 (1911) (adding, “although that counter interest always exists . . . the chance that in some cases it may prove a sufficient motive for crime is greatly enhanced if the whole world of the unscrupulous are free to bet on what life they choose.”).

⁵⁶ *Id.* *Warnock* and *Grigsby* also address a key issue more applicable to STOLI policies than to STATs -- the alienation of the contract to one with no insurable interest. While *Warnock* invalidated an assignment of ninety percent of a policy’s proceeds executed contemporaneously with the application for the policy, see *Warnock*, 104 U.S. at 781, *Grigsby* clarified that a lack of insurable interest on the part of a prospective assignee does not bar the sale of an in-force life insurance policy, see *Grigsby*, 222 U.S. at 156-57. *Grigsby* clarified that this freedom to alienate only applies to policies that are issued with a valid insurable interest in the first instance and there is no pre-existing agreement to assign, noting an important distinction: “And cases in which a person having an interest lends himself to one without any, as a cloak to what is, in its inception, a wager, have no similarity to those where an honest contract is sold in good faith.” *Id.* at 156. While assignment or some other method of alienation is frequently a key component of a STOLI transaction, however, STATs often involve no alienation at all. The application typically just names the third-party investor as owner and beneficiary, and the annuitant signs the application as the annuitant only. See, e.g., *W. Reserve Life Assurance Co. of Ohio v. Conreal LLC*, 715 F. Supp. 2d 270, 274 (D.R.I. 2010).

⁵⁷ See, e.g., *Life Prod. Clearing LLC v. Angel*, 530 F. Supp. 2d 646, 652-55 (S.D.N.Y. 2008) (analyzing rationales given in *Warnock* and *Grigsby*, as well as a December 19, 2005 opinion by the Office of General Counsel on behalf of the New York State Insurance Department noting that STOLI activities seeking to procure a policy “solely as a speculative investment for the ultimate benefit of a disinterested third party . . . is contrary to the long established public policy against ‘gaming’ through life insurance purchases.” (internal quotation marks omitted)); *Lincoln Nat’l Life Ins. Co. v. Calhoun*, 596 F. Supp. 2d 882, 888-89 (D.N.J. 2009); *Lincoln Nat’l Life Ins. Co. v. Schwarz*, No. 09-03361, 2010 WL 3283550, at *7 (D.N.J. Aug. 18, 2010).

⁵⁸ See discussion *infra* Part X.

requirement is not a creature of statute. As the Supreme Court recognized in *Warnock*, the prohibition of the wagering on human lives is founded in public policy “independently of any statute on the subject.”⁵⁹ This distinction is reflected in recent statutory amendments addressing STOLI cases, which are typically worded so as to reflect that insurable interest statutes recognize and apply pre-existing insurable interest requirements, which are based on public policy and common law.

California’s new 2009 legislation, for example, added a subsection providing that certain STOLI arrangements, through the use of trusts or special purpose entities, “violate the insurable interest laws and the prohibition against wagering on life,”⁶⁰ plainly recognizing and referring to pre-existing legal standards. Another provision in the same section, which existed both before and after the 2009 amendment, adds, “[t]his section shall not be interpreted to define all instances in which an insurable interest exists.”⁶¹ In other words, the California legislature recognized that the contours of the insurable interest laws were incapable of being precisely defined by statute. To expect otherwise of state legislators is unreasonable, particularly in a modern world where investors continue to invent new and unanticipated ways to exploit human lives for profit. Thus, by specifically prohibiting certain STOLI practices in 2009, the California legislature was not trying to fix a pre-existing statutory loophole or create a new rule of law, but to confirm that a new, previously unforeseen type of transaction was of a nature that violated existing laws.

When examining the scope of state laws on insurable interest, courts should therefore be mindful not only of pertinent statutes and case law, but also of the fundamental public policy interests underlying those statutes and judicial opinions. Such interests are implicated no differently by STATs than by STOLI policies, both of which are structured to provide a death benefit to a third-party investor who stands to gain financially from the death of a human being. Indeed, STAT investors are essentially using variable annuities *as* life insurance policies; the product is being used in such a manner as to use it almost entirely for its life insurance feature, in conjunction with a short-term market play. STAT investors who purchase annuity products for that purpose should be viewed as subjecting

⁵⁹ *Warnock*, 104 U.S. at 779; *see also Schwarz*, 2010 WL 3283550, at *7 (citing *Warnock*, 104 U.S. at 779) (holding that the original public policy interest in precluding insurance absent an insurable interest “is the law in New York”).

⁶⁰ CAL. INS. CODE § 10110.1(d) (West 2010).

⁶¹ CAL. INS. CODE § 10110.1(i) (West 2010) (amending CAL. INS. CODE §10110.1(g) (2004)).

themselves to a contract that public policy dictates to be of the type that must have insurable interest to be valid and enforceable.

The twin public policy rationales historically given for the insurable interest requirement—prohibiting the morbid practice of gambling on human lives and eliminating a perverse incentive to commit murder (sometimes called the “moral hazard” rationale)—have in some circles been attacked as no longer being compelling concerns in a modern world.⁶² However, as demonstrated by the eagerness of modern legislatures to enact laws prohibiting STOLI practices,⁶³ modern societies do apparently continue to believe that wagers on human lives by disinterested investors still pose a legitimate threat to the public interest. Indeed, at least one recent case suggests that the moral hazard concern, while it may appear to be implausible in modern times, may not be a simple paranoia of the past. In September 2008, 74-year-old Germaine Tomlinson was mysteriously found having drowned in her bathtub in Indiana, fully clothed and wearing high heels. The last person to see her alive was her son-in-law, the beneficiary of a \$15 million insurance policy on her life, who had been with Ms. Tomlinson at a bar the night of her death, drove her home, and escorted her into the house. Police first concluded that the death was accidental, but reopened their investigation after learning that Ms. Tomlinson died the day before her son-in-law’s deadline to either repay a \$1.3 million loan he had taken out to finance the policy premiums or risk surrendering the policy to the lender.⁶⁴ Police were unable to find clear evidence of foul play, but courts allowed civil suits to proceed.⁶⁵ Even if such incidents are unlikely or rare today, the mere threat thereof is not too far-fetched, which helps explain why the moral hazard concern played a part in supporting the recent wave of anti-STOLI legislation nationwide.

⁶² See, e.g., Roy Kreitner, *Speculations of Contract, or How Contract Law Stopped Worrying and Learned to Love Risk*, 100 COLUM. L. REV. 1096, 1123 (2000) (arguing that the gambling rationale has only been paid “lip service” in court decisions like *Grigsby*, and that courts instead relied more heavily on the moral hazard concern implicated by an incentive to hasten another’s death); Jacob Loshin, *Insurance Law’s Hapless Busybody: A Case Against the Insurable Interest Requirement*, 117 YALE L.J. 474, 483-90 (2007) (arguing that even the moral hazard rationale is too imprecise to justify an insurable interest requirement).

⁶³ See *supra* note 14.

⁶⁴ See Mark Maremont & Leslie Scism, *Inquiry Into Death in Indiana Reopened*, WALL ST. J., May 13, 2010, at A7.

⁶⁵ See K. McLaughlin, *Drama Builds in Hilbert Suit*, 31 INDIANAPOLIS BUS. J., November 6, 2010, at A3.

STAT cases create similar moral hazard risks; indeed, at least one STAT plaintiff has alleged that the annuitant had voiced fears that STAT originators sought to kill her.⁶⁶ Although it may arguably be difficult to imagine a white-collar STAT investor carrying out or orchestrating a calculated killing for profit, the moral hazard public policy rationale has never targeted a specific demographic of suspected would-be murderers. Indeed, such temptations could theoretically be exacerbated in STAT cases, given the volatility of the stock market. One might imagine, for example, a sudden downturn decimating the investor's high-risk portfolio, and an urgent need for cash flow that a GMDB payout might provide. Although STAT annuitants are selected with the expectation that they will pass away soon, the uncertainty as to the timing of that passing may prove frustrating for an investor with substantial sums invested in a fluctuating market. A STAT investor might even have fewer qualms about orchestrating the carrying out of such a deed given the individual's terminal illness. The objective of the public policy is simply to eliminate such incentives that could conceivably result in disastrous consequences.

Another public policy concern that supports an insurable interest requirement for STATs is their negative impact on the market itself. The other parties to a STAT investor's high-risk speculation do not know that the investor is not actually undertaking such risks, given its concealed knowledge of the GMDB safety net. Such conduct may expose the investor to liability to such third parties, and, as in *Caramadre's* case, may also invite investigation by the S.E.C. But it can also be seen as sufficiently damaging to the market to justify another public policy rationale for preventing STATs. The securities laws themselves, and related doctrines such as the fraud-on-the-market theory, are based on similar public policy concerns that the integrity of the securities markets requires a "philosophy of full disclosure."⁶⁷ The imposition of an insurable interest requirement for STATs would be an effective way to reduce such risks.

STATs also negatively impact the market by disrupting the economics in the annuity industry. Annuity providers are faced with a

⁶⁶ See, e.g., Complaint in Equity [sic] and Law at 44-45, *Pratt v. Flowers*, No. 2010-L-002155, 2010 WL 687509 (Ill. Ct. Cl. 2010) (alleging that annuitant had stated her fear that "these people are trying to kill me.").

⁶⁷ Tad E. Thompson, *Messin' with Texas: How the Fifth Circuit's Decision in Oscar Private Equity Misinterprets the Fraud-on-the-Market Theory*, 86 N.C. L. REV. 1086, 1093 (2008) (quoting *Basic Inc. v. Levinson*, 485 U.S. 224, 230, (1988)) (discussing public policy interests underlying Rule 10b-5 and the fraud-on-the-market theory).

problematic choice – either they must invest in additional underwriting, or, if they choose not to do so, they must increase the prices charged to the public to account for the market losses that STAT investors will pass on to the company. Either way, the annuity providers would have to pass on these additional costs to the customers who buy their annuity products, and may have already done so.⁶⁸

With the exception of the last two market-based justifications for barring STATs, the other public policy interests noted above are well-established and provide the basis for current statutes codifying insurable interest requirements. As examined below, these public policy concerns are not in conflict with such statutes. These concerns, however, were inexplicably ignored by the Rhode Island District Court in *Conreal*.

IX. THE FLAWED ANALYSIS IN *CONREAL*

Conreal is the sole judicial opinion thus far rendered addressing the applicability of the insurable interest requirement to stranger-originated variable annuities. The justification for that conclusion, however, is flawed in several respects.

First, the court assumed that the insurable interest requirement only applied to products fitting statutory definitions of “insurance.”⁶⁹ The court presupposed that the sole basis for the requirement was statutory, citing a provision in the state insurance code prohibiting the procurement of an “insurance contract” without an insurable interest.⁷⁰ Thus, the court’s entire discussion is framed exclusively within the limited confines of an analysis of whether annuities can be considered “insurance products” or as “hybrid products” under statutory definitions.⁷¹ But the court did not seriously consider the possibility that other non-statutory bases for an insurable interest requirement existed based on common law and public policy.⁷²

⁶⁸ A similar argument has been made regarding STOLI transactions, which caused a reduction in lapse rates due to the fact that investors do not typically allow policies to lapse. This forces insurers to increase premium rates for their products, further harming ordinary consumers.

⁶⁹ *W. Reserve Life Assurance Co. v. Conreal LLC*, 715 F. Supp. 2d 270, 276 (D.R.I. 2010).

⁷⁰ *Id.* (citing R.I. GEN. LAWS § 27-4-27(a) (2010)).

⁷¹ *Conreal*, 715 F. Supp. 2d. at 276-79.

⁷² The court even quoted language from an older Rhode Island case that arguably supported a common-law argument for applying the doctrine outside the context of insurance, holding that “a purely speculative *contract* on the life of another is . . . objectionable on the grounds of public policy.” *Id.* at 276 (quoting

The court did briefly examine state cases in seeking to differentiate annuities from life insurance, quoting an 1877 Rhode Island Supreme Court decision noting that other transactions resulting in “speculation upon the chances of human life,” such as “when a man takes a transfer of an annuity,” have not been held void.⁷³ But a “transfer of an annuity” is an entirely different type of transaction from a STAT. An annuity purchaser buys the right to receive annuity payments lasting as long as the duration of the annuitant’s life, and thus has every hope that the annuitant stays alive. STAT originators, by contrast, set up the transaction from its inception so as to benefit the investor when the annuitant dies. Not until recently, and certainly not in 1877, could the Rhode Island Supreme Court have anticipated that annuities could be exploited in a manner giving a stranger a contractual right to benefit from another’s death.

In fact, the *Conreal* court went out of its way to deliberately skirt the question regarding the pertinence of the moral hazard rationale. The court did briefly acknowledge the possibility that STATs may create a “temptation to shorten life,”⁷⁴ but did not go on to consider whether such a danger was of public concern. Instead, the court focused its discussion solely on a critique of the plaintiff insurers for their failure to ensure that their application procedures screened for insurable interest.⁷⁵ Thus, by censuring the insurers for the fact that they did not foresee how variable annuity products might be exploited by investors recruiting terminally ill annuitants,⁷⁶ the court sidestepped the more important question of whether there existed a valid *public* interest in eliminating an incentive to shorten life.

Further, the *Conreal* opinion is based on a tenuous interpretation of the pertinent state statutes. It noted that the Rhode Island Insurance Code

Cronin v. Vt. Life Ins. Co., 40 A. 497, 497 (R.I. 1898)). This language, unlike the statute cited above, is not constrained to life insurance contracts.

⁷³ *Id.* at 278 (citing *Clark v. Allen*, 11 R.I. 439, 444 (1877)).

⁷⁴ *Id.* at 279 (quoting *Cronin*, 40 A. at 497).

⁷⁵ *Id.*

⁷⁶ *Id.* Interestingly, the court also appears to recognize that these novel schemes were unanticipated, describing Caramadre as having “discovered” a loophole in the product itself, and describing his strategy as based on his “insight” regarding how the product could be exploited. *Id.* at 273-74. The court later describes the STAT originators as having “figured out how to game a flaw in the product.” *Id.* at 278. The court almost appears to be praising Caramadre for his ingenuity, but condemning the insurers for failing to come to the same realization first.

had separately defined the terms “life insurance” and “annuities,”⁷⁷ but failed to examine why that distinction mattered in the STAT context. As noted above, although treatises and cases alike conclude that the products are similar in numerous respects, various reasons exist for distinguishing between the two products in certain contexts, such as for purposes of taxation or securities registration. Thus, while many states define “life insurance” as including annuities, others, like Rhode Island, have defined them differently.⁷⁸ The key question, then, is not whether annuities *are* insurance products, but whether certain rules historically applied to insurance policies should also apply to annuity contracts that have only recently begun to be used in a similar manner. There is no evidence that the Rhode Island General Assembly defined the terms “life insurance” and “annuity” for the purpose of excluding annuities from insurable interest requirements.

The *Conreal* court, however, asserts that the General Assembly “reinforced the statutory distinction” between the two when it failed to mention annuities in the Life Settlements Act (“LSA”), which addressed STOLI practices.⁷⁹ But as noted above,⁸⁰ Rhode Island is but one of many states to recently enact STOLI legislation. Like many other states, the General Assembly based the LSA on a model act recommended by the National Conference of Insurance Legislators.⁸¹ The model act and the LSA were both drafted well before STATs came to national attention in the past two years. Thus, it is likely that the omission of any reference to STATs in the LSA was not a conscious exclusion, but a reflection of the fact that the legislature was simply unaware that variable annuities could similarly be exploited by stranger investors.

Moreover, the language of the LSA itself again indicates that insurable interest legislation is designed to codify pre-existing insurable interest requirements. Like the California anti-STOLI legislation cited above, Rhode Island’s LSA provides that STOLI arrangements through the use of trusts “violate insurable interest laws and the prohibition against

⁷⁷ *Conreal*, 715 F. Supp. 2d at 276-77 (citing R.I. GEN. LAWS § 27-4-0.1 (2010)).

⁷⁸ See discussion *infra* Part X.

⁷⁹ *Conreal*, 715 F. Supp. 2d at 277 (citing R.I. GEN. LAWS ANN. § 27-72-2 (West 2010)).

⁸⁰ R.I. GEN. LAWS ANN. § 27-72-2(26) (West 2010).

⁸¹ Trevor Thomas, *Rhode Island Enacts Settlements Law*, LIFEHEALTHPRO.COM (Nov. 11, 2009), <http://www.lifeandhealthinsurancenews.com/News/2009/11/Pages/Rhode-Island-Enacts-Settlements-Law.aspx>.

wagering on life.”⁸² Thus, the statute sought to clarify that STOLI arrangements violate existing laws, not to announce that all other hitherto-unknown schemes to wager on human life were fair game.

Further, even if it were true that the court was constrained by the statutory language to restrict insurable interest requirements to “insurance” or “hybrid” products, the court still erred in concluding that they were *not* hybrid products, contending that GMDBs merely “sweeten the deal.”⁸³ While that might be the case for non-STAT annuities, where the purchaser expects the annuitant to live long enough to justify pursuing a traditional investment strategy, the GMDB is a fundamental component of a STAT transaction. By placing a wager on whether aggressive investments will turn a profit before a stranger dies, and putting the entire risk of loss on the insurance company, STAT promoters have certainly made the life insurance component of the scam more than a mere “ancillary perk.”⁸⁴

X. A SURVEY OF STATE LAWS RELATING TO ANNUITIES AND INSURABLE INTEREST

Conreal is the sole judicial opinion thus far rendered that examines whether insurable interest requirements might apply to variable annuities. But even if later Rhode Island courts or statutes do not overrule or contradict its holding, *Conreal* does not necessarily spell disaster for insurers or annuitants wishing to declare STATs void under the laws of other states. An examination of other statutory schemes and related caselaw reveals that the framework underlying *Conreal*'s conclusion is not at all typical, and that in each state, sufficient statutory or common-law authority may already exist to support contrary conclusions.

Two considerations are important in this analysis. First, how states define the terms “life insurance” and “annuities” may or may not indicate whether the legislature intended that the latter should be treated as insurance products. Thirteen states, encompassing California,⁸⁵ Colorado,⁸⁶

⁸² R.I. GEN. LAWS § 27-72-2(26) (2010).

⁸³ *Conreal*, 715 F. Supp. 2d at 278.

⁸⁴ *Id.* at 278-79.

⁸⁵ CAL. INS. CODE § 101 (West 2005) (“Life insurance includes insurance upon the lives of persons or appertaining thereto, and the granting, purchasing, or disposing of annuities.”).

⁸⁶ COLO. REV. STAT. ANN. § 10-1-102(12) (West 2011) (“‘Insurance’ means a contract whereby one, for consideration, undertakes to indemnify another or to pay a specified or ascertainable amount or benefit upon determinable risk contingencies, and includes annuities.”).

Florida,⁸⁷ Illinois,⁸⁸ Michigan,⁸⁹ Mississippi,⁹⁰ Nebraska,⁹¹ New Mexico,⁹² North Dakota,⁹³ South Carolina,⁹⁴ Tennessee,⁹⁵ Texas,⁹⁶ and West Virginia,⁹⁷ have statutes or case law that expressly define annuities as

⁸⁷ FLA. STAT. ANN. § 624.602(1) (West 2011) (“The transaction of life insurance includes also the granting of annuity contracts, including, but not limited to, fixed or variable annuity contracts”).

⁸⁸ 215 ILL. COMP. STAT. ANN. § 5/4 (West 2000) (defining “classes of insurance” — “Life. Insurance on the lives of persons and every insurance appertaining thereto or connected therewith and granting, purchasing or disposing of annuities.”).

⁸⁹ MICH. COMP. LAWS SERV. § 500.602(1) (LexisNexis 2008) (“‘Life’ insurance is insurance upon the lives and health of persons and every insurance pertaining thereto, and to grant, purchase, or dispose of annuities.”).

⁹⁰ *Hamilton v. Penn Mut. Life Ins. Co.*, 17 So. 2d 278, 280 (Miss. 1944) (annuities not technically life insurance policies but are subject to provisions of insurance code regulating life insurance); *State ex rel. Gully v. Mut. Life Ins. Co. of N.Y.*, 196 So. 796, 799 (Miss. 1940), *overruled in part on other grounds*, *United Gas Corp. v. Leggett*, 198 So. 763 (1940).

⁹¹ NEB. REV. STAT. § 44-704 (2010) (requiring benefits of any “policy of insurance” to be payable to person with insurable interest in person’s life, and expressly providing that the term “policy of insurance” includes annuity contracts).

⁹² N.M. STAT. ANN. § 59A-7-2 (2000) (“‘Life’ insurance is insurance of human lives and every insurance appertaining thereto, and the granting, purchasing or disposing of annuities. . .”).

⁹³ N.D. CENT. CODE § 26.1-26-11 (2010) (variable annuities categorized along with variable life insurance contracts as “insurance coverage”); *id.* § 26.1-05-02 (same); *id.* § 26.1-34.2-02 (definitions section relating to annuities includes definitions referring to “insurance, including annuities” and “insurance products, including annuities”).

⁹⁴ S.C. CODE ANN. § 38-1-20(19) (2002) (“The term ‘insurance’ includes annuities.”).

⁹⁵ TENN. CODE ANN. § 56-2-201(4) (2008 & Supp. 2011) (“For the purposes of this title, the transacting of life insurance includes the granting of annuities, both with and without a life or mortality contingency or element”); *see also* *H & R Block E. Tax Serv., Inc. v. State Dep’t of Commerce & Ins., Div. of Ins.*, 267 S.W.3d 848, 858 (Tenn. Ct. App. 2008) (noting that statutory definitions of “contract of insurance” and “insurable interest” were circular and ambiguous, and that the broad definition could cover various types of contracts).

⁹⁶ TEX. INS. CODE ANN. § 1102.001(1)(A) (West 2009) (definition of “insurance policy” includes annuity contracts).

⁹⁷ W. VA. CODE ANN. § 33-1-10(a) (LexisNexis 2011) (“*Life insurance.* -- Life insurance is insurance on human lives including endowment benefits, additional benefits in the event of death or dismemberment by accident or accidental means, additional benefits for disability and annuities.”).

insurance products. Further, their rules relating to insurable interest do not seek to carve out annuities or other specific types of insurance products.⁹⁸ Nebraska even expressly *includes* annuity contracts in its insurable interest statute.⁹⁹ Other states are not quite so explicit as Nebraska—which is not surprising, given the very recent advent of STATs—but the fact that these thirteen states define annuities as insurance suggests that courts confronted with STAT disputes in those states would have little choice but to distinguish *Conreal*.

But the second consideration in examining state statutes is far more important: regardless of whether a state legislature or court has chosen to define the products separately, the language of the state’s insurable interest laws may already be broad enough to cover annuities. Many states do not expressly define annuities as insurance, and sometimes even define them as separate products, but their insurance codes still make clear that insurable interest requirements apply to annuities. For example, New Jersey’s insurable interest statute, like Nebraska’s, *explicitly* applies to annuities¹⁰⁰ even though the code elsewhere defines them as separate from insurance products.¹⁰¹ In other states, it is clear from the structure of the code that the insurable interest requirement applies to annuities. For example, Arizona’s insurance code provides, “Except as exemption or other provision is made, all provisions in this title applicable to life insurance shall be deemed applicable also to annuities.”¹⁰² That title includes an insurable interest statute that does not make any “exemption or other provision” excluding

⁹⁸ See, e.g., CAL. INS. CODE § 10110.1 (West 2005) (insurable interest requirement does not carve out annuities); FLA. STAT. ANN. § 627.404 (West 2011) (same); MICH. COMP. LAWS SERV. § 500.2207 (LexisNexis 2008) (same); N.M. STAT. ANN. §§ 59A-18-4, 59A-18-5 (2000) (setting forth insurable interest requirements), and § 59A-18-1 (chapter applies as to all insurance policies and annuity contracts); TEX. INS. CODE ANN. § 1103.052 (West 2009) (subchapter relating to insurable interest for life insurance policies “shall be liberally construed to implement the purposes of this subchapter”); W. VA. CODE ANN. § 33-6-2 (LexisNexis 2011) (insurable interest statute with no carve-out for annuities).

⁹⁹ NEB. REV. STAT. § 44-704 (2010).

¹⁰⁰ N.J. STAT. ANN. § 17B:24-1.1 (West 2006) (setting forth insurable interest requirement and providing that it applies to life insurance, health insurance, and annuities).

¹⁰¹ *Id.* § 17B:17-5 (defining “annuity” and noting that a contract that includes life insurance death benefits is still deemed to be an annuity “if such extra benefits constitute a subsidiary or incidental part of the entire contract”).

¹⁰² ARIZ. REV. STAT. ANN. § 20-254 (2002).

annuities from the requirement.¹⁰³ This type of statutory framework is especially common. Eighteen states, comprising Alabama,¹⁰⁴ Alaska,¹⁰⁵ Arizona,¹⁰⁶ Arkansas,¹⁰⁷ Delaware,¹⁰⁸ Georgia,¹⁰⁹ Idaho,¹¹⁰ Indiana,¹¹¹ Kentucky,¹¹² Louisiana,¹¹³ Maine,¹¹⁴ Maryland,¹¹⁵ Nevada,¹¹⁶ New

¹⁰³ ARIZ. REV. STAT. ANN. § 20-1104 (2010); *see also id.* § 20-1101 (clarifying scope of article that includes insurable interest requirement and excluding certain products, but not annuities).

¹⁰⁴ ALA. CODE § 27-14-2 (LexisNexis 2007) (“[T]his chapter applies as to all insurance contracts and annuity contracts”); § 27-14-3 (very next section, stating insurable interest requirement without any carve-out for annuities). Alabama thus makes its insurable interest requirement applicable to annuities even though it defines them as separate products elsewhere in the code. See § 27-5-3 (defining “annuity” as a separate type of contract from a life insurance policy as defined in § 27-5-2, and noting that a contract that includes certain life insurance death benefits is still deemed to be an annuity “if such extra benefits constitute a subsidiary or incidental part of the entire contract”).

¹⁰⁵ ALASKA STAT. § 21.42.020(d) (2010) (defining insurable interest requirement as referring to “life, annuity, or health insurance”).

¹⁰⁶ ARIZ. REV. STAT. ANN. § 20-1101 (2010) (clarifying scope of article that includes insurable interest requirement and excluding certain products, but not annuities).

¹⁰⁷ ARK. CODE ANN. § 23-79-103 (2004) (defining insurable interest requirement); ARK. CODE ANN. § 23-79-102 (Supp. 2011) (clarifying scope of chapter and excluding certain products, but not annuities).

¹⁰⁸ DEL. CODE ANN. tit. 18, § 2701 (1999) (explaining “this chapter applies to all insurance contracts and annuity contracts”); DEL. CODE ANN. tit. 18, § 2704 (1999) (describing insurable interest requirement with no carve-out for annuities).

¹⁰⁹ GA. CODE ANN. § 33-24-3 (West Supp. 2011) (defining insurable interest requirement); GA. CODE ANN. § 33-24-2 (West 2003) (clarifying scope of chapter and excluding certain products, but not annuities).

¹¹⁰ IDAHO CODE ANN. § 41-1804 (2010) (defining insurable interest requirement); IDAHO CODE ANN. § 41-1801 (2010) (chapter of code applies “as to all insurance contracts and annuity contracts”).

¹¹¹ IND. CODE ANN. § 27-1-15.6-31 (LexisNexis Supp. 2012) (insurable interest law applies to annuities in context of requiring producer to have an insurable interest in life of annuitant in order to have an interest therein); *see also In re Estate of Powers*, 849 N.E.2d 1212 (Ind. Ct. App. 2006).

¹¹² KY. REV. STAT. ANN. § 304.14-040 (West 2012) (defining insurable interest requirement); KY. REV. STAT. ANN. § 304.15-010 (West 2012) (subtitle in code applies to annuities as well as life insurance). Like Alabama, Kentucky has this framework despite explicitly defining annuities as separate products from life insurance. *See* KY. REV. STAT. ANN. § 304.5-030 (West 2012).

Jersey,¹¹⁷ Oklahoma,¹¹⁸ South Dakota,¹¹⁹ Utah,¹²⁰ and Wyoming,¹²¹ have similarly enacted statutes that either expressly state, or whose structure and

¹¹³ LA. REV. STAT. ANN. § 22:914 (2009) (stating provisions of insurance code apply to variable annuity contracts); LA. REV. STAT. ANN. § 22:901 (2009) (defining insurable interest requirement); *see also* bulletin issued by the state insurance department taking the position that STATs would violate insurable interest laws, *see supra* note 28.

¹¹⁴ ME. REV. STAT. ANN. tit. 24-A, § 2404 (2000) (defining insurable interest requirement); ME. REV. STAT. ANN. tit. 24-A, § 2401 (2000) (chapter of code “applies as to all insurance contracts and annuity contracts”). Maine has this framework despite some arguable inconsistencies in its code relating to whether annuities are deemed insurance products. *Compare* ME. REV. STAT. ANN. tit. 24-A, § 3 (2000) (defining “insurance” broadly to include annuities), *with* ME. REV. STAT. ANN. tit. 24-A, § 703 (2000) (defining “annuity” as a separate type of contract from a life insurance policy per § 702).

¹¹⁵ MD. CODE ANN., INS. § 12-201 (LexisNexis 2011) (defining insurable interest requirement); MD. CODE ANN., INS. § 12-102 (LexisNexis 2011) (article applies to insurance and annuity contracts). This framework applies even though annuities are not defined in the code as life insurance products. MD. CODE ANN., INS. § 1-101(d)(3) (LexisNexis 2011) (definition of “annuity” provides that it “does not include life insurance”; *see also* *Matthews v. Matthews*, 647 A.2d 812, 817 (Md. Ct. App. 1994) (annuity contracts are not technically life insurance)).

¹¹⁶ NEV. REV. STAT. ANN. § 687B.040 (LexisNexis Supp. 2011) (defining insurable interest requirement); NEV. REV. STAT. ANN. § 687B.010 (LexisNexis Supp. 2011) (scope of chapter of code “applies to all insurance contracts and annuity contracts”). The statutes so provide despite having defined annuities as separate from insurance. *See* NEV. REV. STAT. ANN. § 688A.020 (LexisNexis Supp. 2011).

¹¹⁷ *See* N.J. STAT. ANN. § 17B:24-1.1 (West 2006); N.J. STAT. ANN. § 17B:17-5 (West 2006).

¹¹⁸ OKLA. STAT. ANN. tit. 36, § 3604 (West 2001) (defining insurable interest requirement); OKLA. STAT. ANN. tit. 36, § 3601 (West 2001) (clarifying scope of chapter and excluding certain products, but not annuities); *see also* *Baird v. Wainwright*, 260 P.2d 1060, 1064 (Okla. 1953) (holding where annuity certificate provided a monthly annuity for insured during his lifetime, and at his death if aggregate of annuities was less than the premium paid the difference was payable to the beneficiary named in the policy, the contract was a combination life and annuity policy authorized to be executed by an insurance company).

¹¹⁹ S.D. CODIFIED LAWS § 58-10-4 (2004) (defining insurable interest requirement); S.D. CODIFIED LAWS § 58-10-1 (2004) (“Chapters 58-10 to 58-12, inclusive, apply as to all insurance contracts and annuity contracts.”).

¹²⁰ UTAH CODE ANN. § 31A-21-104 (LexisNexis 2010) (defining insurable interest requirement); UTAH CODE ANN. § 31A-21-101 (Supp. 2012) (defining scope of chapter and not carving out annuities); *see also* UTAH CODE ANN. § 31A-

placement in the code imply, that annuities are subject to the same insurable interest requirements as life insurance policies.

Altogether, this review indicates that thirty-one of the fifty states either expressly define annuities as insurance products or otherwise indicate that insurable interest requirements apply to annuities. In each of these states, strong arguments could be made that insurable interest requirements already apply to STATs under existing law.

Such arguments might also be made as to *some* variable annuities in Hawaii and Washington, which have developed an interesting approach to the definitional question that is of direct relevance to STATs. Both states have enacted statutes providing that whether life insurance rules apply to annuities depends on the nature of the death benefit. If the GMDB is “not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or the value of the contract at time of death,” the provision “shall not be deemed to be life insurance and therefore not subject to the provisions of this code governing life insurance carriers.”¹²² But “[a] provision for any other benefit on death during the deferred period *shall* be subject to such insurance provisions.”¹²³ Presumably, that would include being subject to insurable interest laws.¹²⁴ Thus, in these states, a STAT that is limited to a standard GMDB allowing it to pursue risk-free investment, with a safety net promising only a premium refund, would arguably *not* be subject to insurable interest requirements, whereas a STAT with an enhanced or “stepped-up” death benefit, such as the “lock in,” “anniversary ratchet,” or “roll-up” options

1-301 (Supp. 2012) (including various definitions of terms that include annuities, including “business of life insurance” and “insurance business”); *but see In re Estate of Clark*, 354 P.2d 112, 117 (Utah Ct. App. 1960) (analyzing statutory definitions of life insurance and annuities in context of tax dispute, and holding, “We find nothing in these sections to justify the claim that an annuity contract such as herein involved should be classified as life insurance either for the purpose of estate tax or otherwise.”).

¹²¹ WYO. STAT. ANN. § 26-15-102 (2011) (setting forth insurable interest requirement); WYO. STAT. ANN. § 26-15-101 (2011) (“This chapter applies to all insurance contracts and annuity contracts.”).

¹²² HAW. REV. STAT. § 431:10D-118(b)(2) (2005); *see also* WASH. REV. CODE ANN. § 48.18A.030 (West 2010).

¹²³ HAW. REV. STAT. § 431:10D-118(b)(2) (2005) (emphasis added); *see also* WASH. REV. CODE ANN. § 48.18A.030 (West 2010).

¹²⁴ *E.g.*, WASH. REV. CODE ANN. § 48.18.030 (West 2010) (imposing insurable interest statute as applying to life insurance).

described above, would more clearly run afoul of insurable interest requirements.

Insurers seeking to rescind STATs in the remaining seventeen states will have to deal with a variety of statutes and cases—or, in some states, an absence thereof—that may make it more difficult to establish that insurable interest is required for variable annuities. Eight of these states—consisting of Connecticut,¹²⁵ Minnesota,¹²⁶ Missouri,¹²⁷ Montana,¹²⁸ New York,¹²⁹ North Carolina,¹³⁰ Vermont,¹³¹ and of course, Rhode Island—present a statutory framework similar to that considered in *Conreal*. In those states, statutes define annuities as separate products from life insurance, but do not explicitly speak to the issue of whether insurable interest laws apply to those separately defined annuities. But again, that fact does not necessarily suggest that the legislatures in those seventeen states meant to *exclude* STATs. Rather, it suggests only that those

¹²⁵ CONN. GEN. STAT. ANN. § 38a-1 (West 2012) (“This definition of ‘annuities’ does not apply to payments made under a policy of life insurance.”).

¹²⁶ MINN. STAT. ANN. § 61A.021 (West 2005) (sale of life insurance and annuity as a single product, e.g. with a rider or otherwise, expressly prohibited in Minnesota).

¹²⁷ MO. ANN. STAT. § 376.671 (West Supp. 2012) (where annuity contracts also provide death benefits by rider, the annuity and life insurance portions of the benefits shall be calculated separately as though it were a separate contract); *see also* Carroll v. Equitable Life Assurance Soc’y of U.S., 9 F. Supp. 223, 224 (W.D. Mo. 1934) (emphasizing distinct characteristics between annuities and life insurance contracts).

¹²⁸ MONT. CODE ANN. § 33-1-208 (2011) (defining life insurance without referencing annuities); *see also* Estate of Miles v. Miles, 994 P.2d 1139, 1144 (Mont. 2000) (analyzing code in detail and noting that legislature could have, but did not, define annuities as life insurance or provide that they should be similarly treated).

¹²⁹ N.Y. INS. LAW § 1113(a)(1-2) (McKinney 2006) (defining annuities and life insurance policies as separate types of contracts); *see also* N.Y. INS. LAW § 3205 (McKinney 2006) (insurable interest requirement only refers to life insurance contracts).

¹³⁰ N.C. GEN. STAT. § 58-7-15 (2001) (defining life insurance and annuities as separate products); *see also* N.C. GEN. STAT. §§ 58-58-70 to -86 (2001) (relating to insurable interest without speaking to which types of contracts require such an interest).

¹³¹ VT. STAT. ANN. tit. 8, § 3717 (2009) (stating an annuity with death benefits of the kind provided by life insurance “shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.”).

legislatures have not yet been confronted with the possibility that strangers lacking insurable interests in the lives of terminally ill annuitants might exploit variable annuities.¹³² Four other states—Massachusetts,¹³³ Oregon,¹³⁴ Virginia,¹³⁵ and Wisconsin¹³⁶—have insurable interest statutes whose phrasing or placement in the code suggests that the legislature did not intend them to apply to annuities. And finally, as to the last five states—Iowa,¹³⁷ Kansas,¹³⁸ New Hampshire,¹³⁹ Ohio,¹⁴⁰ and

¹³² As argued above, if these states later enact legislation making insurable interest a requirement for annuities, such enactments would arguably not reflect a “change” to state law, but a recognition that STATs violate existing common-law and public policy grounds prohibiting the procurement of contracts by total strangers who stand to gain from another’s death. *See supra* p. 136.

¹³³ MASS. GEN. LAWS ANN. ch. 175, § 123 (West 2011) (requiring assent of insured not applicable to “contracts based upon the continuance of life, such as annuity or pure endowment contract . . .”).

¹³⁴ OR. REV. STAT. ANN. § 743.024 (West 2011) (setting forth insurable interest requirement for personal insurance but then stating, “[t]his section does not apply to annuity policies.”). This statute does so despite the fact that the Oregon code defines insurance to include annuities. OR. REV. STAT. ANN. § 731.102 (West 2011) (“‘Insurance’ so defined includes annuities.”); OR. REV. STAT. ANN. § 731.170 (West 2011) (“For convenience, reference to ‘life insurance’ in the Insurance Code includes life insurance as defined in subsection (1) of this section and annuities as defined in ORS 731.154, except if the inclusion of annuities obviously is inapplicable or if the context requires, or the Insurance Code provides, otherwise.”).

¹³⁵ VA. CODE ANN. § 38.2-301 (2007) (setting forth insurable interest requirement); *id.* § 38.2-300 (2007) (chapter does not apply to annuities). This carve-out for annuities is made despite the fact that other statutes define annuities as insurance. *See* VA. CODE ANN. § 38.2-602 (2007) (“‘Life insurance’ includes annuities.”); *id.* § 38.2-501 (2007) (“‘Insurance policy’ or ‘insurance contract’ includes annuities . . .”).

¹³⁶ WIS. STAT. ANN. § 631.01 (West 2004) (chapters addressing life insurance, which include provisions relating to insurable interest, “do not apply to annuities”).

¹³⁷ *See, e.g., Hult v. Home Life Ins. Co. of N.Y.*, 240 N.W. 218, 227 (Iowa 1932) (“[A] life insurance contract must be based upon an insurable interest, in the absence of which it becomes a wager contract.”). *Hult* involved claims by an executor seeking to rescind annuity contracts that the deceased had purchased on her own life. Although the court declined to apply the insurable interest rule to rescind the contracts at bar, its rationale for doing so arguably suggests that it would have reached a different result in a STAT case:

If a person takes out a life insurance policy on the life of one in whom he has no insurable interest, there are three parties involved: First, the party who procures the insurance; second, the

Pennsylvania¹⁴¹—the statutory framework and case law does not provide a concrete answer.

While this review does not exhaustively examine every potentially pertinent statute or case in each state, it at least suggests that *Conreal* should not necessarily be viewed as a dangerous precedent or as an invitation to STAT promoters to target other markets. Because Rhode Island's statutory scheme is unlike those of most other states, *Conreal* is easily distinguishable.¹⁴²

XI. OTHER POTENTIAL ISSUES IN STAT DISPUTES

Even if a STAT dispute does not result in judicial rescission of the annuity contract on insurable interest grounds, other potential arguments

insurance company; third, the party insured. Not so in this case. Here there are but the two parties, the one to whom the contract runs and the insurance company, which makes the contract. There is here no disinterested third party, *whether viewed as an annuity contract or an insurance contract*.

Id. (emphasis added).

¹³⁸ Kansas has a statute prohibiting a “life insurance contract” without insurable interest, KAN. STAT. ANN. § 40-450 (West 2000), but the insurance code does not purport to define that term or to distinguish it from annuity contracts.

¹³⁹ New Hampshire law requires insurable interest for a “policy of life or endowment insurance,” N.H. REV. STAT. ANN. § 408:2 (LexisNexis 2009), but the insurance code does not define that term or to distinguish it from annuity contracts. *But see* Frederick v. Frederick, 687 A.2d 711, 714 (N.H. 1996) (noting a “long history of cases” viewing annuity beneficiaries with the same analysis used in the life insurance context).

¹⁴⁰ Ohio's code does not define insurance or annuities, and its insurable interest rules are primarily based on common law, with uncertain applicability to annuities. *See, e.g.,* Donahue v. Carpenter, No. 91WD057, 1992 WL 66564 (Ohio Ct. App. Mar. 31, 1992) (sustaining appeal of judgment on interpleaded proceeds of annuity contract, but not directly addressing the parties' dispute regarding whether insurable interest rules applied to annuities).

¹⁴¹ Pennsylvania's insurable interest requirement only applies to a “policy of life insurance,” 40 PA. STAT. ANN. § 512 (West 1999), but the code does not define that term or distinguish it from annuities. Some case law exists distinguishing the two types of products, but not in the context of insurable interest. *E.g., In re Estate of Bayer*, 26 A.2d 202, 205 (Pa. 1942) (noting “obvious differences” between annuities and life insurance contracts and finding that they are to be treated differently for taxation purposes).

¹⁴² *See* W. Reserve Life Assurance Co. of Ohio v. Conreal, 715 F. Supp. 2d 270, 276-78, 280 (D.R.I. 2010).

might be made by insurers seeking to recover market losses paid to the investors in the form of GMDBs, such as by bringing causes of action for fraud or material misrepresentations. The annuity contract's contestability clause may bar such claims against the contract owner. However, courts may, as in *Conreal*, still allow insurers to seek fraud damages from the other various sponsors, agents, and other collaborators in STAT schemes.¹⁴³ An insurer might also claim that conduct by participating agents breached brokerage service agreements with the company,¹⁴⁴ or a covenant of good faith and fair dealing implied in such contracts.¹⁴⁵ STAT promoters might also be subject to criminal liability and potential civil actions relating thereto, such as for forging annuitant signatures,¹⁴⁶ paying money in exchange for such signatures,¹⁴⁷ or insurance fraud.¹⁴⁸

Insurance companies should be well-prepared for the possibility that courts and juries may be skeptical of insurers' claims because of companies' failure to eliminate the potential risks of STATs. Insurers draft the annuity applications, contracts, and prospectuses. They do not request additional information or engage in thorough underwriting before issuing a variable annuity. They control the assumptions used to set prices for the annuity fees, and have decided that the annuitant's health is not a relevant factor. Yet, none of these arguments should have any impact on whether a court is willing to enforce the public policy that is part and parcel of an insurable interest analysis. Further, insurers might contend that they had no way of knowing that their annuity products would be exploited in this manner, and that their business decisions regarding the degree of underwriting needed were reasonable in light of historically low mortality rates for annuity applicants. Even *Conreal*, after condemning the insurers for their lack of foresight in declining to recognize an insurable interest

¹⁴³ *Id.* at 281-82.

¹⁴⁴ Such contracts, for example, often require the brokerage firm to train and supervise its agents, to indemnify the insurer for its agents' wrongful acts, *see, e.g.*, Complaint and Jury Demand at 16-17, *W. Reserve Life Assurance Co. of Ohio v. Conreal*, 715 F. Supp. 2d 270 (2009) (No. 09-564-S), and might also obligate agents to use only approved materials to market the insurer's products (which, presumably, do not include flyers distributed at hospices and churches).

¹⁴⁵ *E.g., id.* at 16.

¹⁴⁶ *E.g., id.* at 18.

¹⁴⁷ *See* Consolidated Memorandum in Response to Defendants' Motions to Dismiss at 45, *Transamerica Life Ins. Co. v. Lifemark Sec. Corp.*, No. 09-549/S (D. R.I. Feb. 1, 2010).

¹⁴⁸ *E.g.,* Complaint, *supra* note 144, at 18.

requirement,¹⁴⁹ still allowed the insurers to proceed with their fraud claims against the non-owner defendants despite not having specifically asked for the information withheld.¹⁵⁰

Conreal also acknowledged additional arguments for voiding the contracts that, like insurable interest, could “rope the owners back into the lawsuits” despite the contestability clauses.¹⁵¹ The plaintiff insurers raised arguments that the contracts might be void due to forgery of the annuitant’s signatures and fraud in the factum, based on the theory that the annuitants were tricked into signing without knowing the contracts’ true nature or contents. The court declined to address the merits of such arguments, noting that the complaints had failed to adequately plead such claims, but it did grant them leave to amend.¹⁵² Importantly, the court recognized that such forgery or fraud in the factum could render the annuity contracts “void and not merely voidable,” thus depriving the owners of their incontestability defense because the pertinent clauses “never would have come into effect.”¹⁵³ Thus, depending on the facts of a particular STAT case, such arguments could certainly be made to suggest that the annuity contracts were not validly formed and should be held void.

One other potential argument relating to valid contract formation is also worth discussing, that there was no meeting of the minds between the owner and the insurer. In other words, the insurer might contend that there was a mistake of fact—that the insurer reasonably believed that the selected annuitant was a typical, self-selecting individual whose life expectancy would be of sufficient duration to justify the long-term investment strategy ordinarily expected of the variable annuity product. Mistake arguments, however, have historically been rejected in cases involving annuitants whose health problems were unknown at the time of the annuity purchase.¹⁵⁴ Such cases might theoretically be distinguished based on the

¹⁴⁹ *Conreal*, 715 F. Supp. 2d at 278-79.

¹⁵⁰ *Id.* at 281-82.

¹⁵¹ *Id.* at 287 n.16.

¹⁵² *Id.*

¹⁵³ *Id.* (citing R.I. Depositors Econ. Protection Corp. v. Bowen Court Assocs., 763 A.2d 1005, 1009 (R.I. 2001); Giannone v. Ayne Inst., 290 F. Supp. 2d 553, 563 (E.D. Pa. 2003)).

¹⁵⁴ *See, e.g.*, Aldrich v. Travelers Ins. Co., 56 N.E.2d 888, 889 (Mass. 1944) (“It is difficult to see how any company could carry on an annuity business if the estate of an annuitant could rescind whenever it turned out that the condition of his health did not ‘warrant a reasonable expectation of life.’”); Am. State Bank of Bloomington v. Nat’l Life Ins. Co., 17 N.E.2d 256 (Ill. App. Ct. 1938); Woodworth v. Conn. Mut. Life Ins. Co., 27 F. Supp. 732 (S.D.N.Y. 1939).

fact that they were *mutual* mistake cases brought by unknowingly ill annuitants,¹⁵⁵ while STATs involve a *unilateral* mistake on the insurer's part. But the problem with a unilateral mistake argument, again, is the insurer's typical decision not to inquire as to the annuitant's health. The Restatement of Contracts, for example, holds that the mistake of one party makes a contract voidable only when the mistaken party does not "bear the risk of the mistake."¹⁵⁶ It further explains that a party *does* bear the risk of a mistake—and thus, is not entitled to rescission—if "he is aware, at the time the contract is made, that he has only limited knowledge with respect to the facts to which the mistake relates but treats his limited knowledge as sufficient."¹⁵⁷ An insurer invoking the "meeting of the minds" argument should be prepared to address these considerations.

In sum, various remedies might be sought from collaborators in STAT schemes. Insurers may even in some cases be able to establish that the contracts should be held void for fraud vis-à-vis the annuitant. But if the annuitant did participate knowingly, or there is not enough evidence to prove otherwise, rescission of a STAT contract will likely hinge on whether the insurable interest requirement applies to variable annuities under applicable state laws.

XII. CONCLUSION

STAT investors exploit a *practical* loophole in the variable annuity product, but it is far from clear whether there exists a *legal* loophole making such exploitation lawful. To address the former, insurance companies should consider whether it still makes business sense to continue to engage in limited underwriting of annuity applications, and whether contestability clauses in their annuity contracts should be revised. With respect to the latter, however, it is not yet clear how legislatures and courts will address the issue. Insurable interest requirements at common law and based upon public policy concerns may, depending on the laws of the pertinent jurisdiction, arguably already prohibited any stranger-originated contracts that enable the stranger to benefit from the death of another human being. Insurers may also pursue a number of other

¹⁵⁵ Such cases typically involve suits by the annuitant's estate, seeking to rescind a policy based on the fact that neither the annuitant nor the insurance company knew of the annuitant's failing health. See *generally* sources cited *supra* note 154.

¹⁵⁶ RESTATEMENT (SECOND) OF CONTRACTS § 153 cmt. b (1981).

¹⁵⁷ RESTATEMENT (SECOND) OF CONTRACTS § 154 introductory cmt. (1981).

arguments if considering legal actions against the STAT originators and agents, but rescission of the annuity contracts will in many cases hinge on how courts choose to interpret the scope of existing insurable interest laws.

SUPERVISORY COLLEGES: IMPROVING INTERNATIONAL SUPERVISORY COORDINATION

KELLY KIRBY

This article looks at the insurance industry in the context of its role as a key player in the international financial system. Specifically, how insurers and regulators alike are working towards a higher level of cooperation and coordination, both within their own jurisdictions and beyond, to assure that events such as the 2008 Financial Crisis are never repeated. The article focuses on the rise of supervisory colleges and explains the need for states to meaningfully participate in these international forums which have the potential to identify and eliminate systemic risk. The benefits as well as the obstacles presented by such a grand scheme of international supervision are laid out in detail by the author, who closes by making the case for supervisory colleges as a “step in the right direction for international regulatory success.”

The 2008 Financial Crisis was a devastating wake up to how institutions, both domestically and internationally, are systemically connected in ways regulators did not know existed. To prevent a future breakdown, the United States is working towards identifying risks that are inherent in those connections, and mitigating potential harm to the financial system before it occurs. Inextricably tied into this equation are insurance companies.

In the realm of insurance regulation, there are two trends working towards the same goal of international coordination and cooperation to create a more globally sustainable system of supervision. First, there are the efforts of the National Association of Insurance Commissioners (“NAIC”), representing state regulated insurance. The NAIC has created task groups to address flaws in the United States insurance regulatory scheme to better identify weaknesses before they escalate into systemic risks. Second, there is the creation of the Federal Insurance Office (“FIO”), representing the federal government’s movement into the realm of state dominated insurance. The FIO has been charged with monitoring all aspects of the insurance industry to identify gaps in the regulatory regime that could lead to a systemic financial crisis. In theory, it appears that the state and federal efforts are near mirror images of each other, but in

practice, the states still hold the power. In order to keep control of that power, states and the NAIC are overhauling certain parts of the current insurance regulatory scheme to ensure that the FIO has no other reason but to remain an ally.

In particular, the NAIC is encouraging state insurance commissioners to participate in international forums where supervisors from across the world come together for the regulation, evaluation, and investigation of those insurance companies under their jurisdiction that are part of groups with cross-border operations. These forums are called supervisory colleges. This paper posits that supervisory colleges are a way to enhance state based insurance regulation in an increasingly international environment, but there are several obstacles that must first be addressed, and several concerns that may never go away.

The discussion will read as follows: Part I will introduce the relevant NAIC initiatives for improved supervision; Part II will discuss the controversial new revisions to the Insurance Holding Company System Model Act that exponentially expand a state commissioner's access to information; Part III provides an overview and introduction to supervisory colleges; Part IV discusses confidentiality amongst participating regulators in a supervisory college; Part V briefly discusses the potential implications of the FIO's covered agreements and preemption powers; Part VI looks at Connecticut as a case study for recent developments in state involvement with supervisory colleges and international members; Part VII explains how the NAIC has facilitated state and foreign participation in supervisory colleges, as well as other efforts they have made in conjunction with the International Association of Insurance Supervisors; Part VIII addresses several obstacles and concerns presented by supervisory colleges; Part IX thoroughly discusses whether the authority for state insurance commissioners to participate in supervisory colleges, as well as the commissioner's expansion of powers, are within the McCarran-Ferguson Act's definition of the 'business of insurance'; and Part X concludes by recommending that the efforts taken thus far for state participation in supervisory colleges be continued in the future.

I. SOLVENCY MODERNIZATION INITIATIVE: THE INCEPTION OF SUPERVISORY COLLEGES TO IMPROVE GROUP SOLVENCY ISSUES.

The Solvency Modernization Initiative ("SMI") is a critical self-examination of the U.S. insurance solvency system by state insurance

regulators that began in June of 2008.¹ Through SMI the National Association of Insurance Commissioners (“NAIC”) is working to identify potential weaknesses in the current regulatory scheme exposed by the 2008 financial crisis. The NAIC outlined its objectives for SMI in the “Work Plan,” ranking US solvency framework (the “Framework”), group solvency issues, capital requirements, international accounting and regulatory standards, reinsurance, and corporate governance the top issues in need of attention.² Of particular relevance for this examination is the Group Solvency Issues Working Group (the “GSI Working Group”) and its Draft Memorandum on Groupwide Supervision (the “Draft Memorandum”), and the recently adopted amendments (the “Amendments”) to the NAIC’s Insurance Holding Company System Model Regulatory Act and Regulation (the “IHCA”).³

Insurers and their holding companies are no longer limited to their domiciliary states as separate legal entities; rather, they are more akin to financial enterprises with their operations extending across borders into multiple jurisdictions. In addition to the issues presented by cross-border operations, insurance companies are also subjected to cross-sector risks as part of a larger holding company. The GSI Working Group addresses how these issues impact U.S. insurers, and how state insurance commissioners and regulators can best mitigate the attendant risks. The Draft Memorandum notes that the U.S. insurance regulatory system has long operated with a “solo entity” approach to regulation, where focus channels on the insurer, whereas other jurisdictions have a more consolidated

¹ *Insurance Oversight: Policy Implications for U.S. Consumers, Businesses and Jobs: Testimony Before the Subcomm. On Ins., Hous., and Cmty. Opportunity of the H. Comm. On Fin. Serv.*, 112th Cong. 10 (July 28, 2011) (statement of Susan E. Voss, President, Nat’l Ass’n Ins. Comm’rs) [hereinafter Statement of Susan E. Voss].

² Leah Campbell & Tonisha Calbert, *Overview of the NAIC’s Solvency Modernization Initiative*, 18 METRO. CORP. COUNS. 20 (June 2010).

³ The SMI Task force of the NAIC charged the GSI Working Group with “studying the current state of play of US group supervision recommending needed enhancements to the oversight of U.S. based insurers operating within corporate groups.” See Memorandum from The Group Solvency Issues (EX) Working Group to Director Christina Urias, Chair of the Solvency Modernization Initiatives (EX) Task Force 1 (Feb. 26, 2010) (regarding: “Report to Solvency Modernization Initiative (EX) Task Force on Suggested “Windows and Walls” Approach for Regulation of United States Based Insurers Operating within Corporate Groups) [hereinafter Draft Memorandum].

approach to regulation, with focus on the entire holding company system.⁴ The GSI Working Group's examination adopts an approach more analogous to the latter, investigating how the enterprise group's risks as a whole could potentially affect the insurance companies that operate under the group's direction.

To enhance group supervision, the Draft Memorandum suggests using a "windows and walls" approach to "provid[e] a window into group operations, while building upon, rather than rejecting, the existing walls which provide solvency protection to U.S. insurers."⁵ In general, windows are regulatory enhancements that will strengthen review and access to group affiliate information, increase cooperation between regulatory jurisdictions, expand group financial assessment, and improve standards across regulatory jurisdictions.⁶ Participation in supervisory colleges for internationally active groups fall under these "windows."⁷ More specifically, a selection of regulatory "windows" suggested by the Draft Memorandum includes: state coordination on a national basis for sharing confidential information with international regulators, a "proactive confidential communication" approach in crisis situations between state regulators and international supervisors,⁸ access to meaningful information about unregulated entities, which include non-operating holding companies,⁹ and a "panoramic" view of group capital.¹⁰ Former NAIC

⁴ See Draft Memorandum, *supra* note 3, at 1. The Draft Memorandum goes on to explain that in some cases, the U.S. regulatory scheme could perhaps more accurately be described as "solo plus." *Id.* For instance, the U.S. supervisory regime employs a "lead" state concept for when two or more insurers that operate within a single group are domiciled in two separate states. *Id.*

⁵ See Draft Memorandum, *supra* note 3, at 2. The goal of the "windows and walls" approach is to "provide much needed breadth and scope enhancements to solvency regulation while retaining the highest level of policyholder protection that exists currently." *Id.*

⁶ See *Solvency Modernization in the Spotlight*, NAIC UPDATE 3, Deloitte LLP, (Spring 2010); See also Draft Memorandum, *supra* note 3, at 2-3.

⁷ See Draft Memorandum, *supra* note 3, at 2. The GSI Working Group believes supervisory colleges to be, "the best optics . . . to be used to navigate through any potential financial crisis." *Id.*

⁸ The Draft Memorandum suggests an enhanced "Master MoU" as the mechanism to use when communication must be elevated to a higher standard. See Draft Memorandum, *supra* note 3, at 2.

⁹ The Draft Memorandum suggests that the U.S. group solvency structure should enhance "broader access to information upstream and with regard to all holding company groups with regulated insurance entities and all affiliates in all tributaries." Draft Memorandum, *supra* note 3, at 2.

President Susan Voss emphasized the importance of the GSI Working Group's objectives when she reflected on the organization's experience with insurance companies and their holding entities, affirming that it "is not enough to focus solely on transactions with insurance companies."¹¹ Voss suggested that the insurance industry needed "to look through our "windows" and understand the contagions that could impact insurers," but to maintain "an appreciation of the "walls" in place when examining material exchanges between the insurers and other parts of the group" in order to safeguard the assets supporting policyholder obligations.¹²

II. THE AMENDMENTS TO THE INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT AND REGULATION CHANGE THE PLAYING FIELD FOR STATE INSURANCE COMMISSIONERS

Supervisory colleges are authorized under the NAIC's December 2011 Amendments to the IHCA Model Act (the "Amended Model Act"), the model statute governing control over and acquisitions of insurance companies.¹³ Generally, the Amendments strengthen a state insurance commissioner's access to information so that he may better regulate group financial strength. They affect a greater sharing of regulatory information among states and countries where the affiliates of an insurer conduct business, with the parent company's central place of business designated as the lead regulatory authority. More specifically, the Amendments authorize multi-state coordination of regulatory filings, authorize insurance commissioners' participation in supervisory colleges, strengthen regulators' access to group affiliate information, and provide for the assessment of group financial strength upon initial application for control of a U.S. insurer.¹⁴

The implementation of supervisory colleges would not take away any of the state insurance commissioner's power to regulate and supervise the insurers or their affiliates within its jurisdiction—on the contrary, it would afford them more power than they previously had before the

¹⁰ See Draft Memorandum, *supra* note 3, at 3.

¹¹ See Statement of Susan E. Voss, *supra* note 1, at 8.

¹² See *id.*

¹³ NAT'L ASS'N INS. COMM'RS, NAIC MODEL LAWS, REGS., AND GUIDELINES: INS. HOLDING CO. SYS. REGULATORY ACT § 7 (2011) [hereinafter MODEL ACT].

¹⁴ *Id.* §§ 6-7. See, e.g., Campbell & Calbert, *supra* note 2, for a succinct summary of the Amendments.

Amendments to the IHCA. The Amendments provide for an insurance regulator, and in particular, a state insurance commissioner, to participate in a supervisory college with other regulators in order to better supervisor a domestic insurer that is part of a group with international operations, and to ensure the insurer is in compliance with the state code.¹⁵

Additionally, the Amendments make weighty changes to the ways in which state commissioners are empowered to oversee and examine not only domestic insurers, but also the insurer's holding company and its affiliates outside the commissioner's jurisdiction.¹⁶ To facilitate the best use of these new powers, the Amendments provide for a state insurance commissioner's participation in Supervisory Colleges to enhance the regulation of insurers that are part of an insurance holding company system with international operations. The hope is that examination of the entire group's operations will enhance the commissioner's ability to ascertain the potential enterprise risks posed by the holding company system and affiliates to the domestic insurer. These changes can primarily be found in Sections 6 and 7 of the Amended Model Act.

First, Section 6 addresses the insurance commissioner's powers to obtain the information necessary to best examine an insurer. Section 6A grants state insurance commissioners the authority to examine insurance-company affiliates to "ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system"¹⁷ "Affiliate" is defined in Section 1A of the Model Act to mean, "a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control

¹⁵ MODEL ACT, *supra* note 13, § 7; For a discussion of the Amendments, see Memorandum from Debevoise & Plimpton LLP to Clients, DEBEVOISE & PLIMPTON LLP (Apr. 6, 2011), *available at* <http://www.debevoise.com/files/Publication/a096850b-2e74-40c1-a497-fbbca9cdce5c/Presentation/PublicationAttachment/d4fdb451-ac27-46fa-9906-2012904fab4/NAIC2011SpringNationalMeeting.pdf>; Daniel A. Rabinowitz, *NAIC Approval of "Supervisory College" Leaves Key Implementation Issues Unresolved*, 5 BLOOMBERG LAW REPORTS—INSURANCE LAW (2011), *available at* http://www.chadbourne.com/files/Publication/b0bfb51a-ff95-4b41-ba76-cfa397b83f16/Presentation/PublicationAttachment/19c14f19-e13c-4b4f-b2e4-da0bf56a7420/Rabinowitz_BloombergArticle_April11.pdf.

¹⁶ MODEL ACT, *supra* note 13, § 6; *see also*, Rabinowitz, *supra* note 15 (discussing state insurance commissioner's expansion of powers).

¹⁷ *Id.* § 6A.

with, the person specified.”¹⁸ Additionally, “enterprise risk” is defined in Section 1F of the Model Act to mean, “any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole.”¹⁹

Section 6B explains how the commissioner may gain access to this necessary information for examination. Under Section 6B(1), the commission may order any insurer to, “produce such records, books, or other information papers in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance.”²⁰ If the commissioner deems such information necessary to determine compliance with the act, Section 6B(2) describes the procedure for obtaining information not in possession of the insurer.²¹ The commissioner may order an insurer to, “obtain access to such information pursuant to contractual relationships, statutory obligations, or other method.”²² In the event that an insurer does not comply, or cannot obtain the requested information, the insurer must provide to the commissioner a detailed explanation of its reasons for failure.²³ The commissioner may then use his own discretion to determine whether the explanation is compelling, or whether it is without merit. Upon finding the explanation is without merit, after notice and hearing, the commissioner may then charge the insurer who failed to provide the information a penalty for each day of delay, or suspend or revoke the insurer’s license.

Section 6E further extends how a commissioner may deal with an insurer that fails to produce documents, by providing the power, “to examine the affiliates to obtain the information,” and “to issue subpoenas, to administer oaths, and to examine under oath *any person* for purposes of determining compliance with this section.”²⁴ Failure to comply with a subpoena is punishable as contempt of court.²⁵

These changes are significant because prior to the Amendments the commissioner’s authority was considerably more restricted. A

¹⁸ *Id.* § 1A.

¹⁹ *Id.* § 1F.

²⁰ *Id.* § 6B(1).

²¹ *Id.* § 6B(2).

²² MODEL ACT, *supra* note 13, § 6B(2).

²³ *See id.* § 6B(2).

²⁴ *Id.* § 6E (emphasis added).

²⁵ *See id.*

commissioner could only examine an insurer's affiliates in the limited situations where, "the regulator had ordered the insurer to produce copies of books and records that were 'reasonably' necessary in order to determine compliance with laws, and [where] the insurer had failed to comply with such order."²⁶ The Amended Model Act "extend[s] the extra-territorial reach of state insurance regulators to examine and control insurance holding companies and insurers beyond their state borders."²⁷

Second, Section 7 provides for a state insurance commissioner's participation in supervisory colleges. Under Section 7A of the Model Act, the Commissioner is granted, "the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this Chapter."²⁸

Section 7C further clarifies what the commissioner's participation in the college will entail. This section provides that the commissioner may participate in a supervisory college "with other regulators" to assess the "business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance process" as part of his examination process of individual insurers in accordance with Section 6.²⁹ "Other regulators" include those other "state, federal and international regulatory agencies," responsible for the supervision of the insurer and its affiliates.³⁰ Section 7C also gives the commissioner the power to enter into agreements with other jurisdictions' regulators to ensure cooperation, as long as those agreements are consistent with the confidentiality requirements provided in Section 8³¹ of the Model Act.³²

²⁶ Rabinowitz, *supra* note 15 (citing NAT'L ASS'N OF INS. COMM'RS, MODEL LAWS, REGS., AND GUIDELINES: INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT § 440-1 (1993)).

²⁷ Mary Jane Wilson-Bilk et al., *United States: NAIC Proposes Expansive New Governance, Risk Management and Reporting Duties on Insurance Holding Company Systems; A New Liability Profile Emerges for Directors and Senior Management*, SUTHERLAND ASBILL & BRENNAN LLP 1 (July 26, 2010), <http://www.mondaq.com/unitedstates/article.asp?articleid=105416> (discussing development of the Amendments).

²⁸ MODEL ACT, *supra* note 13, § 7A.

²⁹ *Id.* § 7C.

³⁰ *Id.*

³¹ *Id.* § 8 (discussing confidential treatment of information obtained by the commissioner in the course of an examination).

³² *Id.* § 7C.

Additional Amendments of interest include the requirement that a holding company report its Enterprise Risk at least annually on the newly created “Form F.”³³ Form F, originally discussed as a supplement to Form B, requires the ultimate controlling person of an insurer to file an annual report with the state commissioner, identifying material risks within the holding company system that could pose financial and/or reputational “contagion” to the insurer.³⁴ The form outlines ten areas of a holding company’s operations which could potentially pose Enterprise Risk to an insurer, including items such as: business plans of the insurance holding company for the next twelve months, identification of material concerns of holding company raised by supervisory colleges, and identification of any negative movement with rating agencies.³⁵

Section 8A, Confidential Treatment, of the Amended Model Act authorizes the commissioner to use the “documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner’s official duties. The information contained in Form F would fall under this description. As such, the commissioner would be within his boundaries to share such information with members of a supervisory college, including foreign regulators.³⁶ To ensure compliance with all the adopted revisions, it is likely the NAIC will modify their current accreditation standards to guarantee State implementation of the changes into their respective insurance holding company acts.

III. INTRODUCTION TO AN OVERVIEW OF SUPERVISORY COLLEGES

Succinctly put, “supervisory colleges are groups of regulators from different countries that work together to oversee large cross-border

³³ Anthony Roehl, *NAIC Adopts Revised Holding Company System Model Act Requiring Enterprise Risk Disclosure*, MORRIS MANNING & MARTIN LLP (Mar. 23, 2011), <http://www.mmmlaw.com/media-room/publications/newsletter/naic-adopts-revised-holding-company-system-model-act-requiring-enterprise-risk-disclosure>.

³⁴ Wilson-Bilk et al., *supra* note 27, at 7 (discussing the Enterprise Risk Report in its preliminary context of the “Annual Report”). The Annual Report would have been a supplement to the existing Form B, but instead was made into its own Form F. *Id.*; see also Roehl, *supra* note 33.

³⁵ See Roehl, *supra* note 33; see also Wilson-Bilk et al., *supra* note 27, for a discussion of the Form F development.

³⁶ Wilson-Bilk et al., *supra* note 27, at 8.

financial organizations.”³⁷ They are not decision-making bodies; rather, they are designed to share prudential information about cross-border institutions.³⁸ Supervisory colleges are also meant to supervise companies at the group level, rather than legal entity level.³⁹

Supervisory colleges serve to provide a forum that facilitates a more comprehensive view of “all the activities of a multi-faceted, multi-jurisdictional enterprise that could present a systemic risk to the individual enterprise and the financial system as a whole.”⁴⁰ They purport to act as a further element of an international framework for group-wide supervision, and function to provide a permanent forum for cooperation and communication between its involved members.⁴¹ Furthermore, supervisory colleges operate as a mechanism to develop cooperation and exchange of information among involved supervisors,⁴² and to coordinate supervisory activities on a group-wide scale under both baseline and worst-case scenarios.⁴³

Proponents of supervisory colleges emphasize the numerous potential benefits the forums could bring to the insurance industry. Supervisory colleges would enhance supervisory cooperation and coordination of internationally active groups by providing a uniform forum for crisis management,⁴⁴ help to close regulatory gaps, and increase information flow between home and host supervisors.⁴⁵ As opposed to a temporary committee that is organized for a unique purpose in response to a crisis, supervisory colleges are flexible and permanent, enhancing cooperation and coordination among supervisory authorities.⁴⁶ They would assist in avoiding redundant work because of the expanded coordination

³⁷ Wilson-Bilk et al., *supra* note 27, at 9.

³⁸ Duncan Alford, *Supervisory Colleges: The Global Financial Crisis and Improving International Supervisory Coordination*, 24 EMORY INT’L L. REV. 57, 78 (2010).

³⁹ Rabinowitz, *supra* note 15.

⁴⁰ Wilson-Bilk et al., *supra* note 27, at 9.

⁴¹ INTERNATIONAL ASSOCIATION OF INSURANCE SUPERVISORS, *Guidance Paper on the Use of Supervisory Colleges in Group-Wide Supervision*, Guidance Paper No. 3.8, § 1, ¶ 14 (Oct. 2009) [hereinafter IAIS Guidance Paper].

⁴² *Id.*

⁴³ *Id.* § 5.3, ¶ 62-72.

⁴⁴ *Id.* § 5.3.

⁴⁵ *Id.* § 5.1, ¶ 38; *see also id.* § 5.3, ¶ 63.

⁴⁶ *Id.* § 4, ¶ 34.

and communication, and would help to maintain the necessary levels of protection for policyholders.⁴⁷

Supervisory colleges are also designed to contribute to the stability of financial markets overall.⁴⁸ Aggregated information may help to shed light on systemic risks that would not have been identified with an individual entity analysis. In particular, a supervisory college may be able to consider the impact of a particular group on the insurance industry, on other sectors of an economy, as well as any systemic risks the group may present.⁴⁹ Additionally, a supervisory college would facilitate information collection and analysis at the group level, including the compilation and analysis of information available on risk exposures, financial soundness, and governance of group entities.⁵⁰ This creates a forum for the insurer to provide clarity to the supervisors, with respect to its operations and strategy, at a group-wide, as opposed to an individual entity, level.⁵¹

The concept of supervisory colleges within the insurance sector is not entirely unique. Europe has employed similar concepts with coordinating committees and the United States has a process in place for supervisory cooperation across its state based regulation system.⁵² In particular, the European Union has utilized colleges to supervise financial institutions operating in multiple Member States.⁵³

Supervisory colleges would not replace entity level supervision; rather they would supplement that solo level supervision of single entities within a group, by using the exchange of information to coordinate supervisory activities on a group-wide basis.⁵⁴ Effectively, the operation of a supervisory college is based on mutual trust and confidence among the involved supervisors.⁵⁵ Functionally, supervisory colleges will work differently depending upon the circumstances of the group and the jurisdiction in which the group operates.⁵⁶

⁴⁷ IAIS Guidance Paper, *supra* note 41, § 5.3.

⁴⁸ *Id.* § 2.2, ¶ 28; § 5.2, ¶ 57.

⁴⁹ *Id.* § 5.1, ¶ 42, § 5.2, ¶ 57.

⁵⁰ *Id.* § 5.1, ¶ 42.

⁵¹ *Id.* § 5.2, ¶ 60.

⁵² *Id.* § 1, ¶ 17.

⁵³ See generally Duncan Alford, *The Lamfalussy Process and EU Bank Regulation: Another Step on the Road to Pan-European Regulation?*, 25 ANN. REV. BANKING & FIN. L. 389 (2006).

⁵⁴ IAIS Guidance Paper, *supra* note 41, § 2.1, ¶ 19-21.

⁵⁵ *Id.* § 2.2, ¶ 25.

⁵⁶ *Id.* § 5.1, ¶ 46.

Supervisory colleges will be particularly useful because, as the IAIS guidance paper on the use of the colleges points out, “[t]here is a high level of divergence in the insurance industry regarding the nature of organisations [sic], the nature of regulation and supervision, and the development of markets and supervisory regimes in different jurisdictions.”⁵⁷ Supervisory colleges are strongly recommended for insurance groups that operate in multiple jurisdictions.⁵⁸ More specifically, they are necessary where: “significant cross-border activities and/or intra-group transactions are conducted”;⁵⁹ “effective group-wide supervision is essential to the protection of policyholders”;⁶⁰ and, “effective group-wide supervision is essential to the financial stability of the market as a whole.”⁶¹

IV. THE DISSEMINATION OF INFORMATION IN SUPERVISORY COLLEGES MUST BE CONSISTENT WITH THE APPLICABLE CONFIDENTIALITY REQUIREMENTS

A major concern with the use of supervisory colleges is ensuring that the dissemination of information is consistent with the applicable confidentiality requirements. It will be the group-wide supervisor’s role to gather the relevant information, but it will also be his role to disseminate that information in accordance with the pertinent confidentiality agreements.⁶² Because there is no global law or regulation on confidential information, this responsibility to handle sensitive information appropriately will fall solely to the individual supervisor and the college.⁶³

Section 8 of the Amended Model Act discusses how a commissioner may use confidential documents, obtained in the examination process of an insurer, to assist in the performance of his duties. Amongst the included parties with which the commissioner may share this information, are members of a supervisory college. The section states that a commissioner, “may share documents, materials or other information . . . with other state, federal and international regulatory agencies . . . including members of any supervisory college described in

⁵⁷ *Id.* § 6.1, ¶ 74.

⁵⁸ *Id.* § 6.1, ¶ 75.

⁵⁹ *Id.*

⁶⁰ IAIS Guidance Paper, *supra* note 41, § 6.1, ¶ 75.

⁶¹ *Id.*

⁶² *Id.* § 4, ¶ 36.

⁶³ *Id.* § 6.2, ¶ 102.

Section 7, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document.”⁶⁴ As previously discussed, Section 6 of the Amended Model Act provides for a commissioner to gain access to extensive information from both an insurer and its affiliates as long as he deems it required for an accurate examination.⁶⁵

These confidentiality agreements should touch upon when and what information can be disclosed to third parties and the insurance group.⁶⁶ Pertinent parties could include local supervisory/regulatory bodies, international organizations, or the public where appropriate.⁶⁷ Agreements should also lay out any differences in the confidentiality requirements of information sharing during a normal basis, and sharing during a crisis situation.

Despite the college’s reliance on supervisors laying all known information on the table, in certain circumstance, a “need to know’ basis” for information sharing may be appropriate.⁶⁸ Such restrictions would

⁶⁴ MODEL ACT, *supra* note 13, § 8C(1) (additionally providing that the recipient of such information in a supervisory college has “verified in writing the legal authority to maintain confidentiality”).

⁶⁵ *Id.* § 6.

⁶⁶ The Basel Committee’s *Good Practice Principles on Supervisory Colleges*, recommends what to do before passing confidential information received from a fellow supervisor to a third part with a legitimate interest, as well as what to do in the event that a supervisor is legally compelled to disclose such information. Basel Committee on Banking Supervision, *Good Practice Principles on Supervisory Colleges* (Oct. 2010), at 22. First, in the event of a legitimate third party request for confidential information, the Basel Committee recommends that, “[p]rior to passing information to the third party, the recipient should consult with and seek agreement from the supervisor that originated the information, who may attach conditions to the release of information, including whether the intended additional recipient is or can be bound to hold the information confidential.” *Id.* Second, in the event that a supervisor is legally compelled to disclose information obtained confidentially to a third party, including a third party supervisory authority, the Basel Committee recommends that, “information that has been provided in accordance with a statement of mutual cooperation, [the supervisor that has been legally compelled to disclose] should promptly notify the supervisor that originated the information, indicating what information it is compelled to release and the circumstances surrounding its release.” *Id.* In all instances, the supervisor disclosing the information should use his best efforts to maintain the confidentiality of the information to the extent permitted by law. *Id.*

⁶⁷ IAIS Guidance Paper, *supra* note 41, § 5.3, ¶ 73.

⁶⁸ *Id.* § 5.3, ¶ 65.

likely be dictated in previously drafted confidentiality agreements to avoid unintended turmoil. For instance, during a crisis, the premise of widespread information may need to be limited to ensure timely responses.

The timing and content of information to be disclosed to third parties must also be deliberated carefully. Group-wide supervisors may find it wise to establish appropriate contacts with other sector participants, but they must consider their existing relationships within the college, and weigh these relationships against the potential value of the information additional new members may be able to provide.⁶⁹

Members must also be aware of any existing legal or jurisdictional restraints. Supervisory colleges do not override the various individual jurisdiction's legal responsibilities or standing supervisory relationships.⁷⁰ Where there are legal constraints to information sharing in a particular jurisdiction, supervisors looking to participate in the college should address these constraints to maintain the effectiveness of the college.⁷¹ Ultimately, a supervisory college will need to safeguard against any plan going beyond the authority of a supervisor, or surpassing any jurisdiction's existing legal framework.⁷²

An alternative method of confidentiality to a traditional confidentiality agreement is a Memorandum of Understanding ("MoUs"). MoUs are information sharing agreements that ensure confidentiality and define the parameters in which information can be used.⁷³ They are formal statements of mutual cooperation that outline procedures and provisions for confidentiality.⁷⁴ A MoU should recognize that information must be shared between the relevant authorities in two countries in order to facilitate effective consolidated supervision of institutions that operate across their national borders.⁷⁵

⁶⁹ *Id.* § 4, ¶ 37.

⁷⁰ *Id.* § 5.1, ¶ 40.

⁷¹ *Id.* § 6.1, ¶ 77.

⁷² *Id.* § 6.2, ¶ 80.

⁷³ IAIS Guidance Paper, *supra* note 41, § 5.2, ¶ 54.

⁷⁴ Basel Committee on Banking Supervision, *supra* note 66, at 20. The publication further emphasizes that MoUs must be underpinned by, "trust and a network of relationships that are required for effective information sharing, particularly where confidential information is concerned." *Id.*

⁷⁵ Additionally the MoU between the two countries should recognize the practice of information sharing in order to facilitate "solo supervision of group entities in the host jurisdiction." *Id.* The Basel Committee identified information sharing to be "contact during the authorisation [sic] and licensing process, during

Jurisdictions that are part of the International Association of Insurance Supervisors Multilateral Memorandum of Understanding on Cooperation and Information Exchange (“IAIS MMoU”) are required to have their legislative regimes assessed to ensure strict confidentiality requirements are met as a precondition for joint supervisory activity.⁷⁶ If each member of the supervisory college were a part of the IAIS MMoU, there would be no need for individual bilateral MoUs between the members.⁷⁷ The IAIS MMoU allows regulators in different countries to work together in overseeing insurers, and it has 17 jurisdictions—though currently none are US regulators.⁷⁸ A subgroup of the NAIC’s SMI Task Force working on the issue of supervisory colleges was given the task of surveying state laws to better see if states could participate in the IAIS MMoU.⁷⁹

V. THE FEDERAL INSURANCE OFFICE’S AUTHORIZATION OF THE UNITED STATES PARTICIPATION IN COVERED AGREEMENTS AND THE POTENTIAL FOR PREEMPTION OF STATE LAWS

The Federal Insurance Office (“FIO”) Act authorizes the United States to jointly negotiate and enter into Covered Agreements with foreign governments, authorities, or regulatory bodies, and once entered into, authorizes the FIO to preempt a state insurance measure that conflicts with the Covered Agreement.⁸⁰ A Covered Agreement is defined by the Act to be “a written bilateral or multilateral agreement regarding prudential measures with respect to the business of insurance,” entered into between

supervision of ongoing activities and during the handling of problem institutions.”
Id.

⁷⁶ IAIS Guidance Paper, *supra* note 41, § 5.2, ¶ 54.

⁷⁷ *Id.* § 6.2, ¶ 103.

⁷⁸ Matthew Sturdevant, *Connecticut Insurance Regulators Join Forces With Swiss Counterparts*, HARTFORD COURANT (Sept. 23, 2011), http://blogs.courant.com/connecticut_insurance/2011/09/connecticut-insurance-regulato-1.html.

⁷⁹ *NAIC Pursues International Agenda*, NAIC UPDATE (Deloitte LLP), Spring 2010, at 7.

⁸⁰ Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, § 502, 124 Stat. 1376, 1587 (2010). A “state insurance measure” is defined by the Act to include “any State law, regulation, administrative ruling, bulletin, guideline or practice relating to or affecting prudential measures applicable to insurance or reinsurance.” *Id.*

the United States and a foreign entity that relates to the business of insurance in order to achieve a level of protection “substantially equivalent” to that received under State regulation.⁸¹ This means that the covered agreement must effectuate at least the same level of protection for insurance consumers as they receive under state regulation.⁸² This preemption provision is awakened when a state measure is inconsistent with a Covered Agreement, and produces less favorable treatment for a non-U.S. insurer whose domiciliary jurisdiction is party to the Agreement.⁸³

Imagine a situation where a state joins a supervisory college with a non-U.S. member, and that state shares confidential information with the foreign entity. If that foreign entity were to share that information with its government, and that foreign government were to decide it did not like what it saw, it could potentially use the information obtained from the supervisory college as leverage to wrangle the U.S. into a Covered Agreement that afforded the foreign government’s insurers more protection/similar treatment by a state that was previously afforded. Presented with this new information, the U.S. government may feel pressured into a Covered Agreement. This may not be a bad thing, and the scenario is grossly obscure and unspecific, but should it be decided that the state measure now violates the new Covered Agreement and must be preempted, the state may be worse off than it was before participating in, and sharing information with, the supervisory college. The chances of this

⁸¹ *Id.* More specifically, the covered agreement may be entered into between the United States and “one or more foreign governments, authorities, or regulatory entities.” *Id.* Additionally, the agreement must employ “prudential measures” in achieving said level of protection for insurance consumers. *Id.*

⁸² The phrase “substantially equivalent to the level of protection achieved” is defined by the Act to mean that, “the prudential measures of a foreign government, authority, or regulatory entity achieve a similar outcome in consumer protection as the outcome achieved under State insurance or reinsurance regulation.” § 502, 124 Stat. at 1587. *See e.g.*, Statement of Susan E. Voss, *supra* note 1, at 7. Voss additionally pointed out that the FIO does not have general supervisory or regulatory authority over the business of insurance, but that the NAIC was willing to work with the FIO in terms of suggestions for improvements. *Id.* at 7-8.

⁸³ § 502, 124 Stat. at 1583 (“A State insurance measure shall be preempted pursuant to this section or section 314 if . . . the measure—(A) results in less favorable treatment of a non-United States insurer domiciled in a foreign jurisdiction that is subject to a covered agreement than a United States insurer domiciled, licensed, or otherwise admitted in that State; and (B) is inconsistent with a covered agreement.”).

happening, if at all, are most likely few and far between, but states should be aware of the potential consequences that the FIO's preemption provision could have, when it is examined in conjunction with the role of foreign governments and their possible access to confidential information through supervisory colleges.

VI. CONNECTICUT AS A CASE STUDY FOR RECENT DEVELOPMENTS IN STATE INVOLVEMENT WITH SUPERVISORY COLLEGES AND INTERNATIONAL MEMBERS

Connecticut Insurance Commissioner Thomas B. Leonardi has been a proponent of the proposals recommended by the NAIC for the Amended Model Act since his appointment in February 2011. According to Commissioner Leonardi, "The model Holding Company Act would allow everyone to come to the table together, share information in a unique way, and would inevitably lead to more collaboration and cooperation in the insurance market."⁸⁴

Although Connecticut has not yet officially adopted the changes into its insurance holding company system act, the state has made several moves towards international coordination and supervision. A recent agreement between the Connecticut Insurance Department and the Swiss Financial Supervisory Authority provides for both parties to work together to regulate insurers.⁸⁵ The Connecticut Courant reported that, "A memorandum of understanding between the two is the formal basis for cooperation and coordination, including investigative assistance and the exchange of information, [according to] Donna Tommelleo, the insurance department's spokeswoman."⁸⁶ The Courant additionally reported statements by Connecticut Insurance Commissioner Leonardi saying that: "The insurance industry is an international one and continues to expand its global reach Regulating it cannot stop at the border and must be looked at in its totality. This commitment will allow Connecticut and Swiss regulators to work effectively together and ensure market stability for consumer protection."⁸⁷

⁸⁴ Pullman & Comley LLC, *A Conversation With Connecticut's New Insurance Commissioner Thomas B. Leonardi*, CT INS. LAW UPDATE, 2, <http://www.pullcom.com/news-publications-277.pdf> (last visited Oct. 2, 2012).

⁸⁵ Sturdevant, *supra* note 78.

⁸⁶ *Id.*

⁸⁷ *Id.*

Connecticut also has an agreement already in place with De Nederlandsche Bank in the Netherlands which is similar to the one between the state and Switzerland.⁸⁸ In addition to Switzerland and the Netherlands, Connecticut has a third agreement pending with the Germany Federal Financial Supervisory Authority (“BaFin”).⁸⁹ The agreements with these countries in particular were pursued because Swiss Re and Munich Re are examples of companies that have a presence in Europe and Connecticut.⁹⁰ Furthermore, Connecticut’s Insurance Department is one of at least two states that have applied to be a part of the IAIS MMoU on Cooperation and Information Exchange.⁹¹

VII. THE NAIC’S FACILITATION OF US AND INTERNATIONAL REGULATOR PARTICIPATION IN SUPERVISORY COLLEGES, AND OTHER DEVELOPMENTS IN THE INSURANCE SECTOR WORKING TOWARDS INTERNATIONAL COORDINATION

Within the last year the NAIC took serious steps to facilitate states participation in supervisory colleges. The NAIC recently created an online form that allows international regulators to request a particular State’s participation in an international supervisory college.⁹² The “International Supervisory Colleges Request Form” is submitted to the insurance group’s appropriate leader and/or domestic supervisor who in turn will contact the international regulator directly.⁹³

Former NAIC President Susan E. Voss, is quoted on the NAIC website as saying,

U.S. insurance regulators recognize the important role supervisory colleges can play in providing a forum to foster improved international communication and coordination regarding the

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ Sturdevant, *supra* note 78. See discussion of IAIS MMoU on Cooperation and Information Exchange *supra* p. 163.

⁹² Nat’l Ass’n of Ins. Comm’rs, *NAIC Develops International Supervisory Colleges Request Form* (Mar. 18, 2011), http://www.naic.org/Releases/2011_docs/international_request_form.htm (announcing the web-based tool to facilitate coordination of US insurance regulators’ participation in supervisory colleges).

⁹³ *Id.*

oversight of significant global insurance operations We hope this web-based tool will aid international regulators to promptly notify the appropriate U.S. state insurance regulators regarding a particular supervisory college and secure the appropriate representation.⁹⁴

Furthermore, supervisory colleges are not the only way the NAIC and the IAIS are working towards international supervisory coordination. There are two other significant solutions worth mentioning: one, the Supervisory Forum; and two, the “Common Framework for the Supervision of Internationally Active Insurance Groups” (“ComFrame”). The NAIC chairs the Supervisory Forum at the IAIS.⁹⁵ In addition to the increased use of supervisory colleges, state regulators are advocating the use of the Supervisory Forum to improve coordination.⁹⁶ Former NAIC President Susan E. Voss described the objective of the Supervisory Forum as a way “to strengthen the effectiveness of insurance supervision and to foster convergence of supervisory practices through the exchange of real-world experiences.”⁹⁷

First proposed by the IAIS,⁹⁸ ComFrame lays out how supervisors around the globe can work together to supervise internationally active insurance groups.⁹⁹ The GSI Working Group is aiding in this project by providing its own insight on how to identify internationally active insurance groups, and how to resolve jurisdictional issues.¹⁰⁰ Participation in the development of ComFrame is an effective way for the GSI Working Group to further its original task to find a method of supervision that will allow state insurance regulators to monitor the combined capital adequacy of all entities within an insurance holding company system, including internationally active insurers.¹⁰¹

There has been some concern that ComFrame would not be consistent with NAIC principles of state autonomy. The GSI Working Group responded to this concern by stating that, “given the uniqueness and

⁹⁴ *Id.*

⁹⁵ Statement of Susan E. Voss, *supra* note 1, at 189.

⁹⁶ *Id.*

⁹⁷ *Id.* at 189-90 (comparing the Supervisory Forum as akin to the multi-jurisdictional coordination framework that the United States uses).

⁹⁸ DEBEVOISE & PLIMPTON LLP, *supra* note 15, at 4.

⁹⁹ *Id.*

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

complexity of large insurance group issues, ComFrame should focus on general principles and high-level concepts, rather than specific compliance issues and capital requirements that more likely would be a source of conflict.”¹⁰² Former NAIC President, Susan Voss, further characterized ComFrame as a “multijurisdictional” approach to supervision.¹⁰³ She stated that, “If done right, ComFrame has the potential to create a multijurisdictional approach to supervision that emphasizes robust oversight and cooperation while maintaining the proper balance between home and host jurisdictions.”¹⁰⁴

VIII. POTENTIAL OBSTACLES AND CONCERNS PRESENTED BY SUPERVISORY COLLEGES

The design of a supervisory college turns on the assumption that all regulators will have the goal of group solvency and stability above all in mind. This may not be the case. Each individual regulator may be more focused on his own relevant market or sector in his own country or state.¹⁰⁵ In addition to a lack of consistency between regulator’s jurisdictional goals, there may also be an inconsistency within groups themselves. Entity-level risks vary within a group, and regulators may not agree on how each individual entity should be treated.¹⁰⁶ These differing objectives can be illustrated through how different regulators “in favor” of different entities within a group, may want to treat the group’s liquidity differently. Imagine a scenario where a U.S.-based insurance company is owned by a foreign entity. In this case, it is possible that the state insurance regulator will most want to keep capital with the insurer, while the foreign holding company regulator will want it to flow up as dividends.¹⁰⁷ These inter-affiliate dividends are a potential “zero-sum” problem that could arise in a

¹⁰² *Id.* at 4-5 (explaining the GSI Working Group’s response to such concerns); Susan Voss expressed a similar sentiment on ComFrame’s limited purpose, when she said that it, “should neither be a platform for pushing a global capital standard for insurance, nor create prescriptive ways to promote a particular means for solvency standards, nor create additional layers of regulation.” Statement of Susan E. Voss, *supra* note 1, at 178.

¹⁰³ *Id.* at 190.

¹⁰⁴ *Id.*

¹⁰⁵ Rabinowitz, *supra* note 15.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

supervisory college,¹⁰⁸ and impede on the ultimate success of coordination and cooperation.

Supplemental to the above concern, is the potential for weakness due to a supervisory college's strong reliance on supervisor cooperation and trust. Because there is no mandatory mediation process to resolve supervisor disagreement on an action, supervisors are still legally free act on their own and not in coordination with their peers.¹⁰⁹ It is not a far-fetched argument to make that supervisors will first strive to protect their national interest, and the rights of the residents within their jurisdiction, before conceding to compromises that may not be in their jurisdiction's best interest. This focus could cause inconsistencies in resolutions if individual supervisors do not approach issues with the college's end goals in mind.

An additional concern is that the decision-making schemes for supervisory colleges are not consistent with the NAIC. In particular, there is concern that international supervisors may be more accustomed to one lead supervisor making the decisions, whereas the NAIC fosters a system of "consensus" decision-making.¹¹⁰ The GSI Working Group has responded to such a concern by addressing the role of the "group supervisor" of a supervisory college, and affirming that such supervisor will primarily have a coordinating, rather than decision-making function.¹¹¹

It has already been stressed that in recent years, international coordination has been an essential goal for the NAIC. Each project, solution, and suggestion the NAIC has proposed was ultimately made with the U.S. and global insurance industry's success in mind; however, it should be noted that opening doors in one area could leave potential holes in another. With this in mind, another potential concern resides in the NAIC's recently adopted "Own Risk and Solvency Assessment Model Act" ("ORSA") that requires an insurance company, or insurance group, to produce a self-risk assessment report that must be filed with the insurer's state insurance commissioner.¹¹²

¹⁰⁸ *Id.*

¹⁰⁹ IAIS Guidance Paper, *supra* note 41, § 5.1, ¶ 40.

¹¹⁰ DEBEVOISE & PLIMPTON LLP, *supra* note 15, at 5.

¹¹¹ *Id.*

¹¹² On September 12, 2012, the NAIC adopted the Draft version of the Model Act with some minor changes. The heart of ORSA, the "ORSA Summary Report," is detailed in Section 5 of the Model Act. It reads as follows: "[u]pon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual,

Several concerns were raised at the NAIC's Spring 2011 meeting in regards to the proposed U.S. "ORSA" plan. One concern addressed confidentiality issues in particular, pointing out that information requested by the ORSA would have the potential to expose a company's competitive advantage because the document would contain models that included competitively sensitive and forward-looking information.¹¹³ Should the ORSA reports ever be shared within a supervisory college in the future, this concern would literally be projected onto an international level. When considering whether to allow an ORSA report to be shared and discussed in a supervisory college, the benefit of potentially exposing a risk through a window into an insurance company's capital levels in light of its unique business strategy would have to be carefully weighed against the detriment if such valuable information were to be abused. However, this does not seem to be a major concern of the NAIC.

Section 8 of the ORSA Model Act discusses confidentiality, but not without many opportunities for sharing. After initially addressing that all information collected by commissioners will be recognized as being proprietary and to contain trade secrets, subsection A provides a caveat for disclosure: "However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties."¹¹⁴ Subsection C(1) extrapolates the commissioner's ability to share information in order to assist the commissioner in the performance of his regulatory duties, and specifically addresses a commissioner's ability to share such confidential information within a supervisory college.¹¹⁵ With

applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report(s) required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners." NAT'L ASS'N INS. COMM'RS. RISK MANAGEMENT AND OWN RISK AND SOLVENCY ASSESSMENT MODEL ACT, §§ 1, 5 (2012) [hereinafter ORSA MODEL ACT].

¹¹³ DEBEVOISE & PLIMPTON LLP, *supra* note 15, at 5-6.

¹¹⁴ ORSA MODEL ACT, *supra* note 112, § 8(A).

¹¹⁵ ORSA Section 8(C)(1) provides in relevant part: "In order to assist in the performance of the commissioner's regulatory duties, the commissioner: May upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection A, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including

this allowance for sharing, the NAIC is likely predicting scenarios where the ORSA Report becomes a substantial part of the Commissioner's evaluative and investigatory process when evaluating an insurance company that is within its jurisdiction. Section 8 further expands the commissioner's ability to share ORSA-related confidential information in supervisory colleges by including the complementary subsection C(2), which provides for a commissioner's ability to also *receive* confidential, ORSA-related materials while participating in a supervisory college forum.¹¹⁶

Abuse of confidential information obtained through ORSA-related materials may not manifest in a typical breach; however, members of a supervisory college may become privy to sensitive information that could alter their personal opinions as to whether they would choose to do business with a particular insurer in the future after gaining access to a report that literally outlines the company's greatest risks. The NAIC may implement endless provisions to ensure that the confidential nature of an ORSA Summary Report is legally upheld, but it would be impossible to control how such information could potentially influence each individual's private judgments. Despite group discussions within the forum, whether disclosure of a particular insurer's risks actually warrants such trepidation in future dealings will be a matter each member alone will ultimately decide.

Yet another concern lies with the Form A. Supervisory colleges' influences on Form A are yet to be determined. All acquisitions of insurance companies are subject to prior approval via submission of the Form A under the IHCA. Where a state regulator normally feels neutral towards an acquisition as long as the transaction does not affect policyholder protection or insurer solvency, other interested parties might have a more biased view of controversial terms, like the purchase price.¹¹⁷ This could potentially pose a problem if the domiciliary regulator is part of a supervisory college with these other interested parties. For instance, the

members of any supervisory college" ORSA MODEL ACT, *supra* note 112, § 8(C)(1).

¹¹⁶ ORSA Section 8(C)(2) provides in relevant part: "In order to assist in the performance of the commissioner's regulatory duties, the commissioner: May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college" ORSA MODEL ACT, *supra* note 112, §8(C)(2).

¹¹⁷ Rabinowitz, *supra* note 15.

group that is selling its insurance entity will want to be sure that the purchase price is fair, and likely, is a smart deal. As such, the regulator representing the interests of this holding company may feel more inclined to frame the situation to the state commissioner in a light more favorable to the holding company.¹¹⁸ This could pose problems in the form of unnecessary complexity during the Form A proceedings, as well as misguided decisions by state commissioners receiving biased advice.

Issues with inter-collegiate influence could cause problems of its own if the regulatory community decides to ostracize a particular commissioner that does not heed ill-motivated advice. If a domestic regulator proposed that the supervisory college was treating one of his domestic insurers too aggressively, they could run the risk of effectively excluding themselves from discussions henceforth. Furthermore, conflict at this level has the potential to affect not only the commissioner's personal status in the college, but also his domestic insurers if his fellow regulators choose to collectively lash out as a punishment. It is worth re-mentioning that participants in these colleges represent supervisors and regulators from jurisdictions across borders, as well as jurisdictions across sectors. How each participant is connected with one another is likely to be incestual at times, and these relationships could just as easily be exploited in a negative manner as they could be used to the college's advantage. Regulators are people, and congruency between people—especially those who don't choose to work together—is not a guarantee.

IX. THE ISSUE OF WHETHER SUPERVISORY COLLEGES ARE OUTSIDE 'BUSINESS OF INSURANCE' AS DEFINED IN THE MCCARRAN-FERGUSON ACT

A. THE 'BUSINESS OF INSURANCE' AS DEFINED IN THE MCCARRAN-FERGUSON ACT

There are potential legal challenges that arise with the new powers afforded to a state insurance commissioner under the Amendments to the IHCA. In particular, there are issues concerning whether a state insurance

¹¹⁸ *Id.*

commissioner's new powers are within the accepted definition of the "business of insurance" under the McCarran-Ferguson Act. Policing enterprise risk is outside the traditional realm of policyholder protection, and a commissioner's involvement in a supervisory college is more likely to focus on enterprise risks rather than policyholder interest.¹¹⁹

Put succinctly, the McCarran-Ferguson Act (hereafter "the Act") is the response by Congress to a Supreme Court decision that would have placed regulation of insurance in the hands of the Federal government pursuant to the interstate Commerce Clause.¹²⁰ The Act states that the "business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business," and that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance."¹²¹ As such, what is outside the "business of insurance," is outside the Act's immunity, and thus subject to Federal regulation.

The Supreme Court decided three major cases to shape the present day definition of what constitutes the "business of insurance" under the Act.¹²² First, in *Security & Exchange Commission v. National Securities, Inc.*, the Court highlighted that the Act "did not purport to make the states supreme in regulating all activities of insurance *companies*; its language refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance.'"¹²³ The case involved a merger between two insurance companies that the state insurance commissioner believed to be fraudulent and borne from ill intent.¹²⁴ The commissioner argued that if the Securities Exchange Act were to apply, it would supersede the state laws in place; however, the SEC argued that there was no conflict between the state and federal law, because the applicable state statutes did not give the state insurance commissioner the power to determine whether the interested parties in the merger had made full disclosure.¹²⁵

The court held that it did not believe that "a state statute aimed at protecting the interests of those who own stock in insurance companies

¹¹⁹ *Id.*

¹²⁰ 1 LEE R. RUSS ET. AL., COUCH ON INSURANCE 3D § 2:4 (2009).

¹²¹ 15 U.S.C. § 1012 (2006).

¹²² 2 JOYCE PALOMAR, TITLE INS. LAW § 15:4 (2011).

¹²³ SEC v. Nat'l Sec., Inc., 393 U.S. 453, 459 (1969) (emphasis in original).

¹²⁴ *Id.* at 455. According to the amended complaint, National Securities had concocted a fraudulent scheme that centered around a merger between a insurance company they controlled and a second insurance company. *Id.*

¹²⁵ *Id.* at 457.

comes within the sweep of the McCarran-Ferguson Act.”¹²⁶ Therefore, the court held that such a statute was not an attempt to regulate with ‘business of insurance’ as the phrase is used in the Act.¹²⁷ The Court went on to distinguish the ‘business of insurance’ from the activities of insurance companies in general, by narrowing the scope of the definition to concern only those statutes aimed at protecting the relationship between the insurance company and the *policyholder*.¹²⁸ Because the activity in question involved the insurance company’s relationship with its stockholders, not its policyholders, the court found that such activity was not within the ‘business of insurance.’¹²⁹

In the second major case, the Supreme Court in *Group Life and Health Insurance v. Royal Drug Co.* proposed a three-prong test to determine whether an activity falls within the Act’s scope of the ‘business of insurance.’¹³⁰ This test is still used by courts today. The facts of *Royal Drug* concerned agreements between the insurance company and local pharmacies, requiring the insured to pay only \$2 for prescription drugs.¹³¹ The Court began its examination of whether these agreements were within the Act’s business of insurance by emphasizing what had already been decided in *National Securities*—that the ‘business of insurance’ was categorically distinguishable from the business of insurance companies. From here the Court’s opinion laid out three key points of consideration when determining whether an activity falls within the business of insurance. First, the Court determined that the “significance of underwriting or spreading of risk [is] an indispensable characteristic of insurance.”¹³² The insurance company argued that these agreements fell within the scope of ‘spreading risk’ because such agreements would reduce the premiums policyholders would have to pay in the long run.¹³³ The Court adamantly disagreed with this argument and held that:

By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Nat’l Sec., Inc.*, 393 U.S. at 460.

¹²⁹ *Id.*

¹³⁰ PALOMAR, *supra* note 122.

¹³¹ *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 207 (1979).

¹³² *Id.* at 212.

¹³³ *Id.* at 214.

policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the ‘business of insurance.’¹³⁴

Because the arrangements with the pharmacies did not spread policyholder risk, they did not satisfy the first prong.

Second, the Court extrapolated that Congress’ primary concern in enacting the Act was, “[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the ‘business of insurance.’”¹³⁵ It then held that the cost-saving effect the agreements produced for policyholders was not enough to satisfy the second prong’s insurer-insured relationship standard.¹³⁶ The Court then again stressed the difference between the ‘business of insurance’ and the business of the insurance company, stating that if activity such as the agreements in question were deemed included, then almost every business decision of an insurance company could be included in the ‘business of insurance[,]’ and that “[s]uch a result would be plainly contrary to the statutory language.”¹³⁷

Finally, the Court in *Royal Drug* consulted a brief legislative history of the Act, concluding that Congress intended to shield intra-industry cooperative rate making from anti-trust laws because such activity was essential to underwriting risks accurately.¹³⁸ Staying true to this intent, the Court held that, “[t]here is not the slightest suggestion in the legislative history that Congress in any way contemplated that arrangements such as the Pharmacy Agreements in this case, which involve the mass purchase of goods and services from entities outside the insurance industry, are the ‘business of insurance.’”¹³⁹ As such, the last prong of the *Royal Drug* test

¹³⁴ *Id.*

¹³⁵ *Id.* at 215-16 (quoting *Nat’l Sec.*, 393 U.S. at 460).

¹³⁶ *Royal Drug Co.*, 440 U.S. at 216.

¹³⁷ *Id.* at 217.

¹³⁸ *See id.* at 220-25 (discussing the history of Congress’s original intent for enacting the Act).

¹³⁹ *Id.* at 224.

requires courts to consider whether parties are wholly within the insurance industry.¹⁴⁰

The last chief case where the Supreme Court revisited the question of what comprised the ‘business of insurance,’ was *Union Labor Life Insurance Co. v. Pireno*.¹⁴¹ In *Pireno*, the Court examined whether the use of a peer review committee to determine if a chiropractor’s treatments were unnecessary, or his rates unreasonable, was not within the ‘business of insurance,’ and thus not exempt from antitrust scrutiny.¹⁴² The Court concluded that the peer review committee failed all three prongs of the *Royal Drug* test, and thus was outside the ‘business of insurance.’ In regards to the third prong of the test, whether the involved parties were wholly within the insurance industry, the Court stated that such a failure alone need not deny the anti-trust exemption, but that “the involvement of such parties, even if not dispositive, constitutes part of the inquiry mandated by the *Royal Drug* analysis.”¹⁴³ More generally, the Court refined the test by asserting that none of the three elements alone are determinative of whether an activity is within the ‘business of insurance’; rather, all three elements must be taken together to form a collective picture.¹⁴⁴

These three cases left strong themes for future courts to consider, most notably, that the ‘business of insurance’ is not synonymous with the business of insurance companies. In regards to supervisory colleges, the present concern proponents of the colleges should consider, is whether the new power of a state insurance commissioner to examine not only domestic insurers, but also affiliates, and to subsequently share such information with other regulators, is within the boundaries set by this definition. If the activities and information sharing engaged in under supervisory colleges are considered outside the ‘business of insurance,’ there inevitably arises a corresponding argument that supervisory colleges are outside the power of states’ regulation, and are perhaps more appropriately situated under the jurisdiction of the Federal government.

¹⁴⁰ *Id.*

¹⁴¹ PALOMAR, *supra* note 122, at 20.

¹⁴² See *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 136 (1982) (“[Union Labor Life Insurance Co.]’s use of [New York State Chiropractor Association]’s Peer Review Committee does not constitute the ‘business of insurance’ within the meaning of § 2(b) of the McCarran-Ferguson Act, and thus is not exempt from antitrust scrutiny.”)

¹⁴³ *Id.* at 133.

¹⁴⁴ *Id.* at 129.

A Supreme Court of Nebraska case concerning the acquisition of a domestic insurer by a foreign holding company provides an exemplary discussion of how courts have since muddled the lines of the *Royal Drug* test. Furthermore, the Court's holding that a state statute providing for its insurance department to approve the acquisition of control of any domestic insurer pursuant to its Insurance Holding Company System Act is within the boundaries of the McCarran-Ferguson definition of 'business of insurance,' is a strong argument that the new Amendments to the NAIC's IHCA do not trigger scrutiny of the Amendment's validity under the Act.

In *CenTra, Inc. v. Chandler Ins. Co., Ltd.*, Nebraska's Insurance Holding Company System Act required applicants looking to acquire a domestic insurance company to file a "Form A," but the Act allowed an acquiring party to avoid the insurance department's scrutiny by filing a disclaimer of control.¹⁴⁵ CenTra, the foreign holding company in question, filed such a disclaimer.¹⁴⁶ The insurance department approved the disclaimer, but on the condition that CenTra cease to purchase the insurance company's stock.¹⁴⁷ In the following years, CenTra did not obey the order and continued to purchase the insurance stock from other stockholders until CenTra controlled 49.2 percent of the insurance company.¹⁴⁸

CenTra next took steps to officially acquire the insurance company, but following submission of the Form A, and the Form A hearing, the insurance department denied the applicant's request.¹⁴⁹ The department supported its decision by reasoning that, the financial condition of applicants could jeopardize the financial stability of the insurer or prejudice its policyholders; that applicants' competence, experience, and integrity were such that their acquisition of the insurer would not be in the policyholders' best interests; and that the acquisition of the insurer was likely to be hazardous to the public.¹⁵⁰

¹⁴⁵ *CenTra, Inc. v. Chandler Ins. Co.*, 540 N.W.2d 318, 324 (Neb. 1995).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* ("CenTra filed such a disclaimer in 1989, and the department approved the disclaimer subject to CenTra's voluntary 'Standstill Agreement' to cease its stock purchases.").

¹⁴⁸ *Id.* (stating that upon learning of CenTra's actions, the Nebraska insurance department issued two "cease and desist" orders to CenTra).

¹⁴⁹ *Id.* at 325 (explaining that despite CenTra's prior disclaimer of control, the Form A would have become relevant again upon renewal of CenTra's acquisition efforts).

¹⁵⁰ *Id.*

The Supreme Court of Nebraska employed the three-prong ‘business of insurance’ test to determine “whether a restriction on the sale of stock in a domestic insurer is sufficiently connected to ‘the business of insurance’ to be shielded by the MFA from Commerce Clause attack,” or whether this restriction, “intrudes impermissibly into the federal realm of securities regulation.”¹⁵¹ Under the first prong, the court held that, “the restriction on stock disposition relates, albeit indirectly, to the transferring and spreading of risk The Act affords the Director of Insurance a chance to review the financial stability of the acquiring company so that he can determine whether acquisition is in the best interests of Nebraska policyholders.”¹⁵² The court further found that the power of the director to “bring any threatened change of control under his own control” concerned policyholder protection because it allowed him to consider the impact such changes would have on policyholders.¹⁵³ Ultimately it held that whether a domestic insurer will remain reliable to its policyholders does relate to the transferring and spreading of risk, because a change of control can affect the quality and stability of policies.¹⁵⁴

In discussing the second prong, the court found that the Nebraska Act satisfied the insurer-insured relationship requirement because the statute gives the director the power, ability, and statutory responsibility to ensure, “that the relationship between the insurer and the policyholder is one of mutual understanding and not one of deceit.”¹⁵⁵ The court reconciled the indirect nature of their connection by broadly recognizing that, “the individual policyholder is not in a position to understand the ramifications of a change of control in his insurer until the insurer becomes insolvent and unable to pay claims.”¹⁵⁶

¹⁵¹ *CenTra, Inc.*, 540 N.W.2d at 330.

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.* (citing *Hoylake Invs. Ltd. v. Gallinger*, 722 F. Supp. 573 (D. Ariz.1989) (applying Arizona law); *Hoylake Invs. Ltd. v. Bell*, 723 F. Supp. 576 (D. Kan.1989) (applying Kansas law); *Hoylake Invs. Ltd. v. Washburn*, 723 F. Supp. 42 (N.D. Ill.1989) (applying Illinois law)). The Nebraska court stated that these courts, in examining laws similar to the Nebraska statute in question, “reasoned that because a change of control of an insurer can affect the quality and stability of policies, these laws satisfy the requirement that they related to the transferring and spreading of risk.” *Id.*

¹⁵⁵ *Id.* at 330-31 (citing *Bell*, 723 F. Supp. 576; *Washburn*, 723 F. Supp. 42).

¹⁵⁶ *CenTra, Inc.*, 540 N.W.2d at 330-31 (holding that the second prong of the ‘business of insurance’ test is satisfied).

Finally, the court found the third prong of the ‘business of insurance’ test to be satisfied as well. The court held that, despite the Act’s effects on investors and stockholders seeking to own stock in Nebraska domestic insurers, and despite that the Act restricts when an out-of-state stockholder may sell his interest in the domestic insurer, because the ultimate focus of these restrictions remains with the individual policyholder, the statute still fell within the ‘business of insurance.’¹⁵⁷ The court categorized those looking to acquire the insurance company as those “who wished to control the handling of CenTra’s insurance claims . . . who sought to gain control of their insurer by owning its stock; and . . . who chose to cast into jeopardy the one policy concern for whose protection the department was created: that an insurer should remain as reliable as it promises its insureds it will be.”¹⁵⁸

Prior to concluding, the court went on to distinguish the present case from the issue presented in *National Securities*. Where the Court in *National Securities* held that, “regulation whose focus is the protection of stockholders does not sufficiently relate to the MFA to be shielded from Commerce Clause attack,” the court in *CenTra* thought the present statute in question did not purport to protect stockholders as in *National Securities*; rather, the Nebraska Act was purely concerned with policyholders and had no stake in the “security of or services rendered to stockholders; whether merger or acquisition is equitable to stockholders is immaterial in the eyes of the director.”¹⁵⁹ Furthermore, the court pointed out that the Court in *National Securities*, “found that the section of the Arizona act that empowered the director to determine whether acquisition would substantially reduce the security of *policyholders’* interests clearly relates to the ‘business of insurance.’”¹⁶⁰

B. ARGUMENT IN SUPPORT OF THE ADOPTED REVISIONS TO THE AMENDED MODEL ACT BEING WITHIN THE ‘BUSINESS OF INSURANCE’ AS DEFINED BY THE MCCARRAN-FERGUSON ACT

¹⁵⁷ *Id.* at 331.

¹⁵⁸ *Id.*

¹⁵⁹ *Id.* (finding that despite the stockholder aspect of the Nebraska Act, the three-prong test to determine whether the statute satisfied the ‘business of insurance’ was satisfied).

¹⁶⁰ *Id.* (internal quotation marks omitted) (citing *SEC v. Nat’l Sec., Inc.*, 393 U.S. 453, 462 (1969)).

If a court were to accept the fairly broad interpretation of the *Royal Drug* test from the *CenTra* holding, claims asserting that the Amendments to the IHCA are outside the ‘business of insurance’ would likely fail. Under *CenTra*, the extension of a state commissioner’s oversight jurisdiction to out-of-state affiliates would satisfy the first prong of the *Royal Drug* test because the Amendments afford the commissioner, like Nebraska’s Director of Insurance, a chance to review the financial stability of the holding company so that he can determine whether the group’s health as a whole is in the best interests of the policyholders.

Similarly, under *CenTra* the commissioner’s powers would pass the second prong, relating to the insurer-insured relationship, because the individual policyholder is not in a position to understand the ramifications of multi-jurisdictional supervision, and would not become aware of the risks until the insurer becomes insolvent and unable to pay claims.

Finally, the court in *CenTra* would most likely opine, despite the commissioner’s power to reach outside of his jurisdiction, and, furthermore, to reach outside of the insurance industry per se by examining non-insurance affiliates, that the commissioner’s actions were still ultimately for the benefit of the insurance industry.

This expansive reasoning is easily extended to a state’s participation in supervisory colleges. Supervisory colleges are also provided for under the Amendments to the IHCA, and, under *CenTra*, a court would likely find that the activity fell within the ‘business of insurance,’ because the colleges are ultimately meant to benefit policyholders. Currently, the NAIC has put forth, “existing U.S. case law, [the] interests of other countries, and the renewed vigor that regulators enjoy . . . as a result of the 2008 crisis,” as reasons why the new IHCA Amendments should still be upheld under the McCarran-Ferguson Act.¹⁶¹ Justice Brennan once wrote that “[t]he prevention of insolvency and the maintenance of ‘sound’ financial condition in terms of fixed-dollar obligations is precisely what traditional state regulation [of insurance] is aimed at.”¹⁶² However, should no opposition arise to supervisory colleges’ validity under the McCarran-Ferguson Act’s definition of the ‘business of insurance,’ this concern would be entirely moot.

C. ARGUMENT AGAINST THE ADOPTED REVISIONS TO THE AMENDED MODEL ACT BEING WITHIN THE ‘BUSINESS OF

¹⁶¹ Rabinowitz, *supra* note 15.

¹⁶² *CenTra, Inc.*, 540 N.W.2d at 331 (quoting *SEC v. Variable Annuity Co.*, 359 U.S. 65, 90-91 (1959) (concurring opinion)).

INSURANCE' AS DEFINED BY THE MCCARRAN-FERGUSON
ACT

Conversely, an alternative argument can be made for why the IHCA Amendments, particularly the state commissioner powers, and state's participation in supervisory colleges, do *not* fall within the accepted definition of the 'business of insurance.' Where the *CenTra* court took a very macro approach to the *Royal Drug* test, a more micro examination of the recent changes could be considered outside the accepted 'business of insurance' and more inside the business of insurance companies.

Challenges to the commissioner's cross-jurisdictional reach and participation in supervisory colleges, would likely be brought by a variety of interested parties. These opponents to the revisions have two potential grievances under which they may wish to challenge the Amended Model Act: one, the state commissioner's ability to demand insurance holding company systems and insurance affiliate information; and two, the authority for a state's participation in supervisory colleges.

The first group encompasses those opponents that are most unsettled by the ability of a state insurance commissioner to request sensitive information from whomever they deem relevant. An insurance holding company system's affiliates are wide ranging—some may be less willing than others to relinquish confidential information all in the name of international coordination. Affiliates that shelter information from their own regulators will be vehemently opposed to sharing such information with a state insurance commissioner.

The second group includes potential supervisory college members who may choose not to participate because they have certain risks they do *not* want to surface. The extensive information sharing environment a supervisory college fosters will create an ideal opportunity to unveil hidden perils. For some, this exposure may be exactly what they wish to evade. A successful challenge to the validity of supervisory colleges under the McCarran-Ferguson Act could result in the assurance that, at least while insurance remains under state regulation, information sharing across jurisdictional borders will be avoided.

It was previously discussed that supervisory colleges run the risk of fostering adverse relationships amongst regulators in response to members of the community that do not "go with the flow," so to speak. With the potential for these adverse relationships to escalate into adverse actions, may come feelings of ill will towards what was supposed to be a

harmonious solution to international coordination and supervision.¹⁶³ Shunned members pose a risk to the success of supervisory colleges as a whole if the injured parties decide their unfavorable experience with a college is indicative of its unruly powers. Ostracized regulators could challenge the validity of the Amendments under the McCarran Ferguson Act to ensure the supervisory college's failure. In this case, a regulator, whether domestic or otherwise, may not even be opposed to the state insurance commissioner's expansive powers; rather, he would be using the commissioner's cross-jurisdictional reach as an additional argument for the colleges' violative nature.

In *Pireno*, the court determined that the use of a state peer review committee to share information and make evaluations of its members was outside the business of insurance as defined by the McCarran-Ferguson Act.¹⁶⁴ The peer review board did not satisfy the first two prongs of the *Royal Drug* test because it did not spread policyholder risk, nor was it part of the insurer/insured relationship.¹⁶⁵ It is not a stretch to equate a supervisory college to a peer review board as a basis for a challenge against their validity. In *Pireno*, the committee worked together to determine whether a fellow chiropractor's treatments were unnecessary, or his rates unreasonable. In a supervisory college, members work together to determine whether a particular insurer, holding company system, or enterprise pose risks to global insurance stability. Both groups have the goal of a safer environment for their practice to thrive, and both groups share sensitive information to achieve that goal.

Additionally, a state's participation in a supervisory college, or a state commissioner's authority to access insurer affiliates, are both activities not wholly limited to entities within the insurance industry. A supervisory college involves regulators from a spectrum of sectors, and an insurer affiliate could literally be any entity affiliated with the operations of an insurance company. As such, it would not be a hard argument to make that the revisions in question to the Amended Model Act fail the third prong of the *Royal Drug* test as well.

¹⁶³ It should be noted that the Basel Committee's guidance paper on supervisory colleges recommends that "any confidential information [exchanged between] supervisor[s] should be used exclusively for lawful supervisory purposes." Basel Comm. on Banking Supervision, *supra* note 66, at 22.

¹⁶⁴ *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 134 (1982).

¹⁶⁵ *Id.* at 129-31.

X. CONCLUSION: SUPERVISORY COLLEGES WILL HELP FACILITATE INTERNATIONAL REGULATORY SUCCESS IN THE INSURANCE INDUSTRY

Supervisory Colleges are a way to enhance state based insurance regulation in an increasingly international environment. Where the concept of insurance companies as a completely independent entity is now more a legal fiction than reality, the success of supervisory colleges would help to appease those claims that a federal regulatory system is more adept to handle a global industry than the current state based system. States have expressed that they are willing to implement the necessary regulatory revisions to ensure that the positive track record of state-based insurance regulation continues to evolve with the changing times.¹⁶⁶ State commissioners view themselves not only as policemen of individual insurance companies, but also as stewards of highly interconnected financial systems.

The Amendments to the IHCA are only effective if adopted by individual state legislatures; however, the NAIC is moving to incorporate the changes into the required state accreditation standards, increasing the likeliness of states to comply. Even without the threat of losing its accreditation, already some states are beginning to adopt the recent revisions. West Virginia was first to make the changes to its own regulations in April of 2011, followed by Texas in June.¹⁶⁷ States like Connecticut haven't officially adopted the Amended Model Act as part of their insurance laws, but the state insurance commissioner is mimicking many of the changes the Model Act suggests on their own.

Those opposed to the Amended Model Act should move forward with caution. With the determination that the Model Act's revisions step outside state jurisdiction comes a corresponding argument that such powers should reside with the Federal government. Proponents for Federal insurance regulation could argue that the invalidity of state supervisory control in the international regulatory sector is indicative of the need for a more centralized approach to regulation—a more Federal approach. Banning state participation in supervisory colleges, and limiting a state

¹⁶⁶ Statement of Susan E. Voss, *supra* note 1, at 7-8.

¹⁶⁷ Van R. Mayhall, III, *Form F and Enterprise Risk: NAIC Expands Regulatory Authority under the Model Insurance Holding Company System Regulatory Act*, BREAZEALE, SACHSE & WILSON, LLP (July 20, 2011), <http://www.insuranceregulatorylaw.com/2011/07/form-f-and-enterprise-risk-naic-expands.html>.

insurance commissioner's access to information, may prove to be a temporary dam that subsequently opens a floodgate of Federal regulatory power.

The creation of the FIO should be viewed as the first step in this direction. Even the FIO's description of the Office's function is alarmingly similar to what supervisory colleges set out to achieve. The FIO has the authority "to monitor *all aspects of the insurance industry*, including identifying issues or gaps in the regulation of insurers that could contribute to a systemic crisis in the insurance industry or the United States financial system."¹⁶⁸ Whereas states are limited to the McCarran-Ferguson Act's definition of the "business of insurance," the Dodd-Frank Act expands the federal government's reach to "all aspects of the insurance industry." Furthermore, the power for the Federal government to enter into a covered agreement with respect to the "business of insurance" with foreign parties should draw attention. Covered agreements touch three important points: one, the federal government; two, international parties; and three, the business of insurance. Alternatively, supervisory colleges touch nearly the same three points: one, state insurance regulators; two, international parties; and three, the business of insurance. A centralized regime could require international information sharing where no entity or enterprise would escape its reach.

Supervisory colleges are a step in the right direction for international regulatory success, and the provisions of the Amended Model Act that expand the state commissioner's power will help to facilitate success in a college forum. If not the state insurance commissioner, then it will be another regulatory body that will have access to affiliate information in order to best examine enterprise risk. States should move forward with their commissioner's participation, and opponents should mind that the alternative to colleges and extended commissioner power may prove to be even more evasive than option at hand.

¹⁶⁸ Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, tit. V, § 313(c)(1)(A), 124 Stat. 1376, 1580 (2010) (emphasis added).

**THE EVOLUTION OF THE ADVERTISING INJURY
EXCLUSION IN THE INSURANCE SERVICE OFFICE, INC.’S
COMPREHENSIVE GENERAL LIABILITY INSURANCE
POLICY FORMS**

KYLE LAMBRECHT

This article examines the issue of whether Comprehensive General Liability (CGL) insurance policy forms provide coverage for third party patent infringement claims under the forms’ “advertising injury” provision. The paper traces the evolution of these Comprehensive General Liability forms, from the 1973 CGL standard forms through the 1986 forms and even up to the most recent set of revisions as reflected in the 1998 and 2001 CGL broad form versions. The article then discusses three leading cases on the issue, all of which stand for the proposition that insurers have a duty to defend policyholders against third party patent infringement claims when the insured was alleged to have infringed an advertising technique that was itself patented. In the aftermath of these decisions, however, changes were made to the CGL policy forms which are likely to benefit the insurer seeking to avoid coverage and further the trend towards increasingly limited policyholder coverage for third party patent infringement.

I. INTRODUCTION

Internet commerce is growing at an exponential rate. It is estimated that global usage doubles every one hundred days and increases between 200-600% annually.¹ The drastic increase in internet commerce is directly attributable to the availability and affordability of personal computers and handheld devices equipped with internet connectivity.² As a result of this increase in global usage, some insurance carriers have

¹ See Robert P. Norman, *Virtual Insurance: Is Your Old Policy from InvisibleINC.com? If so, what Cyber Policy Adequately Covers Your Risks?*, 673 PLI/LIT 557, 565 (2002).

² See, e.g., *id.*

suggested that internet commerce will be the “single biggest insurance risk of the twenty-first century.”³

Internet advertising is a relatively inexpensive and efficient means of marketing to a broad audience situated throughout the world. Insurance policyholders engaged in internet business and advertising have seen an increase in intellectual property liability claims, including but not limited to, third party patent infringement claims based on the content and design of company websites. This paper first discusses the evolution of the Insurance Service Office, Inc.’s (“ISO”) standard Comprehensive General Liability (“CGL”) insurance policy forms and then focuses on an insurer’s duty to defend against third party patent infringement claims under the “advertising injury” provision in these forms. Subsequently, this paper will analyze the reasoning espoused by three separate courts holding that the advertising injury provision of a standard CGL insurance policy creates a duty for insurers to defend against third party patent infringement claims, in situations where the advertising technique itself was patented by the third party claimant.

II. ADVERTISING INJURY COVERAGE IN ISO COMMERCIAL OR COMPREHENSIVE GENERAL LIABILITY POLICY FORMS

The ISO is a subsidiary of Verisk Analytics Incorporated and it drafts standardized insurance policy forms that are utilized by over 1,400 member companies operating in every state.⁴ Most of the member insurance companies “adopt ISO forms verbatim while ... other[s] use [general] ISO forms as a starting point for their own modified forms.”⁵ Although the forms used by member companies to service policyholders are substantially similar, standard ISO CGL insurance forms have historically provided varying degrees of coverage for policyholders within the purview of the advertising injury provision.

³ See *id.* at 565 (quoting UDAY KHANDEPARKAR, *Indian Security Firm Expects “Love Bug” Boost*, REUTERS ENG. NEWS SERV. (May 9, 2000); J. OF COM., VIRUS UNDERSCORES RISKS IN E-COMMERCE (May 18, 2000), available at WestLaw 2000 WLNR989539.

⁴ INSURANCE SERVICE OFFICE, INC., <http://www.iso.com> (last visited Oct. 2, 2012).

⁵ Jerold Oshinsky & Damon A. Thayer, *A Primer on Coverage for Infringement Suits*, LAW360.COM, (Feb. 22, 2011, 1:56 PM) <http://www.law360.com/articles/225699/a-primer-on-coverage-for-infringement-suits>.

Generally, an advertising injury is understood to be any injury to a third party brought about through the advertisement of a business' goods and services. Presently, ISO CGL insurance forms indemnify the policyholder from liability to third parties for bodily injury, personal injury, *advertising injury* and property damage under two primary policy provisions: (i) "Coverage A Bodily Injury and Property Damage Liability, and (ii) Coverage B Personal and Advertising Liability."⁶ The ISO CGL insurance forms have been modified extensively since 1973, and the current advertising injury provisions differ greatly from those forty years ago. However, despite these extensive changes, many CGL insurance policies used today still contain the language of older ISO CGL endorsements.

A. THE 1973 ISO BROAD FORM CGL ENDORSEMENT REVISIONS

Prior to 1973, ISO CGL insurance forms did not include coverage for advertising injury and only a few insurers offered advertising coverage as an additional endorsement to their standard CGL policies.⁷ In 1973, the ISO radically altered its standard forms by making "advertising injury" and "personal injury" coverage available through the purchase of a Broad Form CGL endorsement or a Personal Injury Liability endorsement ("PIL").⁸ This was the first time the ISO specifically adopted an advertising injury coverage provision into its Broad Form CGL endorsement.⁹

⁶ See Dawn Dinkins, *Internet Liabilities: A Look at Coverage Under the Traditional Commercial General Liability Policy*, 16 NO. 6 ANDREWS CORP. OFFICERS & DIRECTORS LIABILITY LITIG. REP., Jan. 2, 2001, at 2-; INS. SERVS. OFF., INC., COM. GENERAL LIABILITY COVERAGE FORM CG 00 01 10 01 (2000).

⁷ See Lawrence O. Monin, *ISO Advertising and Personal Injury Revisions: Major Surgery of Just a Band-Aid Fix?*, 4-16 MEALEY'S EMERGING INS. DISPS. 6 (1999).

⁸ The PIL endorsement covered only personal injury, while the 1973 CGL Broad Form combined coverage for personal injury and liability arising out of advertising. See JAMES L. HAIGH & SARAH L. SHOWALTER, HISTORICAL ANALYSIS OF THE CHANGES TO COVERAGE B, *reprinted in* COUSINEAU LAW FORUM SERIES, http://cousineaulaw.com/forum/historical_analysis_of_the_changes_to_coverage_b (last accessed Oct. 2, 2012). As such, this article will not explore the revisions of the PIL endorsement.

⁹ See Bruce Telles, *Insurance Coverage for Intellectual Property Torts*, 602 PLI/LIT 629, 645 (1999); Robert H. Jerry, II & Michele L. Mekel, *Cybercoverage for Cyber-Risks: An Overview of Insurers' Responses to the Perils of E-Commerce*, 8 CONN. INS. L.J. 7, 17 (2001).

The 1973 Broad Form CGL endorsement provided policyholders with coverage for “all sums which the insured [became] legally obligated to pay as damages because of . . . advertising injury to which the insurance applie[d] . . . arising out of the conduct of the named insured’s business . . . and the [insurance] company shall have the right and duty to defend. . . .”¹⁰ Advertising injury was defined as any “[i]njury arising out of an offense committed during the policy period occurring in the course of the named insured’s advertising activities, if such injury ar[ose] out of libel, slander, defamation, violation of right of privacy, piracy, unfair competition, or infringement of copyright, title or slogan.”¹¹

Claims for “advertising injury arising out of . . . infringement of trademark, service mark or trade name, other than titles or slogans, by use thereof on or in connection with goods, products, or services sold, offered for sale, or advertised” were typically excluded from coverage for policyholders in the 1973 Broad Form CGL endorsement.¹² In addition to these exclusions, coverage was not provided for any claims: (i) “[a]rising out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity,” (ii) “[a]rising out of oral or written publication of material whose first publication took place before the beginning of the policy,” and (iii) “[a]rising out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured,” or (iv) “[f]or which the insured ha[d] assumed liability in a contract or agreement.”¹³ The advertising injury provision also did not apply to liabilities arising from damages that the policyholder incurred in the absence of the contract or agreement.

Similar to most other occasions when the ISO implemented detailed changes to an endorsement, certain coverage issues surrounding the 1973 Broad Form CGL endorsement were highly litigated. Most of the litigation relating to third party patent infringement claims focused on the ISO’s failure to define the term “advertising,” in the relevant policy language. When faced with multiple propositions for the appropriate definition of the term “advertising,” courts repeatedly construed the term in favor of the carrier, and in most cases, the policyholder failed to persuade

¹⁰ Richard Bale & Patrick J. Boley, *Advertising Injury Coverage* 1-2 (2007), available at <http://www.larsonking.com/ArticleUploads/Advertising%20Injury%20Coverage.pdf>.

¹¹ *Id.* (quoting *Lebas Fashion Imps. of USA, Inc. v. ITT Hartford Ins. Grp.*, 59 Cal. Rptr. 2d 36, 41 (Cal. Ct. App. 1996)).

¹² HAIGH & SHOWALTER, *supra* note 8.

¹³ *Id.*

the court that the insurer had a duty to defend against third party patent infringement and other intellectual property claims under the advertising injury provision in their CGL policy.¹⁴

B. THE 1986 ISO BROAD FORM CGL ENDORSEMENT REVISIONS

In 1986, the ISO made several major revisions to the 1973 Broad Form CGL endorsement which subsequently enabled courts to find that an insurer had a duty to defend against third party patent infringement claims under the “advertising injury” provision.¹⁵ In an attempt to clarify and expand the coverage provided in the 1973 Broad Form CGL endorsement, the ISO introduced “Coverage B.”¹⁶ “Coverage B” combined the “advertising injury” and “personal injury” provisions of the 1973 Broad Form CGL endorsement into one section and made changes to several of the enumerated offenses covered under the endorsement.¹⁷ Following these revisions to the 1986 Broad Form CGL endorsement, policyholders automatically received coverage for both types of injuries and no longer needed to purchase separate ISO CGL endorsements for “advertising injury” and “personal injury” coverage.¹⁸

Similar to the 1973 Broad Form CGL endorsement, the ISO again failed to define the term “advertising.” However, the ISO attempted to eliminate some of the previous uncertainty by enumerating several offenses to which advertising injury would apply. The ISO 1986 Broad Form CGL endorsement stated that the “advertising injury” provision would provide coverage for any injury, committed during the coverage period, arising out of one of more of the following offenses: (i) “[o]ral or written publication of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services,” (ii) “[o]ral or written publication of material that violates a person’s right of privacy,” (iii) “[m]isappropriation of advertising ideas or style of doing business,” or (iv) “[i]nfringement of copyright, title or slogan.”¹⁹ In an attempt to further

¹⁴ *But see, e.g.,* Playboy Enters., Inc. v. St. Paul Fire & Marine Ins. Co., 769 F.2d 425 (7th Cir. 1985); CNA Cas. of Cal. v. Seaboard Surety Co., 222 Cal. Rptr. 276 (Cal. Ct. App. 1986).

¹⁵ See discussion *infra* Part III.

¹⁶ See Telles, *supra* note 9, at 646; Monin, *supra* note 7, at 2-6.

¹⁷ See Telles, *supra* note 9, at 646; Monin, *supra* note 7, at 2-6.

¹⁸ See Telles, *supra* note 9, at 646; Monin, *supra* note 7, at 2-6.

¹⁹ Policy form CG 00 01 11 85 (copyrighted in 1982 and 1984 by the ISO) (public promulgation and adoption of the states did not occur until the mid-1980s); see HAIGH & SHOWALTER, *supra* note 8, at n.5.

clarify issues that had plagued 1973 Broad Form CGL endorsement, the ISO inserted the same set of advertising injury exclusions, as well as defined a new set of exclusions.²⁰ The new exclusions applied to any of the following claims: (i) a “[b]reach of contract, other than misappropriation of advertising ideas under an implied contract, (ii) “[t]he failure of goods, products, or services to conform with advertised quality or performance,” (iii) “[t]he wrong description of the price of the goods, products or services,” and (iv) any “[o]ffense committed by an insured whose business is advertising, broadcasting, publishing or telecasting.”²¹

The 1986 Broad Form CGL endorsement differed from its 1973 predecessor in that it no longer provided coverage for “piracy” nor the specific exclusion for “infringement of trademark, service mark or trade name other than titles or slogans.”²² Additionally, the ISO provided coverage for “misappropriation of advertising ideas and style of doing business” which replaces the 1973 endorsement’s “unfair competition” coverage. Despite these changes to the 1986 Broad Form CGL endorsement, the ISO described the revisions as “non-substantive clarifications of prior coverage.”²³ However, policyholders had greater success in obtaining coverage under the new revisions, despite the ISO’s characterization of the changes.²⁴ This paper focuses on the 1986 Broad Form CGL endorsement language, “misappropriation of advertising ideas and style of doing business,” specifically, when the provision creates a duty for insurers to defend against third party patent infringement claims.

²⁰ Policy form CG 00 01 11 85 (copyrighted in 1982 and 1984 by the ISO) (public promulgation and adoption of the states did not occur until the mid-1980s); *see* HAIGH & SHOWALTER, *supra* note 8, at n.5.

²¹ Policy form CG 00 01 11 85 (copyrighted in 1982 and 1984 by the ISO) (public promulgation and adoption of the states did not occur until the mid-1980s); *see* HAIGH & SHOWALTER, *supra* note 8, at n.5.

²² Telles, *supra* note 9, at 652.

²³ Jerry, II & Mekel, *supra* note 9, at 18 (discussing the success of policyholders in obtaining coverage for trademark infringement under the “misappropriation of advertising ideas or style of doing business” provision, despite the deletion of the term “trademark”).

²⁴ *See* ROBERT D. CHESLER & CINDY TZVI SONENBLICK, INSURANCE COVERAGE FOR INTELLECTUAL PROPERTY INFRINGEMENT (Bloomberg Finance L.P. Law Reports, 2008).

III. DUTY TO DEFEND AGAINST THIRD PARTY PATENT INFRINGEMENT CLAIMS UNDER THE “MISAPPROPRIATION OF ADVERTISING IDEAS AND STYLE OF DOING BUSINESS” PROVISION IN COMPREHENSIVE GENERAL LIABILITY INSURANCE POLICIES

In the United States, a patent is a property right which grants the owner the power to exclude others from making, using, selling and offering to sell a new, non-obvious, useful invention in the United States for up to twenty years.²⁵ Prior to 1994, it was well settled that patent infringement was not covered under the advertising injury provisions.²⁶ In reaching this conclusion, courts looked to the language of the patent statute which prohibited “making, using or selling” a product which infringed on a patent.²⁷ Based on this language, a majority of courts unequivocally rejected coverage for claims involving patent infringement under the advertising injury provisions of CGL policies.²⁸

In order to comply with the requirements of the General Agreement on Tariffs and Trade Treaty, Congress amended the Patent Act

²⁵ See James R. Warnot, Jr. & Daniel C. Glazer, *Insurance Coverage for Intellectual Property and Cyberspace Liability*, 652 PLI/LIT 407, 409 (2001).

²⁶ See, e.g., *U.S. Fid. & Guar. Co. v. Frosty Bites, Inc.*, 232 F. Supp. 2d 101, 103 (S.D.N.Y. 2002); *BATES, CAREY & NICOLAIDES, LLP., PATENT CLAIMS NOT COVERED AS ADVERTISING INJURY* (2004), available at http://www.bcnlaw.com/newsandarticles/newsletter1_patentclaims.asp (noting that “[t]he Mississippi Supreme Court recently joined the majority of courts in ruling that claims involving patent infringement are not covered under the advertising injury section of a commercial general liability policy.”); *Heritage Mut. Ins. Co. v. Advanced Polymer Tech., Inc.*, 97 F. Supp. 2d 913, 930 n.10 (S.D. Ind. 2000) (stating that patent infringement cannot be misappropriation of style of doing business); *Auto Sox USA Inc. v. Zurich N. Am.*, 88 P.3d 1008, 1011 n.1 (2004) (noting that “the majority of cases hold that patent infringement is not covered by the misappropriation of an advertising idea in an insurance policy”); LINDA A. GALELLA, *LIMITATIONS ON ADVERTISING INJURY COVERAGE CLAIMS* (2000), available at <http://www.capehart.com/Legal-Alerts-Table-of-Contents/Limitations-on-Advertising-Injury-Coverage-Claims.shtml> (concluding that “New Jersey courts do not find coverage for patent infringement under the advertising injury provisions of CGL policies”).

²⁷ See *Auto Sox*, 88 P.3d at 1011; GALELLA, *supra* note 26.

²⁸ See *Auto Sox*, 88 P.3d at 1012; *Frosty Bites*, 232 F. Supp. 2d at 106; *Heritage*, 97 F. Supp. 2d at 930 n.10.

in 1994.²⁹ One of the amendments to the Patent Act was the inclusion of “offers to sell,” as a type of conduct that constituted a direct patent infringement.³⁰ With the changes to the definitions in the patent statute, particularly, the inclusion of “offers to sell,” most courts have since concluded that advertising *can* give rise to a direct patent infringement.³¹ Despite the generally accepted view that advertising can give rise to a direct patent infringement, some courts unequivocally reject insurance coverage for third party patent infringement claims under the advertising injury provisions of a CGL policy.³² However, a few courts have been willing to extend coverage against third party patent infringement claims when a policy contains language similar to that of the ISO 1986 Broad Form CGL endorsement.³³

Generally, misappropriation of a patented advertising idea must occur in the “elements *of the advertising itself* – in its text[,] form, logo, or pictures – rather than in the product being advertised.”³⁴ In determining whether a third party patent infringement claim is covered under the advertising injury provisions of a CGL policy, courts examine several different factors. To establish coverage, a policyholder must generally prove three elements; (i) that the alleged conduct potentially falls within the scope of the policy’s enumerated advertising injury provisions, (ii) that there is a causal nexus between the policyholder’s advertising activities and the alleged offense, in order to satisfy a typical policy’s requirement that the infringement “occur in the course of the insured’s advertising activities,” and (iii) that the conduct constitutes “advertising activity”

²⁹ See, e.g., 35 U.S.C. § 271(a) (and accompanying Historical and Statutory Notes re 1994 Amendments and Effective Date of 1994 Amendments).

³⁰ See *id.*

³¹ See, e.g., *HollyAnne Corp. v. TFT, Inc.*, 199 F.3d 1304, 1309 n.6 (Fed. Cir. 1999) (advertisements may be “offers to sell” and, thus, give rise to direct patent infringement claim); *Homedics Inc. v. Valley Forge Ins. Co.*, 315 F.3d 1135, 1138 (9th Cir. 2003); *Maxconn Inc. v. Truck Ins. Exch.*, 88 Cal. Rptr. 2d 750 (Cal. Ct. App. 1999) (“[T]he amendment of the [patent] statute has nullified the argument that patent infringement could not arise out of the insured’s advertising activities as a matter of law.”).

³² See *Homedics*, 315 F.3d at 1137.

³³ See e.g., *Amazon.com Int’l, Inc. v. Am. Dynasty Surplus Lines Ins. Co.*, 85 P.3d 974 (Wash. App. Div. 1 2004); *DISH Network Corp. v. Arch Specialty Ins. Co.*, 659 F.3d 1010, 1028 (10th Cir. 2011); *Hyundai Motor Corp. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 600 F.3d 1092 (9th Cir. 2010).

³⁴ See *Iolab Corp. v. Seaboard Sur. Co.*, 15 F.3d 1500, 1506 (9th Cir. 1994).

within the meaning of the policy. Decisions finding no duty to defend typically involve either:

- (i) direct infringement from the manufacture or sale of a patented subject matter that lacks the necessary causal relationship between an insured's advertising activities and the infringement;³⁵
- (ii) induced infringement that lacks the necessary causal relationship between the insured's advertising activities and the infringement;³⁶
- (iii) overly technical readings of the scope of a policy's advertising injury coverage for undefined offenses;³⁷ or
- (iv) spurious statements of public policy that reflect a courts misunderstanding of the scienter requirement for induced patent infringement.³⁸

The majority of courts which unequivocally reject coverage under the advertising injury provisions of a CGL policy typically find that an insurer does not have duty to defend against a third party patent infringement claim because there is no causal connection between the policyholder's advertising and the alleged offense.³⁹ Specifically, the courts find that the alleged patent infringement did not occur in the course of advertising.⁴⁰

³⁵ See David A. Gauntlett, *Patents and Insurance: Who Will Pay for Reimbursement*, 4 B.U. J. SCI. & TECH. L. 200, 203 (1998); *Iolab Corp.*, 15 F.3d at 1506-07; *Davila v. Arlasky*, 857 F. Supp. 1258, 1262-63 (N.D. Ill. 1994); *Atlantic Mut. Ins. Co. v. Brotech Corp.*, 857 F. Supp. 423, 429-30 (E.D. Pa. 1994); *Polaris Indus., L.P. v. Continental Ins. Co.*, 539 N.W.2d 619, 622 (Minn. Ct. App. 1995).

³⁶ See Gauntlett, *supra* note 35, at 203; *Gencor Indus., Inc. v. Wausau Underwriters Ins. Co.*, 857 F. Supp. 1560, 1565 (M.D. Fla. 1994); *N.H. Ins. Co. v. R.L. Chaides Constr. Co.*, 847 F. Supp. 1452, 1458-59 (N.D. Cal. 1994); *Gitano Group, Inc. v. Kemper Group*, 31 Cal. Rptr. 2d 271, 274 (Cal. Ct. App. 1994).

³⁷ See Gauntlett, *supra* note 35, at 203; *Iolab Corp.*, 15 F.3d at 1506; *I.C.D. Indus., Inc. v. Federal Ins. Co.*, 879 F. Supp. 480, 485-86 (E.D. Pa. 1995); *Gencor Indus., Inc.*, 857 F. Supp. at 1565-66; *Classic Corp. v. Charter Oak Fire Ins. Co.*, 35 U.S.P.Q.2d 1726, 1728 (C.D. Cal. 1995).

³⁸ See Gauntlett, *supra* note 35, at 203; *Intex Plastics Sales Co. v. United Nat'l Ins. Co.*, 23 F.3d 254, 257 (9th Cir. 1994); *Aetna Cas. & Sur. Co. v. Superior Court*, 23 Cal. Rptr. 2d 442, 447-48 (Cal. Ct. App. 1994); see also David A. Gauntlett, *Changing Winds: Recent Decisions Favor Policyholders in Intellectual Property Coverage Claims*, 1, 20 COVERAGE, (May-June 1995).

³⁹ Brian W. Klemm, *Insurance Coverage for Intellectual Property Claims: A Changing Landscape*, 563 PLI/LIT 421, 424 (1997) ("When considering whether a claimed injury is a covered offense, courts have been asked to interpret the

Three situations currently support an insurer's duty to defend and indemnify a policyholder against third party claims of patent infringement under the advertising injury provisions of a CGL policy; (i) when "a manufacturer advertises [a] component, which is used in a product patented by another party [and] the advertising induces a third party to combine the component with other element, the combination of which produces the product covered by the patent and infringes the patent claims";⁴¹ (ii) when "a product manufactured using a protected process is advertised in such a way that, although the advertisement itself does not constitute infringement, the advertisement induces others to use the process to create the product";⁴² and (iii) when "a manufacturer demonstrates the viability of its non-infringing process by using advertising that infringes another process."⁴³ In each of the cases discussed subsequently, the courts addressed a different situation and found that an insurer had a duty to defend a policyholder against third party patent infringement claims under the advertising injury provision of their CGL policy.⁴⁴ The courts analyzed the "misappropriation of advertising or style of doing business" language in three different CGL policies, each of which contained language mirroring the "advertising injury" provisions of the ISO's 1986 Broad Form CGL endorsement.⁴⁵ Reaching the same conclusion, the courts found that a duty

meanings of the terms piracy, unfair competition, and infringement of copyright, title, or slogan under the 1976 [ISO] form policy and policy, because typical CGL policies provide no definition of these terms.")

⁴⁰ Brian W. Klemm, *Insurance Coverage for Intellectual Property Claims: A Changing Landscape*, 563 PLI/LIT 421, 424 (1997) ("When considering whether a claimed injury is a covered offense, courts have been asked to interpret the meanings of the terms piracy, unfair competition, and infringement of copyright, title, or slogan under the 1976 [ISO] form policy and policy, because typical CGL policies provide no definition of these terms.")

⁴¹ See Gauntlett, *supra* note 35, at 204; *Union Ins. Co. v. Land & Sky, Inc.*, 529 N.W.2d 773, 774-75 (Neb. 1995)

⁴² See Gauntlett, *supra* note 35, at 204; *Norton Alcoa Proppants v. American Motorists Ins. Co.*, No. C-4012-91-A (N.D. Tex. Jan. 5, 1993); *Hyundai*, 600 F.3d at 1103 n.4 ("There may be situations in which an advertisement induces another to infringe a patent.")

⁴³ See Gauntlett, *supra* note 35, at 204; *Omnitel v. Chubb Group of Ins. Cos.*, 26 U.S.P.Q.2d 1933, 1937-38 (Cal. Super. Ct. 1993).

⁴⁴ See, e.g., *Amazon.com*, 85 P.3d 974; *DISH Network*, 659 F.3d 1010; *Hyundai*, 600 F.3d 1092.

⁴⁵ See *id.*

to defend existed when the insured was alleged to have infringed an advertising technique that itself was patented.⁴⁶

A. AMAZON.COM INTERNATIONAL, INC. V. AMERICAN DYNASTY SURPLUS LINES INSURANCE COMPANY

The first case to find that an insurer had a duty to defend a policyholder against a third party patent infringement claim was *Amazon.com International, Inc. v. American Dynasty Surplus Lines Insurance Company*. Applying Washington state law, the Court of Appeals of Washington reversed a decision by the Superior Court of King County granting summary judgment in favor of the insurers.⁴⁷ In the underlying action, Intouch, a software manufacturer alleged that Amazon had infringed upon its patents for “interactive music preview technology, which enabled customers to listen to samples of music products at kiosks and over the internet.”⁴⁸ Specifically, Amazon used Intouch technology to permit its customers to preview music products available for sale on Amazon’s corporate website.⁴⁹

Amazon tendered a defense to its insurers under both its primary insurance and excess carrier policies.⁵⁰ Each policy promised to defend and indemnify Amazon against third party claims alleging “advertising injury,” among other things.⁵¹ One of the enumerated offenses under the “advertising injury” provision mirrored that of the ISO’s 1986 Broad Form CGL endorsement and provided coverage for the “misappropriation of advertising ideas or style of doing business.”⁵² The court stated that “misappropriation of advertising ideas or style of doing business” could be satisfied by: (i) the “wrongful taking of another’s manner of advertising,”⁵³ (ii) the “wrongful taking of an idea concerning the solicitation of business

⁴⁶ *See id.*

⁴⁷ *See Amazon.com*, 85 P.3d at 978.

⁴⁸ *See id.* at 975.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.* at 976 (internal quotation marks omitted) (citing *Am. States Ins. Co. v. Vortherms*, 5 S.W.3d 538, 543 (Mo. Ct. App. 1999); *Fluoroware, Inc. v. Chubb Grp. of Ins. Cos.*, 545 N.W.2d 678, 682 (Minn. Ct. App. 1996)).

and customers,”⁵⁴ or (iii) the “wrongful taking of the manner by which another advertises its goods or services.”⁵⁵ The court determined that “patent infringement may constitute an advertising injury *where an entity uses an advertising technique that is itself patented.*”⁵⁶ The court’s conclusions and rationale set precedent for subsequent courts to find a duty to defend against third party patent infringement claims, when the language of the advertising injury provisions in a CGL policy mirrors that of the ISO 1986 Broad Form endorsement.⁵⁷

After concluding that patent infringement *could* constitute an advertising injury, the court determined that the injury to Intouch occurred in the course of advertising goods for sale.⁵⁸ In the absence of a specific definition of the term “advertising,” the court noted that advertising typically refers to “any oral, written, or graphic statement made by the seller in any manner in connection with the solicitation of business, ... [or the] widespread distribution of promotional material to the public at large.”⁵⁹ Finally, the court concluded that a causal connection existed between the advertising injury and the policyholder’s advertising activities, stating that “an injury that could have occurred independent and irrespective of any advertising is not an advertising injury.”⁶⁰ In most cases, the requisite causal relationship does not exist because the claim against the policyholder is based on the sale of an infringing product, not an advertisement.⁶¹ Courts reject these claims because an advertising injury does not occur “where the injury is caused by the subsequent

⁵⁴ *Amazon.com*, 85 P.3d at 976 (internal quotations omitted) (citing *Green Mach. Corp. v. Zurich-American Ins. Grp.*, 313 F.3d 837, 839 (3d Cir. 2002)); *Frog, Switch & Mfg. Co., v. Travelers Ins. Co.*, 193 F.3d 742, 748 (3d Cir. 1999).

⁵⁵ *Amazon.com*, 85 P.3d at 976-77 (internal quotation marks omitted) (citing *Applied Bolting Tech. Prod., Inc. v. United States Fidelity & Guaranty Co.*, 942 F. Supp. 1029, 1034 (E.D.Pa. 1996)).

⁵⁶ *Id.* at 977 (internal quotation marks omitted) (citing *Iolab Corp. v. Seaboard Sur. Co.*, 15 F.3d 1500, 1507 n.5 (9th Cir. 1994) (citing *Bank of the West v. Superior Court*, 833 P.2d 545, 559 (Cal. 1992)) (emphasis added); *State Auto Prop. & Cas. Ins. Co. v. Travelers Indem. Co. of Am.*, 343 F.3d 249, 258, 258 n.12 (4th Cir. 2003).

⁵⁷ *See* *DISH Network Corp. v. Arch Specialty Ins. Co.*, 659 F.3d 1010, 1018 (10th Cir. 2011); *Hyundai Motor Am. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 600 F.3d 1092, 1101-02 (9th Cir. 2010).

⁵⁸ *See Amazon.com*, 85 P.3d at 977 (citing *Vortherms*, 5 S.W.3d at 544).

⁵⁹ *Id.* (internal quotation marks omitted).

⁶⁰ *See id.* (citing *Simply Fresh Fruit, Inc. v. Continental Ins. Co.*, 94 F.3d 1219, 1222-23 (9th Cir. 1996)).

⁶¹ *See also Amazon.com*, 85 P.3d at 977 n.20.

advertising of an already infringing product.”⁶² As such, the injury derived from the use of the software code as the means to market goods for sale satisfied the causation requirement. In reaching this conclusion, the court noted that it is irrelevant whether the customer or policyholder has actual knowledge of the infringement.⁶³

B. HYUNDAI MOTOR AMERICA V. NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA

The first federal court case finding that an insurer had a duty to defend a policyholder against a third party patent infringement claim was *Hyundai Motor America v. National Union Fire Insurance Co. of Pittsburgh, PA*.⁶⁴ Applying California law, the United States Court of Appeals, Ninth Circuit, reversed a decision by the United States District Court for the Central District of California granting summary judgment in favor of the insurers.⁶⁵ Similar to Amazon and most other major corporations, Hyundai maintained an interactive website.⁶⁶ Hyundai’s corporate website allowed users to “build [their] own” vehicle by navigating through a series of questions on different menus pertaining to colors, engine types, transmission types, etc.⁶⁷ In response to each user’s input, the corporate website “displayed customized vehicle images and pricing information.”⁶⁸ The website also contained a similar feature that allowed customers to select customized parts for the very same vehicles.⁶⁹ In the underlying action pertaining to Hyundai’s interactive website, Orion IP, LLC, a patent-holding company alleged that the “build your own vehicle” feature and the parts catalogue feature infringed on Orion’s patented computer-based system which created customized product proposals, including pictures and text, to be used in the creation of a proposal.⁷⁰ Hyundai tendered a defense under its primary insurance policy, which promised to defend and indemnify Hyundai against claims alleging

⁶² See *Amazon.com*, 85 P.3d at 977-78 & n.21.

⁶³ See *Amazon.com*, 85 P.3d at 978 n.25 (rejecting the insurer’s argument that Intouch’s injury could not have been caused by Amazon’s advertising because customers would not have been aware that they were using an infringing product).

⁶⁴ 600 F.3d 1092 (9th Cir. 2010).

⁶⁵ See *Hyundai*, 600 F.3d at 1104.

⁶⁶ See *id.* at 1095.

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.* at 1095-96.

“advertising injury,” among other things.⁷¹ Similar to the provisions of the insurance policy at issue in *Amazon*, one of the enumerated offenses under the “advertising injury” provision mirrored that of the ISO 1986 Broad Form CGL endorsement, and provided the policyholder with coverage for “misappropriation of advertising ideas or style of doing business.”⁷²

To determine whether the insurer had a duty to defend Hyundai under the “advertising injury” provision of its insurance policy, the court looked to find the existence of three elements: (i) whether Hyundai engaged in “advertising” during the relevant policy period when the alleged “advertising injury” occurred, (ii) whether Orion’s allegations created a potential liability under one of the covered offenses (i.e., misappropriation of advertising ideas), and (iii) whether a causal connection existed between the alleged injury and the “advertising.”⁷³ The court stated that “patent infringement can qualify as an advertising injury if the patent involves any process or invention which could reasonably be considered an advertising idea,” i.e., if the third party “allege[d] violation of a method patent involving advertising ideas.”⁷⁴

Similar to the ISO 1986 Broad Form endorsement, the CGL policy at issue in this case failed to define “advertising,” and the court was forced to determine the appropriate meaning of the undefined term.⁷⁵ In the context of the insurance policy provision, the court concluded that the term “advertising” referred to the “widespread promotional activities usually directed to the public at large,” but it did “not encompass solicitation” under California law.⁷⁶ The court determined that the BYO feature was “widely distributed to the public at large, to millions of unknown web-browsing potential customers, even if the precise information conveyed to each ... varie[d] with user input ... [because] the users [we]re using the

⁷¹ *Hyundai*, 600 F.3d at 1095-96.

⁷² *Compare Hyundai*, 600 F.3d at 1096, and *Amazon.com*, 85 P.3d at 976, with INS. SERV. OFFICE, INC., COMMERCIAL GENERAL LIABILITY COVERAGE FORM CG 00 01 11 85 (1984).

⁷³ *Hyundai*, 600 F.3d at 1098 (quoting *Hameid v. Nat’l Fire Ins. of Hartford*, 71 P.3d 761, 764-65 (Cal. 2003)).

⁷⁴ *Id.* at 1100 (internal quotation marks omitted) (citing *Homedics, Inc. v. Valley Forge Ins. Co.*, 315 F.3d 1135, 1141 (9th Cir. 2003)).

⁷⁵ *See id.* at 1098; INS. SERV. OFFICE, INC., COMMERCIAL GENERAL LIABILITY COVERAGE FORM CG 00 01 11 85 (1984).

⁷⁶ *See Hyundai*, 600 F.3d at 1098 (quoting *Hameid*, 71 P.3d at 764-65) (internal quotation marks omitted).

same BYO feature.”⁷⁷ Therefore, the BYO feature was not a solicitation insofar as it varied for each different user, but rather, it was a widely distributed, public advertisement. After concluding that the interactive website was not merely a “solicitation,” the court determined that Orion’s patent infringement claim constituted a “misappropriation of advertising idea,” because a lay person would reasonably understand the phrase to include Orion’s patent infringement claim.⁷⁸ In reaching its conclusion, the court noted *dicta* in *Iolab* stating that “patent infringement may constitute an advertising injury *where an entity uses an advertising technique that is itself patented.*”⁷⁹ The court also relied on *Amazon*, which it found analogous to the present case, because the BYO feature was the “form of the advertisement itself ... and plainly is not the product being advertised.”⁸⁰

Agreeing with the Court of Appeals of Washington in *Amazon*, the court stated that a causal relationship does not exist when the alleged infringement concerns patents covering the underlying product for sale.⁸¹ The court summarized the causal connection requirement and concluded that “[w]hen the patent infringement occurs independent of the actual advertisement of the underlying product, because the patent concerns the underlying product ... then the causal connection typically is not established, even when the advertising exposes the infringement.”⁸² Conversely, “[w]hen the patent infringement occurs in the course of the advertising ... the causal connection is established.”⁸³ In the summary of the causal connection requirement, the court noted that many of the previous Ninth Circuit decisions suggested that a causal connection would *never* exist, even when the patent concerned the method of advertising.⁸⁴

⁷⁷ *Id.* at 1099-1100 (alteration in original) (noting that the “patent’s *raison d’être* is to create *customized* proposals, *specific to an individual user.*”).

⁷⁸ *Id.* at 1101.

⁷⁹ *Id.* at 1102 (emphasis added) (quoting *Iolab Corp. v. Seaboard Sur. Co.*, 15 F.3d 1500, 1507 n.5 (9th Cir. 1994)).

⁸⁰ *Id.* at 1101-02 (internal quotation marks omitted) (citing *Amazon Int’l, Inc. v. Am. Dynasty Surplus Linens Ins. Co.*, 85 P.3d 974, 977 (Wash. Ct. App. 2004)).

⁸¹ *Id.* at 1102.

⁸² *Hyundai*, 600 F.3d at 1103 (alteration in original). *But see Hyundai*, 600 F.3d at 1103 n.4 (suggesting that situations where advertisements induce others to infringe on a patent may produce the requisite causal connection).

⁸³ *Id.* at 1103 (alteration in original).

⁸⁴ *See id.* at 1102-04; *see also* *Simply Fresh Fruit v. Cont’l Ins. Co.*, 94 F.3d 1219, 1223 (9th Cir. 1996) (noting that “the *advertising activities* must *cause* the

However, the court distinguished the case on the basis that the infringement was Hyundai's use of patented techniques as part of its own "marketing method" or "marketing system" and the claim potentially alleged advertising injury within the insurance policy coverage.⁸⁵ Based on these differences, the court concluded that a duty to defend against the third party patent infringement existed under the CGL insurance policy "advertising injury" provision.⁸⁶

C. DISH NETWORK CORPORATION v. ARCH SPECIALTY INSURANCE COMPANY

The most recent case finding that an insurer had a duty to defend a policyholder against a third party patent infringement claim was *DISH Network Corporation v. Arch Specialty Insurance Company*. Applying Colorado law, the Tenth Circuit of the United States Court of Appeals reversed a decision by the District of Colorado granting summary judgment in favor of the insurers.⁸⁷ In the underlying action, Ronald A. Katz Technology, Licensing, L.P. filed one or more claims on twenty-three different patents, alleging that by DISH Network committed patent infringement by "making, using, offering to sell, and/or selling ... automated telephone systems, including ... the DISH Network customer service telephone system, [which] allow[ed] [DISH's] customers to perform pay-per-view ordering and customer service functions over the telephone."⁸⁸ DISH Network tendered a defense under its primary insurance and excess coverage policies, all of which promised to defend and indemnify DISH against claims alleging "advertising injury," among other items.⁸⁹ Four of DISH Network's five insurance policies enumerated four categories of offenses which constituted "advertising injury," in language identical to the advertising injury provisions in the ISO 1986 Broad Form Endorsement.⁹⁰ The fifth insurance policy explicitly excluded

injury," not merely expose it) (emphasis in original); *Microtec Research v. Nationwide Mut. Ins. Co.*, 40 F.3d 968, 971 (9th Cir. 1994).

⁸⁵ See *Hyundai*, 600 F.3d 1092.

⁸⁶ *Id.*

⁸⁷ *DISH Network Corp. v. Arch Specialty Ins. Co.*, 659 F.3d 1010, 1028 (10th Cir. 2011).

⁸⁸ *Id.* at 1012-13 (alteration in original) (citation omitted). The language of the underlying action mirrors that of the revision to the Patent Act in 1994.

⁸⁹ *Id.* at 1013.

⁹⁰ *Id.*; INS. SERVS. OFFICE, INC., COMMERCIAL GENERAL COMMERCE LIABILITY COVERAGE FORM, CG 00 01 11 85 (1984).

from coverage, “any claim ... [a]rising out of the infringement of copyright, patent, trademark, trade secret or other intellectual property rights,” however, the exclusion did not apply to “infringement, in [the insured’s] ‘advertisement,’ of copyright, trade dress or slogan.”⁹¹

Reviewing the lower court decision *de novo*, Colorado law required the Tenth Circuit to adhere to a “four corners rule,” under which the court was required to “compare the allegations of the underlying complaint with the terms of the applicable insurance policy.”⁹² In the context of a duty to defend against a third party patent infringement claim, the rule requires an insurer to tender a defense if the underlying action alleges *any* facts or claims that might fall within the insurance policy’s provisions.⁹³ Adhering to the “four corners rule,” the court applied a three-part test to determine whether the insurers owed a defense to DISH Network under the advertising injury provisions.⁹⁴ Specifically, the court analyzed: (i) whether DISH Network “engaged in ‘advertising’ during the relevant period, (ii) whether the underlying complaint alleged the predicate “advertising injury” offense under the policy, and (iii) whether a causal connection existed between the advertising activity and the alleged injury suffered by the third party patent holder.⁹⁵

Prior to the analysis of the three-part test, the court first determined whether patent infringement *could ever* fall within the applicable CGL advertising injury provisions.⁹⁶ Looking to other jurisdictions for guiding precedent, the court noted that a clear majority view had emerged and courts “routinely distinguish between claims based on the manufacture and sale of an infringing product-in which case the claim is not covered even if the product is used in advertising and a claim based on the unauthorized use of a patented advertising idea or method- in which case the claim is covered.”⁹⁷ Despite the substantial number of cases suggesting that infringement of a patented idea will qualify for coverage under the advertising injury provisions of a CGL policy, the court noted that many

⁹¹ *DISH Network Corp.*, 659 F.3d at 1013-14 (citation omitted); *See id.* at 1028-29 (remanding the case to the district court to determine whether the unique language regarding the intellectual property exclusion in the fifth insurance barred a duty to defend against the underlying third party patent infringement claim.).

⁹² *Id.* at 1015.

⁹³ *Id.* (citing *Cyprus Amax Minerals Co. v. Lexington Ins. Co.*, 74 P.3d 294, 301 (Colo. 2003)).

⁹⁴ *Id.* at n.4.

⁹⁵ *Id.*

⁹⁶ *Id.* at 1017 (citation omitted).

⁹⁷ *Id.* (citation omitted).

cases “unequivocally reject patent coverage,” where it is not expressly included in the policy.⁹⁸ Distinguishing the existing case law from the present facts, the Tenth Circuit explained that “[t]he bulk of the published case law addressing patent infringement as advertising injury deals with products the insured happened to advertise, rather than a means of advertising that the insured used to market its own [non-infringing] products.”⁹⁹ The court concluded that “[d]epending on the context of the facts and circumstances of th[e] case, patent infringement *can* qualify as an advertising injury if the patent involve[s] any process or invention which could reasonably be considered an advertising idea,” noting that such cases are rare, in which an “allegedly infringed patent is itself and advertising idea rather than merely an advertised product.”¹⁰⁰ In the underlying action, the court explained that DISH Network “allegedly committed patent infringement by using [patented] technology to sell Dish’s own non-infringing ... products and services.”¹⁰¹ The holding seems to suggest that coverage is only appropriate when both the accused activity and the patent’s claims are within the scope of advertising. However, the logic espoused by the court clearly demonstrates a willingness to provide reasonable protection to policyholders in light of the broadly encompassing language in a CGL policy similar to the ISO 1986 Broad Form endorsement.

After determining that patent infringement *could* fall within the applicable CGL advertising injury provisions, the Tenth Circuit applied the *Novell* analysis, and analyzed “whether the complaint potentially alleged a predicate offense, *viz.*, ‘misappropriation of advertising ideas or style of doing business.’”¹⁰² As was previously noted, the ISO 1986 Broad Form endorsement failed to define the meaning of the term “advertising,” and the definition varies between jurisdictions. The court noted that some jurisdictions apply broadly encompassing definitions for “advertising,” such as; (i) the “action of calling something to the attention of the public,”¹⁰³ or (ii) any oral, written or graphic statement made by the seller

⁹⁸ *Id.* at 1019 (citing U.S. Fid. & Guar. Co. v. Frosty Bites, Inc., 232 F.Supp.2d 101, 103 (S.D.N.Y. 2002)).

⁹⁹ *DISH Network*, 659 F.3d at 1017-18 (alteration in original).

¹⁰⁰ *Id.* at 1020 (alteration in original) (emphasis added) (internal quotations marks omitted) (quoting Hyundai Motor Am. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa., 600 F.3d 1092, 1100 (9th Cir. 2010)).

¹⁰¹ *Id.* at 1018 (alteration in original).

¹⁰² *Id.* at 1020.

¹⁰³ *Hyman v. Nationwide Mut. Fire Ins. Co.*, 304 F.3d 1179, 1188 (11th Cir. 2002) (quoting *Adolfo House Distrib. Corp. v. Travelers Prop. & Cas. Ins. Co.*,

in any manner in connection with the solicitation of business.”¹⁰⁴ Conversely, other jurisdictions provide a strict definition: “widespread distribution of promotional materials to the public at large,” in contrast with a one-on-one promotional activity known as a “solicitation.”¹⁰⁵ The court failed to reach a conclusion as to which definition should apply to third party patent infringement claims, however, it concluded that the underlying complaint could be read to potentially allege the misappropriation of advertising ideas.¹⁰⁶ Reasoning that the patented functions conceivably allowed DISH Network to sell their product, *and* conceivably make selling offers to the specific caller, the court stated that “the complaint ... allege[d] misappropriation of a product specifically designed ... for advertising purposes.”¹⁰⁷

After concluding that the complaint potentially alleged misappropriation of advertising ideas or style of doing business under the advertising injury provisions of the insurance policies, the court then analyzed whether the requisite causal connection existed.¹⁰⁸ Specifically, the court examined whether the alleged injury arose in the course of advertising as the policy language mandated.¹⁰⁹ The causal requirement is important for public policy reasons because:

“[v]irtually every business that sells a product or service advertises, if only in the sense of making representations to potential customers. If no causal relationship were required between “advertising activities and ‘advertising injuries, the advertising injury

165 F.Supp.2d 1332, 1339 (S.D.Fla. 2001)); *see also* discussion *infra* Part IV.A. (noting this definition of “advertising” is similar to that of the 1998 ISO Broad Form Endorsement).

¹⁰⁴ *See Amazon.com Int’l, Inc. v. Am. Dynasty Surplus Lines Ins. Co.*, 85 P.3d 974, 977 (Wash. Ct. App. Div. 1 2004) (quoting *State Auto Prop. and Cas. Ins. Co. v. Travelers Indem. Co. of Am.*, 343 F.3d 249, 259 (4th Cir. 2003)).

¹⁰⁵ *See Hayward v. Centennial Ins. Co.*, 430 F.3d 989, 991 (9th Cir. 2005) (quoting *Hameid v. Nat’l Fire Ins. of Hartford*, 71 P.3d 761, 763 (Cal. 2003)).

¹⁰⁶ *See DISH Network*, 659 F.3d at 1022 (alteration in original). It is important to note that under Colorado law the issue is not whether the complaint definitively delineates the specific advertising activities Dish engaged in, but rather whether the alleged facts even potentially fall within the scope of coverage.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

coverage, alone, would encompass most claims related to the insured's business."¹¹⁰

In *DISH*, the court delineated several different approaches, applied by various courts, to determining whether the requisite causal connection was satisfied. In the first approach, causation was satisfied if the "alleged advertising activities alone would be actionable."¹¹¹ Another approach required that "the *advertising activities* must *cause* the injury—not merely expose it."¹¹² The final approach taken by courts fails to find the requisite causal connection "if the injury could have arisen in the absence of advertising," specifically, if "any advertising done through the use of the software [wa]s incidental to [the underlying plaintiff's] core complaint."¹¹³ The court declined to follow the final approach, which was utilized by the United States Court of Appeals, Fifth Circuit in *Delta Computer Corp. v. Frank*, 196 F.3d 589, 591 (5th Cir. 1999), because the approach was inconsistent "with Colorado's rule that a duty to defend arises wherever the complaint even potentially alleges conduct within the policy language."¹¹⁴

¹¹⁰ *Novell, Inc. v. Fed. Ins. Co.*, 141 F.3d 983, 989 (10th Cir. 1998) (alteration in original) (quoting *Bank of the W. v. Super. Ct.*, 833 P.2d 525, 560 (Cal. 1992)).

¹¹¹ *See DISH Network*, 659 F.3d at 1026 (citing *Frog, Switch & Mfg. Co., Inc. v. Travelers Ins. Co.*, 193 F.3d 742, 750 n.8 (3d Cir. 1999)).

¹¹² *See id.* (citing *Novell, Inc. v. Fed. Ins. Co.*, 141 F.3d at 989); *see also Microtec Research v. Nationwide Mut. Ins. Co.*, 40 F.3d 968, 971 (9th Cir. 1994) (alteration in original) ("If the [insured] does some wrongful act and then advertises it, harm caused by the wrongful act alone is not within the scope of the term advertising injury.").

¹¹³ *See DISH Network*, 659 F.3d at 1026, 1028 (quoting *Delta Computer Corp. v. Frank*, 196 F.3d 589, 591 (5th Cir. 1999)); *see also Delta Computer Corp. v. Frank*, 196 F.3d 589, 591 (5th Cir. 1999) (alteration in original) (concluding that the underlying claim was "essentially for infringement of [a] copyrighted software program," not for any advertising the plaintiff may have done with it, and noting that the "underlying pleading state[d] nothing about advertising.").

¹¹⁴ *See DISH Network*, 659 F.3d at 1028 (citing *Compass Ins. Co. v. City of Littleton*, 984 F.3d 606, 614 (Colo. 1999)) (The court citing *Cyprus Amax Minerals Co. v. Lexington Ins. Co.*, 74 P.3d 294, 301 (Colo. 2003), that Colorado requires a duty to defend the entire suit when any claim "might fall within the ambit of the policy").

IV. RECENT CHANGES LIMITING ADVERTISING INJURY COVERAGE IN INSURANCE SERVICE OFFICE, INC. COMMERCIAL OR COMPREHENSIVE GENERAL LIABILITY POLICY FORMS

A. THE 1998 ISO BROAD FORM CGL ENDORSEMENT REVISIONS

In 1998, the ISO made several major revisions in an attempt to resolve some of the issues surrounding the 1986 Broad Form endorsement. The first substantial change was the combination of the definitions of “personal injury” and “advertising injury” into Part B coverage, “Personal and Advertising Injury.”¹¹⁵ In this section, the ISO defined the term “advertisement” for the first time in the advertising injury provisions, as “notice that is broadcast to or published to the general public or specific market segments ... for the purpose of attaining customers or supporters.”¹¹⁶ The second substantial change from the ISO 1986 Broad Form endorsement was the replacement of the provision providing coverage for “infringement of copyright, title or slogan,” with a new provision providing coverage for “infring[ement] upon another’s copyright, trade dress or slogan in your advertisement.”¹¹⁷ Additionally, the ISO 1998 Broad Form endorsement removed the provision providing coverage for “misappropriation of advertising ideas or style of doing business,” and replaced the provision with coverage for “the use of another’s advertising idea in your advertisement.”¹¹⁸ Although the effects of these changes are unclear, these revisions may force courts to reach different conclusions under circumstances similar to those of the previously discussed decisions by the Court of Appeals of Washington and subsequently by the United States Court of Appeals, Ninth and Tenth Circuits.

B. THE 2001 ISO BROAD FORM CGL ENDORSEMENT REVISIONS

The ISO 1998 Broad Form endorsement revisions were released in 2001 following major increases in the global use of electronic

¹¹⁵ See INS. SERVS. OFFICE INC., COMMERCIAL GENERAL LIABILITY COVERAGE FORM CG 00 01 07 98 (1997); See also INS. SERVS. OFFICE INC., COMMERCIAL GENERAL LIABILITY COVERAGE FORM CG 00 01 11 85 (1986).

¹¹⁶ INS. SERVS. OFFICE, INC. *supra* note 115.

¹¹⁷ *Id.* (alteration in original).

¹¹⁸ *Id.*

communications which raised concerns among ISO member companies.¹¹⁹ In the ISO 2001 Broad Form endorsement, advertising injury coverage is described under six enumerated offenses: (i) false arrest, detention or imprisonment, (ii) malicious prosecution, (iii) libel, slander, or disparagement, (iv) violation of the right of privacy, (v) use of another's advertising idea in your advertisement, and (vi) infringement of copyright, trade dress, or slogan in your advertising.¹²⁰ The ISO 2001 Broad Form endorsement explicitly excludes coverage, any injury "arising out of the *infringement of copyright, patent, trademark, trade secret or other intellectual property rights*" from the "Personal and Advertising Injury" provisions.¹²¹ However, this exclusion "does not apply to infringement, in your 'advertisement,' of copyright, trade dress of slogan."¹²² These changes appear to be in response to attempts by policyholder to secure coverage for third party patent infringement claim, as described in the previous sections. Insurance policies that utilize language mirroring the newer editions of the Broad Form endorsements are likely to prevent policyholders from obtaining coverage.

V. CONCLUSION

Courts have not yet addressed the issue of whether the new exclusions in the "Personal and Advertising Injury" provision of the ISO 2001 Broad Form endorsement bar coverage when the policyholder infringes on a patented advertising idea, but it is only a matter of time before the question is presented to a court. Generally, courts faced with issues surrounding CGL policies are increasingly limiting policyholder coverage for infringement of intellectual property rights and third party patent infringement. Although the previously discussed cases are a significant victory for policyholders, the ISO CGL endorsements now contain exclusions which are likely to prohibit courts from following the logic espoused by the Ninth and Tenth Circuits and the Washington Court of Appeals. The revisions in the ISO 1998 and 2001 Broad Form

¹¹⁹ See INS. SERVS. OFFICE INC., COMMERCIAL GENERAL LIABILITY COVERAGE FORM CG 00 01 10 01 (2000). (alteration in original) ("Notices that are published include material placed on the Internet, or on similar electronic means of communication; and [r]egarding web-sites, only the part of a web-site that is about your goods, products or services for the purpose of attracting customers or supporters is considered an advertisement.").

¹²⁰ See *id.*

¹²¹ See *id.* (emphasis added).

¹²² See *id.*

endorsements create more impediments for policyholders and limit the ability to obtain coverage for third party patent infringement claims.¹²³ “The combination of the sharply curtailed advertising injury coverage with the new IP exclusions mean[s] that, except for a tiny number of cases, the commercial general liability [insurance policies] no longer provides coverage for IP infringement generally, including for patent infringement.”¹²⁴

¹²³ See Robert D. Chesler & Cindy Tzvi Sonenblick, *Insurance Coverage for Intellectual Property Infringement* (pt. 3), BLOOMBERG LAW REPORTS (2008), <http://www.lowenstein.com/files/Publication/33ad0bf9-ca30-4c15-a20e-05d8048333be/Presentation/PublicationAttachment/05af2561-74b2-4f37-951e-0b181131c92b/Privacy%20Liability%20Part%203%20Bloomberg%20RC%20and%20CS.%2006.08.pdf>, (“[M]any companies now have essentially no coverage for intellectual property infringement.”).

¹²⁴ See *id.* (alteration in original).

**MEDICALLY UNNECESSARY: HOW THE FLAWS IN
MEDICARE PART D’S COVERAGE OF OFF-LABEL
MEDICINES WITH DEMONSTRABLE MEDICAL NECESSITY
PREVENTS BETTER HEALTHCARE OUTCOMES, INCLUDING
FOR BENEFICIARIES WITH PSYCHIATRIC DISORDERS**

ALEXANDER W. WING*

This article examines the hardships faced by Medicare Part D patients, and especially mental health patients, with respect to obtaining coverage for necessary but off-label drug prescriptions. The article posits that the Medicare Part D system, as it currently exists, is failing not only in its mission for quality of care, but also in its cost-effectiveness. The paper advocates a comprehensive approach to Medicare Part D that addresses both deficiencies by allowing for exceptions to the FDA approved use requirement, on a case-by-case basis, where such exceptions are supported by scientific evidence. An exception process of this nature would allow deserving beneficiaries to acquire the prescriptions they need while also avoiding the heightened costs associated with an abundance of under-treated or mistreated patients.

I. INTRODUCTION

In November 2011, a psychiatrist published an article describing a problem the likes of which she has seen repeatedly in her practice.¹ Her Medicare Part D enrolled patient was refused an antidepressant that he had been stable on for nearly a decade.² Now he was required to go through a laborious prior authorization process that left him unmedicated and

* Alexander W. Wing; Juris Doctor Candidate – University of Connecticut School of Law. I would like to thank my family and friends for supporting me while I wrote and worked on this note. I would also like to thank the professors who gave me feedback and the late Jennifer Jaff for introducing me to this area of the law.

¹ Elissa Ely, *The Run-Around with Medicare Part D*, BOSTON GLOBE, Nov. 26, 2011, at A.11.

² *Id.*

unstable.³ This unfortunate story is an exemplar of coverage issues faced by mentally disordered Medicare Part D beneficiaries. A correlated and serious coverage problem faced by Medicare Part D patients, both mentally disordered and otherwise, is the unreasonable denial of medically necessary off-label medications.

Medicare Part D was created by an amendment to the Social Security Act called, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA).⁴ The MMA was enacted in 2003 and became effective in 2006.⁵ The MMA provides an outpatient prescription drug coverage program for Medicare beneficiaries, on a voluntary basis, by offering a variety of plans from private insurers who have contracted with the Department of Health and Human Services.⁶

Off-label drug use is the use of a drug, approved by the Food and Drug Administration (FDA), for an indication other than that specified in FDA drug labeling.⁷ Beyond prescribing approved drugs for unapproved conditions, off-label use also includes prescribing medication for different populations (e.g. age groups) and at doses higher or lower than approved.⁸ Pursuant to the Food, Drug, and Cosmetic Act (FDCA), new medications are granted FDA approval only after being proven safe and effective for specific ailments at particular dosages.⁹ In 2000, the United States Court of Appeals for the D.C. Circuit noted that, “neither Congress nor the FDA has attempted to regulate the off-label use of drugs by doctors and consumers. A physician may prescribe a legal drug to serve any purpose that he or she

³ *See id.*

⁴ Medicare Prescription Drug, Improvement, and Modernization Act of 2003, 42 U.S.C. § 1395w-101 (2011).

⁵ *Id.*

⁶ *See e.g.*, U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-366R, MEDICARE PART D FORMULARIES: CMS CONDUCTS OVERSIGHT OF MID-YEAR CHANGES; MOST MID-YEAR CHANGES WERE ENHANCEMENTS 1 (2011).

⁷ *See* Wash. Legal Found. v. Henney, 202 F.3d 331, 332-33 (D.C. Cir. 2000) (citations omitted); FOOD & DRUG ADMIN., OFFICE OF THE COMM’R, OFFICE OF POLICY, GOOD REPRINT PRACTICES FOR THE DISTRIBUTION OF MEDICAL JOURNAL ARTICLES AND MEDICAL OR SCIENTIFIC REFERENCE PUBLICATIONS ON UNAPPROVED NEW USES OF APPROVED DRUGS AND APPROVED OR CLEARED MEDICAL DEVICES 1 n.2 (2009), available at <http://www.fda.gov/OHRMS/DOCKETS/98fr/FDA-2008-D-0053-gdl.pdf>.

⁸ *See also With Precautions, Psychiatrists Need Not Shun Off-Label Prescribing*, PSYCHIATRIC NEWS, June 6, 2008, at 1, available at <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=111823>.

⁹ *See* 21 U.S.C. § 355 (2010).

deems appropriate, regardless of whether the drug has been approved for that use by the FDA.”¹⁰ Off-label prescribing is a very common medical practice that is even “ubiquitous in certain specialties.”¹¹ On its website, the FDA cautions physicians to prescribe off-label only when such use is supported by “sound medical evidence” while clearly distinguishing such practices from investigational uses that would fall under their scrutiny.¹²

One district court has held that statute restricts Medicare Part D coverage to FDA approved uses and off-label uses endorsed by statutorily designated medical compendia of drug uses.¹³ Another court has interpreted the statute to be more encompassing and permissive of off-label uses not published in the compendia, provided that the off-label use at issue is medically necessary as supported by scientific evidence.¹⁴ At present, there is proposed legislation in Congress that would expressly require coverage of such meritorious off-label uses.¹⁵

This note advocates for Medicare Part D coverage of off-label medications that are demonstrably necessary as indicated by an appropriate amount of reliable medical evidence. Moreover, this note argues that such a process should have protections built into it to address the particular needs and problems faced by mentally disordered patients. The political debates over Medicare, and Social Security in general, are outside of this note’s scope. Rather, this note aims to make Medicare Part D, a new social safety net, as efficient as possible while still providing the base quality of care that is its objective. By correctly providing optimal care for patients, Medicare would be more compassionate and cost-effective. To curb costs at the expense of reasonably proper healthcare is contrary to Medicare’s purpose of providing coverage for a vulnerable high-risk insurance pool, while also combating the moral hazards posed when insuring these populations.

In part II, this note provides more background information about Medicare Part D including: costs and mechanisms, an explanation of off-label drug uses, and the use of formularies and drug compendia in

¹⁰ Wash. Legal Found. v. Henney, 202 F.3d 331, 333 (D.C. Cir. 2000) (citations omitted).

¹¹ *Id.* (citation omitted).

¹² “Off-Label” and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices - Information Sheet, FOOD & DRUG ADMIN., <http://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm> (last updated Aug. 10, 2011).

¹³ Kilmer v. Leavitt, 609 F. Supp. 2d 750, 753-54 (S.D. Ohio 2009).

¹⁴ Layzer v. Leavitt, 770 F. Supp. 2d 579, 582-86 (S.D.N.Y. 2011).

¹⁵ Part D Off-Label Parity Act, H.R. 1055, 112th Cong. (2011).

determining coverage. Part III will explore problems and issues with off-label uses and the utilization of compendia under Medicare Part D, and will also examine legal and legislative action pertaining to off-label coverage. The concerns of mentally disordered Medicare Part D beneficiaries will be analyzed in part IV by establishing the frequency of mental disorders among Medicare patients. Part IV will continue with an examination of coverage for off-label medications in mental health contexts, followed by a discussion of policy that would expressly ensure mental health parity and facilitate proper access to medically necessary off-label drugs. The note will conclude in Part V, with an emphasis on the mentally disordered, wherein the problems with off-label coverage under Medicare Part D will be recapped and policy solutions will be examined.

II. MEDICARE PART D

A. WHO IS COVERED UNDER MEDICARE PART D AND HOW DOES IT WORK?

In order to be entitled to Medicare Part D prescription benefits, one must be eligible under Medicare Part A or enrolled in Medicare Part B.¹⁶ The MMA also established a program called Medicare+Choice under Medicare Part C.¹⁷ It provides coverage plans that are alternatives to those under Medicare Part A or Part B, and makes Part D coverage available.¹⁸ Medicare Part C (also known as Medicare Advantage) prescription plans are called MA-PD, short form for Medicare Advantage prescription drug, and other Part D plans are called PDPs (prescription drug plans).¹⁹ Medicare Part A (hospital insurance) entitlement extends to seniors aged 65 and older who are eligible for Social Security benefits, as well as to those who have been qualified to receive Social Security Disability benefits for at least two years.²⁰ Medicare Part B (medical insurance) coverage requires enrollment, and eligibility extends beyond that of Part A.²¹ Medicare Part B covers persons entitled to Social Security Benefits, as well as all that

¹⁶ 42 U.S.C. § 1395w-101(a)(3)(A) (2011).

¹⁷ 42 U.S.C. § 1395w-21(a) (2011).

¹⁸ *Id.*

¹⁹ *See* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-366R, MEDICARE PART D FORMULARIES: CMS CONDUCTS OVERSIGHT OF MID-YEAR CHANGES; MOST MID-YEAR CHANGES WERE ENHANCEMENTS 1 n.3 (2011).

²⁰ *See* 42 U.S.C. § 1395(c) (2011).

²¹ *See* 42 U.S.C. § 1395(o) (2011).

have attained the age of 65 (provided that they are a citizen or an alien who has lawfully resided in the United States for at least 5 years).²² Social Security Disability benefits are available for a broad variety of impairments,²³ including mental disorders in both adults²⁴ and children.²⁵

While Medicare Part D prescription drug plans must meet certain statutory guidelines, they differ in implementation when it comes to premiums, gap coverage, copayment tiers, deductibles, and other pricing structures.²⁶ The MMA requires that Medicare Part D plans provide either “standard prescription drug coverage with access to negotiated prices,” as defined by the statute, or the actuarial equivalent thereof.²⁷ The MMA definition of standard prescription drug coverage is codified in 42 U.S.C. § 1395w-102 (b).²⁸ It specifies that many of the listed patient costs be subjected to yearly price increases.²⁹ This is determined by the Secretary of the Department of Health and Human Services (hereinafter Secretary), based on the “annual percentage increase [of the] average per capita aggregate expenditures for covered Part D drugs.”³⁰ When the MMA came into effect in 2006, plan providers could charge beneficiaries a deductible of \$250 that has since been raised to reflect the aforementioned annual percentage based price increase.³¹ The standard plan also requires that the patient pay 25% coinsurance until the costs expended reach \$2,250, adjusted for the annual percentage increase.³² After reaching this cap, Part

²² *See id.*

²³ *See Disability Evaluation Under Social Security: Part III –Listing of Impairments*, SOCIAL SECURITY ONLINE, <http://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm> (last modified Jul. 6, 2012).

²⁴ *See Disability Evaluation Under Social Security: 12.00 Mental Disorders - Adult*, SOCIAL SECURITY ONLINE, <http://www.ssa.gov/disability/professionals/bluebook/12.00-MentalDisorders-Adult.htm> (last modified Jul. 6, 2012).

²⁵ *See Disability Evaluation Under Social Security: 112.00 Mental Disorders - Childhood*, SOCIAL SECURITY ONLINE, <http://www.ssa.gov/disability/professionals/bluebook/112.00-MentalDisorders-Childhood.htm> (last modified Jul. 6, 2012).

²⁶ JACK HOADLEY ET AL., KAISER FAMILY FOUND., ANALYSIS OF MEDICARE PRESCRIPTION DRUG PLANS IN 2011 AND KEY TRENDS SINCE 2006 1 (2011), available at <http://www.kff.org/medicare/upload/8237.pdf>.

²⁷ 42 U.S.C. § 1395w-102(a) (2011).

²⁸ *See id.* § 1395w-102(b).

²⁹ *See id.* § 1395w-102(b)(6).

³⁰ *Id.*

³¹ *See id.* § 1395w-102(b)(1).

³² *Id.* § 1395w-102(b)(2)–(b)(3).

D beneficiaries enter a coverage gap, infamously known as the doughnut hole.³³ While in the coverage gap, beneficiaries pay the next \$3600 (plus the annual increases) for their prescriptions, after which they pay 5% coinsurance.³⁴ The recent Patient Protection and Affordable Care Act of 2010 (PPACA), also known as Obamacare, contains provisions aimed at ameliorating this problem.³⁵ From 2011 onward, the PPACA will provide price discounts and government subsidies for Medicare Part D enrollees mired in the doughnut hole, with plans to phase out the coverage gap entirely by 2020.³⁶ Moreover, most Part D plan insurers tend to opt for actuarial equivalency as implemented via tiered cost sharing schemes.³⁷ As of November 2011, 53% of PDPs had a deductible and 43% used the standard plan amount.³⁸ After charging a deductible, most plans utilized cost contingent tiered copayment schemes instead of the flat 25% coinsurance of the standard plan.³⁹ In 2012 the standard plan deductible was \$320 and the coverage gap was between \$2930 and \$6730.⁴⁰ There are also provisions to provide subsidies and assistance to poor beneficiaries.⁴¹ The Centers for Medicare and Medicaid Services (CMS) reported that over 10 million enrollees received such help in 2011, although an estimated additional 2 million enrollees were eligible for such assistance but did not receive it.⁴² This figure is alarming, and starkly presents some of Medicare Part D's problems, because 29.5 million people were enrolled under Medicare Part D as of September 2011.⁴³

The MMA directs the Secretary to promulgate an administrative grievance process by which a Part D enrollee may appeal a decision

³³ JACK HOADLEY ET AL., KAISER FAMILY FOUND., MEDICARE PART D 2011: THE COVERAGE GAP 1, 3 (2011), *available at* <http://www.kff.org/medicare/upload/8222.pdf>.

³⁴ *See* 42 U.S.C. § 1395w-102(b)(4) (2011).

³⁵ *See* HOADLEY, ANALYSIS OF MEDICARE PRESCRIPTION DRUG PLANS, *supra* note 26, at 1.

³⁶ *See* HOADLEY, THE COVERAGE GAP, *supra* note 33, at 1.

³⁷ *See* HOADLEY, ANALYSIS OF MEDICARE PRESCRIPTION DRUG PLANS, *supra* note 26, at 4.

³⁸ *See* THE MEDICARE PRESCRIPTION DRUG BENEFIT, KAISER FAMILY FOUND. MEDICARE POLICY FACT SHEET 1 (2011), *available at* <http://www.kff.org/medicare/upload/7044-12.pdf>.

³⁹ *See id.*

⁴⁰ *See id.*

⁴¹ *See id.* at 2.

⁴² *See id.*

⁴³ *See id.*

denying drug coverage.⁴⁴ There are four levels of administrative appeal prior to district court jurisdiction.⁴⁵ The four levels of administrative review are: internal to the provider, independent and external review, administrative law judge review, and finally a hearing before the Medicare Appeals Council.⁴⁶ Not surprisingly, the United States Court of Appeals for the Third and Ninth Circuits have each held that the federal district courts have no jurisdiction until administrative remedies are fully exhausted, as required by law.⁴⁷ Therefore, an individual may appeal in a federal district court, only if the amount in controversy is \$1,300.00 or greater and only after the fourth level of appeal has been determined.⁴⁸

B. OFF-LABEL DRUG USE

Prescribing FDA approved medications for off-label use is legal because regulation of the practice of medicine is outside the FDA's purview.⁴⁹ This policy makes sense because once safety is established, innovation in research may find new uses and verify them at a rate faster than the FDA approval process. Such regulation could also pose logistical problems and might raise debate over governmental authority. In 1982, the FDA acknowledged that prescribing off-label drugs often reflects valid clinical applications as established by thorough research.⁵⁰ Since the Food, Drug, and Cosmetic Act (FDCA) does not forbid such usage, many safe and innovative uses of approved drugs aren't promptly added to the FDA medical labeling, because of the time and expense involved.⁵¹ That off-label prescribing is often dangerous or uncertain due to a lack of scientific

⁴⁴ See 42 U.S.C. § 1395w-104 (f)-(i) (2011), cross referencing 42 U.S.C. § 1395w-22 (2011); see appended flowchart *infra* p. 252.

⁴⁵ See appended flowchart *infra* p. 252.

⁴⁶ See appended flowchart *infra* p. 252.

⁴⁷ See *Kopstein v. Indep. Blue Cross*, 339 F. App'x 261, 264-65 (3d Cir. 2009); *Uhm v. Humana, Inc.*, 620 F.3d 1134, 1144 (9th Cir. 2010).

⁴⁸ See appended flowchart *infra* p. 252 (note that the amount in controversy requirements are modified yearly to reflect the consumer price index).

⁴⁹ See *More Information for Better Patient Care: Hearing of the Comm. On Labor and Human Res. U.S. S.*, 104th Cong. 81-82 (1996) (statement of William Schultz, Deputy Comm'r for Policy, Food and Drug Administration), available at <http://www.hhs.gov/asl/testify/t960222a.html>.

⁵⁰ See FOOD & DRUG ADMIN., *Use of Approved Drugs for Unlabeled Indications*, 12 FDA DRUG BULL. 3, 4-5 (Apr. 1982), available at http://www.circare.org/fda/fdadrugbulletin_041982.pdf.

⁵¹ See *id.*

support has been well documented elsewhere.⁵² However, one need only look to the news to learn that FDA approval alone is no guarantor of safety or efficacy.⁵³ Unfortunately, medication errors are so common that the FDA has a program, called MedWatch, whose sole purpose is to monitor adverse drug reactions.⁵⁴ Concurrently, off-label use is frequently well supported by medical research and has therapeutic value embraced by health providers.⁵⁵ A common and prominent example of a drug used for non-FDA sanctioned uses is aspirin.⁵⁶ Aspirin's efficacy in combating heart disease has long been known by the medical community yet its

⁵² See, e.g., David C Radley, et al., *Off-Label Prescribing Among Office-Based Physicians*, 166 ARCHIVES INTERNAL MED. 1021 (2006), available at <http://archinte.ama-assn.org/cgi/content/full/166/9/1021> (statistical analysis of drug use surveys found 21% of prescriptions are for off label use but only 27% of these uses had strong scientific support and cautions that off-label use without such support could be dangerous or fiscally wasteful).

⁵³ See, e.g., Shari Roan, *Avastin Loses Approval as Breast Cancer Drug*, L.A. TIMES, Nov. 19, 2011, at 9, available at <http://articles.latimes.com/2011/nov/18/health/la-he-avastin-breast-cancer-20111119> (FDA approval withdrawn for breast cancer because harms greater than therapeutic benefit, endorsement remains for other cancer types); Rita Rubin, *How did Vioxx Debacle Happen?*, USA TODAY, Oct. 12, 2004, at 1, available at http://www.usatoday.com/news/health/2004-10-12-vioxx-cover_x.htm (Vioxx manufacturer Merck withdrew dangerous drug from market in spite of FDA approval causing many to question and critique FDA).

⁵⁴ *FDA 101: Medication Errors*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048644.htm#Examples> of Medication Errors (last updated Feb. 20, 2009) (this service monitors all adverse drug events, many of which occur independently of the drug approval process).

⁵⁵ See Randall S. Stafford, *Regulating Off-Label Drug Use – Rethinking the Role of the FDA*, 358 NEW ENG. J. MED. 1427 (Apr. 3, 2008), available at <http://www.nejm.org/doi/full/10.1056/NEJMp0802107>.

⁵⁶ See *Bayer: Science for a Better Life*, BAYER.COM, <http://www.bayer.com/en/History.aspx> (last visited Sept. 6, 2012); Joseph Sirven, *New Uses for Older Drugs: The Tales of Aspirin, Thalidomide, and Gabapentin*, 85 MAYO CLINIC PROC. 508, (June 2010), available at <http://171.67.112.83/content/85/6/508.full.pdf+html> (aspirin is a complicated example because its use and discovery profoundly predates the founding of the FDA and its regulatory scheme); Randall S. Stafford, *Regulating Off-Label Drug Use – Rethinking the Role of the FDA*, 358 NEW ENG. J. MED. 1427 (Apr. 3, 2008), available at <http://www.nejm.org/doi/full/10.1056/NEJMp0802107> (aspirin is used off-label to prevent heart disease among diabetes sufferers).

approved indications were slow to reflect that understanding.⁵⁷ Thus, an off-label use of an approved drug is often supported by the medical community and can be of great benefit to a patient's health. A flexible prescription coverage regime predicated on medical evidence and best practices would be the most humane and efficient. Therefore it is of paramount importance to ensure that off-label use, when it occurs, is meritorious. It is illegal for a pharmaceutical manufacturer to label an approved drug for an unapproved indication and for them to market or promote an off-label use.⁵⁸ This law hopefully helps reduce pressure on doctors to base their prescribing practices on biased information. In the absence of information from drug companies, doctors must inform themselves about off-label uses "through compendia, journal articles, continuing medical education programs, symposia, and professional meetings."⁵⁹ To that end, the FDA has recently published guidance for the healthcare industry that stipulates what standards to look for in evaluating medical evidence for off-label use.⁶⁰

⁵⁷ See *Bayer: Science for a Better Life*, BAYER.COM, <http://www.bayer.com/en/History.aspx> (last visited Sept. 6, 2012); Joseph Sirven, *New Uses for Older Drugs: The Tales of Aspirin, Thalidomide, and Gabapentin*, 85 MAYO CLINIC PROC. 508, (June 2010), available at <http://171.67.112.83/content/85/6/508.full.pdf+html> (aspirin is a complicated example because its use and discovery profoundly predates the founding of the FDA and its regulatory scheme); Randall S. Stafford, *Regulating Off-Label Drug Use – Rethinking the Role of the FDA*, 358 NEW ENG. J. MED. 1427 (Apr. 3, 2008), available at <http://www.nejm.org/doi/full/10.1056/NEJMp0802107> (aspirin is used off-label to prevent heart disease among diabetes sufferers).

⁵⁸ *E.g.*, *Washington Legal Found. v. Henney*, 202 F.3d 331, 332-33 (D.C. Cir. 2000) (citations omitted); *United States v. Caronia*, 576 F. Supp. 2d 385, 389 n. 2 (E.D.N.Y. 2008).

⁵⁹ *Testimony on Unapproved Uses of Prescription Drugs: Before S. Comm. On Labor & Human Res.*, 104th Cong. (Feb. 22, 1996) (statement of William Schultz, Deputy Comm'r for Policy, Food and Drug Admin.), available at <http://www.hhs.gov/asl/testify/t960222a.html>.

⁶⁰ See also FOOD & DRUG ADMIN., OFFICE OF POLICY, OFFICE OF THE COMM'R, GUIDANCE FOR INDUSTRY: GOOD REPRINT PRACTICES FOR THE DISTRIBUTION OF MEDICAL JOURNAL ARTICLES AND MEDICAL OR SCIENTIFIC REFERENCE PUBLICATIONS ON UNAPPROVED NEW USES OF APPROVED DRUGS AND APPROVED OR CLEARED MEDICAL DEVICES (2009), available at <http://www.fda.gov/OHRMS/DOCKETS/98fr/FDA-2008-D-0053-gdl.pdf> (last updated Aug. 6, 2009). This guidance was published when 21 U.S.C. § 360aaa, which in certain contexts allowed pharmaceutical manufacturers to disseminate information on their product's off label uses, was still in effect. While such

C. FORMULARIES AND COMPENDIA

The prescription drug plans available to Medicare Part D beneficiaries all provide basic coverage, but often differ in terms of pricing, which pharmacies may be used, and which medicines are covered.⁶¹ Medicare Part D plans typically release a list of which medications are available with a given plan, in a compilation called a formulary.⁶² It is important to understand that a formulary is merely a list of prescriptions available. The formulary does not dictate which ailments a given medicine may be prescribed for. Still, these formularies must be developed and reviewed by a committee of doctors and pharmacists pursuant to scientific evidence.⁶³ While compiling a formulary, a provider is required to provide coverage for certain pharmaceuticals, and classes of pharmaceuticals, as identified by the Secretary.⁶⁴ Finally, the statute mandates that the formulary be periodically evaluated,⁶⁵ explained to patients and healthcare professionals,⁶⁶ and that patients and their healthcare providers are given notice of any adverse changes to the formulary.⁶⁷ Prompted by statute, CMS has promulgated regulations that require formularies to contain “[a]ll or substantially all drugs in the antidepressants, antipsychotics, [and] anticonvulsants.” categories.⁶⁸

However, this regulatory provision does not guarantee that Part D patients suffering from mental disorder will be granted coverage or reimbursement for an off-label prescription drug. This is significant because one study found that as many as 74% of anticonvulsant, and 60%

dissemination is no longer permitted by statute, off label use remains legal and the FDA’s guidance on evaluating medical literature is helpful. *See id.* at 6 & n.9.

⁶¹Centers for Medicare & Medicaid Services, *How Medicare Prescription Drug Plans and Medicare Advantage Plans with Prescription Drug Coverage (MA-PDs) Use Pharmacies, Formularies, and Common Coverage Rules*, CMS. GOV, <http://www.medicare.gov/Publications/Pubs/pdf/11136.pdf> (last updated Feb. 2011).

⁶²42 U.S.C. § 1395w-104(b)(3)(G)(i)(I) (2006).

⁶³*Id.* § 1395w-104(b)(3)(A)(i).

⁶⁴*Id.* § 1395w-104(b)(3)(C), (b)(3)(G).

⁶⁵*Id.* § 1395w-104(b)(3)(F).

⁶⁶*Id.* § 1395w-104(b)(3)(D).

⁶⁷*Id.* § 1395w-104(b)(3)(E).

⁶⁸CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, CMS Pub. 100-18, ch. 6, § 30.2.5 (Rev. 10, Feb. 19, 2010), <https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf>

of antipsychotic, prescriptions were for off-label uses.⁶⁹ Moreover, under this provision, formularies do not necessarily contain both the generic and brand name versions of drugs, all formulations of a drug (such as regular versus extended release), nor all isomers of a molecule.⁷⁰ These classes of drugs are also subject to plan management techniques, such as prior authorization, which have historically chilled the utilization of such drugs.⁷¹ Coverage is similarly uncertain for all medications listed in a formulary if the prescribed use is off-label because of how the MMA determines whether an off-label use is medically necessary.

While the various plans available under Medicare Part D vary in their coverage and cost, regulation stipulates that coverage of a medicine under Medicare Part D is predicated on a “medically accepted indication” as defined by statute.⁷² This terminology is distinguishable from the legal concept of medical necessity and should not be.⁷³ A drug in a plan’s formulary may be denied coverage if the prescription is for a use that does not satisfy the statute’s criteria. Under the MMA, a “medically accepted indication” is defined in various ways.⁷⁴ When the pharmaceutical treatment in question is chemotherapeutic, the use is medically accepted when it is FDA approved, or supported by a designated medical compendium.⁷⁵ A chemotherapeutic medication is also medically acceptable if the carrier determines the use is medically necessary pursuant to established medical practices and peer reviewed empirical literature, commensurate with the guidance of the Secretary.⁷⁶ At least for chemotherapeutic medicines, Medicare Part D coverage is synchronous with typical definitions of medical necessity.

A medical compendium is a compilation of endorsed drug uses and adverse interactions that is supported by established medical practices

⁶⁹ Randall S. Stafford, *Regulating Off-Label Drug Use – Rethinking the Role of the FDA*, 358 NEW ENG. J. MED. 1427 (2008), available at <http://www.nejm.org/doi/full/10.1056/NEJMp0802107>.

⁷⁰ See Haiden Huskamp, et al., *Coverage and Prior Authorization of Psychotropic Drugs Under Medicare Part D*, 58 PSYCHIATRIC SERVICES 308, 308-09 (2007), available at <http://ps.psychiatryonline.org/data/Journals/PSS/3797/07ps308.pdf>.

⁷¹ *Id.* at 308.

⁷² 42 C.F.R. § 423.100 (2011). This regulation’s construction of statute was held to be invalid. *Layzer v. Leavitt*, 770 F. Supp. 579, 587 (2011).

⁷³ See 12 LEE R. RUSS ET. AL., COUCH ON INSURANCE 3D § 181:2 (2011).

⁷⁴ 42 U.S.C. § 1395w-102(e)(4) (2011).

⁷⁵ *Id.* § 1395x(t)(2)(B).

⁷⁶ *Id.*

and scientific research.⁷⁷ Under Medicare Part D, all other types of drugs (non-chemotherapeutic) are medically accepted only if they are FDA approved for an application, or if their use is indicated by the medical compendia listed in 42 U.S.C. §1396r-8(g)(1)(B)(i).⁷⁸ There are no exceptions for non-chemotherapeutic medicines. Recall that 42 U.S.C. § 1396r-8(g)(1)(B)(ii) provides that the medical acceptability of a chemotherapeutic drug's usage can be determined by reference to peer reviewed literature and medical practices. But, this fact-based exception was not included in the MMA framework for non-chemotherapeutic drugs. Furthermore, the statute, as originally drafted, did not allow for exceptions to the compendia for chemotherapeutic drugs either.⁷⁹ This provision came from an amendment contained in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).⁸⁰ This came two years after the enactment of Medicare Part D, which even now is a relatively new program. Since FDA approval of a drug also determines approved uses,⁸¹ in practice these compendia are used to determine whether an off-label usage is medically acceptable.

Under the MMA, the Secretary also has the authority to revise and update the list of approved compendia to insure that medically accepted indications are identifiable by carriers, patients, and health care providers.⁸² Regulation requires that the formation of a federally used compendium be conducted through a transparent process subject to review by the Centers for Medicare and Medicaid Services (CMS).⁸³ The compendia listed in statute are: American Hospital Formulary Service Drug Information, the United States Pharmacopeia–Drug Information, and the DRUGDEX Information System.⁸⁴ However, the United States Pharmacopeia-Drug Information is now defunct and the DRUGDEX Information System was added to this list at a later date.⁸⁵ Thus, CMS configures and revises its

⁷⁷ See 42 C.F.R. § 414.930(a). See also 42 U.S.C. §§ 1396r-8(g)(1)(A) to -8(g)(2) (2011).

⁷⁸ 42 U.S.C. § 1395w-102(e)(4) (2011)(cross referencing 42 U.S.C. § 1396r-8(k)(6) (2011)).

⁷⁹ Medicare Improvements for Patients and Providers Act of 2008, H. R. 6331, 110th Cong. § 182 (2008).

⁸⁰ *Id.*

⁸¹ See generally 21 U.S.C. § 355 (2010).

⁸² See 42 U.S.C. § 1395(w)-102(e)(4)(C) (Supp. IV 2011).

⁸³ See 42 C.F.R. § 414.930(b) (2011).

⁸⁴ 42 U.S.C. § 1396r-8(g)(1)(B)(i) (2000).

⁸⁵ See Ross McKinney et al., *White Paper: Potential Conflict of Interest in the Production of Drug Compendia*, AGENCY FOR HEALTHCARE RESEARCH &

own working list of compendia pursuant to its regulatory authority.⁸⁶ As of this writing, the agency has adopted National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium⁸⁷ and Clinical Pharmacology⁸⁸ to serve alongside Thomson Micromedex DRUGDEX and American Hospital Formulary Service Drug Information as the current working compendia for Medicare.⁸⁹ The various CMS approved compendia differ in their compilation process, but generally all strive to be unbiased and evidence based in their determinations.⁹⁰ Unfortunately, medical compendia also tend to have a substantial price tag. For example, the 2012 edition of the AHFS – Drug Information medical compendium is \$329.00 for a softbound book that comes with access to online updates.⁹¹ One could also presume that because the myriad compendia are produced by independent, competing organizations that the information in a given compendium is not entirely synchronous with others. This reasonable inference has empirical support. A study published in 2000 found discrepancies amongst several leading compendia in their listing and

QUALITY 1-5 (Apr. 27, 2009), <http://www.cms.gov/determinationprocess/downloads/id64TA.pdf>.

⁸⁶ *Id.*

⁸⁷ NCCN Compendium Revision Request - CAG-00389, Centers for Medicare & Medicaid Services (June 5, 2008), *available at* <https://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=14&McdName=NCCN+Compendium+Revision+Request+-+CAG-00389&mcdtype=Compendia&MCDIndexType=6&bc=AgAEAAAAAAAA&>.

⁸⁸ Clinical Pharmacology Compendium Revision Request - CAG-00392, Centers for Medicare & Medicaid Services (July 2, 2008), *available at* <https://www.cms.gov/medicare-coverage-database/details/medicare-coverage-document-details.aspx?MCDId=17&McdName=Clinical+Pharmacology+Compendium+Revision+Request+-+CAG-00392&mcdtype=Compendia&MCDIndexType=6&bc=AgAEAAAAAAAA&>.

⁸⁹ 42 U.S.C. § 1396r-8(g)(1)(B)(i) (2000).

⁹⁰ *See, e.g., Overview*, AHFS DRUG INFORMATION, http://www.ahfsdruginformation.com/off_label/overview.aspx (last visited Jan. 5, 2012); *DRUGDEX System*, THOMSON REUTERS, http://thomsonreuters.com/products_services/healthcare/healthcare_products/a-z/drugdex_system/ (last visited Jan. 5 2012).

⁹¹ *AHFS Drug Information 2012*, ASHP STORE, <http://store.ashp.org/ProductDetails/tabid/216/Default.aspx?ProductID=25018234> (last visited Jan. 5 2012).

evaluation of drug-drug interactions.⁹² For further discussion of issues vis-à-vis medical compendia, see part III infra.

In short, whether or not a (non-chemotherapeutic) medication is deemed medically appropriate for a given patient under Medicare Part D is dependent on either FDA approval for a given usage, or a listed indication in an approved medical compendium (whether it be designated by statute or adopted by the agency). However, this statutory interpretation is in contention and this issue is the crux of this note. How restrictive the term “medically accepted indication” is on coverage has been subject to reasonable debate between courts. In *Kilmer v. Leavitt*, the District Court for the Southern District of Ohio interpreted the statute as limiting coverage to “medically accepted” as determined by FDA approval or compendia endorsement.⁹³ The District Court for the Southern District of New York disagreed in *Layzer v. Leavitt* and interpreted the statutory term “include” to be inclusive rather than exclusive, thereby making strict compendia based restrictions at odds with the statute.⁹⁴ This issue could develop into a circuit split, which would adversely impact the health of many, unless Congress more clearly addresses this issue. To grant these compendia an oligopoly on off-label coverage decisions makes little sense on either a human or fiscal level. There should be more than a limited ability, if any, to appeal for an exception. If cause for an exception exists that is grounded in medical research, there should be a mechanism to pursue that eventuality to counteract the mistake or omission of a compendium. Otherwise any Medicare Part D enrollee, mentally disordered or otherwise, who is prescribed a non-chemotherapeutic medication will only have their drug covered if an approved compendium endorses its use. It is clear such a framework will sometimes deny Medicare enrollees optimal, or perhaps necessary, healthcare.

⁹² See Thomas R. Fulda et al., *Disagreement Among Drug Compendia on Inclusion and Ratings of Drug-Drug Interactions*, 61 CURRENT THERAPEUTIC RES., 540, 540-48 (2000).

⁹³ *Kilmer v. Leavitt*, 609 F. Supp. 2d 750, 753-54 (S.D. Ohio 2009).

⁹⁴ *Layzer v. Leavitt*, 770 F. Supp. 2d 579, 583-85 (S.D.N.Y. 2011).

III. RESHAPING THE COVERAGE OF OFF-LABEL MEDICATIONS

A. MEDICARE PART D ISSUES WITH OFF-LABEL PRESCRIPTIONS AND COMPENDIA USE.

In its relatively short term of life, Medicare Part D has already seen a great deal of litigation regarding how coverage decisions are made. This is particularly interesting given the amount in controversy threshold and the multi-step administrative grievance process that must be exhausted before a federal district court even has jurisdiction.⁹⁵ The holding of *Layzer v. Leavitt*, whose appeal was dismissed by the United States Second Circuit Court of Appeals, has the best prospect of serving as an impetus to meaningful reform of Medicare prescription drug coverage policies.⁹⁶ Recent proposed legislation and regulatory amendments have also coincided with recent cases. Recall that coverage exceptions to compendia indications for chemotherapeutic drugs, based on Secretary approved peer-reviewed medical literature, only came with amendments contained in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).⁹⁷ While this reform is a step in the right direction, it is not enough. A Medicare Part D enrollee should be expressly allowed to appeal for coverage of any medication (not expressly excluded) whose medical necessity has empirical support. This process should also contain protections for the unique needs of the mentally disordered. As of this writing, there is a bipartisan bill proposed in the House of Representatives, currently under committee review, that encapsulates the spirit of *Layzer v. Leavitt* by promoting coverage parity for off-label uses when based on medical evidence.⁹⁸ Unfortunately, the likelihood of this bill passing seems scant, so such legislation should be pursued in subsequent Congresses with the needs of all beneficiaries in mind.

⁹⁵ See e.g., *Kopstein v. Indep. Blue Cross*, 339 F. App'x 261, 264-65 (3d Cir. 2009); *Uhm v. Humana, Inc.*, 620 F.3d 1134, 1144 (9th Cir. 2010); See also Centers for Medicare & Medicaid Services, *Medicare Prescription Drug (Part D): Coverage Determination/Appeals Process*, CMS.GOV, <http://www.cms.gov/MedPrescriptDrugApplGriev/Downloads/PartDAppealsFlowchart.pdf> (last visited Dec. 23, 2011).

⁹⁶ *Layzer v. Leavitt*, 770 F. Supp. 2d 579 (S.D.N.Y. 2011).

⁹⁷ Medicare Improvements for Patients and Providers Act of 2008, H. R. 6331, 110th Cong. § 182 (2008).

⁹⁸ Part D Off-Label Parity Act, H.R. 1055, 112th Cong. (2011).

While the plethora of legal action regarding Medicare Part D coverage is indicative of problems experienced by beneficiaries, it is useful to examine what sorts of difficulties arise. By law, Medicare Part D prescription plans must cover all FDA approved uses.⁹⁹ In 1996, then FDA Deputy Commissioner for Policy, William Schultz, testified before the Senate Committee on Labor and Human Resources regarding off-label drug use.¹⁰⁰ He repeatedly stressed that “many off-label uses are quite appropriate, and some may even be the treatment of choice.”¹⁰¹ While arguing for the necessity of combating off-label promotion, the Deputy Commissioner also cautioned that it was imperative for medical professionals to make informed choices before prescribing off-label, given legitimate concerns about the speed and cost of FDA approval.¹⁰²

However, even off-label use that has been embraced by the medical community is often denied coverage summarily. Frequently off-label usage of medicines, most notably for cancer treatment, is reflexively denied coverage or reimbursement on the grounds that the indication is “experimental” or “investigational” even when that is not the case.¹⁰³ This experience is corroborated by a patient advocacy group who wrote to the Internal Revenue Service to convey that in the course of business they had seen medication coverage denials for many diseases on the grounds that the treatment was experimental or investigational when in fact it was an established and supported off-label use.¹⁰⁴

A report published by the Government Accountability Office found that many physicians are forced to resort to medication regimens that are less efficacious than the off-label use that was denied coverage or

⁹⁹ See 42 U.S.C. § 1395(x)(t)(2)(B)(i) (2006).

¹⁰⁰ *Testimony on Unapproved Uses of Prescription Drugs: Before S. Comm. On Labor & Human Res.*, 104th Cong. (Feb. 22, 1996) (statement of William Schultz, Deputy Comm’r for Policy, Food and Drug Administration), <http://www.hhs.gov/asl/testify/t960222a.html>.

¹⁰¹ *Id.*

¹⁰² *Id.*

¹⁰³ American Society of Clinical Oncology, *Reimbursement for Cancer Treatment: Coverage of Off-Label Drug Indications*, 24 J. CLINICAL ONCOLOGY 1, 1 (Feb. 27, 2006), available at <http://www.asco.org/ASCO/Downloads/Cancer%20Policy%20and%20Clinical%20Affairs/Off-Label%20Drug%20Indications/Off-label%20statement.pdf>; Katherine Tillman, et al., *Compendia and Anticancer Therapy Under Medicare*, 150 ANNALS INTERNAL MED. 348, 348 (Mar. 2009).

¹⁰⁴ Public Comment Letter from Jennifer Jaff, Advocacy for Patients with Chronic Illness, Inc., to Internal Revenue Service (Sep. 15, 2010) at 2, available at <http://www.irs.gov/pub/irs-soi/2010125592-10Jaff>, 2010 WL 3829485 (I.R.S. Sept. 15, 2010).

reimbursement.¹⁰⁵ Logically, a patient on a medication that is not optimal may be sicker and sicker people are likely to have greater total health costs. This is all the more worrisome for patients suffering from mental disorders because of the risk of healthcare prejudice and hardship they already face.¹⁰⁶ The fact that competency issues render many incapable of self-advocacy or thorough understanding of their plight makes this all the worse. The report concluded that while the FDA's process for updating a drug's label to include new uses was faster and more efficient than it once was, the situation could still be improved because erroneous coverage or reimbursement denials persisted.¹⁰⁷ It is perhaps due to this problem that, on its website, the FDA distinguishes investigational drugs from off-label use.¹⁰⁸ Part of why off-label prescribing persists with such prevalence is that the time and expense of garnering FDA approval for a new use is often greater, or perceived to be greater, than any benefit FDA use approval carries.¹⁰⁹ In an industry guidance about approving new uses for approved cancer drugs, the FDA conceded:

[T]here are substantial disincentives, including (1) the cost and effort involved in completing new research (where necessary) to verify whether a product provides patient benefit in a new indication; (2) the cost and effort involved in submitting an application for regulatory approval of new clinical uses; and (3) the lack of perceived commercial benefit of revised labeling if the product is already being used for the new indication — especially if it no longer has

¹⁰⁵ See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO/T-HEHS-96-212, PRESCRIPTION DRUGS: IMPLICATIONS OF DRUG LABELING AND OFF-LABEL USE 4 (1996).

¹⁰⁶ See also *Are People With Mental Illness Getting the Help They Need? New Findings About Parity Laws, Insurance Coverage, and Access to Care*, RAND CORP. (2000), http://www.rand.org/pubs/research_briefs/RB4533/index1.html (last visited Jan. 12, 2011).

¹⁰⁷ See U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 105, at 6-8.

¹⁰⁸ See "Off-Label" and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices - Information Sheet, FOOD & DRUG ADMIN., <http://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm> (last visited Jan. 12, 2011).

¹⁰⁹ See, e.g., Alexander Tabarrok, *Assessing the FDA via the Anomaly of Off-Label Drug Prescribing*, 5 INDEP. REV. 27-29 (2000), http://www.independent.org/pdf/tir/tir_05_1_tabarrok.pdf.

patent protection.¹¹⁰

Some Medicare beneficiaries have diseases so rare that there are no medications that have FDA approved indications for their ailments.¹¹¹ Thus, it is foreseeable that compendia endorsement is similarly difficult to obtain for such afflictions. Uncommon diseases pose a commensurate difficulty in research because of the small population affected, making it difficult to enlist a sufficient number of study participants. Such was the case with the cancer suffered by Ms. Layzer, the plaintiff in *Layzer v. Leavitt*.¹¹² Even with common diseases, proper studies are difficult, as patients often have multiple ailments and treatments. Moreover, the possibility of being given a mere placebo is unappealing to those afflicted with debilitating, or fatal, diseases. There is also little incentive to apply for new use approval when the drug is generic. Here too, aspirin is a poster child for off-label use. As a generic drug that predates the formation of the FDA, some of its new use approvals have been initiated by the agency, independent of pharmaceutical manufacturers.¹¹³ There would seem to be little incentive to seek additional FDA labeling when the medication is producing profit without it and the accompanying ability to promote such use. Imagine a pain medication. Because innumerable maladies cause pain it would be impractical to have a pain reliever approved for every possible application.

The highest profile area with off-label coverage issues is the field of oncology, where desperate patients are often forced to pursue all

¹¹⁰ *Guidance for Industry: FDA Approval of New Cancer Treatment Uses for Marketed Drug and Biological Products*, FOOD & DRUG ADMIN. 2 (Dec. 1998), <http://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm071657>.

¹¹¹ See, e.g., *Off-Base: The Exclusion of Off-Label Prescriptions from Medicare Part D Coverage*, MEDICARE RIGHTS CENTER, 4 (Aug. 2007), http://www.medicarerights.org/pdf/Off_Base.pdf; See also Ross McKinney et al., *White Paper: Potential Conflict of Interest in the Production of Drug Compendia*, AGENCY FOR HEALTHCARE RES. & QUALITY 41 (Apr. 2006), <http://www.cms.gov/determinationprocess/downloads/id64TA.pdf>.

¹¹² *Layzer v. Leavitt*, 770 F. Supp. 2d 579, 582, 586 (S.D.N.Y. 2011) (noting the rareness of plaintiff's disease made FDA approval difficult).

¹¹³ See Joseph Sirven, *New Uses for Older Drugs: The Tales of Aspirin, Thalidomide, and Gabapentin*, 85 MAYO CLINIC PROC. 508, 508 (June 2010), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2878253/pdf/mayoclinproc_85_6_002.pdf.

possible treatment options in a field with finite viable therapies.¹¹⁴ In fact, the National Comprehensive Cancer Network recently estimated that as much as 50 to 75% of cancer treatments were being used off-label.¹¹⁵ As such, it is perhaps unsurprising that cancer medicines were the first category under Medicare Part D to be given an evidence based exception to the compendia requirement.¹¹⁶ All beneficiaries, including the mentally disordered, also deserve to prove they need particular medications covered. As discussed in part IVb, *infra*, off-label use is very common in the mental health field as well. Faced with an overabundance of coverage denials to patients prescribed meritorious off-label uses, Congress relied on medical compendia to curtail these improper denials.¹¹⁷ The utilization of compendia has reduced, but not solved this problem “and concerns have been expressed about the speed with which . . . compendia review the available evidence and issue their conclusions about off-label uses.”¹¹⁸ One example of this arose in October 2009 when a bipartisan group of 30 congressional representatives complained to CMS that the Medicare Parts A and B contractor for their area did not cover an off-label treatment for ovarian cancer, even though at least 29 other states had coverage for this use.¹¹⁹ This coverage denial was based on the recommendations of *one* of the approved compendia *in direct contradiction* to indications of safety and efficacy contained *in the other three* CMS compendia and the results of many clinical studies.¹²⁰

In addition to concerns that compendia may not always reflect the ever-evolving standards of medical practice, medical compendia, are susceptible to bias, error, and mistake much like any human artifice. One study commissioned by the CMS, published in 2009, conducted a comparatively limited inquiry into off-label use of 14 cancer drugs across

¹¹⁴ See McKinney et al., *supra* note 111, at 40 (citations omitted).

¹¹⁵ *Id.* (citations omitted).

¹¹⁶ Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494 (2008) (codified as 42 U.S.C. § 1305 (2008)).

¹¹⁷ See, e.g., American Society of Clinical Oncology, *Reimbursement for Cancer Treatment: Coverage of Off-Label Drug Indications*, 24 J. CLINICAL ONCOLOGY 1, 1-2 (Feb. 27, 2006), available at <http://www.asco.org/ASCO/Downloads/Cancer%20Policy%20and%20Clinical%20Affairs/Off-Label%20Drug%20Indications/Off-label%20statement.pdf>.

¹¹⁸ *Id.* at 2.

¹¹⁹ Kathleen Fairman & Frederic Curtiss, *Regulatory Actions on the Off-Label Use of Prescription Drugs: Ongoing Controversy and Contradiction in 2009 and 2010*, 16 J. MANAGED CARE PHARMACY 629, 634 (Oct. 2010).

¹²⁰ See *Id.*

six compendia (4 of which were utilized by the CMS at the time) and discovered some particularly troubling facts that put the reliability of compendia into question.¹²¹ Generally, the study found that the compendia did not make uniform recommendations of use because of various evidentiary discrepancies between them.¹²² Most had lack of transparency and other indicia of bias.¹²³ Also they used scanty or insufficient citation to evidence too often, and that is poor support for their listed indications.¹²⁴ There was a tendency to use old or otherwise questionable research as well (only one compendium cited research published after 2000 even though all purported to be current as of 2008).¹²⁵ The study expressed concern about the reliability of compendia given their status as “gatekeepers” to drug coverage decisions.¹²⁶ It noted the disproportionate authority agencies give to their recommendations, which is disconcerting in light of their results, because the study surveyed only 14 oncological applications and forwent a broader study of more medications and afflictions.¹²⁷ A report prepared for the Agency for Healthcare Research and Quality found that approved compendia generally did a poor job of citing the evidence for their endorsements.¹²⁸ They did not utilize the most current or well-designed research, and were wracked with potential conflicts of interest and bias.¹²⁹ For example, one compendium combats bias in their publication by requiring that their reviewers not work for a drug company or hold a drug patent while working on the compendium, yet still allows them to hold up to \$25,000 in pharmaceutical company stock.¹³⁰ Another study published in 2000 examined the compendia listings of drug-drug interactions for various sorts of pharmaceuticals and unfortunately found discrepancies between the compendia.¹³¹ In addition to their disagreement, some of the

¹²¹ See Amy Abernathy, *Reliability of Compendia Methods for Off-Label Oncology Indications*, 150 ANNALS INTERNAL MED. 336, 337-341 (Mar. 2009).

¹²² *Id.* at 341-42.

¹²³ *Id.* at 338-41.

¹²⁴ *Id.* at 338-41.

¹²⁵ *E.g., id.* at 340-42.

¹²⁶ *Id.* at 341-42.

¹²⁷ *Id.* at 341-42.

¹²⁸ See generally McKinney, *supra* note 111, at 4-6.

¹²⁹ *Id.*

¹³⁰ Muriel Gillick, *Controlling Off-Label Medication Use*, 150 ANNALS INTERNAL MED. 346 (Mar. 2009).

¹³¹ Thomas Fulda, et al., *Disagreement Among Drug Compendia on Inclusion and Ratings of Drug-Drug Interactions*, 61 CURRENT THERAPEUTIC RES. 540, 540-41 (Aug. 2000).

compendia did not list certain dangerous drug-drug interactions.¹³² It is common knowledge that many people, not just Medicare beneficiaries, take multiple medications for multiple ailments so a deficit in this sort of data is very worrisome.

In general, these findings show that compendia make mistakes. Sometimes they recommend uses that are contraindicated by the evidence and sometimes they omit uses that are indicated. With such authority and a reasonable chance of occasional error, it seems nonsensical not to have an expressly provided exception to compendia authority. Such an exception should require a showing of what compendia purportedly do, that the off-label use is shown to be effective and safe by medical industry practices and medical peer-reviewed literature of acceptable quality. That is not to say that compendia are all bad or that peer-reviewed research is all good. Rather a compendia based coverage regime should be flexible and allow for a reasonable margin of error. This can be done by providing a safety net wherein a patient proves a use to be medically necessary with scientific evidence. Such a healthcare coverage regime would be more sensible and effective. Cancer patients shouldn't exclusively enjoy such an effective failsafe. Rather, optimal pharmaceutical care of all maladies should be provided while striving to insure equity for the mentally disordered.

B. LEGAL ACTION ON OFF-LABEL USE COVERAGE UNDER MEDICARE PART D

In *S.A.B. v. AARP Medicare Rx Plan*, the Medicare Appeals Council considered a claim that a Part D plan should cover CellCept, an immunosuppressive drug, for the off-label use of controlling the symptoms of relapsing polychondritis.¹³³ The enrollee suffered from several other serious conditions that were not deciding factors in this case.¹³⁴ Polychondritis is a rare chronic malady and it causes recurring inflammation and affects cartilage, and biochemically similar tissues, in various parts of the body including: the ears, nose, joints, spine, trachea, eyes, heart, and blood vessels.¹³⁵ The beneficiary's doctors, each of whom are acclaimed in their fields, declared that CellCept was "medically

¹³² *See id.* at 543-46.

¹³³ *S.A.B. v. AARP Medicare Rx Plan*, Medicare Appeals Council, 1 (Dep't of Health and Human Servs. 2009), *available at* http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/case_sab.pdf.

¹³⁴ *Id.* at 2-3.

¹³⁵ *Id.* at 2 n.1 (citation omitted).

necessary for her condition, and that there would be life-threatening consequences if the medication was stopped.”¹³⁶ Methotrexate was used before CellCept, but the Methotrexate had not controlled her symptoms and had likely caused pulmonary fibrosis, a serious side effect.¹³⁷ The Medicare Appeals Council denied reimbursement for CellCept “since it is neither FDA-approved nor supported in the compendia for treatment of any conditions with which the enrollee is diagnosed, it is not a covered Medicare Part D drug.”¹³⁸

This outcome is antithetical to the purpose of Medicare Part D and leaves the enrollee with a quality of life changing, and potentially life-ending, outcome. The fact independent reputable doctors staked their reputations for an off-label use that seemingly has little potential for recreational use or fraud should have counted for something. Moreover, the patient’s record reflects the drug’s efficacy for her at the exclusion of everything else. This is not to say that observational evidence should be dispositive of coverage outcomes. Peer-reviewed empiricism and broadly supported standards of care should be factors. Real people’s health shouldn’t be subject solely to FDA indications and demonstrably imperfect compendia. There should be room for exceptions that are supported by a high scientific evidentiary threshold.

Another Medicare Appeals Council case affirmed the administrative law judge’s decision and granted the Plaintiff an exception and coverage by granting her the off-label use of opium tincture for her Crohn’s disease.¹³⁹ Factors in the decision included the individual patient’s long record of effective use of this treatment.¹⁴⁰ Indeed the patient’s history shows it to be the only drug that has worked for her; this was bolstered by scientific support and the fact that the drug pre-dates the formation of the FDA, making the drug “grandfathered.”¹⁴¹ The opinion of the Medicare Appeals Council put great emphasis on the fact that the FDA has remained relatively silent in regards to opium tincture and many formularies include the drug while one compendium designates the drug as grandfathered.¹⁴² This Part D beneficiary was fortunate to have a

¹³⁶ *Id.* at 2.

¹³⁷ *Id.* at 2-3.

¹³⁸ *Id.* at 5.

¹³⁹ *V.B.M. v. Anthem Blue Cross & Blue Shield, Medicare Appeals Council*, 1 (Dep’t of Health and Human Servs. 2009), *available at* <http://www.hhs.gov/dab/divisions/medicareoperations/macdecisions/vbm.pdf>.

¹⁴⁰ *Id.* at 1.

¹⁴¹ *Id.* at 1-2.

¹⁴² *Id.* at 3.

grandfathered drug that is widely used at issue. In most other circumstances, factors such as the medical industry's standard of care and the patient's history would be of no avail absent FDA approval or clear compendia endorsement. However, this case demonstrates that if an exception predicated on scientific evidence were to be adopted, meritorious claims could readily be differentiated from frivolous and unjustified attempts at obtaining coverage.

While the safety, efficacy, and cost considerations of the drug whose coverage is contested in the next case is beyond the scope of the court's opinion, the human element is compelling and inspires sympathy. In *Kilmer v. Leavitt*, the plaintiff was afflicted with systemic lupus erythematosus and heterotopic bone ossification, a condition that causes bone to form in multiple areas of her body, such as her joints, where there would usually be soft tissue.¹⁴³ As a result, the plaintiff was "unable to walk, stand, or move without assistance, and is confined to a wheelchair."¹⁴⁴ For her pain, the plaintiff was prescribed oral transmucosal fentanyl citrate, also called Actiq, which was provided by the manufacturer, for a time, at no or reduced charge.¹⁴⁵ When the company changed its policy, her Medicare Part D provider denied coverage.¹⁴⁶

She conceded that her prescription did not meet the criteria for "medically accepted indication" as described in statute.¹⁴⁷ Nevertheless, she asserted the statute concurrently did not restrict coverage only to medically accepted indications, but rather she should be granted coverage because the medication was "medically necessary."¹⁴⁸ The plaintiff argued on appeal to the district court that the "medically accepted indication" language in 42 U.S.C. § 1395w-102(e)(1) should not be read as a limitation but rather as an illustration of coverable medications.¹⁴⁹ The court found this argument unpersuasive and contrary to the plain meaning of the statute, reasoning that the phrase "such term includes" most logically means the conclusion of a list of coverable drugs rather than an example thereof.¹⁵⁰ Furthermore, the court goes on to say that while they found the statutory meaning clear, if poorly drafted, even if they were to find it ambiguous the agency nevertheless made a reasonable interpretation and regulation

¹⁴³ *Kilmer v. Leavitt*, 609 F. Supp. 2d 750, 752 (S.D. Ohio 2009).

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 753.

¹⁴⁸ *Id.*

¹⁴⁹ *Kilmer*, 609 F. Supp. 2d at 753.

¹⁵⁰ *See id.* at 753-54.

entitled to deference under a *Chevron* analysis.¹⁵¹ Assuming arguendo that the court's statutory interpretation was correct, it compels one to reexamine said statute. A person afflicted with lupus, as well as a condition that turns her soft tissue into bone, undoubtedly suffers a great deal of pain. If the plaintiff could demonstrate that this particular pain medication was medically necessary for her pain, a law that purports to provide needed care but summarily denies it due to a technicality is antithetical to its purpose and seems inhumane.

A few years later a district court in another jurisdiction disagreed with the statutory interpretation in *Kilmer v. Leavitt*.¹⁵² In *Layzer v. Leavitt*, the plaintiff suffered from a granulose cell tumor, an uncommon form of ovarian cancer.¹⁵³ Her oncologists prescribed Cetrotide for cancer control and one oncologist stated that Cetrotide was medically necessary because there was no alternate treatment at that time.¹⁵⁴ Specifically, he contended (and had other doctors and medical literature to support him) that Cetrotide was needed to prevent tumor growth and bleeding; even a temporary cessation in treatment would have dire consequences.¹⁵⁵ The court also repeatedly restated the administrative law judge's observation.¹⁵⁶ Namely, the administrative judge observed that the Plaintiff's medication had established medical necessity but that the use had neither compendia endorsement nor FDA approval most likely because her form of ovarian cancer was so rare.¹⁵⁷

The court held that the compendia requirement is undoubtedly inconsistent with the purpose of the MMA under the rules of statutory interpretation, and that even if it were ambiguous, that the Secretary's interpretation was unreasonable.¹⁵⁸ The chief reason this court disagreed with the interpretation of *Kilmer v. Leavitt* is that the language at issue contains the word "includes."¹⁵⁹ This word was expressly defined in the definitions section of the Act to not "exclude other things otherwise within the meaning of the term defined."¹⁶⁰ Thus, the court reasons that had Congress intended the list of coverable drugs to be exhaustive, they could

¹⁵¹ *Id.* at 755-56.

¹⁵² *Layzer v. Leavitt*, 770 F. Supp. 2d 579, 584 (S.D.N.Y. 2011).

¹⁵³ *Id.* at 581-82.

¹⁵⁴ *Id.* at 582.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.* at 582, 586.

¹⁵⁷ *Id.*

¹⁵⁸ *Layzer*, 770 F. Supp. 2d at 584.

¹⁵⁹ *Id.* (quoting 42 U.S.C. § 1301(b)).

¹⁶⁰ *Id.*

have easily included language that would limit the list and impose the compendia requirement.¹⁶¹ Furthermore, the court notes that the phrase “medically accepted indication” is a cross-reference to another section of the Social Security Act.¹⁶² As such the Secretary’s argument that the interpretation they adopt renders the term superfluous, is unavailing.¹⁶³ Moreover, the court cites precedent requiring them to interpret such legislation broadly in a way that avoids unjust results.¹⁶⁴ In particular, the court is obligated to interpret Social Security Act provisions in a way favorable to beneficiaries.¹⁶⁵ Finally, the court points out that Medicare Part D legislation expressly excludes drugs from coverage elsewhere, thereby implying that “medically accepted indication” is but an addition to a list and not an end to it.¹⁶⁶ As such, the court held that there was no restrictive compendia requirement in statute and instructed the Secretary to provide coverage.¹⁶⁷ Alone this holding will not resolve this issue; the case was dismissed from the docket for the United States Second Circuit Court of Appeals (and was then being litigated by Ms. Layzer’s estate).¹⁶⁸ Still, this outcome is based on a reasonable interpretation, and more importantly, is facially more equitable. If a Medicare Part D enrollee can demonstrate the reasonableness and medical necessity of their treatment, lack of FDA approval or compendia endorsement for a use seems an arbitrary and unfair basis to withhold life preserving therapy.

Currently there is legislation proposed that would resolve the issue if enacted. Days after the ruling in *Layzer v. Leavitt*, a bill was introduced in the U. S House of Representatives, known as H.R. 1055, that would expressly allow compendia exceptions based on the guidance of the Secretary and peer reviewed medical literature.¹⁶⁹ That this bill would clear any statutory ambiguity to align with the ruling of *Layzer v. Leavitt* is obvious. The bill would amend the MMA by adding an additional subparagraph.¹⁷⁰ The proposed act’s language when it was submitted to committee was,

¹⁶¹ *Id.*

¹⁶² *Id.* at 585.

¹⁶³ *Id.*

¹⁶⁴ *Layzer*, 770 F. Supp. 2d at 585.

¹⁶⁵ *Id.* (quoting *Hurley v. Bowen*, 857 F.2d 907, 912 (2d Cir. 1988)).

¹⁶⁶ *Id.* at 586.

¹⁶⁷ *Id.* at 587.

¹⁶⁸ *Id.* at 581 n.1, *appeal docketed*, No. 11-1922 (2d Cir. May 10, 2011).

¹⁶⁹ Part D Off-Label Parity Act, H.R. 1055, 112th Cong. (2011).

¹⁷⁰ 42 U.S.C. § 1395w-102(e)(4) (2010).

(D) Clarification. Notwithstanding subparagraph (A)(ii), none of the provisions of this subsection shall prevent a PDP sponsor offering a prescription drug plan or an MA organization offering an MA-PD plan from determining (whether through a determination, or an appeal of such determination under section 1852(g) or subsection (g) or (h) of section 1860D-4, as applicable) that a use of a covered Part D drug is for a medically accepted indication for purposes of coverage of such drug under such plan if such determination is based upon guidance provided by the Secretary for determining accepted uses of covered Part D drugs and on supportive clinical evidence in peer reviewed medical literature.¹⁷¹

U.S. Representatives Mac Thornberry (R-TX) and Russ Carnahan (D-MO) introduced the bill and Thornberry said,

Doctors and patients should be able to choose the safest and most effective medications for their treatments. Right now, the requirements for coverage of the off-label use of a drug are burdensome and often result in Medicare patients not being able to get the drug coverage they need. Our bill helps fix that problem.¹⁷²

Several mental health advocacy groups have given their support for the provisions of this bill.¹⁷³ However, the bill does not expressly contain provisions for parity for mental health prescriptions or any standards addressing considerations unique to off-label prescribing for mental disorder.¹⁷⁴ Given the critical relationship between mental wellness and total health, the lack of such language is a mistake. This mistake is more egregious when considered in light of the historical marginalization of mental health treatment and the unique problems associated with drugs used to treat these conditions. Because it seems improbable, at the time of publication, that this bill will be passed before the next Congress, this note

¹⁷¹ H.R. 1055.

¹⁷² Press Release, Thornberry Introduces Bipartisan Bill to Let Patients Get the Care They Need (Mar. 18, 2011), <http://thornberry.house.gov/News/DocumentSingle.aspx?DocumentID=229911>.

¹⁷³ *Id.*

¹⁷⁴ H.R. 1055.

urges that this line of legislation be resumed in a manner cognizant of mental health needs.

IV. MENTAL HEALTH PARITY CONCERNS IN REFORM

A. MANY MEDICARE PART D BENEFICIARIES HAVE MENTAL HEALTH CONCERNS

Mental disorders are extremely prevalent. Published in 2005, the results of the U.S. National Comorbidity Survey Replication (NCS-R) demonstrate that approximately 26% of Americans aged 18 and older were afflicted with a 12 month DSM-IV mental disorder.¹⁷⁵ The DSM-IV is the current, and standard, diagnostic manual for mental disorders in the United States.¹⁷⁶ A 2007 update of this survey viewed a smaller age range, 18-44, and found that roughly 32% of that population had a mental disorder.¹⁷⁷ The results of this study are conservative and are possibly higher in fact, because only 70.9% of the sample responded and lay people administered the survey.¹⁷⁸ There is also a stigma that discourages those surveyed from admitting to their mental issues for fear of embarrassment, and the study design did not allow for the homeless, the institutionalized, or the non-English speaking to be examined.¹⁷⁹ Moreover not all DSM-IV diagnoses were part of the NCS-R, for example schizophrenia was not included.¹⁸⁰ A related study found that 46.4% of Americans will have a DSM-IV disorder at some point in their lives, whereas 27.7% had two or more such disorders

¹⁷⁵ Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 617, Tbl. 1, Twelve-Month Prevalence and Severity of DSM-IV and WMH-CIDI Disorders in 9282 Respondents (2005), available at <http://archpsyc.ama-assn.org/cgi/content/full/62/6/617>.

¹⁷⁶ AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed.), available at <http://www.psych.org/MainMenu/Research/DSMIV.aspx> (last visited Jan 10, 2012).

¹⁷⁷ HARVARD MED. SCH., NAT'L COMORBIDITY SURVEY, Tbl. 1, 12-Month Prevalence of DSM-IV/WMH-CIDI Disorders by Sex and Cohort (n=9282) (2007), available at http://www.hcp.med.harvard.edu/ncs/ftpdir/NCS-R_12-month_Prevalence_Estimates.pdf.

¹⁷⁸ Kessler et. al, *supra* note 175, at 623-24.

¹⁷⁹ *Id.*

¹⁸⁰ *Id.* at 624.

and 17.3% had three or more.¹⁸¹ Much like its sister study, the NCS-R was the evaluative tool and thus the data is similarly conservative, including for older cohorts.¹⁸² Given the prevalence of mental illness it is troubling that less than half of people with such issues seek treatment, in part due to cultural norms and stigma, and many who do pursue therapy receive it from their general physician and not a psychiatrist.¹⁸³ Clear data reflecting how Medicare Part D enrollees relate to this generalized health problem is elusive. A cry for more research is not uncommon in the academic literature. Part of the difficulty in conducting research on Medicare Part D enrollees stems from information access issues (such as confidentiality) and the newness of the program. In March 2008, the National Opinion Research Center (NORC) submitted a report on improving the accessibility of Medicare Part D claims data while ensuring enrollee privacy.¹⁸⁴ At that time the data was inaccessible even to other government agencies and was used only for payments.¹⁸⁵ Happily, CMS promulgated rules allowing access to *some* information, under certain conditions, that May.¹⁸⁶ Far more troubling, a 2008 report by the Government Accountability Office identified issues with oversight and data reporting for Medicare Part D complaints and grievances.¹⁸⁷ Of particular concern was data (or lack thereof) from the grievance process wherein a beneficiary files a complaint

¹⁸¹ Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 595 (2005), available at <http://clclinic.cos.ucf.edu/Documents%20and%20Files/Kessler,%20Berglund,%202005.pdf>.

¹⁸² *Id.* at 598-601.

¹⁸³ Michelle Andrews, *For People with Mental Health Problems, Care Can Be Elusive*, L.A. TIMES (Mar. 21, 2011), <http://articles.latimes.com/2011/mar/21/health/la-he-healthcare-mental-health-20110321>.

¹⁸⁴ ELIZABETH HARGRAVE & JACK HOADLEY, NAT'L OPINION RES. CTR., NO. 08-2, FACILITATING ACCESS TO MEDICARE PART D DRUG CLAIMS DATA (2008) available at http://www.medpac.gov/documents/Mar08_PartD_CONTRACTOR_RS.pdf.

¹⁸⁵ *Id.* at 1.

¹⁸⁶ CTRS. FOR MEDICARE & MEDICAID SERVS., CMS-4119-F, FACT SHEET: FINAL MEDICARE PART D DATA REGULATION (CMS-4119-F), OFFICE OF MEDIA AFF. (2008), <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/PartDClaimsDataFactSheet.pdf>.

¹⁸⁷ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-08-719, MEDICARE PART D: COMPLAINT RATES ARE DECLINING, BUT OPERATIONAL AND OVERSIGHT CHALLENGES REMAIN (2008).

with the plan provider.¹⁸⁸ This is problematic given that these processes include coverage appeals, exceptions, and fraud and abuse data.¹⁸⁹

In spite of issues with data, available research does indicate medicine coverage issues for mental health patients enrolled in Medicare Part D. While various studies and surveys investigating the pervasiveness of mental disorder among population groups differ slightly in their conclusions, all conservatively find that psychiatric conditions are common. The elderly are at greater risk than the rest of the adult population for certain mental disorders.¹⁹⁰ For example, clinical depression affects at least 15% of seniors.¹⁹¹ Depression among the elderly is underreported and undertreated.¹⁹² In fact, suicide is more common among people 65 and older than any other segment of the population.¹⁹³ Concurrently, mental illnesses afflict people with disabilities and chronic illnesses at rates higher than the general population. For example, people afflicted with chronic diseases are more likely to have concomitant depressive disorders.¹⁹⁴ Moreover, many are eligible for Medicare Part D enrollment from a mental illness driven disability.¹⁹⁵ Prior to the advent of Medicare Part D, the 2002 Medicare Beneficiary Survey reported that 27% of the Medicare population had some form of cognitive or mental impairment.¹⁹⁶ This group commonly has dual eligibility for Medicare and

¹⁸⁸ *Id.* at 24.

¹⁸⁹ *Id.* at 27-28.

¹⁹⁰ *Seniors*, HEALTHYMINDS.ORG, <http://www.healthyminds.org/More-Info-For/Seniors.aspx> (last visited Jan. 11, 2012).

¹⁹¹ *Depression in Late Life: Not A Natural Part Of Aging*, GERIATRIC MENTAL HEALTH FOUND., http://www.gmhfonline.org/gmhf/consumer/factsheets/depression_latelife.html (last visited Jan. 9, 2011).

¹⁹² *Older Adults: Depression and Suicide Facts (Fact Sheet)*, NAT'L INST. MENTAL HEALTH (Apr. 2007), <http://www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts-fact-sheet/index.shtml#conwell-later-life>.

¹⁹³ Lauren Neergaard, *Senior Suicide Rate Alarms Doctors*, CBS NEWS (Feb. 11, 2009, 9:04 PM), <http://www.cbsnews.com/stories/2002/07/24/health/main516175.shtml>.

¹⁹⁴ Daniel Chapman et al., *The Vital Link Between Chronic Disease and Depressive Disorders*, 2 PREVENTING CHRONIC DISEASE 1 (2005), available at http://www.cdc.gov/pcd/issues/2005/jan/04_0066.htm.

¹⁹⁵ 42 U.S.C. § 1395c (1989).

¹⁹⁶ *Key Medicare and Medicaid Statistics*, KAISER FAMILY FOUND., <http://www.kff.org/medicaid/upload/Key%20Medicare%20and%20Medicaid%20Statistics.pdf> (last visited Jan. 12, 2011).

Medicaid and they comprise 29% of Medicare Part D enrollees.¹⁹⁷ 60% of dually eligible disabled persons, and 20% of the elderly dually eligible, have at least one mental disorder.¹⁹⁸ Thus it is unsurprising that at least a quarter of the senior, and half of the disabled, people eligible for Medicare use at least one psychotropic medication.¹⁹⁹

Considering that estimations of mental disorder prevalence are conservative, these usage figures translate into a decidedly sizable problem. When Medicare Part D came into effect it was estimated that 20% of all Americans with mental disorders were covered by another section of Medicare.²⁰⁰ In September 2011 29.5 million people were enrolled under Medicare Part D, of which 10.7 million had MA-PD plans.²⁰¹ In 2010, the CMS published a statistical supplement of Medicare and Medicaid data that reported 2009 figures that demonstrated that of the nearly 28 million people enrolled in Part D that year, almost 13% of MA-PD enrollees and nearly 24% of PDP enrollees were under 65 years of age.²⁰² Given the sheer volume of psychiatric issues in this population, perhaps it is of no surprise that medications for the treatment of mental conditions were among the most heavily prescribed under the various drug plans.²⁰³ Such prescriptions are expensive and Medicare beneficiaries with mental disorder historically

¹⁹⁷ Julie Donohue, et al., *Dual Eligibles with Mental Disorders and Medicare Part D: How are they Faring?*, 28 HEALTH AFF. 746 (2009).

¹⁹⁸ *Id.*

¹⁹⁹ Jack M. Rosenberg, *Overview of Medicare Part D Prescription Drug Benefit: Potential Implications for Patients with Psychotic Disorders*, 64 AM. J. HEALTH-SYS. PHARMACISTS S18, S19 (2007).

²⁰⁰ CHRISTOPHER LOFTIS & EILEEN SALINSKY, NAT'L HEALTH POL'Y FORUM, MEDICARE AND MENTAL HEALTH: THE FUNDAMENTALS 19 (2006).

²⁰¹ KAISER FAMILY FOUND., THE MEDICARE PRESCRIPTION DRUG BENEFIT (Nov. 2011), available at <http://www.kff.org/medicare/upload/7044-12.pdf>.

²⁰² OFFICE OF INFO. PRODS. & DATA ANALYSIS, CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE & MEDICAID STATISTICAL SUPPLEMENT, FIG. 14.2 – MEDICARE PART D PERCENT DISTRIBUTION OF ENROLLEES, BY TYPE OF PLAN AND DEMOGRAPHIC CHARACTERISTICS: JULY 1, 2010 (2011), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2011.html> (scroll to “downloads”; select “Medicare Part D 14.1-14.8 with Figures [ZIP, 790KB]”); *Id.* at TBL. 14.1, MEDICARE PART D: TYPE OF PLAN OR RETIREE DRUG SUBSIDY FOR PART D ENROLLEES, BY AREA OF RESIDENCE: JULY 1, 2010 (2011).

²⁰³ See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, CMS Pub. 100-18, ch. 6 (Rev. 10, Feb. 19, 2010), <https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf>.

have higher annual prescription costs than those who do not.²⁰⁴ The scope of this issue is poised to expand. At present, roughly 12% of the total United States population is 65 or older, by 2030 it is predicted the figure will be closer to 20%.²⁰⁵ This is concerning because suicide is rampant among the elderly now.²⁰⁶ Baby-Boomers have historically been more suicide prone than other generations and the suicide rate amongst this age bracket is rising again.²⁰⁷ This is concerning when considered alongside predictions that recent healthcare reform will increase the proportion of Medicare Part D enrollees with mental health ailments.²⁰⁸ Because people with mental illness are historically marginalized, and often have issues with competency and self-advocacy, reform needs to be made to accommodate them. This is particularly pressing because off-label use in psychiatric contexts has problems distinguishable from those of generalized health care.

B. PROBLEMS WITH OFF-LABEL USE AND COVERAGE FOR MENTAL DISORDER OR ILLNESS

Off-label use is widespread in mental health contexts. Psychiatric News, a newspaper of the American Psychiatric Association (APA), published a story on a study that found 75% of antidepressants, 80% of anticonvulsants, and 64% of antipsychotics prescribed to Georgia Medicaid beneficiaries in 2001 were off-label.²⁰⁹ This trend was particularly

²⁰⁴ Julie Donohue, *Mental Health in the Medicare Part D Drug Benefit: A New Regulatory Model?*, 25 HEALTH AFF. 707, 710-11 (2006).

²⁰⁵ Shari Roan, *Preparing For A Groundswell of Elderly People With Mental Illness*, L.A. TIMES (May 16, 2011), <http://articles.latimes.com/print/2011/may/16/news/la-lab-mental-illness-elderly-20110516>.

²⁰⁶ Neergaard, *supra* note 193.

²⁰⁷ *Baby Boomers Raise Midlife Suicide Rate, Study Suggests*, SCIENCE DAILY (Sep. 28, 2010), <http://www.sciencedaily.com/releases/2010/09/100927105201.htm>.

²⁰⁸ See e.g., Rachel Garfield, et al., *The Impact of National Health Care Reform on Adults with Severe Mental Disorders*, 168 AM. J. PSYCHIATRY 486, 490 (2011); Rachel Garfield, et al., *Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services*, 61 PSYCHIATRIC SERVS. 1081 (2010).

²⁰⁹ *Off-Label Psychotropic Use Reveals Complex Patterns*, PSYCHIATRIC NEWS (July 21, 2006), <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=110157>.

prevalent among the elderly.²¹⁰ The article also characterized these findings as “certainly no surprise . . .” and noted that some of the uses found were reassuring in their appropriateness while others were alarming in their contraindication.²¹¹ Much like other pharmaceuticals, off-label medications used for mental disorders range from safe, established, and effective, to unsupported and potentially dangerous. Because of this there was a workshop at the APA’s 2008 national meeting in Washington D.C. about off-label prescribing and liability.²¹² There it was stressed that off-label uses should be prescribed only with adequate medical evidence.²¹³ More importantly, the workshop cautioned practitioners to only prescribe off-label drugs with well informed consent from the patient, or in the event of competency issues, from the patient’s family or guardian.²¹⁴ Such training about off-label prescribing for the mentally disordered is wise. Many off-label uses have poor evidence of efficacy and subject patients to substantial danger. In June 2008 the FDA promulgated an alert cautioning physicians not to prescribe conventional antipsychotics for dementia because, much like atypical antipsychotics, use of these drugs to treat dementia comes with an unacceptably elevated risk of death.²¹⁵

But, not all off-label uses in mental health contexts are so full of doom and gloom. For example, selective serotonin reuptake inhibitors (SSRIs) were FDA approved as antidepressants but have found safe, common, effective, and well supported off-label uses for conditions such as anxiety, premature ejaculation, and migraine.²¹⁶ Moreover there are demonstrably effective, and much safer, off-label uses for some atypical antipsychotics.²¹⁷ While CMS has required formularies to cover “[a]ll or substantially all drugs in the antidepressants, antipsychotics, [and]

²¹⁰ *Id.*

²¹¹ *Id.*

²¹² Jun Yan, *With Precautions, Psychiatrists Need Not Shun Off-Label Prescribing*, PSYCHIATRIC NEWS, June 6, 2008, at 1.

²¹³ *Id.* at 36.

²¹⁴ *Id.*

²¹⁵ *Information for Healthcare Professionals: Conventional Antipsychotics*, U.S. FOOD & DRUG ADMIN. (June 16, 2008), <http://www.fda.gov/drugs/drugsafety/postmarketdrugsafetyinformationforpatientsandproviders/ucm124830.htm>.

²¹⁶ Kimberly Stone et al., *Off-Label Applications for SSRIs*, 68 AM. FAM. PHYSICIAN 498 (2003).

²¹⁷ *Cf. Atypical Antipsychotics May Aid Symptoms for Some Off-Label Conditions, but Not Others*, RAND CORP. (Sep. 27, 2011), <http://www.rand.org/news/press/2011/09/27.html>.

anticonvulsants.” classes that does not ensure coverage of off-label applications.²¹⁸ It may come as no shock that compendia are imperfect as applied to the mental health field as well.²¹⁹ In response to studies published regarding compendia in oncological contexts, two doctors found that, “[t]o its credit, DRUGDEX is the only available compendium recognized by the U.S. government as a guide to reimbursement decisions that provides detailed evaluations for off-label indications of psychoactive drugs.”²²⁰ Unfortunately, when they looked into the off-label uses of seven atypical antipsychotic drugs they found that the compendium cited scanty evidence to support its endorsements.²²¹

C. MENTAL HEALTH PARITY LAW IN GENERAL AND AS APPLIED TO MEDICARE

In 2000, RAND published a study that found that the mentally ill still lacked healthcare coverage equal to that of the general population and general illness, despite the passage of laws mandating mental health parity in the 1990’s.²²² To address this issue Congress expanded mental health parity laws in 2008 with the Mental Health Parity and Addiction Equity Act.²²³ Many applauded President Obama’s signing of the Act despite the fact that it did not provide total parity, such as its lack of applicability to Medicaid.²²⁴ While the act made advances (as most plans under its scope

²¹⁸ CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL, CMS Pub. 100-18, ch. 6, § 30.2.5 (Rev. 10, Feb. 19, 2010) (alteration in original), <https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf>.

²¹⁹ Richard Paczynski & Stefan Kruszewski, Letter to the Editor, *Inadequacies of Statutory Drug Compendia also Affect the Mental Health Field*, 151 ANNALS INTERNAL MED. 364, 365 (2009).

²²⁰ *Id.*

²²¹ *Id.* Recall that off-label use of atypical antipsychotics is occasionally problematic, thus they might not be representative of other off-label mental health drugs. See Chapman, *supra* note 194; Stone, *supra* note 216.

²²² *Are People With Mental Illness Getting the Help They Need? New Findings About Parity Laws, Insurance Coverage, and Access to Care*, RAND CORP. (2000), http://www.rand.org/pubs/research_briefs/RB4533/index1.html.

²²³ See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, § 512, 122 Stat. 3881 (2008) (codified as amended, 29 U.S.C. § 1185a (2008), 42 U.S.C. § 300gg-26 (2008)).

²²⁴ Cf. Sarah Kershaw, *Mental Health Experts Applaud Focus on Parity*, N.Y. TIMES (Mar. 29, 2010), <http://www.nytimes.com/2010/03/30/health/30mental.html>.

provide mental health benefits because it is well accepted that mental wellness affects total health) it also did not apply to Medicare.²²⁵

The Medicare Improvements for Patients and Providers Act (MIPPA), was another law passed in 2008 that addressed some mental health parity concerns and issues with Medicare Part D.²²⁶ MIPPA provided that Part D data be made available for research and evaluation²²⁷ and requires the Secretary to collect data to monitor and prevent healthcare disparities predicated on race, gender, or ethnicity.²²⁸ There was no provision mandating the monitoring of care and coverage disparity between the mentally ill and the general Medicare beneficiary population. This was a grievous oversight that should be ameliorated in the future. The act also added barbiturates and benzodiazepines to the classes of drugs covered under Medicare Part D²²⁹ and installed a compendia exception solely for anti-cancer off-label uses.²³⁰ MIPPA also required Part D formularies to include drugs that were unique and had no reasonable substitute.²³¹ This was because a lack of access could be life threatening or force less than optimal care. The CMS issued rules mandating formulary inclusion of antidepressants, antipsychotics, and anticonvulsants in response to this directive.²³² While a great step forward, coverage for such drugs still hinges on FDA approval or the endorsement of a CMS adopted compendium. Sadly, MIPPA did not explicitly provide a broader off-label exception or mental health drug parity. For many Medicare Part D enrollees, coverage is an uncertain thing as demonstrated by the conflicting holdings of *Kilmer v. Leavitt* and *Layzer v. Leavitt*.²³³ These remaining defects in Medicare Part D law need to be rectified. This fact is all the more pressing because MIPPA will also phase out Medicare's

²²⁵ *Mental Health Parity and Addiction Equity Act: Frequently Asked Questions*, AM. PSYCHOLOGICAL ASS'N (Aug. 2009), <http://www.apa.org/helpcenter/parity-law.aspx>.

²²⁶ Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, 122 Stat. 2494 (2008) (codified as 42 U.S.C. § 1305 (2008)).

²²⁷ *Id.* § 181.

²²⁸ *Id.* § 185.

²²⁹ *Id.* § 175.

²³⁰ *Id.* § 182.

²³¹ *Id.* § 176.

²³² *The Medicare Improvements for Patients and Providers Act of 2008: Mental Health Benefits*, BAZELON CTR. FOR MENTAL HEALTH LAW, <http://www.bazelon.org/LinkClick.aspx?fileticket=F9YIJMmyGvs%3D&tabid=353> (last visited Jan. 3, 2012).

²³³ See *supra* Part IIIb for a discussion of cases.

discriminatory cost sharing scheme for outpatient mental health services by 2014.²³⁴ Some commentators argue this was an economic move because the outpatient pricing scheme for mental health services may have encouraged the utilization of inpatient services.²³⁵ Perhaps now more patients will use outpatient services and decrease costs for general care commensurately.²³⁶ Furthermore, “studies have shown that improvements in mental health decrease costs for physical health care.”²³⁷ The need to revise Medicare to ensure medically appropriate access to off-label drugs, with parity for the mentally ill, is incredibly urgent. This is because, outpatient cost-sharing reform, when coupled with the aging of the baby boomer generation, and projections that the PPACA will expand utilization and coverage of psychiatric services, all forecast a growing problem.²³⁸ In light of litigation within the Second Circuit, a revision of the proposed Part D Off-Label Prescription Parity Act could address these concerns and prevent problems that are likely to occur, if such reform is not made, as the Medicare beneficiary population swells over the coming years. Besides, there are prescription drug coverage issues for mentally ill Medicare Part D enrollees at present. That is why it is imperative that such legislation, mindful of psychiatric ailments, remains a focus until passed.

Restricting coverage of medically necessary medication is dangerous and costly for all. This includes medically accepted off-label use in general, and among the mentally ill. As Tom Leibried, APA deputy director of congressional affairs, aptly told *Psychiatric Times*, “[l]ook at the complete cost picture. If a psychotic [person] suddenly loses access to a medication he has been taking successfully and has to be switched to an alternative, there may be a problem with compliance. It could result in higher utilization of emergency room services, for example.”²³⁹ In 2009, a study was published detailing the experiences of dually eligible persons

²³⁴ Medicare Improvements for Patients and Providers Act § 102.

²³⁵ See Laysha Ostrow & Ron Manderscheid, Letter to the Editor, *Medicare and Mental Health*, 28 HEALTH AFF. 922 (2009).

²³⁶ See *id.* Please note that a proposed bill is currently in Congressional committee that, if enacted, would remove Medicare’s 190 day lifetime limit for inpatient psychiatric treatment. Medicare Mental Health Inpatient Equity Act of 2011, H.R. 2783, 112th Cong. § 2 (2011).

²³⁷ Ostrow & Manderscheid, *supra* note 235.

²³⁸ See e.g., Garfield et al., *The Impact of National Health Care Reform*, *supra* note 208, at 490; Garfield, et. al., *Health Reform and the Scope of Benefits*, *supra* note 208, at 1085.

²³⁹ Stephen Barlas, *Mental Health Drugs at Issue in Part D Debate*, 24 PSYCHIATRIC TIMES 48, 48 (2007).

with mental disorders in the first year of Medicare Part D (2006).²⁴⁰ The study found that 35% of this population had trouble getting new or refilled psychiatric medications, while 19% were forced to switch from a stable medication to a new one.²⁴¹ After, there was an increased number of emergency room visits for this cohort and it disproportionately impacted women.²⁴² Dual eligibles were automatically enrolled in plans at Part D's outset and are subject to utilization management techniques such as prior authorization.²⁴³ It goes without saying that an off-label use may have greater difficulty obtaining prior authorization. However this should be based on a lack of medical necessity and not a convoluted rule. This is also concerning because the mentally ill have been subjected to more and more utilization techniques over time.²⁴⁴ These hurdles and barriers to coverage have restricted access to needed medication for some.²⁴⁵ For 2010 there were fewer low-income subsidy plans available.²⁴⁶ Such cost and utilization management tools have been found to sometimes provide an economic incentive to prescribe drugs inappropriate for seniors as well.²⁴⁷ Thus, some dually eligible enrollees had to find new prescription plans where prior authorizations and other drug coverage requirements would have to be satisfied anew. Because of the expense of psychiatric drugs and the extended nature of their use, summary denial of coverage for off-label medications was a concern for some pharmacists and psychiatrists from

²⁴⁰ Haiden Huskamp, et al., *Part D and Dually Eligible Patients with Mental Illness: Medication Access Problems and Use of Intensive Services*, 60 PSYCHIATRIC SERVICES 1169, 1171-72 (2009).

²⁴¹ *Id.* at 1171.

²⁴² *Id.* at 1171-72.

²⁴³ *Id.* at 1169-70. Such management techniques can be applied retroactively. See Ely, *supra* note 1 (demonstrating a doctor's frustration with prior authorization).

²⁴⁴ *The Medicare Part D Program: Ability of Individuals with Mental Illnesses to Access Needed Prescription Medications*, NAT'L COUNCIL FOR CMTY. BEHAV. HEALTHCARE 1, 1 (2009) (citation omitted), available at http://www.the-nationalcouncil.org/galleries/policy-file/Access%20to%20Medications_Part%20D%20Survey%20Results.pdf.

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ Rosenberg, *supra* note 199, at S21.

Part D's inception.²⁴⁸ Remember that different forms of a drug (such as extended release) or different doses can also be considered off-label use.²⁴⁹

Off-label uses in psychiatric contexts are often dangerous and poorly proven, despite the frequent appropriateness of off-label prescribing. As such, it is all the more important to clearly delineate the evidentiary requirements to support off-label use and coverage in either a compendium indication or as an exception thereto. The mentally ill often have competency issues or similar disadvantages and are an easy demographic to take advantage of. For example, the FDA reported that Jazz Pharmaceuticals paid a \$20 million dollar settlement for its subsidiary's illegal off-label promotion scheme.²⁵⁰ In that scam, they paid off a psychiatrist to promote one of their drugs for unsafe off-label psychiatric use and to also help prescribers hide the unsafe off-label prescribing to ensure that insurers paid for it.²⁵¹ With such risks it is imperative to make sure that off-label psychiatric indications listed in compendia are accurate and that an exception to a compendia also has a sound evidentiary basis. Real world patients do not reflect the controlled conditions of a study; they often have multiple conditions, different drug tolerances, and some suffer from afflictions so rare that good scientific data is unobtainable.²⁵² Such difficulties are unsurprising. A well-constructed and statistically significant experiment has a large sample population and excludes external variables that skew data. In 2003 a study was published that analyzed how evidence based practices were formulated in the field of geriatric psychiatry and it noted that certain limitations,

²⁴⁸ *Id.* at S21-22.

²⁴⁹ See LOFTIS & SALINSKY, *supra* note 200, at 19. It seems reasonable to presume the off-label dosages are often unsafe or ineffective even if it is sometimes indicated.

²⁵⁰ *Jazz Pharmaceuticals Settlement Totals \$20 Million; Subsidiary Pleads Guilty*, 16 NO. 7 FDA ENFORCEMENT MANUAL NEWSL. 12 (Thompson Publ'g Grp., Washington, D.C.), Sept. 2007.

²⁵¹ *Id.*

²⁵² See *Layzer v. Leavitt*, 770 F. Supp. 2d. 579, 582, 586 (S.D.N.Y. 2011) (noting that the rareness of Plaintiff's disease made FDA approval more difficult for researchers to obtain); ROSS MCKINNEY ET AL., AGENCY FOR HEALTHCARE RES. & QUALITY, WHITE PAPER: POTENTIAL CONFLICT OF INTEREST IN THE PRODUCTION OF DRUG COMPENDIA 41 (2006), *available at* <http://www.cms.gov/determinationprocess/downloads/id64TA.pdf>; MEDICARE RIGHTS CENTER, OFF-BASE: THE EXCLUSION OF OFF-LABEL PRESCRIPTIONS FROM MEDICARE PART D COVERAGE 4 (2007) (footnote omitted), *available at* http://www.medicarerights.org/pdf/Off_Base.pdf.

[M]ay result in overly conservative exclusion of informative studies, or alternatively, may cluster studies with inadequate attention to important differences. For, example, common problems affecting meta-analyses and evidence-based reviews include small sample sizes and lack of power, study heterogeneity, lack of interchangeable instruments, lack of extractable data, definitions of outcomes, quality and duration of studies, and reliance on statistical (as opposed to clinical) significance.²⁵³

While randomized, placebo controlled, studies are valuable they have limitations because their narrow, variable controlled approach does not adequately predict important facets of clinical efficacy.²⁵⁴ The results of studies designed to test for one condition are not easily applicable to real world patients suffering from multiple conditions and comorbidities, or those who are refractory and need different medications or a combination thereof.²⁵⁵ Refractory patients are undoubtedly at issue in off-label use controversies. These people are non-responsive to many drugs.²⁵⁶ Why then deny them a medication that works for them, provided it is safe and has solid evidentiary support? Because patients often have multiple conditions and take multiple medications, it is imperative to verify and document data on such treatment. The study suggested that evidence based practices should be established by various types of data such as: medical expert consensus guidelines, clinical studies, randomized controlled studies, patient records, and other medical data.²⁵⁷ Peer-reviewed studies that are not randomized or controlled still can provide scientifically valid and informative data on drug use.²⁵⁸ The study concluded that there were problems with various types of evidence, and the biases therein, and therefore called for evidence based practices to be predicated on as much credible data as possible as applied to the specific age and treatment

²⁵³ Stephen J. Bartels et al., *Evidence-Based Practices in Geriatric Mental Health Care: An Overview of Systematic Reviews and Meta-Analyses*, 26 PSYCHIATRIC CLINICS N. AM. 971, 984 (2003).

²⁵⁴ *Id.*

²⁵⁵ *Id.*

²⁵⁶ *Refractory Definition*, MERRIAM-WEBSTER.COM, <http://www.merriam-webster.com/medical/refractory> (last visited Sept. 1, 2012).

²⁵⁷ Bartels et al., *supra* note 253, at 984-85.

²⁵⁸ *Id.*

population.²⁵⁹ With improvements in technology it would be easier than ever before to make and implement such a database. Medicare Part D can set such standards by cataloging its data (while preserving confidentiality and identifying data). It may be advisable for Medicare to create or utilize compendia specific to the elderly or disabled, as well as compendia devoted to psychiatric uses. A broad base of potential evidence sources, provided they meet exacting standards, will also provide a complete picture of which therapies are sound and advisable, and which are not. Generally the government gives its agencies, such as HHS and CMS, broad discretion and deference to their expertise as well as their reasonable interpretation of their statutory directives.²⁶⁰ Prescription drug parity reform has the opportunity to ensure equal access to care for the mentally ill by explicitly directing the Secretary as to how drug coverage standards and exceptions thereto should be constructed. They should be based on scientific evidence and medical standards of care. Such measures will make Medicare more just and efficient, and possibly cheaper too.

Some reports have found that Medicare has lower administrative costs than the private insurance industry.²⁶¹ Conversely, one analysis found that Medicare's administrative costs were greater than those of private insurance, and it also found that coverage claims were a relatively small proportion of those costs (although the study did not evaluate Part D claims nor directly examine Part D administrative costs).²⁶² Either way, it seems intuitive that a clearer and more flexible coverage regime could reduce the number of coverage appeals that exhaust multiple steps in the process. By more accurately analyzing meritorious drug use earlier in the process, costs may be reduced. Also, an optimally treated patient is likely to be healthier and less expensive than one who is sick and unstable. For example, an untreated patient with depression has higher healthcare costs across the

²⁵⁹ *Id.*

²⁶⁰ *See generally* Chevron, U.S.A., Inc., v. Natural Res. Def. Council, 467 U.S. 837 (1984) (establishing the analysis regarding whether administrative agencies act properly in interpreting enabling statutes).

²⁶¹ MARK E. LITOW, COUNCIL FOR AFFORDABLE HEALTH INS., MEDICARE VERSUS PRIVATE HEALTH INSURANCE: THE COST OF ADMINISTRATION 2 (2006), available at http://www.cahi.org/cahi_contents/resources/pdf/CAHI

MedicareTechnicalPaper.pdf (using data before Medicare part D came into effect and extrapolating projections).

²⁶² Robert A. Brook, *Medicare Administrative Costs Are Higher, Not Lower, Than for Private Insurance*, HERITAGE FOUND., 1-5 (June 25, 2009), <http://heritage.org/research/reports/2009/06/medicare-administrative-costs-are-higher-not-lower-than-for-private-insurance>.

board than one who does not.²⁶³ Clearly, successful treatment could mitigate the heightened healthcare costs of such a patient. Therefore preventing patients from having medically necessary off-label medication due to a lack of a reasonable, and expressly provided for, exception process makes little sense. This is not just because it seems unfair to the patient, but also because the appeals process and untreated or undertreated (and therefore sicker) patients also cost money.

V. CONCLUSION

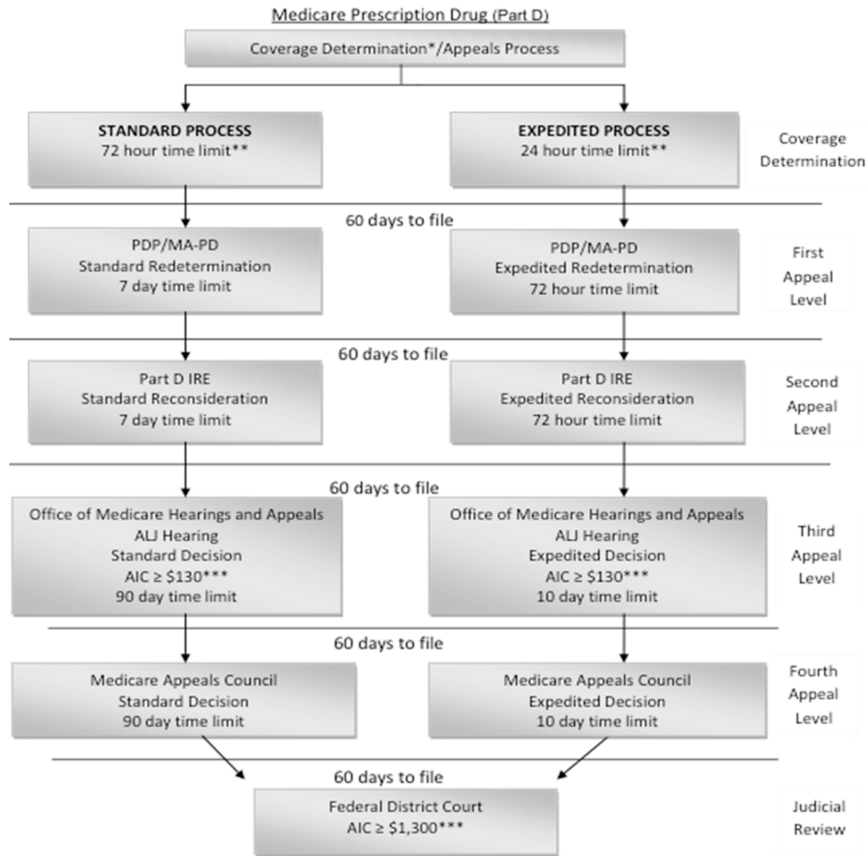
As general policy, close scrutiny of off-label prescribing is wise. Assuming *arguendo* that FDA approval is a guarantor of safety and efficacy, then all inappropriate drug use is off-label. However, as established in this note, off-label use is frequently appropriate commensurate with the medically necessary standard of care. Because bias, error, and suggestibility are endemic to the human experience it is folly to allow disparate compendia to absolutely dictate what uses should be coverable. There need to be exceptions for unforeseen contingencies and compendia inaccuracy or mistake. To deny or delay coverage of a medically necessary off-label drug is detrimental to enrollees' health and antithetical to the legislative purpose of the Medicare Part D program. A program that doesn't adequately satisfy its objectives is a waste. Moreover, patients deprived of their medicines are likely to have deterioration of health and the resultant rise in other health costs. Also, such enrollees are likely to file appeals, some of which may make it through to federal jurisdiction with meritorious cases that prevail. It is obvious that both worsening health from a lack of drug coverage and the appeals process cost the government, the plan providers, and the beneficiaries money and time. If coverage ultimately is, or should be, granted to such enrollees, it would be more efficient and therefore cheaper to fairly and accurately reach this outcome as quickly as possible without unduly delaying coverage or exhausting multiple steps in the appeals process.

In the instance of rare or complicated conditions where the ideal standard of placebo controlled, peer-reviewed, evidence is difficult to obtain, the individual patient's record, the results of less stringent but nevertheless statistically significant peer reviewed studies, clinical evidence, and medical industry best practices should also be factors. Such

²⁶³*E.g.*, Barlas, *supra* note 239, at 48; Gregory E. Simon, et al., *Health Care Costs of Primary Care Patients With Recognized Depression*, 52 ARCHIVE GEN. PSYCHIATRY 850-56 (1995).

clear factors and exceptions will allow coverage determinations and exceptions to be made quickly pursuant to what is demonstrably the medical industry's standard of care. While incompetent, negligent, and unscrupulous doctors are definitely out there, in general a physician's ethical and professional interests are aligned with providing their patients with the safest and most effective healthcare. These standards should be built into any legislative reform or should be taken into account in the event that the compendia only requirement is obviated by litigation.

However, off-label use in the treatment of psychiatric conditions is distinct. The interests of the mentally disordered are still marginalized. Mental health has historically had disparate coverage and this is a pity given that mental well-being is integral and essential to total healthiness. Recent healthcare reform and proposed legislation, coupled with the aging of the baby-boomers, are very likely to profoundly increase the use of psychiatric medications under Medicare Part D. Moreover, because some off-label uses in the mental health field are dangerous and unsupported it would be easy to categorically deny off-label psychiatric drugs, even medicines with a safe and medically necessary indication. This foreseeable problem can be prevented with the utilization of psychiatry specific compendia and express provisions for compendia exceptions. An evidentiary framework for coverage of off-label mental health drugs would establish parity under Medicare Part D for all, while also giving due consideration to the unique needs of patients with mental disorders.



AIC = Amount In Controversy
 ALJ = Administrative Law Judge
 IRE = Independent Review Entity
 MA-PD = Medicare Advantage plan that offers Part D benefits
 PDP = Prescription Drug Plan
 *A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.
 ***The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.
 ***The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year (CY) 2011.

<http://www.cms.gov/MedPrescriptDrugApplGriev/Downloads/PartDAppealsFlowchart.pdf>