15-1559

IN THE

United States Court of Appeals

FOR THE FOURTH CIRCUIT

ST. PAUL MERCURY INSURANCE COMPANY,
Plaintiff-Appellee,

—v.—

AMERICAN BANK HOLDINGS, INC.,
Defendant-Appellant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
BEFORE THE HONORABLE ROGER W. TITUS

BRIEF OF AMICUS CURIAE UNITED POLICYHOLDERS, IN SUPPORT OF APPELLANT AMERICAN BANK HOLDINGS, INC.

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Rules 26.1 and 29(c)(1) of the Federal Rules of Appellate Procedure of the United States Court of Appeals for the Fourth Circuit, United Policyholders, Amicus Curiae herein, states that it is a tax-exempt, non-profit 501(c)(3) organization, incorporated under the laws of the State of California and funded by donations and grants.

RULE 29(C)(5) STATEMENT

Pursuant to Federal Rule of Appellate Procedure 29(c)(5), United Policyholders states that this brief was not prepared, in whole or in part, by counsel for any party; that neither a party nor a party's counsel has contributed money intended to fund preparation of submission of this brief; and that no person, other than United Policyholders, its members, or its counsel, contributed money intended to fund preparation of this brief.

STATEMENT OF THE CASE

This is an insurance coverage action between policyholder[1] American Bank Holdings, Inc. ("ABHI"), and its insurer St. Paul

[1] For ease of reading, this brief will generally refer to the "policyholder" rather than the "insured," a word that can easily be mistyped as "insurer."

Mercury Insurance Co. ("St. Paul"). ABHI seeks review of the District Court's grant of summary judgment to St. Paul. Amicus Curiae United Policyholders adopts and incorporates by reference here the Statement of the Case set forth in ABHI's Opening Brief at 3-6.

INTEREST OF AMICUS CURIAE

United Policyholders ("UP") is a non-profit organization founded in 1991 and dedicated to educating the public about insurance issues and consumer rights. UP serves as an information resource and a voice for a diverse range of insurance consumers across the United States, from low-income homeowners to international businesses. UP serves an important purpose by advocating for the interests of policyholders. Most consumers can scarcely afford legal counsel to pursue their rights under their insurance policies. Insurance companies, in contrast, have extensive resources to retain lawyers at major law firms to oppose providing the coverage promised to their policyholders. In coverage disputes, insurers also enjoy a major advantage because their policies are written on standardized forms, which require approval by state regulators and which individual policyholders have no power to revise. UP seeks to level the playing field by offering similar resources and

comparable counsel to represent otherwise vulnerable policyholders in cases raising important insurance coverage issues.

UP has been active since its founding in helping a diverse range of policyholders throughout the United States. Donations, foundation grants and volunteer labor support the organization's work, which is divided into three program areas:

i) *Roadmap to Recovery* (helping disaster victims navigate the insurance claim process and recover fair settlements);

ii) *Roadmap to Preparedness* (promoting disaster preparedness and insurance literacy for homeowners and businesses); and

iii) *Advocacy and Action* (advancing the interests of insurance consumers in courts of law and before lawmakers and regulators).

UP serves as an important resource on public-policy issues relating to insurance. UP's Executive Director has been appointed for six consecutive terms as an official consumer representative to the National Association of Insurance Commissioners. The American Law Institute also appointed her in 2010 to serve as one of the Advisors to its project creating a RESTATEMENT OF THE LAW, LIABILITY INSURANCE. UP works closely with State Insurance Commissioners on issues affecting insurance consumers. The media and academics also regularly seek UP's input on insurance issues.

Since its founding, UP has filed amicus curiae briefs in federal and state courts in nearly 400 cases. Many courts, including the following state high courts, have adopted UP's arguments:

- The Pennsylvania Supreme Court in *Babcock & Wilcox Co, et al. v. American Nuclear Insurance Co., et al.*, Case No. 2 WAP 2014, 2015 WL 4430352 (Pa. July 21, 2015), and *Allstate Property & Casualty Co. v. Wolfe*, 105 A.3d 1181 (Pa. 2014);
- The Louisiana Supreme Court in *Kelly v. State Farm Mutual Insurance Co.*, Case No. 2014-CQ-1921, 2015 WL 2082540 (La. May 5, 2015);
- The Texas Supreme Court in *Excess Underwriters at Lloyd's, London v. Frank's Casing Crew & Rental Tools, Inc.*, 246 S.W.3d 42 (Tex. 2008);
- The California Supreme Court in *Vandenberg v. Superior Court*, 982 P.2d 229 (Cal. 1999); and numerous other proceedings, including *TRB Investments, Inc. v. Fireman's Fund Insurance Co.*, 145 P.3d 472 (Cal. 2006).

UP has also been granted leave to file briefs as an amicus curiae in numerous U.S. Supreme Court cases, including:

- *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S. Ct. 604 (2013);
- *US Airways v. McCutchen*, 133 S. Ct. 1537 (2013);
- *Hardt v. Reliance Standard Life Insurance Co.*, 560 U.S. 242 (2010); and
- *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008).

SUMMARY OF THE ARGUMENT

In addressing this appeal, it is important to keep key principles applicable to insurance in mind. Insurance provides a stabilizing force that allows individual customers, small businesses, international corporations, and the economy as a whole to thrive. Liability insurance policies provide two types of protection for the policyholder who faces a claim or suit: the promise to pay defense costs; and the promise to indemnify settlements or judgments. Policyholders often view the promise to pay defense costs as the more valuable protection, because even the defense of even a frivolous lawsuit can be ruinous.

However, insurance policies are a unique type of contract. They are highly standardized across providers, using standard-form terms that are generally not open to negotiation — even by the largest insurance customers. They also require the insurer to perform only upon the occurrence of the insured contingency, and thus the policyholder may pay premiums for years before the insurer is called on to pay. The delayed, contingent nature of the insurer's performance gives insurers incentives to breach, and unlike most other contracts, the

policyholder cannot replace the insurer's promises of defense and indemnification in the marketplace.

The purpose of insurance is to insure. Indeed, Insurance is defined as the transfer of risk from the policyholder to the insurer in exchange for the policyholder's payment of a premium. The insuring agreements of liability insurance policies, including the Policy at issue, state that "the Insurer shall pay on behalf of the Insured loss for which the Insured becomes legally obligated to pay." Few policies state that the policyholder must pay (or repay) the Insured – and any such requirement must be stated clearly in the policy language. No such language exists in the Policy at issue.

By its very nature, then, insurance is designed to protect policyholders, and any effort to deviate from that principle must be set forth unambiguously in the policy language itself. Maryland courts, like those in other states, recognize that the risk-transfer purpose of insurance is served by broadly construing the duty to defend to benefit policyholders. Thus, for example, Maryland courts have consistently construed an insurer's duty to defend as broader than its duty to indemnify. Similarly, Maryland courts have allowed policyholders to

rely on extrinsic evidence to establish the duty to defend, but have not allowed insurers to rely on extrinsic evidence to defeat it. Pro-policyholder rules such as these exist to ensure that policyholders get the full benefit of the risk transfer for which they pay premiums to insurers.

The District Court made a fundamental error in equating the *insurer's* duty to defend — and the attendant responsibilities that come with it — with the unique policy language at issue in this matter. By equating the language in this Policy with the traditional duty to defend of an insurer, the District Court's decision threatens to undermine the universal protections on which millions of policyholders rely.

St. Paul agreed to indemnify the policyholder here for its defense (and other) costs arising from liability claims. The Court should enforce St. Paul's defense obligation and reject St. Paul's clever, but unsupportable, argument that ABHI should protect, and repay, St. Paul for one of the key protections ABHI purchased here.

ARGUMENT

I. INSURANCE POLICIES ARE UNIQUE CONTRACTS THAT SERVE A VITAL PUBLIC-POLICY FUNCTION

A. Insurance is Different, Playing a Distinctive Role in Our Society

Insurance policies are a unique species of contract. They provide a vital service, protecting hundreds of millions of policyholders and their lives, homes, cars, property, incomes, and businesses. Insurance spreads risk and provides the financial security necessary for people and businesses to succeed, secure in the knowledge that a single catastrophic event will not lead to bankruptcy. The security and peace of mind that insurance provides benefit not just the individual policyholder, who is able to avert financial ruin, but the economy as a whole. Indeed, regulators from the Financial Stability Oversight Council[2] have recognized the stabilizing effect of insurance by

[2] The Financial Stability Oversight Council was created by the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. 111–203, H.R. 4173, 24 Stat. 1376–2223 at Title V, 31 U.S.C. § 313 (establishing the Federal Insurance Office within the U.S. Department of the Treasury).

designating several large insurance companies (as well as financial institutions) as "systemically important."[3]

Besides the overarching public-policy function that insurance serves, there are power imbalances inherent in the insurer-policyholder relationship that are not present in other commercial contracts, and that justify applying heightened duties to insurers. While insurers may seek to maximize profits by minimizing payments for claims, the economic safety-net function of insurance — and the resulting economic stability that it provides — is of paramount importance to policyholders, and Society. The perennial tension between the public-policy role of insurance and the economic interests of individual insurers has led to decades of case law governing the integrity of insurance products and imposing heightened duties on insurers that are not applicable to other types of commercial contracts. As the California Supreme Court recognized more than 35 years ago:

> Insurers' obligations are . . . rooted in their status as purveyors of a vital service labeled quasi-

[3] *See* Emily Stephenson, *Council Proposes AIG, Prudential, GE Capital as Systemically Important, Due Extra Scrutiny*, REUTERS INS. J. (June 4, 2013), *available at* http://www.insurancejournal.com/news/national/2013/06/04/294264.htm.

> public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements . . . . [A]s a supplier of a public service rather than a manufactured product, the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary.

Egan v. Mut. of Omaha Ins. Co., 620 P.2d 141, 146 (Cal. 1979); *accord Prudential Ins. Co. v. Benjamin*, 328 U.S. 408, 415-16 (1946) (explaining that the "[insurance] business-affected with a vast public interest"); *Robertson v. California*, 328 U.S. 440, 447 (1946); *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 540 n.14 (1944) ("Insurance . . . is practically a necessity to business activity and enterprise. It is, therefore, essentially different from ordinary commercial transactions, and . . . is of the greatest public concern"); *Osborn v. Ozlin*, 310 U.S. 53, 65 (1940) ("Government has always had a special relation to insurance."); *O'Gorman & Young, Inc. v. Hartford Fire Ins. Co.*, 282 U.S. 251, 257 (1931) ("The business of insurance is so far affected with a public interest that the State may regulate [insurance] rates").

Several points form an important backdrop for analysis of insurance-coverage disputes. *First*, insurance policies use standard-form terms, and, as a result, the substantive terms of a policy (as opposed to terms identifying, for example, the policy period or premium to be paid) are typically not open to negotiation. They are thus contracts of adhesion, and insurance customers — large and small alike — are generally without power to alter their terms.[4]

Because of their limited exemption from the antitrust law, granted in recognition of the crucial public function served by insurance, insurance companies are able to meet in insurance industry groups to discuss and draft standardized insurance contracts and their terms. Insurers reap substantial benefits from this standardization:

> Use of the same language in the policies of most companies has enabled court interpretations which clarify the meaning of policy language in any given area to be extended, in most cases, as an acceptable interpretation in similarly worded contracts and has thus avoided repeat litigation.

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[4] Most jurisdictions recognize standard-form insurance policies as contracts of adhesion. *See, e.g., Lambert v. Liberty Mut. Ins. Co.*, 331 So. 2d 260, 263 (Ala. 1976); *Gordinier v. Aetna Cas. & Sur. Co.*, 742 P.2d 277, 282 (Ariz. 1977); *Hallowell v. State Farm Mut. Auto. Ins. Co.*, 443 A.2d 925, 926 (Del. 1982); *Powers v. Detroit Auto. Inter-Ins. Exch.*, 398 N.W.2d 411, 413 (Mich. 1986).

American Soc'y of Ins. Mgmt., *Customer Analysis of the Comprehensive General Liability Policy* at iii (Professional Risk Managers ed., adopted Oct. 1966) (quoted in Lorelie S. Masters, Jordan S. Stanzler, & Eugene R. Anderson, INSURANCE COVERAGE LITIGATION § 1.02[B], at 1-26 (2d ed. 2000 & Supp. 2015)[5] ("Masters & Stanzler")). Insurers could not sell their products to the millions of ordinary people and businesses who purchase them without standardizing their substantive terms. See, for example, discussion and citations in Masters & Stanzler § 1.02, at 1-14–1-16. The terms of standardized coverages for homeowners and automobile liability insurance, as well as commercial general liability ("CGL") insurance, must be submitted to state insurance regulators for approval before those policy forms or terms can be offered to the public.

Because insurers control the terms of their policies, courts have not hesitated to apply the doctrine of *contra proferentem* to construe ambiguities in these boilerplate provisions against insurers. *See, e.g.*, Jeffrey E. Thomas, 1 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 5.02 (2015) (*contra proferentem* has been cited and used in

[5] Authorities that are not generally available are collected alphabetically in the attached Addendum of Unreported Authorities.

thousands of insurance cases); *see also* Masters & Stanzler § 2.02, 2.04 (same).

Second, insurance policies are aleatory contracts: They promise a future performance that the insurer is required to undertake only in the event that the policyholder suffers a covered loss.[6] The policyholder may pay premiums for years – even decades – before the insurer is called on to pay[7] (if, indeed, the insurer ever must perform). As one commentator recognized, the delayed nature of an insurer's performance creates incentives for breach:

> Insurance is far from the market ideals of complete information and no transaction costs. Opportunistic breaches are especially likely, and

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[6] The International Risk Management Institute ("IRMI"), a firm that analyzes insurance products, defines an aleatory contract as:

> [A]n agreement concerned with an uncertain event that provides for unequal transfer of value between the parties. Insurance policies are aleatory contracts because an insured can pay premiums for many years without sustaining a covered loss. Conversely, insureds sometimes pay relatively small premiums for a short period and then receive coverage for a substantial loss.

IRMI, *Glossary of Insurance & Risk Management Terms*, http://www.irmi.com/online/insurance-glossary/terms/a/aleatory-contract.aspx (last visited Aug. 12, 2015).

[7] *See generally* Richard E. Stewart & Barbara D. Stewart, *The Loss of the Certainty Effect*, 4 RISK MGMT. & INS. REV. 29, 29-30 (2001).

> traditional damage rules do not sufficiently deter them. Additionally, it is the very nature of the insurance contract that payment is to be made automatically without the need for a lawsuit.

Mark Pennington, *Punitive Damages for Breach of Contract: A Core Sample from the Decisions of the Last Ten Years*, 42 ARK. L. REV. 31, 54 (1989); *see also Communale v. Traders & Gen. Ins. Co.*, 328 P.2d 198, 200-02 (Cal. 1958).

These incentives justify application of the interpretive rules that construe ambiguities in standard-form policy language against the insurance-company drafter and that enforce insurance's "dominant purpose of indemnity." *Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034, 1041 (D.C. Cir. 1981). Such rules deviate from general contract principles when necessary to protect the value of the protection bought by the policyholder. In traditional contract law, the goal is not to enforce performance by the promisor, but to ensure "compensation of the promisee for the loss resulting from breach." *See* RESTATEMENT (SECOND) OF CONTRACTS, Intro. Note Ch. 16 (1981). Thus, for example, punitive damages have traditionally not been available for breaches of contract. *Id.* However, this model does not ensure the value of the bargain between a policyholder and its insurer because, once the

policyholder has suffered a loss, it cannot replace the insurer's promises of defense and indemnification in the marketplace. Insurance, therefore, is "different" from other types of contracts, as the Delaware Supreme Court recognized:

> Unlike other contracts, the insured has no ability to 'cover' if the insurer refuses without justification to pay a claim. Insurance contracts are like many other contracts in that one party (the insured) renders performance first (by paying premiums) and then awaits the counter-performance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counter-performance. In a typical contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counter-performance. With insurance this is simply not possible. This feature of insurance contracts distinguishes them from other contracts and justifies the availability of punitive damages for breach in limited circumstances.

E.I. du Pont de Nemours & Co. v. Pressman, 679 A.2d 436, 447 (Del. 1996) (footnotes omitted).

B. It is Important to Preserve the Distinctions Between Duty to Defend Policies and Other Policies Guaranteeing Coverage for Defense Costs

Policyholders who sought – and purchased – the protection of a duty to defend policy should receive the benefit of that bargain – a promise to protect the policyholder from the moment suit is brought.

Courts should not lightly use cases that protect this duty to defend in disputes that do not involve an insurance company's duty to defend. The court below did just that – loosely and without clear (or any) analysis, using case law enforcing an insurer's crucial duty to defend in a situation with different facts and different policy provisions.

Liability insurance policies include two key promises of protection for the policyholder should it face a claim or suit:

- The promise to pay defense costs, and
- The promise to pay settlements or judgments.

Policyholders often prize the insurer's defense obligation to defend as the more valuable promise because, even if a case is baseless, defense costs can be ruinous.

The promise to pay for the policyholder's defense – an insurer's defense obligation – can take one of two forms:

1. *The duty to pay defense costs*, or
2. *The duty to defend*.

The duty to defend includes the duty to pay defense costs, but the inverse is not true. Depending on case law and policy language, the duty to defend arises at the moment of suit and for any case where the allegations against the policyholder raise even a potential for coverage.

The duty to defend in a CGL, automobile or homeowners liability policy usually is outside of limits. The duty to pay defense costs also provides the policyholder important protection from defense costs and applies if there is a potential for coverage; however, it is a form of indemnification coverage and does not either give the insurer the right to control the defense or necessarily apply at the moment suit is brought.

The duty to defend is a cornerstone promise in CGL, automobile, and homeowners coverages. A duty to defend gives the insurer the "right and duty" to defend, and the insurer then controls the defense for the policyholder's benefit and protection. In contrast, the defense obligation in the kind of coverage at issue here – bankers' professional liability insurance – is an indemnification coverage. By indemnifying the policyholder, the insurer agrees to protect the policyholder from the risk posed by defense costs. The insurer does not control the defense; however, the benefit of the promise of defense coverage, as with the specific duty to defend, protects the policyholder who, after all, purchased the coverage and sought protection.

Both the duty to defend and the duty to pay defense costs – concomitant parts of an insurer's defense obligation – are purchased by

a policyholder, with the intent and objective of protecting the policyholder. It is specious to think that a policyholder – which sought out, and paid, the insurer to obtain protection from liability for defense costs (and settlements and judgments) – should pay an insurer for acts associated with the policyholder's own defense.

In addressing these issues, it is key, we submit, to remember what insurance is. Insurance is the transfer of risk from the purchaser – the policyholder who pays a premium – to the insurer who promises to perform at a future date, under contractually defined conditions. Thus, an insurance dictionary defines "insurance" as:

> *The contractual relationship which exists when one party, for consideration, agrees to reimburse another for loss caused by designated contingencies.* The first party is called the insurer; the second, the insured; the contract, the insurance policy; the consideration, the premium; the property in question, the risk; the contingency in question, the hazard or peril.

Lewis E. Davids, DICTIONARY OF INSURANCE, at 243 (7th rev'd ed. 1990) (emphasis added); *accord Aetna Cas. & Sur. Co. v. Cochran*, 651 A.2d 859, 863-64 (Md. 1995). A recognized claims-handling treatise defines an insurance policy as a promise to pay by the insurer in exchange for the policyholder's premium.

> **The Insurance Policy – The Promise to Pay.** The transfer of financial risks from individuals and businesses to the insurance company is accomplished through a written contract – the insurance policy.
>
> A special relationship is formed between the insurance buyer and the insurance company in an insurance transaction. The insurance buyer pays a premium, and instead of receiving a tangible product or immediate service, the buyer receives [from the insurance company] a conditional promise to pay in the event of a covered loss. The promise is neither tangible nor certain to ever be performed.

James J. Markham, *et al.*, THE CLAIMS ENVIRONMENT 5 (1st ed. 1993). The United States Court of Appeals for the District of Columbia Circuit, in a seminal insurance coverage case, similarly recognized the fundamental transfer of risk from policyholder to insurer as the "starting point for analysis":

> An insurance contract represents an exchange of an uncertain loss for a certain loss . . . . By issuing the policy, the insurer agrees to assume the risk of the insured's liability in exchange for a fixed sum of money. At the heart of the transaction is the insured's purchase of certainty – a valuable commodity.

Keene, 667 F.2d at 1041 (citation omitted).

Finally, an insurance policy is not an exchange of equal promises or amounts:

> The insurance transaction inherently involves an exchange of unequal amounts. Those who do not suffer a loss during a policy period will not receive any payments from the transaction. Those who do suffer a loss will likely receive amounts that significantly exceed the amount of premium paid.

Id. It is a contract transferring the uncertainty about future loss – including the specter of defense costs – to the insurer. Insurance thus is designed – and by its very nature – protects policyholders. Any effort to change that fundamental transfer of risk should be unambiguously set out in the contract. That was not done in the Policy here. ABHI bought insurance and sought the protection promised by the transfer of risk to the insurer. A decision here to require the policyholders – which sought to transfer risk to the insurer – to pay and thus "protect" the insurer turns the risk-transfer function of insurance on its head.

For these public-policy reasons, and for the reasons discussed below, the trial court's decision should be reversed and remanded.

II. THE COURT SHOULD DECIDE THIS CASE IN A MANNER THAT PRESERVES MARYLAND'S PRO-POLICYHOLDER CONSTRUCTION OF THE TRADITIONAL DUTY TO DEFEND

A. The Duty to Defend Provides Policyholders with Valuable "Litigation Insurance," Which is Governed by the Contract's Terms

The duties to defend and to indemnify are distinct concepts in the law of liability insurance. Each is governed by case law interpreting the policy language.

The duty to indemnify requires an insurer to compensate its policyholder for liability to pay the settlement or judgment in a claim covered under the terms of the policy. *See Jones v. Hyatt Ins. Agency, Inc.*, 741 A.2d 1099, 1104 (Md. 1999). The duty to defend, on the other hand, grants the insurer under traditional CGL policy language, for example, both the "right" and the "duty" to defend the policyholder against a third-party's claim of liability, and to control the defense from dollar one. *Sherwood Brands, Inc. v. Hartford Acc. & Indem. Co.*, 698 A.2d 1078, 1083 (Md. 1997). These duties arise from the risk-transfer function of insurance – and the insuring agreement and related provisions defining the insurer's defense obligation. No obligation to pay or reimburse the insurer is proper unless it is clearly stated in the

contract. The Policy here contains no such requirement, and St. Paul points to none.[8]

When policyholders purchase liability insurance, they seek "'litigation insurance'" that will protect them "'from the expense of defending suits.'" *Cochran*, 651 A.2d at 865 (citing *Brohawn v. Transamerica Ins. Co.*, 347 A.2d 842, 851 (Md. 1975)). Maryland courts, like those in other states, recognize the strong public-policy interest in broadly construing the duty to defend to benefit policyholders. The District Court's ruling, however, subverts and ignores the risk-transfer function of insurance and Maryland's public policy enforcing insurers' defense obligations, requiring the *policyholder*, ABHI, to pay its insurer without any contractual provisions that set forth such a requirement. There is no basis in law, public policy, insurance theory, or the contract language at issue here to support this result.

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[8] The insurance contract, therefore, should not in effect be rewritten to include such a requirement. *See Fultz v. Shaffer*, 681 A.2d 568, 578 (Md. Ct. Spec. App. 1996) ("[C]ourt[s] may not rewrite the terms of the contract or draw a new one when the terms of the disputed contract are clear and unambiguous, merely to avoid hardship or because one party has become dissatisfied with its provisions.").

B. Under Maryland Law, the Duty to Defend Exists "Primarily" for the Benefit of the Policyholder

Maryland courts have stated clearly that "[t]he duty to defend is primarily, . . . for the benefit of the" policyholder. *Sherwood Brands*, 698 A.2d at 1083. As this Court has recognized, "it is axiomatic that [under Maryland law] that the duty to defend is broader than the duty to indemnify." *Perdue Farms, Inc. v. Travelers Cas. & Sur. Co. of Am.*, 448 F.3d 252, 257 (4th Cir. 2006). Thus, while the insurer need indemnify its policyholder only for losses *actually* covered under the policy, it is obligated to *defend* and pay defense costs for any action whose allegations are "*potentially covered* by the policy, no matter how attenuated, frivolous, or illogical that allegation may be." *Sheets v. Brethren Mut. Ins. Co.*, 679 A.2d 540, 544 (Md. 1996) (emphasis added).

Maryland courts have long held that any doubts about whether a complaint alleges a cause of action within the coverage of the policy must be resolved in favor of the policyholder. As the Maryland Court of Appeals explained, "'in case of doubt as to whether or not the allegations of a complaint against the insured state a cause of action within the coverage of a liability policy sufficient to compel the insurer to defend the action, *such doubt will be resolved in the insured's favor*.'"

U.S.F. & G. v. Nat. Paving & Contracting Co., 178 A.2d 872, 879 (Md. 1962) (emphasis in original).

The courts in Maryland, and throughout the country, thus have adopted rules to ensure that the duty to defend and pay defense costs benefits the policyholder as intended. A prime example of this is the rule governing use of extrinsic evidence in evaluating whether an insurer's defense obligation applies. This is a "one way rule," consistent with the risk-transfer function of insurance and the traditional liability insurance language in which the insurer – not the policyholder – agrees to pay. Under this rule, insurers may not use extrinsic evidence to contest the duty to defend when the underlying complaint establishes, on its face, a potential for coverage. *E.g., Cochran*, 651 A.2d at 863-64 (citing *Brohawn*, 347 A.2d at 850). Policyholders, on the other hand, *may* rely on extrinsic evidence to show the potential for coverage when it is not necessarily clear on the four corners of the underlying complaint that a potential for coverage exists. *Cochran*, 651 A.2d at 865-66. Indeed, an insurer has the *duty* to "examine any relevant extrinsic evidence" when the "underlying complaint . . . neither conclusively establishes nor conclusively negates a potentiality of

coverage." *Montgomery Cnty. Bd. of Educ. v. Horace Mann Ins. Co.*, 860 A.2d 909, 915 (Md. 2004).

Rules like this are universal and arose to ensure that policyholders get the benefit of the transfer of risk to the insurer, in exchange for payment of premium, that defines insurance. As the Maryland Court of Appeals has emphasized: "'[t]he [insurance company's] promise to defend the insured, as well as the promise to indemnify, is the consideration received by the insured for payment of the policy premiums.'" *Cochran*, 651 A.2d at 865 (quoting *Brohawn*, 347 A.2d at 851) (emphasis added).

By equating, without analysis, an insurer's duty to defend with the Policy provisions at issue here, the decision below threatens to undermine the universal rule enforcing the litigation insurance upon which millions of policyholders depend. It should be reversed.

III. THIS CASE, AND THE INSURANCE POLICY IT INVOLVES, DO NOT IMPLICATE THE "DUTY TO DEFEND" AS IT IS TRADITIONALLY UNDERSTOOD IN THE LAW OF INSURANCE

A. The Terms of St. Paul's Policy do not Impose an Insurer's "Duty to Defend" on the Policyholder

In Policy Number EC03800512 ("the Policy"), St. Paul promises to protect ABHI by providing a defense obligation. The Policy includes no

duty to defend by the insurer but rather a duty to pay defense costs; indeed, it includes a provision confirming its status as indemnification coverage:

> *Indemnification*
>
> For purposes of this Policy, the Company agrees, to the fullest extent permitted by law, to indemnify the Insured Persons for all Loss. The Company will also take all steps necessary or allowable to provide such indemnification.

Joint Appendix ("JA") 925. Standard duty to defend policies include no such provision.

The relevant Insuring Agreement in the Policy provides Bankers Professional Liability Insurance, including Lender Liability Coverage. JA 906. In that Insuring Agreement, St. Paul promises that

> [T]he Insurer shall pay on behalf of the Insureds Loss for which the Insureds become legally obligated to pay on account of any Claim first made against them, individually or otherwise, during the Policy Period, the Automatic Discovery Period, or, if exercised, the Additional Extended Discovery Period, for a Lending Act taking place before or during the Policy Period.

JA 940. The insurer here drafted the insuring agreement – and all the other standard provisions here, including the Declarations of the Policy. JA 907-08. The Declarations include for each coverage in the Policy two

boxes relating to the defense obligation: one called "Duty of the *Insureds* to Defend," and one called "Duty of the *Insurer* to Defend." *Id.* (emphasis added). St. Paul, the master of the Policy,[9] filled in the "Duty of the Insureds to Defend" box. *Id.*

The Bankers Professional Liability Insuring Agreement contains a clause that St. Paul, the drafter, labeled "Duty to Defend Provision." JA 940. It cross-references to a similar, but longer provision in the General Terms, Conditions and Limitations section (JA 915-31) of the Policy (at JA 926-27). The "Duty to Defend Provision" set forth in the relevant Insuring Agreement provides:

> If the Duty of the Insurer to Defend is selected as set forth in the Declarations, then subject to the provisions of the Defense and Settlement section of the General Terms, Conditions and Limitations, the Insurer shall have *the right and duty to select counsel and defend* any Claim covered by this Insuring Agreement. If the Duty of the Insureds to Defend is selected as set forth in the Declarations, then subject to the provisions of Defense and Settlement section of the General Terms, Conditions and Limitations, *it shall be the duty of the Insured and not the duty of the Insurer*

[9] There is no record evidence that ABHI drafted the standard-form Declarations Page or Policy, filled in the Declarations Page, or put together the Policy. Indeed, it would be contrary to insurance industry custom and practice if ABHI, the policyholder, had done so.

> *to select counsel and defend* any Claim covered by this Insuring Agreement.

JA 940 (italics and underscoring added). Neither here nor anywhere else in the Policy does it ever state that ABHI is required to "pay" "the Insurer," St. Paul. The Policy, by its terms and consistent with what insurance is (a payment of premium in exchange for a future promise to pay by the insurer), places the payment obligation in the event of claim on the insurer.

Case law is clear that titles assigned to a contract provision – and especially one in the standard-form policy provisions drafted by insurers, without negotiation by policyholders – do not dictate what the provisions mean or how they operate. *E.g.*, *Fultz*, 681 A.2d at 578. The fact that St. Paul drafted a provision it called "Duty of the Insured to Defend" does not negate the risk-transfer function of ABHI's insurance. Nor does it make the case law enforcing an insurer's duty to defend its policyholder under traditional CGL, auto and homeowners insurance applicable to the Policy language at issue.

The defense provisions in the Policy, by their terms, make this clear. The two "duties" differ and do not mirror one another. The "Duty of the Insurer to Defend" provides that, "[i]f Duty of the Insurer to

Defend is selected . . . the Insurer shall have the right and duty to select defense counsel and defend any Claim covered by such Insuring Agreement under this Policy." JA 927. That provision requires the insurer to "defend Claims . . . even if any of the allegations are groundless, false or fraudulent." *Id.* Importantly, in the event that the insurer ceases to defend the policyholder against a claim and transfers control of the defense back to the policyholder, the insurer must "take whatever steps are necessary to avoid a default judgment during a transfer of control of the defense of any outstanding Claim." *Id.*

In contrast, the provision purporting to impose a "duty to defend" on the policyholder states that, "[i]f Duty of the Insureds to Defend is selected . . . it shall be the duty of the *Insureds* and *not* the duty of the Insurer to select defense counsel and defend any Claim covered by such Insuring Agreement under this Policy." JA 926 (emphasis added). Even under this provision, St. Paul retains the right "to effectively associate with" and "be consulted in advance by" the policyholder with regard to selection of defense counsel, defense strategies (including "decisions regarding the filing and content of substantive motions"), and settlement negotiations. *Id.* Even more importantly, the provision does

not negate the risk-transfer mechanism by requiring ABHI to pay St. Paul; nor does it set forth any standards or requirements for *how* the policyholder must conduct its defense and does not include any provision addressing default judgments.

The trial court's decision did not include this analysis – or any analysis – of the Policy's contractual provisions. No obligation to pay (or repay) the insurer should be placed on the policyholder unless such an obligation is clearly stated in the contract. The Policy here contains none.

B. The District Court's Ruling Incorrectly, and Without Analysis, Applies Case Law on Enforcing an Insurer's Duty to Defend to a Policyholder

The manner in which the Policy at issue allocates and describes the "duty to defend" is *sui generis*. The traditional duty to defend, as described in greater detail *infra*, is a component of CGL insurance policies (and other types of third-party liability insurance) that requires an insurer to pay for its policyholder's costs in defending a claim. *See* Barry R. Ostrager & Thomas R. Newman, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 5.01 (17th ed. 2014).

In its summary judgment briefing before the District Court, St. Paul asserted that there is no reason "why insurers and insureds should be held to different standards when the purpose of the duty to defend is the same in both cases." JA 566. The District Court appeared to agree, stating that, while in "[t]he usual case . . . the insurance company has the exclusive right to control the defense of the action, . . . this policy is exactly the opposite and has a duty to defend that rests upon the insured, not the insurer." JA 685. However, the two cases on which St. Paul relied below do not advance its duty to defend argument or include its Policy language, and the District Court appears to have conflated, and applied, inapposite case law to the unique situation presented here. The Policy here in no way imposes a duty on the policyholder to protect, or repay, the insurer.[10]

At the outset, the Court should view *Heil Co. v. Evanston Insurance Co.* with great skepticism because the policyholder-plaintiff in that case failed to timely respond to the insurer's summary judgment

[10] Indeed, insurance should never make the policyholder worse off for having purchased insurance. At a minimum, any requirement for the policyholder to reimburse its insurer must be stated clearly and unambiguously in the policy. St. Paul has pointed to no such provision, and cannot do so.

motion, and thus "the Court review[ed] the motion . . . without the benefit of Plaintiff['s] counter-arguments." No. 1:05-cv-284, 2009 WL 596001, at *1 (E.D. Tenn. Mar. 6, 2009). The issues before the court thus were not fully vetted, and the persuasive value of this out-of-circuit, unreported district court decision is at best minimal.

Heil also involved materially different policy language. The policy there created a $500,000 self-insured retention and required the policyholder to "provide, at his own expense, proper defense and investigation of any claim" until "the exhaustion of the Self-Insured Retention." *Id.* at *2 (quotation marks omitted). Exhaustion of the self-insured retention was a condition precedent to coverage. *Id.* at *1.

In contrast to the Policy here, the policyholder there agreed to negate the risk-transfer function of insurance, accepting an explicit requirement for the policyholder to pay "at his own" expense for "proper" defense and investigation of claims. The court analogized that requirement to that applicable to the relationship between a primary and an excess insurer. As the court observed, "most jurisdictions allow an excess liability carrier to recover from a primary insurer for an

improper and inadequate defense." *Id.* at *3. No such policy provisions exist here.

St. Paul asserted below that the "duty to defend" language at issue imposes the same standards on the policyholder that it does on insurers because "the purpose . . . is the same in both cases." JA 566. Not true. That statement distorts beyond recognition the unique relationship between an insurer and its policyholder, and negates the transfer of risk that defines "insurance." The insurer's duty to defend here, and in all cases, involves a transfer of risk from the policyholder to the insurer in exchange for a premium. The policyholder cannot transfer to itself a risk that it already bore. St. Paul's subsequent reliance on *Delatorre v. Safeway Insurance Co.*, 989 N.E.2d 268 (Ill. App. 2013), is thus unavailing.

CONCLUSION

Policyholders are uniquely vulnerable to insurer recalcitrance, and courts should avoid accepting clever arguments that ignore the purpose and function of insurance. Policyholders perform their obligations under the contract first, by paying premiums in order to obtain security, "a piece of the rock," the "umbrella"; the insurer's

obligation to counter-perform arises only in the event of a claim. If the insurer breaches by refusing to defend or indemnify a claim, the policyholder cannot seek a substitute performance in the market because the contingency that it sought to insure has already occurred. That is one of the reasons why the law on the duty to defend so strongly favors policyholders. It is also why St. Paul is incorrect that the burdens of the duty to defend should be placed on ABHI.

This Court should reverse the District Court's grant of summary judgment to St. Paul and remand with instructions to enter partial summary judgment in ABHI's favor, declaring that ABHI is entitled to indemnification in full from St. Paul for its defense costs. That result would recognize the function of insurance, enforce the Policy language as written, and properly analyze and apply the myriad Maryland and other states' decisions enforcing a traditional duty to defend.

Dated: August 12, 2015

Respectfully submitted,

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/s/ Lorelie S. Masters
Lorelie S. Masters
Attorney for Amicus Curiae, United Policyholders
Dated: August 12, 2015

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that, on this 12th day of August, 2015, the foregoing Brief of Amicus Curiae United Policyholders, in Support of Appellant American Bank Holdings, Inc., was filed electronically through the Court's CM/ECF system. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system.

/s/ Christopher R. Healy
Christopher R. Healy

ADDENDUM OF UNREPORTED AUTHORITIES

CASES **PAGE**

Handbook on Insurance Coverage Disputes - Ostrager and Newman, §5.01, INTRODUCTION

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When an insured becomes a defendant in litigation or otherwise becomes the target of a claim, the first question that typically arises between the insured and its insurer is whether the insurer has an obligation to pay for the insured's defense. This issue is highly fact-specific, depending on the terms of the insurance policy under which defense is sought, the allegations against the insured, and other issues discussed below.

[a] Insurer's Duty Generally

The duty of a general liability insurer to provide a defense for claims asserted against its insureds is contractual, and courts will therefore look to the language of the policy at issue to determine an insurer's defense obligations. *See, e.g.*, *Barney Greengrass Inc. v. Lumbermans Mut. Cas. Co.*, No. 09 Civ. 7697 (NRB), at *1 n.2 (S.D.N.Y July 27, 2010) (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.02[a][1] (15th ed. 2009)); *In re Sept. 11th Liability Ins. Cov. Cases,* 458 F. Supp. 2d 104, 116 (S.D.N.Y. 2006) (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.01 (12th ed. 2004)); *Henkel Corp. v. Hartford Accid. & Indem. Co.*, 399 F. Supp. 2d 607, 613 (E.D. Pa. 2005) (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.01 (12th ed. 2004)), *aff'd*, No. 06-4856 (3d Cir. Mar. 27, 2008) (unpublished opinion); *Mine Safety Appliances Co. v. AIU Ins. Co.*, No. N10C-07-241, at *3 n.19 (Del. Super. Jan. 21, 2014) (unpublished opinion) (citing *Henkel* and Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.01 (12th ed. 2004)); *Metlife Capital Corp. v. Westchester Fire Ins. Co.*, 224 F. Supp. 2d 374, 387 (D.P.R. 2002) (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.01 (11th ed. 2002)); *Farrell Lines, Inc. v. Insurance Co. of N. Am.*, 789 F.2d 300, 304 (5th Cir. 1986); *Western World Ins. Co. v. Hartford Mut. Ins. Co.*, 784 F.2d 558, 562 (4th Cir. 1986); *Milbank Ins. Co. v. Garcia*, 779 F.2d 1446, 1448 (10th Cir. 1985); *Hancock Labs., Inc. v. Admiral Ins. Co.*, 777 F.2d 520, 522 (9th Cir. 1985); *Foreman v. Continental Casualty Co.*, 770 F.2d 487, 489 (5th Cir. 1985); *Boyd Bros. Transp. Co. v. Fireman's Fund Ins. Co.*, 729 F.2d 1407, 1410 (11th Cir. 1984); *Frankart Distribs., Inc. v. Federal Ins. Co.*, 616 F. Supp. 589, 591 (S.D.N.Y. 1985); *Klein v. Salama*, 545 F. Supp. 175, 177 (E.D.N.Y. 1982); *Patrons Oxford Mut. Ins. Co. v. Marois*, 573 A.2d 16 (Me. 1990); *Gross v. Lloyds of London Ins. Co.*, 121 Wis. 2d 78, 358 N.W.2d 266, 270 (1984) ("each case involving a promise to defend must be considered independently on the basis of the particular language in the contract at issue"); *Ruder & Finn, Inc. v. Seaboard Sur. Co.*, 52 N.Y.2d 663, 422 N.E.2d 518, 439 N.Y.S.2d 858 (1981); *Ehrlich v. Aetna Casualty & Sur. Co.*, 95 A.D.2d 936, 463 N.Y.S.2d 934, 936 (3d Dep't 1983); *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966). *Cf. Uniroyal, Inc. v. American Re-Ins. Co.*, No. A-6718-02T1, at *17-*19 (N.J. Super. App. Div. Sept. 13, 2005), *cert. denied*, 186 N.J. 363, 895 A.2d 450 (N.J. 2006) (excess insurer's obligation to reimburse defense costs is determined by explicit language in policy).

Some courts have held that an insurer has no "duty to defend" unless the obligation is expressed in the policy. *See, e.g.*, *Genaeya Corp. v. Harco National Ins. Co.*, 991 A.2d 342, 347 (Pa. Super. Ct. 2010) (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.01[a] (14th ed. 2008)); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 536 F.2d 730, 736 (7th Cir. 1976); *Mattocks v. Daylin, Inc.*, 452 F. Supp. 512, 514 (W.D. Pa. 1978), *aff'd without opinion*, 614 F.2d 769 & 770 & 771 (3d Cir. 1979); *All-Star Ins. Corp. v. Steel Bar, Inc.*, 324 F. Supp. 160, 163 (N.D. Ind. 1971) ("The nature of insurer's duty to defend is purely contractual. There is no common law duty as to which the courts are free to devise rules."). *See also Newmont USA Ltd. v. American Home Assurance Co.*, 676 F. Supp. 2d 1146, 1155 (E.D. Wash. 2009) ("Where an insurance policy confers a right to defend, but not an obligation to defend, the insurer's election not to take over the defense is not a breach of duty owed to the insured.").

However, a growing number of courts have held that an insurer has a duty to defend where the policy language gives the insured a reasonable expectation that the insurer will provide a defense. *Homedics, Inc. v. Valley*

Forge Ins. Co., 315 F.3d 1135, 1140 (9th Cir. 2003). This approach can be traced to the landmark California case of *Gray v. Zurich Insurance Co.*, 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966). *See also Centennial Ins. Co. v. Applied Health Care Sys.*, 710 F.2d 1288, 1295 (7th Cir. 1983) ("Under California law an insurer bears the obligation to defend where the policy reasonably leads the insured to expect a defense.... Even an apparent exclusion of coverage cannot defeat that duty."); *Gon v. First State Ins. Co.*, 871 F.2d 863 (9th Cir. 1989); *Okada v. MGIC Indem. Corp.*, 823 F.2d 276 (9th Cir. 1987); *Cal-Farm Ins. Co. v. TAC Exterminators, Inc.*, 172 Cal. App. 3d 564, 218 Cal. Rptr. 407 (2d Dist. 1985); *Jaffe v. Cranford Ins. Co.*, 168 Cal. App. 3d 930, 214 Cal. Rptr. 567 (1985). *See also Truck Insurance Exchange v. Insurance Co. of the West*, No. G028278 (Cal. App. 4th Dist. Sept. 30, 2002) (duty to defend is owed despite insured's corporate suspension by the state Franchise Tax Board).

Other jurisdictions have adopted the California rule. *See, e.g., IDG, Inc. v. Continental Casualty Co.*, 275 F.3d 916, 920 (10th Cir. 2001) (quoting *First Bank of Turley v. Fidelity & Deposit Ins. Co.*, 928 P.2d 298 (Okla. 1996)), *cert. denied*, 536 U.S. 940 (2002); *Atwater Creamery Co. v. Western Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 278 (Minn. 1985); *Estrin Constr. Co. v. Aetna Casualty & Sur. Co.*, 612 S.W.2d 413, 417 (Mo. Ct. App. 1981); *Mills v. Agrichemical Aviation, Inc.*, 250 N.W.2d 663 (N.D. 1977); *Sterilite Corp. v. Continental Casualty Co.*, 17 Mass. App. Ct. 316, 458 N.E.2d 338, 341, *review denied*, 391 Mass. 1102, 459 N.E.2d 826 (1984); *Raska v. Farm Bureau Mut. Ins. Co.*, 412 Mich. 355, 314 N.W.2d 440, 445 (1982); *Am. Economy Ins. Co. v. Liggett*, 426 N.E.2d 136, 141 (Ind. Ct. App. 1981); *Rodman v. State Farm Mut. Auto. Ins. Co.*, 208 N.W.2d 903, 906-08 (Iowa 1973).

[b] Tender of Defense

It is generally held that "a tender of defense is a condition precedent to the creation of a duty to defend," and tender of defense cannot occur until the insured notifies the insurer of the claim against it. *Towne Realty, Inc. v. Zurich Ins. Co.*, 201 Wis. 2d 260, 267-68, 271, 548 N.W.2d 64, 66-68 (1996); *see also Mutual of Enumclaw Ins. Co. v. USF Ins. Co.*, 164 Wash. 2d 411, 191 P.3d 866, 873 (2008) (a breach of the duty to defend cannot occur before tender); *Sanem v. Reliance Ins. Co. of Illinois*, No. 99-35690 (9th Cir. Feb. 26, 2001); *Domtar, Inc. v. Niagara Fire Ins. Co.*, 563 N.W.2d 724, 739 (Minn. 1997) ("an insured does not invoke its insurer's duty to defend until it properly tenders a defense request"); *Holmes v. Morgan Guar. & Trust Co.*, 223 A.D.2d 441, 442, 636 N.Y.S.2d 778, 779 (1st Dep't 1996) (compliance with proper notice-of-claim provision in insurance policy is condition precedent to all of insurer's duties under policy, including duty to defend).

Some courts have held that specific tender of defense is required to trigger the insurer's defense obligation. *See Travelers Indem. Co. v. W.M. Barr & Co.*, No. 2:08-CV-02649 (W.D. Tenn. Oct. 31, 2011) (dismissing policyholder's breach of contract claim against insurer, finding that because policyholder failed to expressly tender the defense of any lawsuit to the insurer, the insurer had no duty to defend); *Unigard Ins. Co. v. Leven*, 97 Wash. App. 417, 426-27, 983 P.2d 1155, 1160 (Ct. App. 1999), *review denied*, 140 Wash. 2d 1009, 999 P.2d 1263 (2000); *First Bank of Turley v. Fidelity & Deposit Ins. Co. of Md.*, 928 P.2d 298, 304 (Okla. 1996); *American Gen. Fire & Casualty Co. v. Progressive Casualty Co.*, 110 N.M. 741, 747, 799 P.2d 1113, 1119 (1990).

However, others deem notice alone to constitute tender of defense. For example, in *Garcia v. Underwriters at Lloyd's, London*, 182 P.3d 113, 143 N.M. 732 (N.M. 2008), the New Mexico Supreme Court departed from previous precedent, and held that an insurer's actual notice of a claim against its insured is sufficient to trigger defense obligations unless the insured affirmatively declines a defense. Noting a split among jurisdictions, the court reasoned that its decision "more effectively protects the expectations of the parties...and addresses more compelling policy concerns...." 182 P.3d at 117-18. Additionally, the court noted that although the "new rule" does not "impose some kind of automatic duty [on insurers] to become involved in litigation," it does change "the inquiry at the summary judgment stage." 182 P.3d at 118. *See also OneBeacon America Ins. Co. v. Fireman's Fund Ins. Co.*, 175 Cal. App.4th 183, 200, 95 Cal Rptr.3d 808, 821 (2d Dist. 2009) (noting that "tender" can be either formal or constructive); *Medical Mut. Ins. Co. of North Carolina v. American Cas. Co. of Reading, Pa.*, No 721 F. Supp. 2d 447 (E.D.N.C. 2010) (policy language requires only that insured provide written notice of suit against him to implicate duty to defend; policy does not require insured "to explicitly demand a defense"); *Hoppy's Oil Serv., Inc. v. Insurance Co. of N. Am.*, 783 F. Supp. 1505, 1509 (D. Mass. 1992) ("No duty to

defend or to participate in a defense can arise before the insurer has notice of the suit against the insured...."); *Cincinnati Cos. v. West Am. Ins. Co.*, 183 Ill. 2d 317, 323-30, 701 N.E.2d 499, 502-05 (1998); *cf. Town of Mount Pleasant v. Hartford Accid. & Indem. Co.*, 241 Wis. 2d 327, 333-34, 625 N.W.2d 317, 320-21 (Ct. App. 2001) ("[N]otice from the insured does not have to meet technical requirements in order to trigger the duty of the insurer to defend; if an insurer is made aware of a lawsuit against one of its insureds, the burden is on the insurer to clarify the needs of the insured.").

[c] Pre-Tender Defense Costs

As a general rule, "an insurer has no duty to defend until it receives notice of a claim" and thus is not responsible for pre-tender defense costs. *Dreaded, Inc. v. St. Paul Guardian Ins. Co.*, 904 N.E.2d 1267 (Ind. 2009); *AMI Entertainment Network, Inc. v. Zurich American Ins. Co.*, No. 12-2511 (6th Cir. May 20, 2013) (unpublished opinion) (Michigan law); *American Mut. Liab. Ins. Co. v. Beatrice Cos.*, 924 F. Supp. 861, 872-84 (N.D. Ill. 1996); *see also Ingalls Shipbuilding v. Federal Ins. Co.,* 410 F.3d 214, 227 (5th Cir. 2005); *Elan Pharm. Research Corp. v. Employers Ins. of Wausau*, 144 F.3d 1372, 1381-82 (11th Cir. 1998), following *O'Brien Family Trust v. Glen Falls Ins. Co.*, 218 Ga. App. 379, 380-81, 461 S.E.2d 311, 313 (1995). *But see National Surety Corp. v. Immunex Corp.*, 176 Wash. 2d 872, 297 P.3d 688 (Wash. 2013) (insurer's duty to defend arises upon filing of complaint alleging facts that could potentially require coverage, but pre-tender defense costs are not recoverable where notice is untimely and insurer is prejudiced).

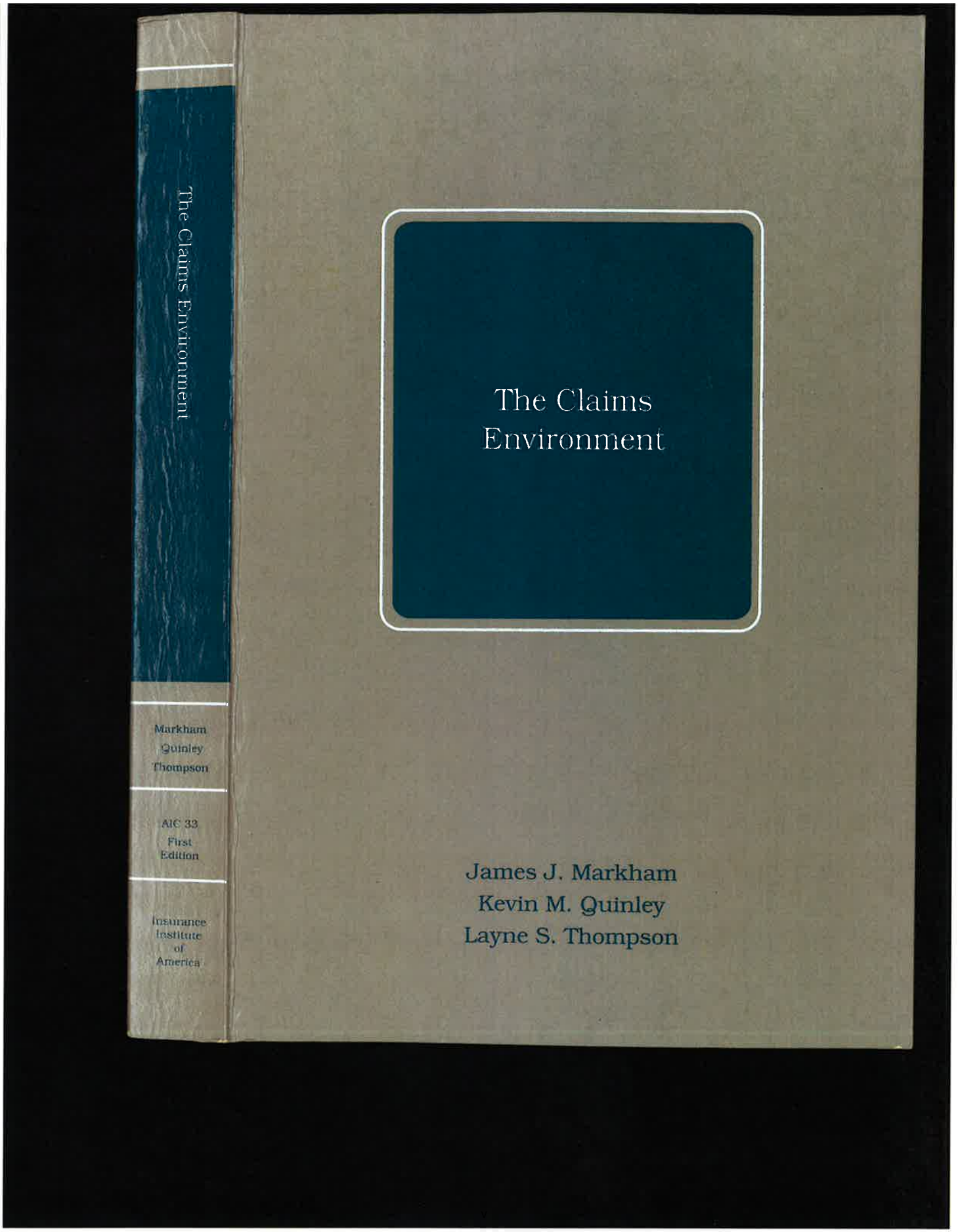
Pre-tender defense costs consistently have been held not recoverable under an insurance clause prohibiting voluntary payments made without the consent of the insurer. If the insured makes no demand for a defense, there is no duty to defend and pre-tender defense costs are lawfully precluded by the no-voluntary payment provision. *Dreaded, Inc. v. St. Paul Guardian Ins. Co.*, 904 N.E.2d 1267 (Ind. 2009); *OneBeacon America Ins. Co. v. Fireman's Fund Ins. Co.*, 175 Cal. App.4th 183, 204, 95 Cal Rptr.3d 808, 824 (2d Dist. 2009); *Ivan Insua v. Scottsdale Ins. Co.*, 104 Cal. App. 4th 737, 743-44, 129 Cal. Rptr. 2d 138, 144 (2d Dist. 2002), *review denied*, (Cal. Feb. 25, 2003); *Concept Enters. v. Hartford Ins. Co.*, No. CV 00-7267 NM (C.D. Cal. May 22, 2001); *Comsat Corp. v. St. Paul Mercury Ins. Co.*, No. 97-2236 (D. Minn. Mar. 6, 1998); *Smart Style Indus., Inc. v. Pennsylvania Gen. Ins. Co.*, 930 F. Supp. 159, 164 (S.D.N.Y. 1996); *County of Santa Clara v. United States Fidel. & Guar. Co.*, No. C-93-20169 JW (N.D. Cal. Nov. 1, 1993), *vacated on reconsideration on other grounds*, No. C-93-20169 RPA (N.D. Cal. Oct. 23, 1995); *Travelers Property Cas. Co. of America v. Hillerich & Bradsby Co., Inc.*, 598 F.3d 257, 273 (6th Cir. 2010) ("the majority of other jurisdictions do not allow recovery for pre-tender costs because those are deemed waived by the insured, especially when an insurance contract prohibits voluntary payments without the consent of the insurer"); *ACE American Ins. Co. v. RC2 Corp., Inc.*, No. 07 C 5037, at *3-*4 (N.D. Ill. Apr. 23, 2009) (even where insurer denies duty to defend, insured is still obligated to comply with notice requirements and voluntary payment clause; insured's payment of defense costs made without insurer's consent violate those policy provisions and thus are not reimbursable), *rev'd on other grounds*, 600 F.3d 763 (7th Cir. 2010); *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 316-17 (Minn. 1995); *see also Tenneco Inc. v. Amerisure Mutual Ins. Co.*, 281 Mich. App. 429, 761 N.W.2d 846 (Mich. Ct. App. 2008) (breach of "voluntary payments" provision precludes coverage, regardless of prejudice to the insurer).

Thus, in *Northern Insurance Co. of New York v. Allied Mutual Insurance Co.*, 955 F.2d 1353, 1360 (9th Cir.), *cert. denied*, 505 U.S. 1221 (1992), the Ninth Circuit, applying California law, held that where the insured had time to identify its insurer and tender the defense but did not do so, it incurred defense costs voluntarily and could not recover them from the insurer. More recently, in *Dreaded, Inc. v. St. Paul Guardian Ins. Co.*, 904 N.E.2d 1267 (Ind. 2009), the Indiana Supreme Court denied an insured's motion for reimbursement of defense costs expended during the pre-notice period, holding that absent tender and notice, the insurer's duty to defend did not arise and prejudice was irrelevant.

A number of courts have ruled that an insurer need not reimburse pre-tender defense costs, even where the policy does not include a "no voluntary payment" provision. *American Mut. Liab. Ins. Co. v. Beatrice Cos.*, 924 F. Supp. at 872 n.17; *see also Domtar v. Niagara Fire Ins. Co.*, 563 N.W.2d at 739; *Elan Pharm. Research Corp. v. Employers Ins. of Wausau*, 144 F.3d at 1381-82. *But see Dale Corp. v. Cumberland Mut. Fire Ins. Co.*, No.

09-1115 (E.D. Pa. June 30, 2010) (pre-notice defense costs are recoverable absent a showing of prejudice); *Liberty Mut. Ins. Co. v. Black & Decker Corp.*, 383 F. Supp. 2d 200, 207 n.5 (D. Mass. 2004) (same) (citing Ostrager & Newman, *Handbook on Insurance Coverage Disputes* §5.02 (12th ed. 2004)).

The rule that pre-tender defense costs are not recoverable does not result in a complete forfeiture of coverage, but gives the insured the option of defending a claim on its own. "There are tactical reasons why an insured may want to withhold the defense from an insurer that clearly covers a risk. For example, especially in a high-profile case, an insured may not want to lose control of events to the insurer." *American Mut. Liab. Ins. Co. v. Beatrice Cos.*, 924 F. Supp. 861, 872-74 (N.D. Ill. 1996); *Cincinnati Cos. v. West Am. Ins. Co.*, 183 Ill. 2d at 326, 701 N.E.2d at 503 ("It is true that an insured may choose to forego an insurer's assistance for various reasons, such as the insured's fear that premiums would be increased, or the policy cancelled, in the future. Moreover, an insured's ability to forgo that assistance should be protected." (Citation omitted)).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may be greater than the value of the property or in which personal injury could be exaggerated or feigned. The availability of insurance proceeds provides an incentive to file fraudulent claims. Fraudulent and inflated claims drive up the cost of insurance and reduce the funds available to pay for legitimate losses.

Morale Hazard. Morale hazard is a condition created by not having to suffer much of the financial consequences of a loss. Rather than be careful about incurring or causing losses, individuals and businesses with insurance may become cavalier about protecting their valuables and about conducting their personal and business activities safely. This increases the frequency and severity of losses and drives up costs.

Claims and the Insurance Mechanism

The essential function of a claim department is to fulfill the insurance company's promise, as set forth in the insurance policy. In so doing, the claim department interacts with all other major functions of the insurance company: underwriting, loss control, marketing, and actuarial.

The Insurance Policy—The Promise To Pay. The transfer of financial risks from individuals and businesses to the insurance company is accomplished through a written contract—the insurance policy.

A special relationship is formed between the insurance buyer and the insurance company in an insurance transaction. The insurance buyer pays a premium, and instead of receiving a tangible product or immediate service, the buyer receives a conditional promise to pay in the event of a covered loss. The promise is neither tangible nor certain to ever be performed.

The insurance transaction inherently involves an exchange of unequal amounts. Those who do not suffer a loss during a policy period will not receive any payments from the transaction. Those who do suffer a loss will likely receive amounts that significantly exceed the amount of premium paid. Yet, individuals and businesses are willing to participate in this pooling and sharing of risks because it gives every participant peace of mind to know that funds will be available to pay for the unfortunate few and because financial uncertainty is removed for all.

Most other commercial transactions are considered deals between parties of comparable bargaining power, and thus, courts will not normally interfere or reform contracts every time bad bargains are made. The insurance transaction, on the other hand, is generally considered a personal transaction requiring complete honesty and full

New Appleman on Insurance Law Library Edition

NEWAPL Volume 1--Essentials of Insurance Law
Chapter 5 INSURANCE POLICY INTERPRETATION

1-5 New Appleman on Insurance Law Library Edition § 5.02

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§ 5.02 *Contra Proferentem* and Ambiguity

The rule of *contra proferentem* has been described as "the first principle of insurance law." n11 In short, it provides that ambiguous provisions are to be construed against the insurer. n12 *Contra proferentem* has been cited and used in thousands of insurance cases. n13 Although it has ancient roots n14 and is used in contract law, n15 it has evolved to be more prominent and commonly used in insurance law. In contract law, *contra proferentem* is a doctrine to be used as a last resort, as a way of breaking ties, n16 but in insurance law it is used as a primary rule (perhaps even *the* primary rule) of interpretation for insurance policies. n16.1

[1] Historical Evolution of *Contra Proferentem*

Contra proferentem came to the United States as part of the English common law. The doctrine was included as one of the "maxims of the law" in the work of Sir Francis Bacon on the Common Law. After quoting the rule in Latin, n17 he describes the rule: "that a man's deeds and his words shall be taken strongliest [sic] against himself," which he notes is "one of the most common grounds of the law." n18 Blackstone also references the rule in connection with deeds. n19 The doctrine was cited and used in a number of early American cases. n20 This original version of the doctrine treated it as a last resort for interpretation. n21

Although not specifically identified as *contra proferentem*, the early use of the doctrine for insurance policy interpretation is illustrated by *Yeaton v. Fry*, n22 an 1809 case decided by the U.S. Supreme Court. That case involved a claim on a marine policy. The insurer sought to preclude coverage on the basis of an exception from coverage for "blockaded ports and Hispaniola." The loss occurred during a trip to Curracao, which was a blockaded port. However, the captain of the ship did not know of the blockade until warned off by a British ship of war during the voyage, and so he diverted the ship to Norfolk. The ship was captured and plundered on the way to Norfolk. The insurer argued that the exception for blockaded ports was a warranty, and because the voyage was to a blockaded port there was no coverage. The Court, in an opinion by Justice Marshall, found for the insured.

Justice Marshall's analysis is consistent with *contra proferentem*. He noted that the exception was in the "words of the insurer, not of the insured;" that insurance policies were "informal" instruments; and that "there are no more instruments

which are more liberally construed." n23 Although the Court might have treated all blockaded ports as synonymous with Hispaniola, and therefore excluded, the Court chose not to. Instead, it adopted a more narrow construction by focusing on the risk that was excluded. In the case of Hispaniola, all risks associated with that port were excluded, but in the case of blockaded ports, the court held that only the risks of the blockade were excluded.

While this case is consistent with the modern use of *contra proferentem*, it does not signal the beginning of the modern era. The court used the principle as a tie-breaker because there was no other basis to interpret the intent of the parties. The secondary status of the *contra proferentem* doctrine is illustrated by in *Palmer v. Warren Ins. Co*., an 1840 case decided by a U.S. Circuit Court in Massachusetts. n24 That case involved the interpretation of a marine policy containing an exception similar to the one in *Yeaton* that provided coverage for a ship for a year "excluding during the term all ports and places in Mexico and Texas, also the West Indies from July 15th to October 15th, 1839, each at noon." n25 Justice Story, relying to some extent on the decision in *Yeaton v. Fry*, cites the *contra proferentem* doctrine as "clearly established, as a general rule, that words of exception in any instrument, are to be construed most strongly against the party, for whose benefit they are introduced; and this rule has been expressly applied to words of exception in policies of insurance." n26 However, the rule was not yet a primary rule; Justice Story continued that "it by no means follows, that [*contra proferentem*] supersedes all other rules of construction." n27

In analyzing the particulars of the case, Justice Story did not rely on *contra proferentem*, but instead found that the "natural" meaning of the phrase limited its meaning to risks. He identified three possible interpretations of the phrase: that it was a warranty that the ship would not travel to ports in Mexico, Texas or the West Indies during the time period; that it was an exclusion for losses caused by sailing to the identified ports; or that it was an exclusion for risks of damage at those ports. He found that the last interpretation was the most natural because it was well known that the identified ports were more risky, especially during hurricane season, and because the exclusion was limited to a specific "term," therefore the phrase most likely intended to exclude the risks from the identified ports during the specified period. n28

Discussion of *Palmer* in a Nineteenth Century insurance treatise foreshadows the more liberal use of *contra proferentem*. Although *Palmer* was based on plain meaning rather than ambiguity and *contra proferentem*, a commentator suggested that "a more attentive examination will show, that the true ground of the decision was, that the words of an exception are the words of the insurer, and therefore subject to the rule '*verba fortius accipiuntur contra proferentem*' " (a contract is interpreted against the person who wrote it). n29 Such a reading of *Palmer* shows a willingness to resort to *contra proferentem* before doing the more challenging work of sorting out the possible meaning of the provision in question.

The use of the modern version of *contra proferentem* in the insurance context can be traced to an 1877 U.S. Supreme Court decision: *First National Bank v. Hartford Fire Insurance Co*. n30 This case concerned the interpretation of conflicting provisions regarding the insured's representation of the value of the insured property. On one hand, a provision in the policy provided that it would be declared void if the insured made any "erroneous representation." n31 On the other hand, the application, which became part of the policy, provided that the statements made in the application concerning the value of the property were true "so far as known to him." n32 The insurer argued that the insured's erroneous statement of the value of the property made the coverage void. The Court, in an opinion by Justice Harlan, found that the conflict could be resolved in two possible ways. First, the court could construe the warranty to be consistent with the application and to require a good faith estimate of the property's value. Second, a more narrow interpretation could be given, that the warranty only applied to facts within the actual knowledge of the insured, and therefore that the value of the property, which of necessity was depending on the vagaries of the market and therefore at best was an estimate, would not be subject to the warranty. The Court did not actually choose an interpretation, but found for the insured on the basis that the court should "lean" against a warranty and that the insurer could not complain because it was "both reasonable and just that [the insurer's] own words should be construed most strongly against itself." n33

Although the Court did not refer directly to the doctrine of *contra proferentem*, it is significant that the court relied on a general principle of construction to favor the insured when faced with an ambiguity without considering the parties' intention. n34 Subsequent cases therefore were able to use *First National Bank* as authority for the general rule of construing ambiguities against the insurer. n35 Over time, the statement became more strongly worded in favor of the insured and closer to the modern version. By 1901, the rule had evolved to this: "where a policy of insurance is so framed as to leave room for two constructions the words used should be interpreted most strongly against the insurer." n36 By 1923, the Court, in *Mutual Life Insurance v. Hurni Packing Co.*, n37 was prepared to state that "[t]he rule is settled that in case of ambiguity that construction of the policy will be adopted which is most favorable to the insured." n38 The justification for the rule is the classic rationale for the *contra proferentem* doctrine: the "language employed is that of the company and it is consistent with both reason and justice that any fair doubt as to the meaning of its own words should be resolved against it." n39 The rule stated by *Hurni Packing Co*. was widely cited. n40

State courts also played a role in the development of the modern *contra proferentem* doctrine. One of the leading cases was *Hoffman v. Aetna Fire Insurance Co.* n41 decided by the New York Court of Appeals in 1865. In that case the court noted that when the meaning of a term is left in doubt, the "construction should be adopted which is most *beneficial* to the promise," n42 and that this "rule has been very uniformly applied to conditions and provisos in policies of insurance." n43 *Hoffman* was widely followed in New York n44 and outside the state. n45

A 1948 North Carolina case citing to *First National Bank* shows the use of the modern *contra proferentem* rule:

> Policies of liability insurance, like all other written contracts, are to be construed and enforced according to their terms. If plain and unambiguous, the meaning thus expressed must be ascribed to them. But if they are reasonably susceptible of two interpretations, the one imposing liability, the other excluding it, the former is to be adopted and the latter rejected, because the policies having been prepared by the insurers, or by persons skilled in insurance law and acting in the exclusive interest of the insurance company, it is but meet that such policies should be construed liberally in respect of the persons injured, and strictly against the insurance company. n46

[2] Modern *Contra Proferentem* Doctrine: Ambiguity Is the Key

[a] *Contra Proferentem* Test

The majority, almost universal, rule is that if terms of an insurance policy are ambiguous, those terms will be construed in favor of coverage. n47 On the other hand, if the plain and ordinary meaning of the policy is not ambiguous, but is clear, then the policy will be enforced as so understood. n48 Consequently, the critical determination is whether the policy is ambiguous. n48.1

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To find cases discussing the doctrine of *contra proferentem*, use the Search by Topic feature: Click the Search tab and the Search by Topic or Headnote sub-tab. Click through the following topical hierarchy and select your jurisdiction. Search by Topic: Insurance Law > Claims & Contracts > Policy Interpretation > Ambiguous Terms > Construction Against Insurers.

[b] Justifications for *Contra Proferentem*

Courts and commentators have identified a number of justifications for the *contra proferentem* doctrine. Perhaps the most common is the historical basis for the rule, that the party who drafts the agreement has responsibility for eliminating ambiguity. n49 This rationale takes on some additional force in the case of insurance because many of the forms and much of the policy language is used industry wide, so the "drafter" includes many sophisticated companies who share expertise, information and experience. Indeed, many insurance forms are developed by the Insurance Services Office, Inc. ("ISO"), an entity owned by insurers that collects and analyzes data about insurance policy forms.

On the other hand, this rationale fails to fully justify the doctrine because the nature of language and the infinite variety of claims circumstances makes it virtually impossible to draft an insurance policy that is free from ambiguities. n50

A second common rationale for the doctrine is that insurance policies are contracts of "adhesion." n51 This is a variation on the first rationale (drafter is responsible) that focuses more on the insureds' side and their inability to vary the terms of the agreement. Insurance policies, however, are not completely contracts of adhesion. Most policies have optional endorsements that can alter certain provisions of the policy. But this limited flexibility is not the same as the ability to change specific wording of the policy. This comparative disadvantage of the insurance consumer has several additional variations. Insured have much less bargaining power, n52 less information n53 and less expertise n54 than insurers. The comparative disadvantage of the insured also is the basis for the rationale that insurers are in a better position to avoid the risk of ambiguity and, because of the pooling mechanism, are in a better position to bear the risk. n55 A court has opined that the disadvantage is no less when the insured is a sophisticated commercial enterprise, and courts, therefore, apply the doctrine even though two sophisticated parties have engaged in an arms-length transaction in entering the insurance contract. n55.1 On the other hand, when there is a coverage dispute between insurers courts do not apply the doctrine. n55.2

A third set of reasons are related to public policy. Insurance has long been recognized as having indemnity of its purpose. This indemnification serves an important public purpose of managing and distributing risk. n56 Because the insurers who manage this risk have comparatively greater expertise and bargaining power, and because insureds rely on that expertise, some courts have found that insurers have a quasi-fiduciary duty. n57

A fourth set of reasons are more pragmatic and arise out of the nature of the insurance transaction. For example, while the traditional contract rule would rely on parol evidence to interpret the meaning of an ambiguous contract provision, because of the use of policy forms, parol evidence often provides little insight regarding interpretation of an insurance policy. Similarly, because insureds have little opportunity to negotiate the policy terms (or in many cases even read them in advance) the search for the parties' intention is strained and artificial (*see Section 5.01*).

Lexis.com Search:

To find cases discussing insurance policies as contracts of adhesion, use the Search by Topic feature: Click the Search tab and the Search by Topic or Headnote sub-tab. Click through the following topical hierarchy and select your jurisdiction. Search by Topic: Insurance Law > Claims & Contracts > Policy Interpretation > Adhesion Contracts.

[c] The Majority Rule Test for Ambiguity

The predominant test for ambiguity is whether the policy, under the circumstances of the case, is susceptible to two or more reasonable interpretations. n58 The mere fact that the parties disagree over coverage, of course, does not show that the competing interpretations are "reasonable." n59 So the key determination is whether the interpretation proffered by the insured is reasonable. If it is, and that interpretation does not agree with the one offered by the insurer, the policy will be found to be ambiguous and the insured's interpretation adopted.

The courts have not articulated a test for determining whether an interpretation is reasonable or not, but instead tend to simply state the conclusion that the meaning is plain n60 or that the provision is ambiguous. n61 The results in two lines of cases: those finding policies ambiguous and construing them for the insured, and those finding the policies are plain and unambiguous construing them for the insurer, but the cases can be difficult to harmonize.

[i] Guidelines for Assessing Ambiguity

There are, of course, some general guidelines to assist in evaluating an interpretation. For example, courts often state that a strained interpretation is not permitted, n62 that a court cannot create ambiguity, n63 and that a court cannot

rewrite the policy. n64 While this puts some limit on the interpretive exercise, it does not add much to the conclusion that the meaning is plain or that the proffered interpretation is unreasonable. A "strained" interpretation or one that "rewrites" the policy would not be "reasonable."

Some courts also state that the usual conventions for English should be used, such as grammar and syntax. n65 However, that is just another way of saying that the interpretation should be reasonable. An interpretation that is grammatically unsupportable is not "reasonable." Moreover, grammatical rules and syntax evolve over time or are ambiguous in their own right, so in some cases the rules are not helpful.

Another common guideline is that when considering the meanings of words, it is appropriate to consult definitions. n66 If the word is defined in the policy, that definition will be used. If the word is not defined, the courts often use dictionary definitions. This provides some limit on what will be reasonable in that a definition proffered but unsupported would be unreasonable. But dictionaries generally contain multiple definitions. The general purpose of the dictionary is to collect and report on all customary usages, n67 so the dictionary definitions are broadly inclusive and therefore may support competing interpretations. For example, the term "sudden," which was used in an exception to the general liability pollution used at one time, had a dictionary definition of both abrupt and unintended, which supported some courts finding that the term was ambiguous. n68

[ii] Guidelines Leave Courts Broad Discretion

These guidelines leave broad latitude for the courts in deciding between ambiguity and plain meaning. The suggestion that courts should not "strain" the meaning and the requirement that litigants follow grammar rules and use accepted definitions only eliminates the absurd interpretations. That still leaves thousands of cases in which *contra proferentem* has been applied and will be applied in the future. How are those cases to be decided?

[iii] Courts Use Their Own Sensibilities

The predominant method used by the courts is for the judge to simply use his or her own linguistic sensibilities to decide whether the two interpretations are reasonable or not. Judges, of course, often have differing views, leading to inconsistent judgments and the opportunity to be influenced by personal bias for or against the parties in their roles or as individuals. n69 Judges' personal opinions may be limited or influenced by contextual information, when it is considered, and are subject to the discipline of appellate review. Because policy interpretation is considered a question of law, appellate review of the issues is generally *de novo*, which promotes uniformity within a jurisdiction for repeated ambiguities.

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[iv] Efforts to Harmonize Disparate Case Law

The broad discretion afforded by the *contra proferentem* doctrine, and resulting inconsistency makes it difficult to harmonize and explain the body of case law. Some commentators suggest that the case law can be roughly divided into those courts that apply a "strong" or liberal version of the *contra proferentem* doctrine and those that apply a "weaker" or more conservative version of the doctrine. n70 Another commentator suggests that the case law can be explained by looking at the level of linguistic culpability on the part of the drafter (negligence versus strict liability) and the imputed "demand" for the coverage from the insured (coverage for which insureds would be willing to pay versus coverage for which they would not that is provided as a penalty). n71 The traditional rule uses linguistic strict liability and imposes a penalty of coverage for which insureds would not be willing to pay. Courts' discomfort with this rule has led to the

implicit application of more stringent standards of culpability or imputed demand. Although these efforts are laudable, and bring a modicum of order to the conflicting case law, they are ultimately not very satisfying because they do not provide much explanatory power as to when the courts will take one approach or the other.

[v] Efforts to Reform *Contra Proferentem*

The broad discretion courts have in applying the *contra proferentem* doctrine, and the accompanying inconsistency, has also led to recommendations for reform. One suggestion is to abandon the use as *contra proferentem* as a primary interpretive tool and to return to original use of the doctrine (consistent with current contract law) as a tie-breaker after a full effort to resolve the ambiguity by searching for the parties' intent through extrinsic evidence and interpretive tools. n72 The approach has the limitation that it is premised on the insurance policy being a contract, which has limitations (*see Section 5.01* above). A similar suggestion is that the doctrine should be used as a tie-breaker only if the competing interpretations are *equally* reasonable after applying other interpretive rules, in a particular context. The suggestion, however, differs from the "original" use of the doctrine because it does not take the parties' intent as the goal of interpretation. Instead, the goal is to use linguistic conventions to determine the objective meaning of the text. Other commentators have detected some judicial skepticism about the doctrine n73 and a trend toward retrenchment. n74

[d] Minority Approaches to Ambiguity

The majority rule is so widely followed that it can hardly be said that there are minority rules. The "minority" approaches are not consistently followed in any particular jurisdiction, but instead are categories of outlying cases. The two categories are at either end of the spectrum. At the more liberal end of the spectrum (liberal meaning more inclined towards coverage than the majority rule) are those cases that go a step beyond "reasonable" interpretations of a policy to those that are "semantically permissible" n75 or merely "plausible." n76 At the conservative end of the spectrum are cases that use the *contra proferentem* doctrine as a tie-breaker consistent with its contract version. These conservative cases are generally of two types: (1) those cases that follow the contract version of *contra proferentem* and use all means, including extrinsic evidence to ascertain the intentions of the parties; n77 and (2) those cases that simply evaluate the reasonableness of the two interpretations, generally relying on context to assist in that determination, and then apply *contra proferentem* if the competing interpretations are equally reasonable. n78

Categorizing the cases is not an easy or precise task. Some courts will state a rule in a particular way, but do not apply the rule in the way that it was stated. So what is characterized as a minority "rule" may actually be just an imprecise statement. In addition, some courts in articulating and applying the majority rule will often include language that suggests one of the minority rules. For example, it is very common for courts to state that insurance policies are contracts and that the contract rules of interpretation apply (*see Section 5.01* above). In general, this language does not signify that the court is actually treating the insurance policy the same way as a contract, but is just verbiage that has been picked up from another case or seems theoretically appealing.

Sometimes courts will use language that suggests a minority rule, but while the language is an operative part of the test, it falls short of the minority rule. For example, courts may say that context is relevant to determining whether there is ambiguity, which is consistent with the minority rule that uses context to evaluate the most reasonable interpretation. However, these courts allow context to be considered to determine *whether* the interpretation is reasonable, not to evaluate which interpretation is *more* reasonable. This is simply a more linguistically appropriate version of the majority rule rather than an example of a minority rule.

From a normative standpoint, the minority rule that uses *contra proferentem* as a tie-breaker but does not try to determine the parties' intent is superior. The liberal minority view that allows an interpretation to be used if it is merely plausible provides a significant benefit to the insured, but is likely to stretch coverage well beyond its underwriting intention. This will skew the risk pooling mechanism and will likely result in higher premiums. The conservative minority approach that treats an insurance policy the same as a contract may reduce the inconsistency in outcomes, but

relying on the intention of the parties is artificial, increases transaction costs, n79 and creates the risk of inconsistency in the determination of the parties' intention. The minority view that uses *contra proferentem* as a tie breaker but does not seek to determine intentions avoids the problems of the contract rule and is more consistent with the nature of the insurance transaction. Instead of looking for the intentions of the parties, this approach seeks to understand the meaning of the text of the policy in light of the relevant context.

Cross Reference:

For a summary of selected state highest court decisions setting forth and applying the Ambiguity Rules organized by state, see the appendix to the article by Jeffrey E. Thomas, *The Role of Ambiguity in Insurance Policy Interpretation in* New Appleman on Insurance: Current Critical Issues in Insurance Law (Oct. 2006).

[e] Examples of Application of *Contra Proferentem*

The most common kinds of ambiguity in insurance policies can be organized into three categories: ambiguous meaning of a word or phrase, ambiguity from the interaction of policy provisions, and ambiguity caused by a gap of some sort in the policy. n80 Cases from these three categories will be used to illustrate the application of *contra proferentem* from both the majority view and with selected examples of the minority rules.

[i] Words and Phrases

[A] Overview

Cases that focus on the on the meaning of a particular word or phrase are by far the most frequent type of case applying *contra proferentem*. Courts use both dictionary definitions n81 (and in some cases definitions contained in the policy) and other sources of meaning. When a court finds that the meaning is clear or "obvious," it generally will find that the meaning is unambiguous. In other cases finding that the meaning is unambiguous, the court will reject the competing interpretation as unreasonable. If the court uses the most liberal minority rule, as long as the competing interpretation is plausible the court will hold in favor of coverage. Each of these approaches is illustrated with case law in the following subsections.

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[B] Use of Dictionary Definitions

One of the general guidelines for interpretation is to use definitions. Consequently, the use of definitions, while not universal, is very common. In some cases the definition comes from the policy. This definition will be treated as "controlling," but may lead to a question about the meaning of some term or phrase used in the definition. In some cases the term or phrase is not defined in the policy, so the court will look to other sources of meaning, including dictionary definitions.

The analysis of the Illinois Supreme Court in *Outboard Marine Corp. v. Liberty Mutual Insurance Co.*, n82 addressing an exception to the pollution exclusion in a Commercial General Liability ("CGL") policy, is a classic example of this approach. In that case various governmental entities had brought actions against Outboard Marine Corp. seeking redress for pollution. When insurers refused to defend Outboard Marine under a CGL policy, Outboard Marine brought a declaratory relief action. After the trial court entered various partial summary judgment orders, the parties appealed.

One of the issues on appeal was whether the exception to the pollution exclusion for "sudden and accidental" releases applied. That issue came down to the meaning of the term "sudden." The appellate court had found that the term was unambiguous and that required that the release be "abrupt" with a temporal element to it. The Illinois Supreme Court rejected this analysis on the strength of dictionary definitions. The court noted: "Numerous dictionaries define 'sudden' as happening unexpectedly, without notice or warning, or unforeseen." n83 Because "these same dictionaries also define 'sudden' as abrupt," n84 the court concluded that there were two reasonable definitions of the term, and therefore that the term "sudden" was ambiguous and would be construed in favor of the insured. n85

Although it is less common, a dictionary definition can also be used to find that a term or provision is unambiguous. An example of this usage can be seen in *Bituminous Cas. Corp. v. Sand Livestock Systems, Inc.*, n86 decided by the Iowa Supreme Court. That case involved the interpretation of the modern pollution exclusion in a Commercial General Liability policy. Carbon monoxide from a propane power washer accumulated in a washroom and caused the death of a worker at the facility. The widow filed a wrongful death suit against the insured, which tendered the case to the insurer. The insurer filed a declaratory relief action arguing that the pollution exclusion applied. The provision excluded bodily injury "which would not have occurred in whole or in part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants.' " n87 "Pollutant" was defined to include "any ... gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." n88 In determining that the pollution exclusion applied, the Iowa Supreme Court quoted the definition of carbon monoxide as "a colorless odorless very toxic gas." n89 It found that the exclusion unambiguously applied because the death was caused by release of a pollutant, a gaseous contaminant. n90

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[C] Meanings From Other Sources

Courts also use other sources besides a definition to determine the meaning of words or phrases. For example, the court may use plain or customary meaning, or some form of logic to determine the possible meanings. A fairly common alternative to a dictionary definition is plain or customary meaning. Plain meaning generally refers to a generally accepted core meaning of the term. The term automobile, for example, has a plain meaning that applies to most cars. Customary meaning is based on usage, and when a usage has reached a certain frequency or breadth of audience, the customary usage may become the plain meaning. Customary usage, however, also may include a custom within a particular industry or profession, and an example of such usage will be given below. If a court relies on plain or customary meaning, it is likely to find that the term or phrase is unambiguous. Plain or customary meanings are less likely to have multiple reasonable meanings. However, there are occasions when the court will find that more than one plain or customary meaning could apply.

An example of the use of plain or customary meanings to support a finding of ambiguity can be seen in *Hurst v. Grange Mutual Casualty Co.*, n91 decided by the Georgia Supreme Court. That case concerned the interpretation of an exclusion for "any person ... using a vehicle without a reasonable belief that person is entitled to do so." n92 A friend of the insured, whose license had been suspended, was driving the vehicle at the insured's request and became involved in a collision. The insurer, relying on the exclusion and the fact that the driver's license had been suspended, refused to defend and initiated a declaratory relief action. The trial court granted summary judgment for the insurer, and the court of appeals affirmed in an unpublished opinion. The Georgia Supreme Court reversed. The key issue was the meaning of

the term "entitled." Instead of using a dictionary definition, the court reviewed the case law construing the exclusion and found three possible meanings: (1) the right to drive as the holder of a valid license, (2) the permission to drive from the owner of the vehicle, and (3) the right to drive as a person with a license *and* permission. n93 Thus, the meaning of "entitled" was based on the plain and customary meaning used in the case law. The court found all three of the possibilities to be reasonable. Using the *contra proferentem* rule, the court adopted the interpretation that was most favorable to the insured--that the exclusion applied only if the person driving did not have permission. n94

Plain or customary meaning also can be used to support a finding that a term or phrase is not ambiguous. An example of this usage can be seen in the case of *United States Fidelity & Guaranty Co. v. Goudeau*, n95 decided by the Texas Supreme Court. That case concerned the meaning of "occupying" for purposes of underinsured motorist insurance. Goudeau was driving a company car and left that car to aid another driver. He was then hit by a third car and pinned between the cars and a retaining wall. The employer's policy provided underinsured motorist coverage for employees who were "occupying" a covered vehicle when the collision occurred. In construing the meaning of the term "occupying," the court did not rely on any definition of "occupying," n96 but instead simply concluded that "a driver who has exited the car, closed the door, walked around the front, and then has the vehicle smashed into him cannot be said to be 'occupying' the vehicle at the time of the collision." n97

Courts will occasionally rely upon a specialized customary usage of a term or phrase. One reason this is so rare is that a common refrain is that terms are to be construed in their plain or ordinary sense. n98 It does happen on occasion, however. For example, in *Cincinnati Insurance Co. v. Milliken & Co.* n99 the Fourth Circuit Court of Appeals was considering the meaning of the term "damages" in a Commercial General Liability insurance policy. The issue was whether a CERCLA claim seeking a judgment for the cleanup costs of contamination was covered. The policy agreed to pay "all sums which the insured shall become legally obligated to pay as damages." n100 The court did not cite to any definition of "damages," but concluded that the term was unambiguous and meant legal damages, n101 as compared to equitable relief, which is the customary meaning within the legal profession and insurance circles. n102

Another relatively uncommon method for determining meaning, but one worth mentioning, is the use of logical reasoning. This category is more abstract than the others, and therefore it can be difficult to know what cases fit into it. Cases in this category sometimes could also be placed in the plain meaning group of cases because they tend to implicitly rely on the plain meaning of words. But these cases generally have something more to them than plain meaning, something that has an analytical or logical quality to it.

A good illustration of the logical reasoning group of cases is *State Farm Fire & Casualty Co. v. Reed*, n103 decided by the Texas Supreme Court. That case involved the interpretation of a somewhat circular provision of a homeowner's policy, an exception to an exclusion for business pursuits for "activities which are ordinarily incidental to non-business pursuits." n104 The insureds ran a licensed day care business. One of the children for which they were caring crawled through a hole in a fence around a swimming pool and drowned in a puddle of water on a tarp covering a swimming pool. In construing the phrase "non-business pursuits," definitions, plain meaning, and common usage were not helpful because the phrase did not have such meanings. Instead of looking at the meaning of the phrase, the court looked at the applicability of the phrase to the facts. On one hand, the running of a licensed day care facility could be considered a business pursuit (case law was split on the issue, however). On the other hand, the failure to maintain the fence could be considered incidental to a non-business pursuit because most homeowners with swimming pools would have the pool fenced and would need to maintain the fence. Because either of these applications would be reasonable, the court found the provision ambiguous and therefore adopted the application the provided coverage. n105

Lexis.com Search:

To find cases discussing the plain meaning of policy terms, use the Search by Topic feature: Click the Search tab and the Search by Topic or Headnote sub-tab. Click through the following topical hierarchy and select your jurisdiction. Search by Topic: Insurance Law > Claims & Contracts > Policy Interpretation > Plain Language.

[D] Rejection of Unreasonable Interpretations

The examples used to this point show the courts' use of various techniques to determine the meaning of a term or phrase, but do not specifically show the courts rejecting an interpretation. When a party argues that a provision is ambiguous, that party necessarily will advance its own interpretation to compete with that of the opposition. So when a court finds that a particular interpretation is the plain meaning, or that the relevant definitions support only one interpretation, the court is implicitly rejecting the competing interpretation. The court may not provide more explanation because it is not a close case, or perhaps the judge is more inclined towards one side or the other and simply uses plain meaning as a convenient rationale. In any event, these cases do not tell us very much about the process used by judges to select one interpretation over another. When judges do provide additional detail, it typically involves some kind of linguistic analysis. Sometimes a proffered interpretation just does not have enough linguistic coherence to be reasonable. Other times, one interpretation is eliminated based on context.

An example of linguistic coherence can be seen in *LeMars Mutual Insurance Co. v. Joffer*, n106 decided by the Iowa Supreme Court. In that case, the insureds were injured in an accident with an uninsured motorist while driving their personal automobile on a business errand for their farm. They had two insurance policies, one on their personal car and one for the truck they used in their farming business. The day of the accident, the insureds had taken their personal car because the truck was not working. The insurer paid the uninsured motorist claim on the policy covering the car, but refused to pay on the policy covering the truck. The insureds argued, among other things, that they had coverage under the business policy because their car was a substitute for the truck. In support of this argument they relied upon a clause in the provision defining the insured under the policy. That clause stated that insureds under the policy included "anyone else 'occupying' a covered 'auto' or a temporary substitute for a covered 'auto'." n107 The district court used dictionary definitions of "anyone" as "any person at all" and "else" as "being different in identity" to conclude that the substitute clause only applied to people who were not listed in the policy. n108 The insureds argued that an alternative definition of "else" made the term ambiguous. Another dictionary definition of "else" was "additional; more. *Would you like anything else?*" n109 The Iowa Supreme Court rejected this argument as requiring a "strained reading of the policy and a strained usage of the English language." n110 That interpretation (the substitute clause applied to "anyone more") would have made the substitute clause applicable to anyone. Had that been what the policy was supposed to mean, the insurer could have left out the term "else," or could have constructed the policy in some other way. n111 In other words, this interpretation just doesn't make linguistic sense. If that is what was meant, a person would not write it that way.

A second example shows the use of context, which is still closely related to the notion of linguistic coherence because context is generally so important to the determination of meaning. n112 In *Bay Cities Paving and Grading, Inc. v. Lawyers' Mutual Insurance Co.*, n113 the California Supreme Court addressed the meaning of "related" in the aggregation clause of a professional liability policy. The clause provided that "Two or more claims arising out of ... a series of related acts, errors or omissions shall be treated as a single claim." n114 The insured had allegedly failed to serve a stop notice on a construction project's lenders after filing a mechanic's lien and also had failed to foreclose on that lien. The insurer contended that the two acts were related and therefore would be treated as a single claim. The insured contended that they were not "related" claims within the meaning of the policy and therefore that they should have coverage for two claims under the policy.

The insured contended that the term "related" was ambiguous because it could be broadly or narrowly construed. The broad version of the term was a logical connection, and the narrow version was a causal connection. Although the court conceded that the term was susceptible to these two potential definitions, the court found that the context of the policy and the circumstances showed that the narrow interpretation was unreasonable. The narrow version of the term, limiting the relationship to causal connections, failed to account for the context of the term "claim" and the per-claim limitation of the policy. If the "related" acts had to cause one another, then they would be part of the same chain of causation leading to a single claim. The aggregation provision would be pointless under that approach, however, because a single claim was already subject to a per-claim limitation under the policy. Moreover, the narrow version also fails to account for the role of the injury. If there were two independent acts not causally related, such as two independent errors at trial,

these acts could lead to the same single injury (e.g., the adverse judgment). But while there was a single injury, the interpretation suggested by the insured would treat it as two claims. n115 Thus, in light of this context, the court held that the term was not ambiguous. n116

Lexis.com Search:

To find cases considering the use of context in determining the meaning of policy terms, use the Search by Topic feature: Click the Search tab and the Search by Topic or Headnote sub-tab. Click through the following topical hierarchy and select your jurisdiction and sources. Search by Topic: Insurance Law > Claims & Contracts > Policy Interpretation > Entire Contract. Under Option 1 "Search across Sources," Search Source(s), type in the search terms "context! w/s interpret! or ambiguous! and atleast3(context!)" without the quotation marks.

[ii] Interaction of Policy Provisions

[A] Overview

The consideration of context can also be used to show ambiguity or to resolve it. Sometimes policy provisions not directly in dispute will provide some insight that can resolve a potential ambiguity, or in other cases the existence of such a policy provision can cast the meaning of the provision under consideration into doubt. Although not as numerous as cases dealing with words or phrases, a significant number of cases consider the interaction of policy provisions when analyzing potential ambiguity. Although it is difficult to draw the lines precisely, some of these cases fit into the category for the conservative minority rule that uses interpretive rules including context to assess meaning before reaching the conclusion that the policy is ambiguous. n117

[B] Showing Ambiguity

The cases using interaction of policy provisions to demonstrate ambiguity typically use policy provisions not directly under consideration to cast doubt on the probable interpretation of the provisions in question. The use of the same term in multiple provisions, for example, may provide some contextual insight as to the meaning of the term. Alternatively, the presence of different but somewhat related terms can also provide insights. Because it is presumed that the terms are meant to add something to the meaning of the policy, n118 the presence of an overlapping term may help cast doubt as to the meaning of a term.

Expert Insight: Read the Entire Policy Carefully.

It is advisable to read the entire policy carefully to look for contextual clues and arguments. Sometimes the use of standard forms, the revision of those forms and the use of endorsements creates an insurance policy that does not fit together tightly from a linguistic standpoint, which can lead to the finding arguments for ambiguity. On the other hand, a thorough understanding of the policy provisions and how they work together can help to identify arguments that revolve potential ambiguities.

The case of *Douglas v. Allied American Insurance* n119 provides a good example of the interaction of policy provisions creating ambiguity. In that case the question was whether the insurer was relieved of its duty to defend by tendering its policy limits to the court in the pending litigation. The insurer argued it did not have an obligation to defend because its policy limits had been exhausted by the tender. The policy contained a provision stating that, "It is understood and agreed that the company has no obligation to any insured after the applicable limits of the policy has been exhausted by payment." n120 This provision may seem plain enough, but other language in the policy made it ambiguous. After noting that the court must "construe the policy as a whole" and that provisions should be read "in light of each other," n121 the court found that the exhaustion provision was ambiguous in light of the language in the

insuring agreement that the insurer would pay sums "which the insured shall become *legally obligated* to pay." n122 The phrase "legally obligated" suggested that the payment would be made to satisfy a judgment or pursuant to a settlement. n123 Because the payment was not made to satisfy a judgment or pursuant to a settlement, it left open the possibility that the policy limits had not been exhausted. The court therefore found the policy to be ambiguous, and construed it in favor of the insured. n124

[C] Resolving Ambiguity

Interaction between policy provisions can also be used to resolve ambiguity. A provision that may have multiple meanings when considered in isolation may become clearer in the context of other provisions. The case of *La Jolla Beach & Tennis Club v. Industrial Indemnity Co.*, n125 decided by the California Supreme Court, provides a good example. In that case the insured was sued by a former employee for alleged discrimination. The suit was brought in state court with multiple counts seeking damages. The insured tendered the claim under a workers compensation policy, which provided that the insurer would pay "benefits required ... under the workers compensation law." n126 The policy also provided that the insurer had a duty to defend "any claims, proceedings or suits" against the insured for benefits covered by the insurance. n127 The insured, relying on the duty to defend language, argued that it was entitled to a defense under the policy. Although the lawsuit was not technically a workers compensation claim, it had the potential to become a workers compensation claim. The duty to defend under California law applies when there is a potential for coverage under the policy, and the language of the policy specifically required the insurer to defend "any suits."

The California Supreme Court, among other things, rejected this argument using the context of the policy. The policy included a second part for "employers' liability" that was meant to fill the gap between workers compensation's exclusive remedy and tort liability. The employers' liability part covered bodily injury to an employee and included a duty to defend. n128 Significantly, the employers' liability part had an exclusion for discrimination claims. n129 Using this context, the court determined that the workers compensation part did not cover the claim. If the workers compensation were construed to be sufficiently broad so as to include claims that might become workers compensation claims, the employers' liability part would be superfluous. n130 The court therefore concluded that the workers compensation part was not ambiguous and did not provide coverage for an employee's suit for civil damages. n131

[iii] Ambiguity From a Gap in the Policy

Cases in the last category of ambiguity are the least common. These cases involve ambiguity from a gap in the policy. The gap is the result of the language in the policy, often caused by the interaction of multiple provisions. But unlike the cases discussed above, these cases tend to focus less on the text of the policies. Rather, these cases focus more on what is *not* said in the policies. Because these cases are less textual, they can be hard to predict. On one hand the absence of text can justify a finding of no coverage. On the other hand, the absence of text can leave uncertainty and ambiguity, which may result in a finding of coverage.

An example of a case using a gap to find coverage based on ambiguity is *Boggs v. Commercial Mutual Insurance Co.*, n132 decided by the Appellate Division of the New York Supreme Court. In that case the insured's barn was damaged in a windstorm. The insurer denied coverage relying on an exclusion for structures "designed or used for business." n133 The barn had in fact been built more than 40 years earlier to store lumber that was to be sold to a paper company. However, the barn had not been used for any commercial purpose for more than 30 years. The policy did not have a time frame for the exclusion. The insured argued that it only applied to design or use during the policy period whereas the insurer argued that the exclusion was not time limited. The court held that under these circumstances the exclusion was ambiguous. n134 The policy had a gap as to the time frame for the exclusion. The court supported its conclusion with the argument that the insurer could have filled that gap: if the insurer "intended to exclude coverage for structures designed for a business purpose at the time they were built, it should have done so in clear and unambiguous language." n135

Another New York case illustrates the use of a gap to find that a policy is unambiguous. In *United States Fidelity & Guaranty Co. v. Annunziata*, n136 the Court of Appeals of New York considered whether a mortgagee had a duty in a property insurance policy to submit to an examination under oath. The named insured had such a duty, but while the mortgagee was specifically obligated to provide a proof of loss under the policy, there was no specific provision requiring the mortgagee to submit to an examination under oath. n137 Because the policy did not provide that the mortgagee had a duty to submit to an examination under oath, the court found that the policy's plain meaning was that only the named insured had such a duty. n138 Thus, in this instance instead of filling the gap by finding the provision ambiguous, the court held that the gap was intended to limit the duty of submitting to the examination under oath.

Cross Reference:

For further discussion of the rule of *contra proferentem*, see *New Appleman Insurance Law Practice Guide § 3.06*.

Legal Topics:

For related research and practice materials, see the following legal topics:
Insurance LawClaims & ContractsPolicy InterpretationAmbiguous TermsGeneral OverviewInsurance LawClaims & ContractsPolicy InterpretationAmbiguous TermsConstruction Against InsurersInsurance LawClaims & ContractsPolicy InterpretationAmbiguous TermsCoverage FavoredInsurance LawClaims & ContractsPolicy InterpretationAmbiguous TermsUnambiguous TermsInsurance LawClaims & ContractsPolicy InterpretationAppellate Review

FOOTNOTES:

(n1)Footnote 11. Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation, 95 Mich. L. Rev. 531 (1996).*

(n2)Footnote 12. *See, e.g.*:

***US/MI/OH**-- Auto Owners Ins. Co. v. Redland Ins. Co., 549 F.3d 1043 (6th Cir. 2008)* ;

***US/PA**-- Nationwide Mut. Ins. Co. v. CPB Int'l, Inc., 562 F.3d 591, 595 (3d Cir. 2009)* ;

***CA**-- E.M.M.I. v. Zurich American Ins., 84 P.3d 385, 389 (Cal. 2004)* ;

***FL**-- State Farm Fire & Cas. Co. v. CTC Dev. Corp., 720 So. 2d 1072, 1076 (Fla. 1986)* ;

***IL**-- Outboard Marine Corp v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1212 (Ill. 1992)* ;

***MA**-- McGregor v. Allamerica Ins. Co., 868 N.E.2d 1225, 1227 (Mass 2007)* ;

NY-- *In re Mostow v. State Farm Ins. Cos., 668 N.E.2d 392, 394 (N.Y. 1996)* .

(n3)Footnote 13. *See* Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation, 95 Mich. L. Rev. 531, 532 & n.4 (1996);* Mark A. Rahdert, *Reasonable Expectations Reconsidered, 18 Conn. L. Rev. 323, 328 (1986).*

(n4)Footnote 14. In Roman times, it was understood that ambiguity was to be avoided "if one did not want to run the risk of being held bound, by the gods, to the (for them) more favourable interpretation of a promise." Reinhard Zimmermann, The Law of Obligations: Roman Foundations of the Civilian Tradition 640 n.121 (1990). In the Seventeenth Century, Francis Bacon, Lord Chancellor of England, stated in his *Maxims of the Law* that "a man's deeds and his words shall be taken most strongliest [sic] against himself."

(n5)Footnote 15. *See Restatement (Second) of Contracts § 206* (1981) ("In choosing among the reasonable

meanings of a promise or agreement or a term thereof, that meaning is generally preferred which operates against the party who supplies the words or from whom a writing otherwise proceeds.").

(n6)Footnote 16. *See* Corbin on Contracts § 24.27 (2009).

(n7)Footnote 16.1. ***MN**-- Econ. Premier Assur. Co. v. Western Nat'l Mut. Ins. Co., 839 N.W.2d 749 (Minn. Ct. App. 2013)* (in contract law, *contra proferentem* has historically been regarded as last resort, used only when other interpretive methods have failed to reveal parties' intent, but rule has assumed more prominent role in insurance law and is now analytical starting point for courts interpreting ambiguous insurance language).

(n8)Footnote 17. *Verba fortius accipiuntur contra proferentem.*

(n9)Footnote 18. Francis Bacon, *Maxims of the Law* in 4 The Works of Francis Bacon 21 (New Edition London, William Pickering 1826) (originally published in 1597). Although not on-point to this discussion of *contra proferentem*, Sir Francis Bacon's maxim using *contra proferentem* was cited and discussed by the Virginia Supreme Court in 1794. *See Field v. Harrison, Wythe 273 (Va. 1794).*

(n10)Footnote 19. William Blackstone, Commentaries on the Laws of England, at 315 (2d ed., William Curry ed. 1809) (1766) (noting that deeds are "to be taken most strongly against the agent or contractor, and in favour of the other party.").

(n11)Footnote 20. *See, e.g.*, ***US**-- Manella, Pujals, and Co. v. Barry, 7 U.S. 415 (1806)* ;

***LA**-- Duncan v. Cevallos' Ex'rs., 4 Mart. (o.s.) 571 (La. 1817)* (citing the doctrine but refusing to apply it in a civil law context because of its common law heritage);

MD-- Buchanan's Lessee v. Steuart, *3 H. J. 329 (Md. 1813)* (citing the rule but refusing to invoke it because the intent of the parties could be determined);

***VA**-- Rowton v. Rowton, 11 Va. 92 (1806)* (invoked in the opinion by Judge Ticker regarding a will).

(n12)Footnote 21. *See* ***CT**-- Hartford Bridge Co. v. Union Ferry Co, 29 Conn. 210, 223 (1860)* (declining to apply *contra proferentem* because "we do not feel ourselves driven to this extremity");

MD-- Buchanan's Lessee v. Steuart, *3 H. J. 329 (Md. 1813)* (citing the rule but refusing to invoke it because the intent of the parties could be determined); *Varnum v. Thruston, 17 Md. 470, 496 (1861)* (*contra proferentem* "is a rule of strictness and rigor, and not to be resorted to but where other rules of exposition fail").

See also Joseph Chitty, A Practical Treatise on the Law of Contracts, Not Under Seal; and Upon the Usual Defenses to Actions Thereon 96-97 (5th American ed. from 3d London ed., Thompson Chitty ed. 1842).

(n13)Footnote 22. ***US**-- 9 U.S. 335 (1809)* .

(n14)Footnote 23. ***US**-- 9 U.S. at 341-342* .

(n15)Footnote 24. ***US**-- 18 F. Cas. 1056 (C.C. Mass. 1840)* .

(n16)Footnote 25. ***US**-- 18 F. Cas. at 1057 (C.C. Mass. 1840)* .

(n17)Footnote 26. ***US**-- 18 F. Cas. at 1057 (C.C. Mass. 1840)* .

(n18)Footnote 27. ***US**-- 18 F. Cas. at 1058 (C.C. Mass. 1840)* .

(n19)Footnote 28. ***US**-- 18 F. Cas. at 1058-1059 (C.C. Mass. 1840)* .

(n20)Footnote 29. John Duer, The Law and Practice of Marine Insurance 214 (1845).

(n21)Footnote 30. ***US**-- 95 U.S. 673 (1877)* .

(n22)Footnote 31. ***US**-- 95 U.S. at 676* .

(n23)Footnote 32. ***US**-- 95 U.S. at 676* .

(n24)Footnote 33. ***US**-- 95 U.S. at 679* .

(n25)Footnote 34. To be fair, the court does repeat the usual reference that it has a "duty" to try to "reconcile" the conflicting provision "consistently with the intention of the parties," if possible, based on the terms of the policy. *95 U.S. at 677* . But once it has made that statement, the Court does nothing more to determine the parties' intent. If may be that the conflict was so great that it was impossible to determine the intent, and therefore that the rule was used as a secondary tie-breaker, but even if that was the court's thinking, that was not explained in the opinion so that subsequent cases would not feel bound to use the rule as a tie-breaker.

(n26)Footnote 35. *See, e.g.*, ***US**-- London Assurance v. Companhia E Moagens O Barreiro, 68 F. 247 (3d Cir. 1895)* (stating that "if an exception in a policy of insurance be capable of two interpretations equally reasonable, that one must be adopted which is most favorable to the insured"); *Ferguson v. Providence Washington Ins. Co., 125 F. 141 (S.D.N.Y. 1903)* (stating that "If there were any ambiguity in the policy, it would be the duty of the court, in construing it, to adopt the interpretation most favorable to the assured");

***IN**-- Rogers v. Phenix Ins. Co., 121 Ind. 570 (1890)* ("when an insurance company tenders a policy to a party seeking to be insured, and uses in the policy ambiguous words, these words will be held to have the meaning most favorable to the insured, as the presumption is that on this construction he took the policy").

(n27)Footnote 36. ***US**-- Liverpool & London & Globe Ins. Co. v. Kearney, 180 U.S. 132 (1901)* .

(n28)Footnote 37. ***US**-- 263 U.S. 167 (1923)* .

(n29)Footnote 38. ***US**-- 263 U.S. at 174* .

(n30)Footnote 39. ***US**-- 263 U.S. at 174* .

(n31)Footnote 40. *See, e.g.*:

***US**-- Empire Carting Co. v. Employers' Reinsurance Corp., 64 F.2d 36, 38 (2d Cir. 1933)* ; *St. Paul Fire & Marine Ins. Co. v. Bachman, 49 F.2d 158, 159 (4th Cir. 1931)* ;

***GA**-- Mutual Life Ins. Co. v. Childs, 14 S.E.2d 165, 171 (Ga. Ct. App. 1941)* ;

***IL**-- Midwest Dairy Products Corp. v. Ohio Cas. Ins. Co., 190 N.E. 702, 703 (Ill. 1934)* ;

***MN**-- Econ. Premier Assur. Co. v. Western Nat'l Mut. Ins. Co., 839 N.W.2d 749 (Minn. Ct. App. 2013)* ;

***NY**-- Killian v. Metropolitan Life Ins. Co., 166 N.E. 798, 799 (N.Y. 1929)* .

(n32)Footnote 41. ***NY**-- 32 N.Y. 405 (1865)* .

(n33)Footnote 42. ***NY**-- 32 N.Y. at 414* .

(n34)Footnote 43. ***NY**-- 32 N.Y. at 414* .

(n35)Footnote 44. *See, e.g.,* ***NY**-- Griffey v. New York Cent. Ins. Co., 3 N.E. 309, 311 (N.Y. 1885)* ; *Steen v. Niagara Fire Ins. Co., 89 N.Y. 315 (N.Y. 1882)* ; *Wolf v. United States Cas. Co., 101 Misc. 541, 546 (N.Y. App. Term 1917)* ; *Levine v. Accident & Cas. Ins. Co., 203 Misc. 135, 141 (N.Y. Mun. Ct. 1952)* .

(n36)Footnote 45. *See, e.g.*:

***US/KS**-- Kelley v. Home Ins. Co., 14 F. Cas. 243 (U.S. Cir. Ct. 1875)* ;

IL-- Joseph v. New York Life Ins., 139 N.E.32, 33 (Ill. 1923) ;

***ME**-- Bickford v. Aetna Ins. Co., 63 A. 553, 553 (Me. 1906)* ;

***MA**-- Ferguson v. Union Mut. Life Ins. Co., 72 N.E. 358, 361 (Mass. 1904)* .

(n37)Footnote 46. ***NC**-- Gould Morris Electric Co. v. Atlantic Fire Ins. Co., 229 N.C. 518, 520 (1945)* .

(n38)Footnote 47. *See, e.g.:*

***US/GA**-- Alea London Ltd. v. Am. Home Servs., 638 F.3d 768 (11th Cir. 2011) , cert. denied, 132 S. Ct. 553 (2011)* ; Burnett v. Combined Ins. of Am., No. 5:10-cv-338 (MTT), *2011 U.S. Dist. LEXIS 137938,* at * 7-8 (M.D. Ga. Dec. 1, 2011) ;

***US/MI/OH**-- Auto Owners Ins. Co. v. Redland Ins. Co., 549 F.3d 1043 (6th Cir. 2008)* ;

***US/PA**-- Nationwide Mut. Ins. Co. v. CPB Int'l, Inc., 562 F.3d 591, 595 (3d Cir. 2009)* ;

***CA**-- E.M.M.I. v. Zurich American Ins., 84 P.3d 385, 389 (Cal. 2004)* ;

***FL**-- State Farm Fire & Cas. Co. v. CTC Dev. Corp., 720 So. 2d 1072, 1076 (Fla. 1986)* ;

***IL**-- Outboard Marine Corp v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1212 (Ill. 1992)* ;

***MA**-- McGregor v. Allamerica Ins. Co., 868 N.E.2d 1225, 1227 (Mass 2007)* ;

NY-- *In re Mostow v. State Farm Ins. Cos., 668 N.E.2d 392, 394 (N.Y. 1996)* .

(n39)Footnote 48. *See, e.g.:*

***US/MN**-- Leonard v. Exec. Risk Indem., Inc. (In re SRC Holding Corp.), 545 F.3d 661, 666 (8th Cir. 2008)* ; *FACE, Festivals & Concert Events, Inc. v. Scottsdale Ins. Co., 632 F.3d 417 (8th Cir. 2011)* ;

***CA**-- Palmer v. Truck Ins. Exch., 988 P.2d 568, 572 (Cal. 1998)* ;

***CT**-- Metropolitan Life Ins. Co. v. Aetna Cas. & Sur. Co., 765 A.2d 891, 897 (Conn. 2001)* ;

***GA**-- Hurst v. Grange Mut. Cas. Co., 470 S.E.2d 659, 663 (Ga. 1996)* ;

***IL**-- Travelers Ins. Co. v. Elier Mfg., Inc., 757 N.E.2d 481, 494 (Ill. 2001)* ;

***NY**-- United States Fid. & Guar. Co. v. Annunziata, 492 N.E.2d 1206 (N.Y. 1986)* ;

***TX**-- U.S. Fid. & Guar. Co. v. Goudeau, 272 S.W.3d 603, 607 (Tex. 2008)* .

(n40)Footnote 48.1. In theory, application of *contra proferentem* would lead insurers to redraft standard contracts and eliminate ambiguity. There is some doubt, however, the doctrine is having the desired effect. *See, e.g.*, Boardman, *Penalty Default Rules in Insurance Law, 40 Fla. St. U.L. Rev. 305 (2013)* (describing doctrine of *contra proferentem* as penalty default rule creating default mechanism for filling contractual gaps; arguing that when insurers retain ambiguous language in face of court application of doctrine, gap between consumer understanding of policy language and its "legal" meaning, as applied by courts, widens).

(n41)Footnote 49. *See* James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1002-1003 (1992).*

See also, e.g., ***CT**-- National Grange Mut. Ins. Co. v. Santaniello, 961 A.2d 387, 393 (Conn. 2009)* .

(n42)Footnote 50. *See* Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation, 95 Mich. L. Rev. 531, 543-545 (1996).*

(n43)Footnote 51. James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1010-1015 (1992).*

See also, e.g.:

***IA**-- Bituminous Cas. Corp. v. Sand Livestock Systems, Inc., 728 N.W.2d 216, 220 (Iowa 2007)* ;

***MN**-- General Cas. Co. of Wisconsin v. Wozniak Travel, Inc., 762 N.W.2d 572, 575 (Minn. 2009)* ; *Econ. Premier Assur. Co. v. Western Nat'l Mut. Ins. Co., 839 N.W.2d 749 (Minn. Ct. App. 2013)* ;

***MO**-- Am. Nat'l Prop. v. Wyatt, 400 S.W.3d 417 (Mo. Ct. App. 2013)* .

(n44)Footnote 52. James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1016-1020 (1992).*

See also, e.g.:

***AK**-- Whittier Properties, Inc. v. Alaska Nat. Ins. Co., 185 P.3d 84, 88 (Alaska 2008)* ;

***ID**-- Gravatt v. Regence Blueshield of Idaho, 42 P.3d 692, 695 (Idaho 2002)* .

(n45)Footnote 53. *See* James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1052-1057 (1992).*

(n46)Footnote 54. James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1048-1050 (1992).*

(n47)Footnote 55. James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1061-1063 (1992).*

(n48)Footnote 55.1. ***US/IL**-- Homeowners Choice, Inc. v. AON Benfield, Inc., 938 F. Supp. 2d 749 (N.D. Ill. 2013)* (because insurer writes contract and there is generally little negotiation over its language, Illinois courts apply *contra proferentum* even with sophisticated parties).

(n49)Footnote 55.2. ***MN**-- Econ. Premier Assur. Co. v. Western Nat'l Mut. Ins. Co., 839 N.W.2d 749 (Minn. Ct. App. 2013)* (to apply *contra proferentum* in suit between two insurers, one of which was not party to disputed contract, competing to avoid primary coverage removes the doctrine from its primary rationale; holding doctrine does not apply in coverage suit between insurers and that ambiguous contract provision should be analyzed from neutral perspective).

(n50)Footnote 56. James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context, 24 Ariz. St. L.J. 995, 1022-1025 (1992).*

See also, e.g., ***NJ**-- Shotmeyer v. New Jersey Realty Title Ins. Co., 948 A.2d 600, 605-606 (N.J. 2008)* .

(n51)Footnote 57. *See, e.g.:*

***CO**-- State Farm Mut. Auto. Ins. Co. v. Kastner, 77 P.3d 1256, 1259-1260 (Colo. 2003)* ;

***FL**-- Berges v. Infiniti Ins. Co., 896 So. 2d 665, 677 (Fla. 2004)* .

(n52)Footnote 58. *See, e.g.*:

***US/FL**-- James River Ins. Co. v. Ground Down Eng'g, Inc., 540 F.3d 1270, 1274 (11th Cir. 2008)* ;

***AZ**-- Sparks v. Republic Nat'l Life Ins. Co., 647 P.2d 1127, 1132 (Ariz. 1982)* ;

***CA**-- Foster-Gardner, Inc. v. Nat'l Fire Ins. Co., 959 P.2d 265, 272 (Cal. 1998)* ;

***IL**-- Outboard Marine Corp v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1212 (Ill. 1992)* ;

***IN**-- Northern Assur. Co. of Am. v. Thomson Inc., 996 N.E.2d 785 (Ind. Ct. App. 2013)* ;

***IA**-- Bituminous Cas. Corp. v. Sand Livestock Systems, Inc., 728 N.W.2d 216, 221 (Iowa 2007)* ;

***TX**-- Balandran v. Safeco Ins. Co., 972 S.W.2d 738, 741 (Tex. 1998)* .

(n53)Footnote 59. *See, e.g.:*

***CT**-- Liberty Mut. Ins. Co. v. Lone Star Indus., Inc., 967 A.2d 1, 22 (Conn. 2009)* ;

***MT**-- Heggem v. Capitol Indem. Corp., 154 P.3d 1189, 1195 (Mont. 2007)* .

(n54)Footnote 60. *See, e.g.*, **US/ID**--Ferguson *ex rel. McLeod v. Corgeis Ins. Co., 527 F.3d 930 (9th Cir. 2008).*

(n55)Footnote 61. *See, e.g.*, ***MS**-- United States Fid. & Guar. Co. v. Martin, 998 So. 2d 956, 963 (Miss. 2008)* .

(n56)Footnote 62. *See, e.g.:*

***KS**-- Am. Family Mut. Ins. Co. v. Wilkins, 179 P.3d 1104, 1110 (Kan. 2008)* ;

***IL**-- Rich v. Principal Life Ins. Co., 875 N.E.2d 1082, 1090 (Ill. 2007)* .

(n57)Footnote 63. *See, e.g.:*

***CT**-- Liberty Mut. Ins. Co. v. Lone Star Indus., Inc., 967 A.2d 1, 28 (Conn. 2009)* ;

***MT**-- Newbury v. State Farm Fire & Cas. Ins. Co., 184 P.3d 1021, 1025 (Mont. 2008)* .

(n58)Footnote 64. *See, e.g.:*

***MT**-- Heggem v. Capitol Indem. Corp., 154 P.3d 1189, 1193 (Mont. 2007)* ;

***WI**-- Lisowski v. Hastings Mut. Ins. Co., 759 N.W.2d 754, 757 (Wis. 2009)* .

(n59)Footnote 65. *See, e.g.,* ***IL**-- Rich v. Principal Life Ins. Co., 875 N.E.2d 1082, 1091 (Ill. 2007)* .

(n60)Footnote 66. *See, e.g.*:

***FL**-- Garcia v. Fed. Ins. Co., 969 So. 2d 288, 292 (Fla. 2007)* ;

***WI**-- Stuart v. Weisflog's Showroom Gallery, Inc., 753 N.W.2d 448, 456 (Wis. 2008)* .

(n61)Footnote 67. *See* Peter M. Tiersma, Legal Language (1999).

(n62)Footnote 68. *See, e.g.,* ***IL**-- Outboard Marine Corp v. Liberty Mut. Ins. Co., 607 N.E.2d 1204, 1218 (Ill. 1992)* .

(n63)Footnote 69. *See* Lawrence M. Solan, The Language Of Judges 66 (1993) (concluding that courts' application of *contra proferentem* rules "leads the careful observer to develop serious questions about the predictability, and perhaps even the sincerity, of their application in particular cases").

(n64)Footnote 70. *See* Jeffrey W. Stempel, Stempel on Insurance Contracts § 4.08[G] (2009); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should not be Construed Against the Drafter, 30 Ga. L. Rev. 171 178-185 (1995).*

(n65)Footnote 71. *See* Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation, 95 Mich. L. Rev. 531 (1996).*

(n66)Footnote 72. *See* Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should not be Construed Against the Drafter, 30 Ga. L. Rev. 171 (1995).*

(n67)Footnote 73. *See* Jeffrey W. Stempel, Stempel on Insurance Contracts § 4.08[C] (2009).

(n68)Footnote 74. *See* Susan Randall, *Freedom of Contract in Insurance, 14 Conn. Ins. L.J. 107, 120-122 (2007).*

(n69)Footnote 75. *See, e.g.,* ***CA**-- Spaid v. Cal-Western States Life Ins. Co., 182 Cal. Rptr. 3, 5 (Cal. Ct. App. 1982)* .

(n70)Footnote 76. *See, e.g.,* ***UT**-- Village Inn Apartments v. State Farm Fire & Cas. Co., 790 P.2d 581, 583 (Utah Ct. App. 1990)* .

(n71)Footnote 77. *See, e.g.:*

***MD**-- Cheney v. Bell Nat'l Life Ins. Co., 556 A.2d 1135, 1138 (Md. 1989)* ;

***NM**-- Bird v. State Farm Mut. Auto. Ins. Co., 165 P.3d 343 (N.M. Ct. App. 2007)* , *cert. denied, 165 P.3d 326 (N.M. 2007)* .

(n72)Footnote 78. *See, e.g.:*

***CA**-- E.M.M.I. Inc. v. Zurich Am. Ins. Co., 84 P.3d 385, 389 (Cal. 2004)* ;

***IA**-- Am. Family Mut. Ins. v. Petersen, 679 N.W.2d 571, 576 (Iowa 2004)* .

(n73)Footnote 79. *See* Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation, 95 Mich. L. Rev. 531, 554-555 (1996).*

(n74)Footnote 80. *Cf.* Steven J. Burton, Elements of Contract Interpretation 134-138 (2009) (suggesting four types of ambiguity: term, sentence, structural and vagueness).

(n75)Footnote 81. *See, e.g.*, ***IA**-- LeMars Mut. Ins. Co. v. Joffer, 574 N.W.2d 303, 307 (Iowa 1998)* ("In determining the ordinary meaning of undefined terms in a policy, we commonly refer to dictionaries.").

*But see **MO**-- Am. Nat'l Prop. v. Wyatt, 400 S.W.3d 417 (Mo. Ct. App. 2013)* (although examination of various dictionary definitions will no doubt be useful, it does not necessarily yield "ordinary and popular" sense of word if it disregards policy context).

(n76)Footnote 82. ***IL**-- 607 N.E.2d 1204 (Ill. 1992)* .

(n77)Footnote 83. ***IL**-- 607 N.E.2d at 1218* (citing Webster's Third New International Dictionary, American Heritage Dictionary of the English Language, and Black's Law Dictionary).

(n78)Footnote 84. ***IL**-- 607 N.E.2d at 1218* .

(n79)Footnote 85. ***IL**-- 607 N.E.2d at 1218* .

(n80)Footnote 86. ***IA**-- 728 N.W.2d 216 (Iowa 2007)* .

(n81)Footnote 87. ***IA**-- 728 N.W.2d at 219* .

(n82)Footnote 88. ***IA**-- 728 N.W.2d at 219* .

(n83)Footnote 89. ***IA**-- 728 N.W.2d at 221* (quoting Webster's Third New International Dictionary 336 (unabr. ed. rev. 2002)).

(n84)Footnote 90. ***IA**-- 728 N.W.2d at 221* .

(n85)Footnote 91. ***GA**-- 470 S.E.2d 659 (Ga. 1996)* .

(n86)Footnote 92. ***GA**-- 470 S.E.2d at 661* .

(n87)Footnote 93. ***GA**-- 470 S.E.2d at 663* .

(n88)Footnote 94. ***GA**-- 470 S.E.2d at 663-664* .

(n89)Footnote 95. ***TX**-- 272 S.W.3d 603 (Tex. 2008)* .

(n90)Footnote 96. **TX**--The court did note that "occupying" was defined in the policy as "in, upon, getting in, on, out or off." *272 S.W.3d at 606* . It also considered whether Goudeau's landing on top of the car would meet the definition of "upon," concluding that to construe "upon" "to include the situation here would 'ascrib[e] to one word a meaning so braod that it is inconsistent with its accompanying words.' " *272 S.W.3d at 606* .

(n91)Footnote 97. ***TX**-- 272 S.W.3d at 606* .

(n92)Footnote 98. *See, e.g.,* ***IA**-- LeMars Mut. Ins. Co. v. Joffer, 574 N.W.2d 303, 308 (Iowa 1998)* .

(n93)Footnote 99. ***US/SC**-- 857 F.2d 979 (4th Cir. 1988)* .

(n94)Footnote 100. ***US/SC**-- 857 F.2d at 981* .

(n95)Footnote 101. ***US/SC**-- 857 F.2d at 981* . Part of the explanation for the brevity of the court's analysis is that it relied upon precedent. One case, *Continental Ins. Cos. v. Northeastern Pharmaceutical & Chem. Co., 842 F.2d 977, 985-986 (8th Cir. 1988)* .

(n96)Footnote 102. *See also:*

***US/MD**-- Maryland Cas. Co. v. Armco, Inc., 822 F.2d 1348, 1352 (4th Cir. 1987)* ;

***US/MO**-- Continental Ins. Cos. v. Northeastern Pharmaceutical & Chem. Co., 842 F.2d 977, 985-986 (8th Cir. 1988)* .

(n97)Footnote 103. ***TX**-- 873 S.W.2d 698 (Tex. 1993)* .

(n98)Footnote 104. ***TX**-- 873 S.W.2d at 698* .

(n99)Footnote 105. ***TX**-- 873 S.W.2d at 701* .

(n100)Footnote 106. ***IA**-- 574 N.W.2d 303 (Iowa 1998)* .

(n101)Footnote 107. ***IA**-- 574 N.W.2d at 305* .

(n102)Footnote 108. ***IA**-- 574 N.W.2d at 307-308* .

(n103)Footnote 109. ***IA**-- 574 N.W.2d at 308* .

(n104)Footnote 110. ***IA**-- 574 N.W.2d at 308* .

(n105)Footnote 111. ***IA**-- 574 N.W.2d at 308* .

(n106)Footnote 112. *See* 1 Keith Allan, Linguistic Meaning 77-78 (1986).

(n107)Footnote 113. ***CA**-- 855 P.2d 1263 (Cal. 1993)* .

See also ***MO**-- Bar Plan Mut. Ins. Co. v. Chesterfield Mgmt. Assocs., 407 S.W.3d 621 (Mo. Ct. App. 2013)* .

(n108)Footnote 114. ***CA**-- 855 P.2d at 1270* .

(n109)Footnote 115. ***CA**-- 855 P.2d at 1271-1272* .

(n110)Footnote 116. ***CA**-- 855 P.2d at 1271* .

(n111)Footnote 117. *See Section 5.02[1][d]* above.

(n112)Footnote 118. *See, e.g.:*

***CT**-- R.T. Vanderbilt Co., Inc. v. Continental Cas. Co., 870 A.2d 1048, 1059 (Conn. 2005)* ;

***IL**-- Home & Auto. Ins. Co. v. Scharli, 293 N.E.2d 914, 916 (Ill. App. Ct. 1973)* ;

***ND**-- Haugen v. Auto-Owners Ins. Co., 191 N.W.2d 274, 280 (N.D. 1971)* .

(n113)Footnote 119. ***IL**-- 727 N.E.2d 376 (Ill. App. Ct. 2000)* .

(n114)Footnote 120. ***IL**-- 727 N.E.2d at 380* .

(n115)Footnote 121. ***IL**-- 727 N.E.2d at 380* .

(n116)Footnote 122. ***IL**-- 727 N.E.2d at 380* (emphasis supplied).

(n117)Footnote 123. ***IL**-- 727 N.E.2d at 380-381* .

(n118)Footnote 124. ***IL**-- 727 N.E.2d at 383* .

(n119)Footnote 125. ***CA**-- 884 P.2d 1048 (Cal. 1994)* .

(n120)Footnote 126. ***CA**-- 884 P.2d at 1050 n.1* .

(n121)Footnote 127. ***CA**-- 884 P.2d at 1050 n.1* .

(n122)Footnote 128. ***CA**-- 884 P.2d at 1050 n.1* .

(n123)Footnote 129. ***CA**-- 884 P.2d at 1056* .

(n124)Footnote 130. ***CA**-- 884 P.2d at 1056* .

(n125)Footnote 131. ***CA**-- 884 P.2d at 1059* .

(n126)Footnote 132. ***NY**-- 632 N.Y.S.2d 870 (N.Y. App. Div. 1995)* .

(n127)Footnote 133. ***NY**-- 632 N.Y.S.2d at 871* .

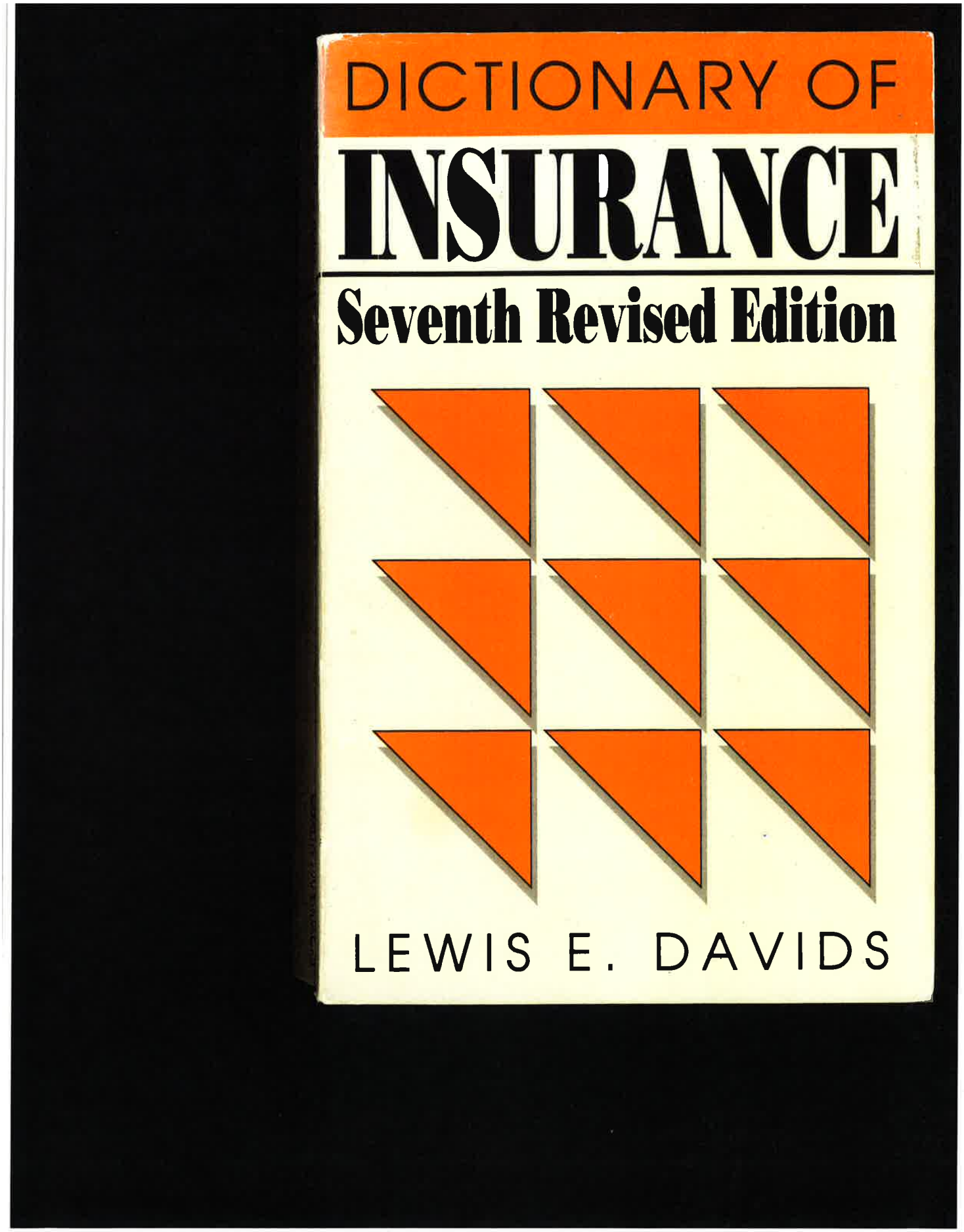
(N128)Footnote 134. ***NY**-- 632 N.Y.S.2d at 871* .

(n129)Footnote 135. ***NY**-- 632 N.Y.S.2d at 871* .

(n130)Footnote 136. ***NY**-- 492 N.E.2d 1206 (N.Y. 1986)* .

(n131)Footnote 137. ***NY**-- 492 N.E.2d at 1207* .

(n132)Footnote 138. ***NY**-- 492 N.E.2d at 1207-1208* .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LEWIS E. DAVIDS

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tarily detained.

Insulation A heat-retarding material applied in outside walls, top floor ceiling, or in roof to prevent passage of heat or cold in or out of building.

Insurable interest Relationship such that loss or destruction of life or property would cause a pecuniary loss. An interest in the life of an individual or in property by which there will be a financial loss if the insured dies or in the case of property if it is lost, damaged, or destroyed. For example, if you sell an automobile to another and are being repaid in installments you have an insurable interest in the automobile in proportion to the amount of money still unpaid. The purchaser also has an insurable interest.

Insurable Risk The requisite of an insurable risk are these:
(1) There must be a large group of homogeneous exposure units;
(2) The loss produced by the risk must be definite;
(3) The occurrence of the loss in the individual cases must be accidental or fortuitous;
(4) The potential loss must be large enough to cause hardship;
(5) The cost of insuring must be economically feasible;
(6) The chance of loss must be calculable;
(7) The risk must be unlikely to produce loss to a great many insured units at the same time.

Insurable Title A title on which a title insuring company is willing to issue its policy of insurance.

Insurable value *See* **Actual cash value.**

Insurance The contractual relationship which exists when one party, for a consideration, agrees to reimburse another for loss caused by designated contingencies. The first party is called the insurer; the second, the insured; the contract, the insurance policy; the consideration, the premium; the property in question, the risk; the contingency in question, the hazard or peril. The term assurance common in England, is ordinarily considered identical to and synonymous with insurance.

Insurance agent *See* **Producer.**

Insurance broker *See* **Producer.**

Insurance carrier The insurance company, since it assumes the financial responsibility for the risks of the policyholders.

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Second Edition

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insurance company is at avoiding that promise, the more money it makes."[39]

§ 1.02 STANDARDIZATION

Liability insurance policies typically use standard-form policy provisions. Insurance industry trade groups—traditionally called "rating bureaus"[40] and authorized by state statutes[41]—developed these standard-form provisions and revised them periodically. As shown in **Table 1-1**, many standard-form policy provisions, including the crucial insuring agreement and key definitions of the CGL policy, have remained unchanged for years, even decades. The 1955, 1966, 1973, and 1986 Forms of the CGL policy are reproduced Online.[41.1] In an often-cited case, the Insurance Company of North America wrote:

> [S]tandard-form insurance policies are used throughout the insurance industry, to provide broad, "comprehensive," coverage; the insurance policies in issue here are standard policies used now and for many years before throughout the country by virtually the entire insurance industry. More importantly, these policies are "general" or "comprehensive" liability policies which provide coverage for claims arising from all types of products.[42]

Insurance companies have worked jointly on the drafting of insurance policy language since the 19th century, beginning with fire insurance. At that time, insurance company representatives began meeting in

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[39] Baker, 72 Tex. L. Rev. at 1401.

[40] *E.g.*, 1A Long § 10.03[1]; Sayler & Zolensky at 3.

[41] *See, e.g.*, N.Y. Ins. Law §§ 2313 *et seq.* (McKinney 1996).

[41.1] CGL policy forms provided by the insurance services office, Inc., for years beginning in 1985 are available at www.lexis.com.

[42] Insurance Company of North America's Petition for a Writ of *Certiorari* to the United States Court of Appeals for the Sixth Circuit at 14–15, Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 454 U.S. 1109 (1981). *See* Hawkins Chem., Inc. v. Westchester Fire Ins. Co., 159 F.3d 348, 350-52 (8th Cir. 1998) (applying Minnesota law) (unapproved policy language is void; simply referring to language as "manuscript" does "'not alter the fact that [the policy] is a form.'" (quoting lower court decision)) (*Hawkins Chemical*). *See also* Marianne Bonner, *Seven Common Coverage Gaps in the ISO CGL Policy*, published in XXXIII The Risk Report, No. 12, at 1 (Aug. 2011) (the CGL policy's "generic design makes it readily adaptable to a broad range of business entities . . . in many different industries.").

committees to discuss the scope of coverage provided by their insurance policies and the premiums charged. In the 1930s, the committees began formally drafting standard general liability insurance policy forms and endorsements.[43] The insurance industry sought language broad enough to cover new common law and statutory law liabilities without changing the policy during the policy period. Hence, the CGL drafters anticipated expansions of legal liability and developed language to automatically cover those expansions. In 1940, CGL drafter J.M. Sweitzer wrote:

> The legal liability of the 1920's has been expanded to an entirely different liability at the present time. Some of this change has been brought about by statutory enactments broadening the field of liability. Court decisions have extended the common law to create new, and to expand recognized, hazards. A change in the interpretation of the law with respect to warranties and the elimination of the necessity of privity in some cases has greatly increased the liability for the sale of products.[44]

In 1941, insurance industry committees promulgated the first standard-form comprehensive general liability insurance policy form.[45] Thereafter, the insurance industry periodically revised the standard CGL insurance policy form (the CGL policy), making revisions in 1943, 1947, 1955, 1966, 1973, 1986, 1988, 1990, and 1993.[46]

In making changes from one form to the next, the insurance industry sought to satisfy demands of the insurance-buying public for new or

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[43] Lyman J. Baldwin, Address to American Society of Insurance Management 17 (Oct. 20, 1965) (on file with authors).

[44] J.M. Sweitzer, *The Trend of the Times in Revision of Policy Forms and Broadening of Coverages*, Ins. Couns. J. at 51, 52 (Oct. 1940). Mr. Sweitzer was general counsel of the Employers Mutual Liability Insurance Company of Wisconsin.

[45] Most CGL insurance policies today are either fully standardized or employ standardized language. *See, e.g.*, Hoechst Celanese Corp. v. National Union Fire Ins. Co., 623 A.2d 1128, 1129 (Del. Super. Ct. 1992) (*Hoechst Celanese*) ("[M]ost if not all insurers use ISO [Insurance Services Office, Inc.] standard-form language in their policies and . . . insurers are frequent participants in the drafting process."); C.A. Kulp, Casualty Insurance: An Analysis of Hazards, Companies and Rates 78 (4th ed. 1968).

[46] *See, e.g.*, Sawyer at 20-21; 1A Long at § 10.03[2]; 1 Gibson & McLendon at IV.D.1; *In re* Ins. Antitrust Litig., 938 F.2d 919 (9th Cir. 1991), *aff'd in part and rev'd in part*, 506 U.S. 714, *on remand*, 5 F.3d 1556 (9th Cir. 1993) (*Insurance Antitrust*). *See, e.g., American Home Prods.* I, 565 F. Supp. at 1500-03.

broader coverages.[47] The insurance industry also sought to resolve inconsistencies or ambiguities that resulted in a significant court decision or series of decisions construing the ambiguity against the insurance company.[48]

For example, the 1966 CGL Form responded in part to customers' demands for the new "occurrence"-based coverage and in part to adverse court decisions entered under the prior form.[49] Before 1966, the CGL forms covered the policyholder's liability arising from an "accident" and were said, in insurance parlance, to be written on an accident basis. Beginning in the late 1950s and continuing through the early 1960s, the insurance industry worked a major revision of the CGL policy. According to a historical summary given at an insurance industry conference in 1992, the 1966 revision sought to simplify complexities in the 1955 CGL policy arising from the structure of the 1955 Form.

[47] Timothy Stanton, Comment, *Now You See It, Now You Don't: Defective Products—The Question of Incorporation and Liability Insurance*, 25 Loy. U. Chi. L.J. 107, 114 (1993) [hereinafter *Incorporation and Liability Insurance*].

[48] George H. Tinker, *Comprehensive General Liability Insurance—Perspective and Overview*, 25 Fed'n Ins. Couns. Q. 217, 222 (1975) [hereinafter Tinker]; John J. Tarpey, *The New Comprehensive Policy: Some of the Changes*, 33 Ins. Couns. J. 223, 223 (1966). *See also Incorporation and Liability Insurance*, 25 Loy U. Chi. L.J. at 114.

[49] *Incorporation and Liability Insurance*, 25 Loy. U. Chi. L.J. at 114. *See also* Tinker at 254-57.

every business need. I believe, however, that this sacrifice is minor in the revised form."[65]

In analyzing the 1966 revision of the CGL policy, a group called Professional Risk Managers recognized the 35-year history of standardization of the CGL policy and the insurance industry's efforts to achieve a "phraseology" that "best express[es] the coverage intended":

> [S]tandardization of casualty policies has developed through cooperation within the insurance industry [within the last] thirty-five years.
>
> * * *
>
> One reason for standardization is an attempt by the insurers to agree upon phraseology designed to best express the coverage intended. Saying the same thing in different words may be quite satisfactory in some fields, but generally it does not work well in the law—an insurance policy is a legal contract. Use of the same language in the policies of most companies has enabled court interpretations which clarify the meaning of policy language in any given area to be extended, in most cases, as an acceptable interpretation in similarly worded contracts and has thus avoided repeat litigation.[66]

An ISO memorandum written in 1984 during the process of reviewing the CGL policy to produce the 1986 CGL form explained some of the advantages of standardization: "Reasons for this effort include savings on printing costs, simplified assembly, ease in locating policy information and one set of forms and rules standardized for all lines of coverage."[67]

[B] Effects of Standardization

In summary, standardization has allowed the insurance industry to pursue several objectives:

- To make rating and premium calculations based on comparable loss experience data from different types of businesses with the same insurance coverage[68];

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[65] Katz at 32.

[66] American Soc'y of Ins. Management, Customer Analysis of the Comprehensive General Liability Policy at iii (Professional Risk Managers ed., adopted Oct. 1966).

[67] Interoffice memo to file from Bob Patton regarding ISO seminar, Hartford, Connecticut, at 1 (Aug. 16–17, 1984).

[68] J.B. Donovan, National Standard Provisions for Casualty Policies, paper delivered to the American Bar Association at 2 (Sept. 6, 1949) ("Rating organizations . . . were

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PERSPECTIVES

THE LOSS OF THE CERTAINTY EFFECT

Richard E. Stewart
Barbara D. Stewart

ABSTRACT

Recent changes in the commercial property-liability insurance business have made it unlikely that large claims will be paid promptly and willingly. The situation is not limited to asbestos, pollution, and medical product liability, though certainly evident there. The authors examine the situation from three economic and psychological perspectives—option theory, asymmetric information theory, and prospect theory. All three indicate that if insurance were seen by customers as less than fully certain and reliable, the resulting discounting of its value—and hence buyers' willingness to pay for it—would be much deeper than one would expect. Although competitive and legal steps could be taken to head off such a disaster, none of them is likely.

INTRODUCTION

A defining characteristic of insurance is that the product is sold and paid for long before it is delivered. For a certain payment now, the buyer of insurance gets the insurance company's promise to deliver money and services in the future should an uncertain event occur.

From the insurance company's perspective, the separation of the point of sale from the point of claim is the greatest challenge and the greatest benefit. To set prices, the insurance company has to project costs, sometimes years into the future. But during the time between sale and claim, the company also gets to hold and invest the premium.

From the buyer's perspective too, the separation of sale and claim is a benefit and a problem. It is at the core of the value of insurance—the known premium now in return for a larger payment later if the loss occurs—but it also creates problems of quality or reliability. If in the interval between sale and claim the insurance company becomes

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unable or unwilling to pay claims, its promise becomes worth a lot less than when it was sold and paid for.

The buyer's assumption that claims will be paid is the key to the value of what insurers sell. Recent changes in the insurance business have placed a cloud over this assumption. Recent scholarly work in economics and psychology has illuminated the likely effect on insurance if the assumption about its reliability were to fade away.

This article examines the insurance changes, the applicable thinking in economics and psychology, the implications for insurers, some historical precedents, and finally, steps that might be taken to avoid what looks like a rather unattractive future.

RECENT CHANGES IN INSURANCE

Property-liability insurance benefits greatly from people's belief that it can eliminate the financial consequences of specified risks. Recent research has shown that people give disproportionate weight to eliminating the smallest chance that the product or service being purchased will fail. The difference between eliminating a risk and only reducing it is called the "certainty effect" (Kahneman and Tversky, 1979). The certainty effect is discussed in the section of this article titled "Prospect Theory."

Insurance can become uncertain in two ways. One is by the insurance company's financial inability to pay claims. Preventing harmful insolvencies of insurance companies has long been considered the primary goal of insurance regulation (Patterson, 1927, p. 192). The other way for insurance to become uncertain is by the insurance company's decision not to pay claims willingly and to make policyholders fight for coverage after claims come in.

Over the past three decades, the commercial property-liability insurance business has undergone significant changes. Taken together, the changes make it more likely that an insurance company will deny coverage for a large claim today than, say, 30 years ago. The changes include the following nine.

First, price competition has come to insurance. For the half century ending in 1945, property-liability rates were, in most states, prescribed by a cartel reinforced by government (see Wandel, 1935, for a description of how the cartel worked). This practice was legal, because insurance was thought to be outside the antitrust laws. With judicial, congressional, and state regulatory action in the period from 1945 through 1975, all that changed (see National Association of Insurance Commissioners, 1974, for the story). The legal and regulatory framework for insurance switched to favoring competition.[1] It was sound public policy, and eventually it had the intended effect. With the price competition came an unaccustomed emphasis on controlling the costs that go into prices—expenses and claims.

Second, the risk management movement enabled corporate policyholders to save money by keeping against their own capital the smaller and more predictable risks. The natural focus of risk managers and brokers has been on the point of sale, where premiums are saved and commissions earned, and not on the point of claim.

[1] One of the authors proposed, and helped secure enactment of, New York's change from cartelized to competitive rating, with antitrust prohibitions stronger than federal law (see New York Insurance Department, 1968, pp. 13-14, 133-336).

The risk management movement has had two other effects. First, the insurance market has changed from being based on relationships, in which each party was committed to taking care of the other in the long run, to being based on transactions, in which each deal stands on its own. Second, the overall books of business of insurance companies have been rendered less stable. The most stable parts—the numerous small losses that occur every year—have been retained by the policyholders.

Closely related to the risk management movement is the third factor—the increased power of brokers. Insurance agents and brokers have always been important in insurance as both a business and a public-policy matter. But recently, two changes have increased their market power greatly.

One of the changes traces to risk management, in which brokers have been major, perhaps dominant, participants. The other comes from the internal economics of brokers as intermediaries. As in other financial services, the competitive need to reduce costs and to offer national and international services has led to a rapid consolidation of brokerage firms. The few remaining giant firms have unprecedented influence over both insurance companies and policyholders. But they are still compensated by commissions and fees at the point of sale, not on performance with claims.

A fourth change in the insurance business has been from orientation toward policyholders to orientation toward stockholders. Traditionally, insurance companies declared their devotion to policyholders, and insurance regulators declared that they were the primary constituency. Starting in the 1980s, securities analysts and corporate managements emphasized "shareholder value" and, by stock options, the alignment of management's interests with those of stockholders. Through dividends and appreciation, stockholders get the benefit of what is not paid out for claims.[2]

The shift from policyholders to stockholders has led to the fifth change—in the role of capital in an insurance company. Traditionally, an insurance company could not be too well capitalized. Regulators, agents, and rating agencies would jump on a company that wrote too much business in relation to its capital resources, while they would look past operating difficulties in another company that appeared rich in capital. Prudent managements naturally preferred having too much capital to having too little (see Ruebhausen et al. 1968, pp. 191-195).

But the new focus on shareholder value has brought with it a focus on return on equity (ROE) and a focus on consistency of earnings growth. Both tend to increase management's sensitivity to large losses. Leveraging one's equity—in insurance, writing more business against it—is now the key to a higher and highly praised ROE.

Yet because of a 12-year price war and rising stock and bond markets, the key measure of capitalization—premiums to surplus—has gone down. The prevailing explanation for the price war has been "overcapitalization" (see "The Capital Trap," 2000, for a discussion of the reasons for and responses to the industry's overcapitalization).[3] That implies managements will try to get the ratio up, thereby thinning the cushion against large

[2] The policyholder-stockholder tension is apparent in a statement by a spokesman for the Chubb Group two days after the terrorist attack on the World Trade Center: "We'd be sued by our shareholders if we paid and no one else did" (Oster, 2001).

[3] The property-liability industry overall is currently writing one dollar of premium for every dollar of policyholders' surplus (equity), whereas during the 1980s the industry was

losses. The new emphasis on consistency of earnings growth implies that managements have to be very sensitive to large losses already.

The sixth change includes insurance but extends throughout finance. It is the elimination of intermediaries between users of capital and the main capital markets. Insurance companies are intermediaries, just as agents and brokers are. But unlike agents and brokers, the companies have to have capital, because in effect they guarantee their own performance, and the capital backs it up. Capitalized intermediaries, such as banks and insurance companies, have a cost of capital that is not needed with direct access to the stock and bond markets. On a cost basis, those intermediaries cannot compete with direct-access vehicles of equal quality, such as money funds and securitized insurance risks.

But that is in theory and in the very long run. For now, the direct-access approach to property-liability insurance risks—securitization of property catastrophe reinsurance—appears to be loaded with such heavy risk premiums and other costs that conventional reinsurance remains highly competitive on a cost basis (Froot, 2001, p. 12). And the capitalized intermediaries, the familiar property-liability insurance and reinsurance companies, can also compete by doing something stringent about other costs—expenses and claims.

A seventh change was an explicit recognition of the earnings on funds reserved for claims as the most significant component of earnings for a property-liability insurance company. In banking, such funds are called "float." Traditionally, this investment income was ignored by the insurance business (Investment Income Task Force, 1984, p. 42; New York Senate and Assembly, 1911, p. 55). Besides the interest rate, the benefits of float depend on two things. First, they depend on how long the float is—how long the premium funds are held before being paid as claims, for that is how long the money can be kept invested. Second, the benefits depend on the cost of the float—the losses and expenses incurred in obtaining it (Buffett, 1994, p. 13; Buffett, 2000, p. 9; Stewart, 1979, p. 111). Insurance managements are more than sufficiently intelligent to see that delaying the payment of claims increases the float period and denying claims decreases the cost.

The eighth change was unexpected liability catastrophes, the change that has received the most attention in the insurance press. The insurance industry's rating bureaus had been broadening the standard comprehensive general liability policy for 25 years after its introduction in 1941. Then in the 1970s through the 1990s, three disasters hit—asbestos liability, pollution liability, and medical product liability.

Most people think of insurance catastrophes in terms of property insurance—hurricanes, floods, and earthquakes.[4] What makes catastrophes so bad for insurance is not their terrible physical manifestations but the fact that they are huge and hit all at once, and they cannot be predicted, priced, or spread through the insurance mechanism. That can happen in liability insurance as well as property insurance, and it did in asbestos, pollution, and medical product liability.

writing about two dollars of premium for every dollar of policyholders' surplus (A.M. Best Company, 2001, p. 262).

[4] The classic case is the San Francisco earthquake and fire of 1906, after which many companies refused to pay or discounted claims (see Alfred M. Best Company, 1907).

Whereas property catastrophes are limited to the value of the property, liability catastrophes threaten to be open-ended, even unending. The response of many insurance companies to these three liability catastrophes was to try to slow down, reduce, and spread out over time the payment of the claims—to make them a big loss but not a catastrophe.[5]

The ninth change, growing out of the preceding one, was the birth of a sophisticated, aggressive, and expensive coverage bar serving both insurers and policyholders, displacing in big cases the specialized bar that had exclusively represented insurers. It is one thing to have an average law firm representing the insurance company and the policyholder in an automobile-accident case, but it is quite another to pick a lawyer to handle a coverage case with $1 billion at stake and a million documents to be studied.[6] As a result, now on each side a set of first-class lawyers is looking forward to the next fight.

All the changes point in the same direction. From an insurer's point of view, resisting large claims has become an effective, perhaps even necessary, competitive strategy. From a policyholder's point of view, the cost of collection has gone way up and reliability has gone way down.[7]

How far has the reliability problem progressed? The direct evidence is buried in insurance company claims and litigation records, and insurers guard that information fiercely. But the authors believe it pervades large claims in general liability and probably extends to large claims in directors' and officers' liability and all-risk property.[8]

Does the reliability problem exist with all insurers of big commercial risks or just some of them? At this point the authors do not know for sure. But the changes in insurance described above, together with the fact that not paying claims can lead to lower prices, suggest that the reliability problem will reach all insurers and all kinds of large claims sooner or later.

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[5] A RAND Corporation study estimated that 88 percent of the money spent by insurers on pollution cleanup under the 1980 Superfund law has gone for transaction costs, that is, coverage disputes and policyholder defense (Dixon, 1992). For asbestos bodily injury, transaction costs took 63 percent of the total spent by both insurers and policyholders (Hensler et al., 2001, p. 37). The pattern was noted earlier in the context of pharmaceutical products liability. "With the growth of claims that have taken years to manifest themselves and the size of the class of potential claimants, many insurance companies faced with such claims have run for cover rather than coverage" (*Sandoz v. Employers Liability Assurance Corp.*, 1983, pp. 257-258).

[6] Although the authors do substantial work for insurance companies in non-coverage areas, they have served as expert witnesses for policyholders in over 100 very large coverage lawsuits. They have observed firsthand the high quality of the lawyers on both sides, the long duration and great expense of the proceedings, and the ingenuity of the arguments both for and against coverage.

[7] A leading insurance scholar has called it "a *de facto* 'big claim' exclusion" (Abraham, 2001a).

[8] Nobody—not even insurers and their trade and statistical organizations—has information about large claims handling for the entire property-liability insurance industry. No court, insurance department, policyholder, or member of the public has such information for even a single insurer. Hence the evidence for the problem is largely anecdotal or inferential. Occasionally a bit of it is revealed in trials, but always under seal. Occasionally a bit is reported in the press (see Scism, 1996). The RAND statistical studies (Dixon, 1992; Hensler et al., 2001) point the same way—in asbestos and pollution liability, disputes consume much more money than compensation does.

Normally one would expect the market to correct such a problem, as it corrects quality problems with other goods and services. Consumers see that a product is shoddy or that a service is sloppy or hostile, and they steer away from it. In insurance, the separation in time of the sale and claim impedes the market's ability to self-correct for quality. But correction does happen. In personal insurances such as automobile and homeowners, some companies have the reputation for paying fairly and some do not, their reputations based on people's collective experience with an extremely large number of claims. Insurance department examiners can look at thousands of claim files in a market conduct examination. *Consumer Reports* even ranks companies by customer satisfaction.

But the problem of delay and denial of very large commercial claims is ill suited to market correction for several reasons. By contrast to personal lines, very large commercial claims are rare in the experience of a single corporation. A risk manager may see only one or two in an entire career. Out-of-court settlements of large claims are usually secret. So a given buyer lacks the evidence from which he or she could pick up a pattern of harsh claims practices, and the buyer can easily believe the assertion that the particular claim at hand is being treated on its unique, fact-dependent merits. Even if a risk manager picked up a pattern of bad treatment, where else could he or she go? And most important, the market gives no participant an economic incentive to focus on performance at the point of claim.

To report the changes in insurance is not to condemn them. They are not defects or moral shortcomings. But to understand any business, it is good to know how it works and the incentives that surround it.

ECONOMIC AND PSYCHOLOGICAL PERSPECTIVES ON THE INSURANCE CHANGES

In the last 30 years, three lines of scholarship in economics and psychology have developed that cast light on the subject of insurance reliability. The three are intellectually independent of one another. They all point the same way, though each sees the insurance situation from a different angle.

First, option theory observes that financial proxies for economic outcomes are effective only so long as they really correspond with the outcome and the other party is sure to perform.

Second, asymmetric information theory observes that when sellers are known to have more information about the quality of a traded item than buyers do, the buyers will pay only on worst-case assumptions.

Third, prospect theory observes that people place a higher-than-rational value on certainty and, conversely, react to the loss of certainty by reducing what they are willing to pay by more than they rationally should.

All three of these approaches lead to the same conclusion—that the loss of the certainty effect would be very expensive for insurers, perhaps disastrous.

Option Theory

The first perspective on the claims-reliability question is provided by option (or hedging) theory. Techniques for hedging risks have been used for centuries, chiefly against price fluctuations in farm products, but in recent years they have been at the cutting edge of the economics of finance. To determine the price of options, the new techniques rely on

computers running mathematical models. They have inspired new investment strategies and a host of new financial derivatives (for an overview of the development and uses of option-pricing theory, see Merton, 1998; Bernstein, 1992, 1996; Bodie and Merton, 2000, pp. 313-416; "Future Perfect," 1999). Although derivatives are useful and the financial ingenuity has been exciting, a few well-known episodes have provided sobering and expensive reminders of hedging fundamentals.[9]

The basic idea of option or hedging theory is that one financial instrument—a forward purchase or sale, or a call or put option—can represent another instrument or another economic reality. If so, the one can replace the other, and pretty soon the replacements can be traded and offset against the opposite realities. The hedging instrument is known as a "derivative," because its value is derived from the "underlying" instrument or economic situation.

Derivatives are valuable tools for managing risks of many kinds, and vast amounts of them are traded every day. But hedging turns on two questions. One is whether the derivative really squares with the underlying risk—whether it is indeed a perfect hedge. This is called basis risk.[10] The other is whether the other party can or will deliver. This is called counterparty risk (Smithson, Smith, and Wilford, 1995; Kolb, 1999).

For a long time, insurance has been considered a perfect hedge against the perils it addresses. Implicitly it is the perfect derivative, one with no basis risk and no counterparty risk. Of course, the chance of insolvency is not ignored in real life or insurance literature.[11] But the risk that a solvent insurer would deliberately refuse to pay appears not to have been raised at all.[12]

Perhaps the greatest advantage of insurance as a hedge has been its excellent fit with the exposure to loss being dealt with, its lack of basis risk. When changing conditions have made the fit less good, the insurance industry has amended the policy form. Just before the Second World War, the perceived general liability risks of business corporations got out of line with the standard named-peril or scheduled-hazard liability policies. So the insurance industry reduced the basis risk by adopting the comprehensive general liability form known today (Sawyer, 1943, pp. 11-33). Customers have been willing to accept a little counterparty risk based on insolvency in order to enjoy the benefits of insurance as a hedge with practically no basis risk.

The loss of the certainty effect would mean that insurance had come to be seen as no longer a perfect hedge or even a particularly good one. If the certainty effect were to be lost, insurance would look to potential buyers like a derivative with a great deal of

[9] Long-Term Capital Management, the hedge fund whose unraveling threatened the international financial system in 1998, had as its partners two originators of option-pricing theory, Robert Merton and Myron Scholes. Lowenstein (2000) describes the rise and fall of the firm.

[10] Basis risk is a recognized challenge in designing property catastrophe insurance derivatives (see Harrington and Niehaus, 1999; Cummins, Lalonde, and Phillips, 2000; Insurance Services Office, Inc., 1999; Thomas, 1997).

[11] In reinsurance, the presence of counterparty risk and the absence of basis risk are described in Doherty (1997, p. 867).

[12] The risk of a solvent counterparty's refusing to pay, however, is known in non-insurance contexts. It was illustrated several years ago when Procter & Gamble, Gibson Greetings, and Federal Paper Board took huge losses in derivatives, refused to pay, and then sued Bankers Trust, the counterparty (see Loomis, 1995).

counterparty risk. In the financial markets, a derivative with substantial counterparty risk is not considered worthwhile and does not trade.[13]

What does option theory say about insurance? It says that if insurance were to lose the certainty effect, it would become a derivative with substantial counterparty risk. Its privileged status in finance would disappear. That would change everything. But exactly how? Two other perspectives help answer this question.

Asymmetric Information Theory

In economics in recent years, another important development has been in the economics of information.[14] Particularly useful for this discussion is the part of it that deals with markets in which the seller and buyer do not have the same amount of information about the quality of the product or service being offered. The two parties have information that is not symmetric.

Asymmetric information has been modeled in a variety of theoretical and real-world settings (Rothschild and Stiglitz, 1976). One of the most famous is the market for used cars, in which the seller knows more about the condition of the vehicle than the buyer does. Being aware of this disparity of information, buyers offer less, and the prices of all used cars gravitate toward the price level for bad ones. The consequence of bad cars selling at the same price as good cars is that more bad cars than good ones get offered for sale. As a result, bad cars tend to drive good ones out of the market (see Akerlof, 1970).[15]

The scholarly writing about asymmetric information in an insurance setting addresses two problems—moral hazard and adverse selection (see Hillier, 1997, pp. 77-111; Macho-Stadler and Pérez-Castrillo, 1997, pp. 9-12). In both situations, the buyer has better information about his or her likelihood of causing a loss than the insurance company does. Moral hazard in insurance occurs when the policyholder uses insurance to increase the likelihood of loss, say, by taking less care of insured property. Adverse selection in insurance occurs when the policyholder uses superior knowledge of his or her risk characteristics to buy insurance when it is advantageous and to forgo insurance when it is safe or the insurance is too expensive. Insurers cope with these problems by using deductibles and coinsurance, by underwriting carefully, and by basing their rates on a pool of past loss data that includes losses due to moral hazard and adverse selection.

Asymmetries of information in insurance are not confined to situations in which the buyer knows more than the seller. Insurers have statistics and underwriting expertise that buyers do not. And for one kind of information, the insurer has an absolutely

[13] A current example is Enron, the giant energy and derivatives trader that quickly collapsed after counterparties started to worry it might not perform (see Norris, 2001). Similar loss of confidence precipitated the failure of several large life insurers in the 1980s and early 1990s, such as Baldwin United, Executive, and Mutual Benefit. The extreme sensitivity of deposits to erosion of confidence is not a new discovery (see Bagehot, 1883, ch. 2). Deposits in banking and insurance may be more vulnerable than casualty insurance is, because customers can pull out faster and demand cash all at once. But Enron did not issue deposit products, and casulty policies have to be renewed every year.

[14] The significance of asymmetric information theory to economic thought was recently highlighted by the award of the 2001 Nobel Prize for economics to three of its pioneers: Joseph E. Stiglitz, George A. Akerlof, and A. Michael Spence.

[15] This is a theoretical example in which the market is greatly simplified, as in all economic models.

exclusive inside track—knowledge of what the insurer itself intends to do under certain circumstances.

How the insurer will handle large claims is one of those asymmetries. Only the seller knows for sure. The insurance company's management obviously knows what its current claims philosophy is. But buyers do not, because they are not privy to the insurer's thinking.

Buyers are also not privy to information every insurer protects, such as how many claims it resisted, what kind and size they were, how long they took to resolve, and for how much they were settled. Nor can buyers protect themselves against this asymmetry by using any of the techniques insurers use to deal with moral hazard and adverse selection.

What does asymmetric information theory say about insurance? It says that as buyers became aware of the tightened claims practices of insurers, insurance would move from being an item with assured quality to one whose quality was better known to the seller than to the buyer.

As with used cars, buyers would assume the worst, and prices would gravitate toward the price of the least reliable insurance. At that depressed price level, only unreliable insurance would be able to turn a profit. As with used cars, unreliable insurance would tend to drive reliable insurance out of the market.

As option theory indicated the loss of the certainty effect would utterly change the position of insurance in the world of finance, asymmetric information theory begins to quantify the change. All insurance prices would decline toward the price of unreliable insurance. The counterparty risk posed by some insurers would push down the prices for all, because buyers would not know how to tell them apart. Would it be by an amount proportionate to the loss of reliability? A third perspective addresses this question.

Prospect Theory

Since the Second World War, nearly all economists have used a rationalist model of how people make choices in the market. The idea is that each actor has a "utility function" that sums up in a single number his or her total value system, and that the person makes choices that will maximize that "expected utility."

For example, in deciding on buying a car, the buyer would factor in the alternative uses of the money for next year's vacation and for college tuition for the baby. The theory also assumes that decisions about such matters as preferences and prices will be totally rational and solely devoted to maximizing utility.[16]

The advantage of expected-utility theory is that it is amenable to mathematical techniques and quantitative analysis, and it has played a key role in the rise of those disciplines in economic studies. As applied to insurance, expected-utility theory says that if a fully reliable insurance policy is worth $100 in the market, then a 90 percent reliable one will bring $90. Put differently, the theory says that in insurance, as elsewhere, the value function is linear.

[16] Although there were precursors of expected-utility theory as early as the eighteenth century, in recent times chapter two of John von Neumann and Oskar Morgenstern's book is probably the most famous of many sources for the description in this paragraph (von Neumann and Morgenstern, 1944).

The disadvantage of expected-utility theory is that it does not describe how many decisions are made in real life.[17] But if expected-utility theory does not explain much actual decision making, what does? Are humankind's deviations from the rational ideal random, or are they systematic, moving in consistent directions?

A small but growing scholarly literature in psychology and economics says the deviations are systematic, that the departures from expected-utility maximization can be figured out, measured, and explained.[18] Expected-utility theory is still the mainstream of economics, but behavioral decision theory (or prospect theory) is making headway at the juncture of economics and psychology.[19]

Prospect theory contains many ideas (see Bernstein, 1996, pp. 269-283, for a description of prospect theory). One idea is of particular interest here: When expected-utility theory says that differences in buyers' confidence in product quality are reflected in commensurate differences in the price buyers are willing to pay, the theory is not describing what happens in real life. Instead, buyers attach more than proportional weight and value to the last, highest reaches of confidence. Put another way, the value function is not linear, and people overweight low probabilities of loss or failure. That behavior is called the "certainty effect" (Kahneman and Tversky, 1979, p. 269; Kahneman and Tversky, 1992, pp. 297-298).

The certainty effect may explain why such great value is attached to eliminating the slightest chance of default on bonds and guaranties, reflected in the emphasis given to having a AAA rating rather than "only" a AA (Wakker, Thaler, and Tversky, 1997, p. 20). It may explain the purchase of insurance at prices far above the actuarial value of losses (Plous, 1993, p. 99), as well as the remarkable financial success of "dread disease" insurance.[20] Finally, it may explain the flight to quality by commercial insurance buyers and the absorption of weak insurers by those with stronger balance sheets ("Catalysts of Change," 2001).

[17] Herbert A. Simon's book *Administrative Behavior* (1947) is probably the earliest and most famous of many sources for this critique. His *Reason in Human Affairs* (1983) is a short explanation of expected-utility theory and its shortcomings. About insurance, Professor Simon (1986) observed: "Utility maximization is neither a necessary nor a sufficient condition for deducing who will buy insurance" (p. 32).

[18] Daniel Kahneman and Amos Tversky's article "Prospect Theory: An Analysis of Decision Under Risk" (1979) is probably the earliest and most famous of many sources, and the one that coined "prospect theory" and "certainty effect." This article and others by scholars of prospect theory have recently been republished in *Choices, Values, and Frames*, edited by Kahneman and Tversky (2000).

[19] Although prospect theory tends to portray the rules of thumb and shortcuts that depart from expected utility as failures of rationality, it is not necessary to do so. To some scholars of decision theory who also reject expected utility as unrealistic, such "fast and frugal heuristics" are not failures of rationality but just the rules that enable us to make reasonable and satisfactory decisions (see Gigerenzer and Todd, 1999). For purposes of this discussion, it does not matter whether the certainty effect is seen as a shortcoming compared to a rational ideal or as a practical shortcut that works in real life.

[20] For many years, AFLAC, Inc.—whose main subsidiary is American Family Life Assurance Company of Columbus, the world's largest cancer insurer—has been at or near the top of the insurance business in such key financial measures as earnings growth, stock performance, and return on equity (see the company's annual reports at http:www.aflac.com).

A simple way to test the theory is to imagine yourself in a familiar setting—independent business, corporate life, government, politics. Then ask yourself two questions in that setting. What is the value to you of a deal with someone whose handshake is 100 percent solid and dependable? Now, what is the value of the same handshake from someone who performs most of the time, but not always?

Much of the scholarly empirical work on prospect theory in general and the certainty effect in particular has been in laboratory experiments, such as testing a sample group's aversion to risk. Laboratory experiments have the advantage of control but the disadvantage of not coming from real economic life.

Some examples of the certainty effect have been drawn from such areas of life as overbetting longshots at the track and betting on lotteries (Camerer, 1998, pp. 6-8).[21] But those examples are not from mainstream economic activities. By any measure, insurance is a mainstream economic activity.

What does prospect theory say about insurance? It says that buyers attach great importance to closing off the smallest chance of nonperformance. One leading study found that "people demand about a 30% reduction in the premium to compensate them for a 1% chance that their claim will not be paid" (Wakker, Thaler, and Tversky, 1997, p. 9).

If this finding is true, then if insurance were ever perceived as less than reliable and certain—for reasons of insolvency or claims practices—the willingness of buyers to pay for it would drop by an amount far greater than expected-utility theory would predict and insurance professionals would expect.

IMPLICATIONS FOR THE INSURANCE INDUSTRY

All three of these lines of economic reasoning suggest that if property-liability insurance changed from being a certain way to cope with risk of loss to being a less certain way, buyers' willingness to pay what it costs and to forswear alternatives would go down by a surprisingly large amount.

Option theory—wherein the derivative is assumed to be exact and reliable—implies that when these qualities are lost, the instrument becomes much less valuable, perhaps nearly worthless, and certainly impossible to price.

Asymmetric information theory—wherein sellers know more about the quality of the traded item than buyers do, and buyers then assume the worst—implies price declines for all insurers toward the level of prices for the unreliable ones.

Prospect theory—wherein buyers give disproportionate weight to closing off the last bits of risk—implies that the loss of the certainty effect would cost insurers a great deal more than an amount proportional to the reduction in reliability.

This process of disproportionately devaluing commercial insurance as it is seen to lose its certainty also has the potential to become a spiral in which insurers can profit at the

[21] The two examples are of unlikely gains, not unlikely losses. But another observation of prospect theory is for "losses to loom larger than gains" (Kahneman and Tversky, 1979, p. 288). So the certainty effect should be even more intense with respect to unlikely losses, such as the failure of insurance to perform.

reduced price levels only by getting even tougher on claims. That would further alienate buyers, who would pay even less, and so on (Abraham, 2001b).

As the loss of the certainty effect could spiral, so also its manifestations could broaden beyond price. At some point, risk managers and brokers could conclude that commercial insurance companies were so unreliable that they were irrelevant to the needs of large and sophisticated corporations.

The industry may have experienced symptoms of both a spiral problem and an irrelevance problem in the recent, exceptionally long price war and, during the same period, in expansions of the risk management movement, expansions that one would not expect in a soft market.[22] If so, spiral and irrelevance problems are likely to show up in continued pressure on insurer profit margins even as prices increase.

How rapidly could really dire consequences occur? It is natural to picture the process as gradual or proportionate to the loss of reliability. But this may be another area where the rationalist model does not accurately describe the way things work. In many areas of natural and social science, pressure builds up with little or no visible effect on the existing structure. And then, at some point, the structure changes rapidly or even breaks.[23]

For purposes of this discussion, the structure is the social capital of the insurance business—the belief that it will perform—and the mounting pressure is from the changes in the insurance business discussed earlier in this article.

If this analysis is correct, then the situation is not just serious for the commercial property-liability insurance business. It is worse.

SIMILAR THREATS IN THE PAST

Although the economic analyses—option theory, information theory, and prospect theory—are comparatively new, the problem of the loss of the certainty effect is not. On four occasions in the past, insurers' responses to unexpectedly heavy claims have led to major changes in the law and practice of insurance in the United States. One could see all four as examples of what was done to head off the loss of the certainty effect, although naturally the problem was not seen that way at the time.

The first episode was after the Civil War, when life insurance became the leading way for families to provide for the early death of the breadwinner. When death claims came

[22] Price competition has been a main theme of recent communications of such leaders as American International Group, Chubb, Hartford, and St. Paul. In risk management, a notable expansion is the many new insurers formed (1) offshore and (2) to write finite risks rather than the familiar, broad commercial coverages. One can even see the growing use of finite risk and captive insurers not so much as efforts to hold cash, reduce taxes, and save premiums—the usual explanations—but as efforts to increase reliability. The founder and CEO of the W. R. Berkley insurance group recently said, "Most of our captives are formed because enterprises want more control over the insurance process" (McDonald, 2001, p. 56).

[23] This phenomenon is called an "inflection point" in business strategy, as seen with the introduction of electric motors or integrated circuits. It is called a "paradigm shift" in natural science, as seen with Galileo's view of the cosmos or quantum physics; a "tipping point" in social policy, such as integration of schools and neighborhoods; a "breaking point" in physical activities such as bending a stick; and "crush depth" in submarines.

in, some insurers looked for ways to avoid paying (see Villaronga, 1976; Amrhein, 1933, pp. 146-165; McGill, 1959, pp. 817-829).

A favorite way out was to assert that the deceased insured had not made full disclosure when applying for coverage many years before (see *Connecticut Mutual Life Insurance Co. v. Union Trust Co. of New York*, 1884, for a sample of the questions in a life insurance application in the late nineteenth century). Since the cause of death was usually known once the claim came in, the insurer could often quite truthfully say that the fatal disease, or a predisposition to it, was not disclosed in the application. This was particularly true where the applicant did not know about it either.

Popular resentment grew so harmful to life insurance marketing that, in 1879, the largest life insurance company introduced the "incontestable clause," in which the company gave up all defenses, except nonpayment of premium, once a policy had been in force for a few years (Buley, 1967, p. 251). After New York's 1906 Armstrong Committee investigation into life insurance abuses, the law of that state and many others required an incontestable clause in all life policies (Villaronga, 1976).

The second episode also occurred in the second half of the nineteenth century. Then, fire insurance was by far the largest property-liability coverage and was essential to the development of cities and factories. Competition among fire insurers was intense. One way to compete was to pay agents high commissions and not to restrain their sales efforts by underwriting.

After a large fire of the sort that destroyed entire cities in that era, some insurance companies looked for ways out. One popular way was to invoke obscure warranties, limitations, and exclusions in the fire insurance policy, the "fine print" of insurance song and story. The result could be to deny funds to rebuild cities or factories just when the money was needed most (see *DeLancey v. Rockingham Farmers' Mutual Fire Insurance Co.*, 1873, for an entertaining description of the fire insurance claims problem).

As with life insurance, public resentment of abusive claims practices threatened to undermine the value, and the sales appeal, of this essential coverage. The principal reform was to take away from fire insurance companies the power to write their own policies. State legislatures either enacted the full text or delegated to the insurance commissioner the authority to do so. Either way, the laws required the enacted policy wording, and nothing else, to be used for all fire insurance on properties in the state. Eventually, the New York Standard Fire Insurance Policy became the national fire insurance form (Patterson, 1927; Deitch, 1905; Bissell, 1904).

In addition, nearly half the states passed "valued policy" laws. The laws required fire insurance companies to pay the face amount of a policy in the event of a total loss (Grant, 1979, pp. 71-74).[24] It was a measure of public antagonism toward fire insurers that states with good government traditions, led by Wisconsin, passed the laws, well aware of the temptations to overinsurance and arson they presented (Dean, 1901).

The third episode was in accident and health insurance, a line that was a principal insurance protection for workplace injuries before workers' compensation. The policy con-

[24] Whereas the standard policy was the creation of urban states, with the conflagration hazard posed by cities, the valued policies came from agricultural states, where farm fires posed no conflagration hazard. The claims problem must have been across-the-board.

tained prohibitions against increasing the risk, such as changing occupation, without the consent of the insurance company. Once claims came in, insurers that were disposed to get out of paying could look closely at what the worker was doing at the time of the accident that might differ from what he or she did when the insurance was sold.

As with life and fire insurance, these claims practices led to resentment and loss of confidence in the coverage. They also led in 1911 to a major investigation by the National Convention of Insurance Commissioners. From the investigation came crackdowns on individual companies, a proposed standard policy form, and prohibition of such practices as profit sharing for loss adjusters (National Convention of Insurance Commissioners, 1911; Patterson, 1927, p. 464).

The fourth episode concerned cancellation and claims practices in automobile insurance. In the late 1940s, most companies cut back on their automobile writings, and those that stayed open got more business than they could handle. For a time, insurers coped by getting tougher on cancellations and claims. Responding to the public resentment, regulators and legislatures restricted cancellations and prohibited unfair claims practices. When both kinds of legislation were pending, the major insurers did not oppose them, and many supported them (New York Insurance Department, 1969, p. 37; National Association of Insurance Commissioners, 1997, pp. 900-901).

Two of the four remedies—for accident and automobile insurance—were moderate and in the regulatory tradition of general guidelines and specific enforcement. The other two were radical and self-enforcing. Life insurers lost even the defense of fraud. Fire insurers lost the power to write their own contracts. On the historical record, the two radical reforms worked better.[25]

Despite this difference, the four episodes have two features in common. One is that the problem was a decline in public confidence that insurance would pay—the loss of the certainty effect. The other feature is that insurers or the government or the two together responded by imposing a remedy that applied to all insurers, either legally or competitively or both. No one company could unfairly refuse to pay claims and thereby offer customers lower prices and increase its own profits.

POSSIBLE RESPONSES

If today the prospects for inaction are all that dire, and the insurance business and its regulators have come to the rescue of the certainty effect in the past without even knowing the theory, then there really ought to be steps that can be taken to head off this new calamity.

Such steps do indeed exist. But first it is necessary to recognize one more economic characteristic of the present situation: It is a classic externality or harmful side effect, like industrial pollution (Coase, 1960).

Each insurance company with each large claim has an economic incentive to resist paying. The damage to the insurance institution—specifically to the certainty effect—affects the individual company only slightly and only in the indefinite future, whereas the benefit

[25] One of the authors was an originator of the unfair claims practices laws and a sponsor of the non-cancellation laws, and both authors have studied the earlier episodes extensively.

from lengthening the period of float and lowering the cost of float is immediate and inures entirely to the one company.

The power of the claims externality should not be underestimated. In the last 50 years, competition has become the norm in insurance. The race for survival and success has become vigorous, even ferocious. Many companies have not survived, and the survivors know it. In such a situation, the ability to save money for oneself while offloading the costs on the community at large is attractive, perhaps irresistible. Consider how hard it was to make progress in workplace safety, consumer protection, and control of industrial pollution—all involving externalities no stronger than those in insurance claims.

Any successful response to the threat of losing the certainty effect will have to deal with the fact of that externality in order to remove the competitive edge from resisting claims. Here are some possibilities.

One approach would be disclosure. As noted earlier in this article, insurers do not willingly open their claims files or disclose their overall claims practices, and they maintain that they handle each claim fairly and on its own merits. What else can they say? The anecdotal evidence, and such statistical studies as there are, point very much the other way.[26] As long as insurers will not disclose data on overall claims practices, individual stories and broad statistical generalizations will be all that are publicly available.

Other ways to get the information are available. An insurance department in a market conduct examination, or a court in a punitive damages trial, could require an insurance company to disclose all of its handling of comparable claims. A business journal could poll leading corporations about their experience with large claims during the past 20 years.

The public policy embodied in the unfair claims practices laws was not to push the legislative and executive branches of government into individual disputes, but rather to detect and deter patterns of repeated, deliberate claims abuse. If there is a systematic collection problem with large claims, disclosure would expose it. If there is no such problem, disclosure would show that too. Disclosure and publicity have always been valuable tools of regulation, closely tied to the public's right to know (see McCraw, 1984, pp. 1-56, for Charles Francis Adams's use of information and disclosure to regulate railroads in Massachusetts in the late nineteenth century).

A second approach would be for some insurance company to figure out a way to make dependable, even liberal, claims practices in large commercial insurance a competitive advantage, a product differentiation in what is largely a commodity business. This possibility would be the classic competitive, free-market solution. A few companies have made claims handling a competitive edge in personal insurance, but the claims are much smaller and much more frequent there. Personal policyholders can experience the superior claims performance for themselves.

An insurer's concern for its reputation is not an effective countervailing factor in large commercial claims, for reasons discussed earlier in this article.But it could work the

[26] For RAND's statistical studies of pollution and asbestos liability, see Dixon, 1992 (88 percent of insurer payments went for transaction costs, i.e., coverage disputes); Hensler et al., 2001 (63 percent of the total spent by both insurers and policyholders went for transaction costs).

other way around. An insurer that had differentiated its response to large claims would naturally want to use that superiority in its marketing. It might publish measures of its claims performance, implicitly daring its competitors to do likewise.

Sustainably differentiating claims practices might involve revising policy text. Revisions could resemble an incontestability clause or a change of warranties into representations.[27] But they would have to make commitments other insurers could not bear and would not copy. Differentiation might come from a new use of option theory.[28] It might come from large policyholders, drafting the text and inviting insurers, or other capital providers, to bid on it.

A third approach would also be a free-market solution: securitization. This approach—called a liability derivative—has been used with reinsurance of property catastrophes. The investor buys a bond that is wholly or partly forgiven if a designated proxy for catastrophes such as hurricanes does in fact occur. As with all derivatives, its worth depends on having as little basis risk and counterparty risk as possible.

Today's claims-reliability problem centers on general liability insurance, particularly at the excess levels, and getting a good fit and reliable collection for those risks would be much more difficult than with property catastrophes. Securitization would require a proxy for the risk, a quick and fair coverage-determination process, or a willingness to follow the settlements of the primary insurer.

A fourth approach would be to motivate insurance brokers and client corporations to pay more attention to performance at the point of claim. After the recent consolidations in the brokerage world, the dominant brokers are very large and sophisticated organizations. They have great market leverage and know a lot about insurer claims practices. At the moment, they lack an incentive to use that knowledge and power to improve these practices. One way to refocus the brokers' attention from the point of sale to the point of claim would be to tighten their liability for selecting an insurer that willfully refused to pay claims.

As for the client corporations, the main problem seems to be an unawareness of the claims-reliability situation high enough up in the corporation, that is, at the CEO and board of directors level. As long as insurance is handled exclusively by midlevel managers and is seen as a purchasing, legal, or financial matter, the corporations are just asking for trouble at the point of claim.

One way to get the attention of the senior management of policyholders would be for the Securities and Exchange Commission, the accounting profession, or an influential insurance department to look into and appropriately regulate situations in which the policyholder and the insurance company are taking inconsistent views of a large claim,

[27] At English common law, the policyholder's breach of a warranty made the policy voidable by the insurer, even if the breach was not related to either the risk or the loss. It was a forfeiture. A representation, however, voided coverage only if the breach was material to the risk or the loss (Park, 1789, pp. 194-249). In the late nineteenth and early twentieth centuries, courts and legislatures laid down rules that converted many warranties into representations (Keeton, 1970). Some of today's defenses against coverage—fraud, concealment, late notice, failure to cooperate—operate as forfeitures.

[28] The authors are grateful to Peter L. Bernstein for this suggestion. One such application, in the credit area, is "default swaps" (see "Is There Money in Misfortune," 1998).

with each taking the view that increases its earnings and worth. The clearest example is when the policyholder sets up an insurance recoverable as an asset on its balance sheet, while the insurer sets up no reserve liability or only a nominal one on its books.

All four of these possibilities have in common raising the standard for all insurance companies, either directly by law or indirectly by competition. No one company could gain an advantage by being less reliable so as to have both lower prices and higher profits. Raising standards is a common competitive and public-policy response to quality problems and harmful externalities in important industries.[29] Many more approaches than the four suggested here may exist.

All four of the possibilities sound idealistic and unreal, unlikely to occur, and far from certain to succeed. But the biggest failing of any remedy now is the lack of desire of any participant in the insurance transaction—insurers, brokers, policyholders, regulators, lawyers, courts, or commentators—to consider it, to do anything about the certainty problem other than deal with individual claims. But if nothing prevents the loss of the certainty effect, it will indeed be lost, with unfortunate consequences for insurers and the corporate clients that stick with them.

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[29] Examples of more reliable products, services, and conduct being established by law are airline, highway, pharmaceutical, and food safety. Examples of its being done by competition are more numerous, but would include electric starters replacing hand cranks in cars, transistors replacing vacuum tubes in radios and TVs, and title insurance replacing legal opinions in land transfers.

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