

THE ROLE OF THE PROFIT IMPERATIVE IN RISK MANAGEMENT

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Risks in the world abound. Every day there is a chance that each of us could be in a car accident. Or, one of us could be the victim of a tornado, flood or earthquake. Every day someone becomes deathly ill from an insidious disease. Our properties are in constant peril—one's house could catch fire at any time or a tree could fall on it during a storm. Any one of these events could have devastating financial consequences, and they are just a few of the many risks that impact our daily lives. One of the principal ways we manage risk is by purchasing insurance. In the absence of insurance, many losses would cause financial ruin. Thus, for some lines of insurance such as health and homeowners, insurance serves a critical function in America as a social safety net.

This Article explores the role the profit imperative has and should have in risk management today. As publicly traded stock companies, which are driven by the profit imperative, have come to dominate the insurance industry in the past two decades, inherent conflicts between the purpose of insurance and the goal of insurers have developed. These conflicts are manifested by insurers' refusal to insure certain people and businesses and the hollowing out of the coverage provided by insurance policies through the addition of exclusions for risks of loss that insurers have concluded do not provide adequate profit margins. The profit imperative also has forced insurers and their policyholders to become adversaries with respect to the valuation and payment of claims because every dollar paid for a policyholder's loss is a dollar that cannot be paid to

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the insurer's shareholders.

After discussing the history of these conflicts, the Article then explores various ways to resolve them. Some of the resolutions are: the elimination of some exclusions in policies, the creation of restrictions on insurers' ability to refuse to insure certain people and businesses, and the imposition of penalties when insurers fail to pay claims timely and in full. For socially critical lines of insurance, if any voids in insurance markets were to develop due to the current laws being changed in the ways discussed in the Article, then state sponsored insurance programs could be created to fill the voids.

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INTRODUCTION

The world is a very dangerous place. Every day there is a chance that each of us could be in a car accident. Or, we could be the victims of a natural catastrophe such as a tornado, flood or earthquake. Every day

someone is diagnosed with a deadly disease. Our properties are in constant peril—houses catch fire every day and trees regularly fall on houses during storms. Any one of these events could have devastating financial consequences, and they are just a few of the many risks that surround our daily lives. There a number of ways we attempt to reduce these risks. For example, we fasten our seat belts and maintain our vehicles in an attempt to avoid accidents and minimize the consequences of accidents. We cut down trees next to our houses and install smoke alarms in an attempt to prevent damage to our homes and the people in them. In addition to loss prevention measures, however, one of the principal ways we manage risk is by purchasing insurance. This Article focuses upon our attempts to transfer the risk of loss to insurers and explores the role that the profit imperative plays with respect to insurers' behavior.

The central thesis of this Article is that the profit imperative is in conflict with the objective of insurance. The purpose of insurance is to transfer the risk of loss from entities that do not want, or cannot afford, to absorb the financial losses that arise from natural and unnatural events to well-capitalized insurers that are able to spread the risk of loss across large pools of policyholders. In the absence of insurance, we face the risk of financial ruin with each passing car or storm. On the other hand, the providers of the vast majority of insurance today are publicly traded stock companies whose corporate mandate is to maximize profits for the benefit of their shareholders. In the absence of legal or regulatory intervention, the profit imperative dictates that insurers accept the transfer of risk only with respect to entities and perils that they can consistently insure at high profit margins, leaving those in most need of insurance without it. This irreconcilable conflict between the purpose of insurance and the profit imperative is the primary source of discord in insurance law today. This conflict did not always exist and it does not have to continue to exist unmitigated.

As originally conceived and implemented in America in the mid-1700s, insurance functioned as a social safety net through which a community or group as a whole acted for the benefit of the unlucky few who suffered losses. People and businesses each contributed a premium to a "mutual" company or group to create a pool of money from which losses were paid. Essentially, the insurance company acted as a third-party administrator that collected the premiums to create the pool of money from which losses would be paid and then paid such losses as they arose. Initially, these mutual insurance companies only covered fire losses. Over time, however, insurance expanded to cover the other myriad risks of loss that exist.

The need for insurance is even greater today than it was in the 1700s.

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Imagine being a homeowner in Oklahoma when tornadoes rip through the state each spring or on the coast in the Gulf of Mexico, Florida or the East Coast when a hurricane makes landfall. Or, imagine being diagnosed with cancer. Now imagine that the afflicted homeowner or person does not have property insurance or health insurance. What happens to such people? Financial ruin unless they are the beneficiaries of the generosity of strangers or a government bailout.

Not only does insurance provide peace of mind and ensure one's financial security in the event of a catastrophe in ways that hoping for a government bailout or the generosity of strangers do not, but insurance actually has become a necessity to live and function in America today. It is required, for example, in order to legally drive a car to work or to obtain a mortgage for a home. In short, in most parts of this country a person cannot hold a job or be a homeowner today without insurance.

Yet, as the need for insurance has increased, insurers' willingness to cover certain people and risks has decreased. Although the profit imperative began forcing insurers to begin refusing to insure some perils, such as floods, in the 1950s and 1960s, insurers' efforts to avoid insuring certain people and certain risks have accelerated since the 1970s. The reason is simple: profits. The idea of insurance as a social safety net, in which a group of people or businesses as a whole acts for the benefit of the unfortunate few, was lost when the corporate structure of insurance companies shifted from mutual companies to for-profit, publicly traded stock companies. Although this shift had been occurring for some time, it accelerated in the 1980s and 1990s to the point that the vast majority of insurance companies today are for-profit, publicly traded stock companies.

As profit-maximizing enterprises, publicly traded stock companies' overriding mandate is to make as much money as possible for their shareholders. Policyholders who pay premiums are merely revenue streams for publicly traded stock companies. And the payments of policyholders' losses are expenses that reduce insurers' profits. Thus, the profit imperative dictates that insurers relentlessly seek to increase revenues while decreasing expenses for the benefit of their shareholders.

Insurers have sought to fulfill this mandate on both the front end and the back end of the business of insurance. On the front end—the underwriting stage—insurers quickly have moved to eliminate coverage from their policies for risks that do not have satisfactory profit margins as soon as such risks have been identified. Insurers also have used the claims data they have collected and analyzed over the course of many decades to identify the people who are most likely to have losses (i.e., the “bad” risks) and then refuse to insure those people.

On the back end—paying claims—insurers have become professional

litigators in order to avoid or at least minimize the amounts they have to pay for their policyholders' losses. In the words of one insurer, an insurer today is "a professional defender of lawsuits."¹ Or, as described by one federal judge, insurers are like "major league team[s]" in the game of "hardball litigation."² Indeed, when it comes to the payment of policyholders' losses, insurers and policyholders are adversaries. The profit imperative dictates that insurers minimize the amounts they pay for their policyholders' losses in order to maximize their shareholders' profits.

Although much of this Article is dedicated to developing the claim that the profit imperative that drives insurers today is inconsistent with the purpose of insurance and is the primary source of conflict in contemporary insurance law, the Article proposes some normative solutions to the complex problem of ensuring that insurance is available for all at affordable prices despite the profit imperative that currently drives insurers. For example, in the absence of a finding that an insurer acted in bad faith, which is very difficult to prove, insurers currently have no incentive to pay the full amount of a loss timely because their liability for failing to do so is limited to paying the unpaid amount they already owe plus interest. Consequently, under the current laws, the profit imperative demands that insurers attempt to pay less than the full value of losses and to make payments on losses as slowly as possible because there are no negative consequences for doing so. Although the number of potential solutions to this problem is limited only by our imaginations and thus a truly fulsome discussion of the subject is beyond the scope of a single article, one idea is to create and impose penalties on any insurer that refuses to pay a loss timely or offers less than the full value even if the insurer's conduct does not amount to bad faith. For example, if a fact finder determines that the value of a claim is \$1000, but the insurer only paid or offered to pay \$700, then the insurer would be liable not just for the additional \$300 plus interest, but also for the policyholder's attorneys' fees and a 20% penalty on the unpaid \$300 (which, not coincidentally, is the same penalty amount the IRS imposes on taxpayers who underpay their taxes).

To address the problem of insurers refusing to cover the most common types of catastrophic risks we face in this country such as hurricanes, tornadoes and floods under property policies, legislation could be passed

1. John N. Ellison et al., *Bad Faith and Punitive Damages: The Policyholder's Guide to Bad Faith Insurance Coverage Litigation*, in *Environmental Insurance: Emerging Issues and Latest Developments on the New Coverage and Insurance Cost Recovery*, Philadelphia: ALI-ABA 159 (2008) (quoting Liberty Mutual Insurance Company's Memorandum in Support of Motion for Partial Summary Judgment at 7, filed July 5, 1988, *National Union Ins. Co. v. Liberty Mut. Ins. Co.*, 696 F. Supp. 1099 (E.D. La. 1988)).

2. *Adolph Coors Co. v. American Ins. Co.*, 164 F.R.D. 507, 509 (D. Colo. 1993).

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that prevents insurers from excluding coverage for such risks. Also, for lines of insurance that are determined to be socially critical such as property, auto and health insurance,³ additional restrictions could be placed on insurers' ability to refuse to insure applicants who are willing to pay for the insurance but currently are rejected by insurers because they are considered "bad" risks.

Of course, we need to recognize that if certain exclusions in policies were eliminated and insurers' ability to refuse to insure certain applicants were reduced, then insurers may refuse to sell the insurance. There are at least three reasons for this: (1) insurers believe that some risks such as catastrophes are highly correlated risks for which they cannot charge premiums high enough to satisfy their target profit margins; (2) insurers' shareholders demand profitability on both long-term and short-term bases, which could not be ensured if insurers were required to insure catastrophic risks because the losses associated with such risks create periods of short-term unprofitability; and (3) the profit margins on applicants who are "bad risks" are inadequate or negative.

So, what would happen if insurers were to refuse to sell insurance in the normative legal regime being discussed? State sponsored insurance programs could be created to fill any voids. Unlike private insurers, state sponsored insurance programs are able to take a long-term view regarding the financial needs of insurance programs that cover catastrophic risks and "bad risk" policyholders because such programs do not have to generate short and long-term profits for shareholders.

In many respects, state sponsored insurance programs are actually better vehicles to fulfill the purpose of insurance than private insurers for certain types of insurance. For example, the tax and accounting laws currently create disincentives for insurers to insure catastrophic risks because they discourage insurers from accumulating and holding the capital needed to pay widespread catastrophic losses. Further, publicly traded stock companies that accumulate large capital surpluses become takeover targets for corporate raiders. State sponsored insurance programs, on the other hand, can accumulate capital for the purpose of paying catastrophic widespread losses tax-free and cannot be acquired by corporate raiders.

The premiums charged by state sponsored insurance programs also should be lower than insurance sold by private insurers. Insurers spend literally billions of dollars annually on advertising in order to compete for customers' premium dollars. Indeed, auto insurance commercials during prime time television are so pervasive that everyone knows the Geico

3. As discussed in Part III.C.4, this idea currently is being implemented for health insurance under the Affordable Care Act.

Gecko and Progressive's spokeswoman, Flo. A sitcom based upon Geico's cavemen commercials was actually created at one point because Geico's commercials ran so frequently that the Geico cavemen became part of America's pop culture. Policyholders, of course, ultimately paid for all of those commercials that made the Geico cavemen a pop culture phenomenon through their premiums. If private insurers were to decline to sell property insurance that covers catastrophic risks, then state sponsored insurance programs obviously would not need to spend money advertising because they would not be competing with dozens of other insurers for premium dollars. Thus, the premiums they would charge should be lower.

Insurers also spend significant amounts of money on underwriting and claims handling in their attempts to ferret out the "bad" risks to avoid insuring them and to fight to lower the amounts they must pay for their policyholders' losses. State sponsored insurance programs, on the other hand, would not need to spend significant amounts on underwriting and could spend less on claims handling because the profit imperative would not mandate that they fight to reduce the amounts paid on legitimate claims because their primary goal would not be the maximization of profits for the benefit of their shareholders. Thus, the premiums they charge should be lower for these reasons as well.

Further, under state sponsored insurance programs, policyholders and their insurers would not need to be adversaries during the claims adjustment process. Although such programs would, of course, still need to verify the legitimacy of the claims submitted, state sponsored insurance programs would not have shareholders demanding quarterly dividend payments that are generated by paying as little as possible for policyholders' losses and waiting as long as possible to make such payments regardless of the value or validity of the losses. Thus, the claims payment process should be far less adversarial.

In many respects, state sponsored insurance programs would be a natural evolution of states' existing involvement in the insurance industry because states already heavily regulate the insurance industry by, among other things, establishing capital surplus requirements, approving premium rates and policy language, and running insurance guarantee programs to cover the claims of insolvent insurers.

Although limited in scope and type, state sponsored insurance programs already are being used for some lines of insurance in certain parts of America. California, for example, created an earthquake insurance program when insurers began refusing to cover earthquakes following the Northridge earthquake in 1994. Similarly, the Gulf and southeastern coastal states have been forced in recent years to become the primary sources of insurance for property damage caused by hurricanes as insurers

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have refused to sell insurance that covers such losses. In addition, for many years, states have had auto insurance programs for drivers who insurers refuse to insure.

Even better evidence, however, of the viability and desirability of state sponsored insurance programs can be found in Europe. Several European countries have state sponsored insurance programs that are demonstrably cheaper than private insurance and, unlike insurers in America, are viewed quite favorably by their citizens when it comes to the payment of claims.

This Article develops the claim that the principal conflict in risk management and insurance law today can be traced to the inconsistency between the purpose of insurance and the profit imperative that is driving private insurers in three parts. Part One discusses the origins and purpose of insurance. It begins with a discussion regarding risk transfer and the theory of the “law of large numbers” that underlie the concept of insurance. It then traces the evolution of insurance from contracts of “bottomry” created for maritime traders in Babylonia in 2250 B.C. to the creation of mutual companies in America to serve as a social safety net for fire losses in the 1700s to the rise of for-profit, publicly traded stock insurance companies that dominate the insurance market today. Part One concludes with a discussion regarding the crucial role insurance plays in modern society.

Part Two sets forth the bases for the claim that the profit imperative has driven insurers to refuse to cover any risks that threaten their profit margins. As examples to develop the claim, insurers’ treatment of environmental claims and asbestos-related liabilities, as well as insurers’ creation of numerous exclusions under comprehensive general liability policies, are discussed. Insurers’ refusal to insure certain risks of loss such as earthquakes, floods, and hurricanes under property policies, as well as the insertion of numerous exclusions in such policies, is also discussed. Part Two concludes by discussing how the profit imperative has caused the claims payment process under both consumer and commercial lines of insurance to become adversarial as insurers have sought to minimize the amounts they pay for covered losses.

Part Three discusses some ideas regarding normative solutions to the conflict between the profit imperative and the purpose of insurance in risk management that exists today, as well as the anticipated objections to such solutions. The implementation of the ideas contemplated in this Article, with or without private insurers’ willing participation, should allow the purpose and role of insurance in risk management—the transfer of the risk of loss from those who cannot afford to bear the loss to those who can—to once again be fulfilled.

II. THE ORIGINS AND PURPOSE OF INSURANCE

A. *The Concept of Insurance*

The concept underlying insurance is quite simple. A person or a business transfers the risk of loss to another entity in exchange for the payment of a premium.⁴ The principal reason most people and businesses purchase insurance is to avoid uncertain, but potential, future losses.⁵ The purchaser of insurance incurs a relatively small certain loss by paying a premium in order to avoid the risk of larger, uncertain future losses.⁶ Although the law has sought to diminish insurance's similarity to gambling by requiring, for example, that a person purchasing insurance actually have an "insurable interest" in the object being insured (i.e., a reason to want the person or item insured not to be injured or damaged),⁷ a person who purchases insurance is hedging against the risk of something terrible

4. J. David Cummins, *Should the Government Provide Insurance for Catastrophes?*, 88 FED. RES. BANK OF ST. LOUIS REV. 337, 342 (2006).

5. See, e.g., ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 10 (5th ed. 2012) (observing how people become more risk averse as the potential magnitude of loss increases). Corporations sometimes purchase insurance for reasons beyond risk aversion. For example, there are tax advantages for corporations that purchase insurance. Corporations can deduct premiums as business expenses. See TOM BAKER & SEAN J. GRIFFITH, ENSURING CORPORATE MISCONDUCT: HOW LIABILITY INSURANCE UNDERMINES SHAREHOLDER LITIGATION 63 (2010) (explaining how the tax benefits of corporate insurance turn on the favorable treatment of market insurance over self-insurance). On the other hand, a corporation that simply puts aside the funds that would be used to pay premiums into a reserve fund to pay claims would not be able to receive a deduction for those amounts and the company also would have to pay taxes on the income the reserves earned. *Id.* Insurance also protects against the risk of bankruptcy. *Id.* at 63–64. In addition, many lenders require corporate borrowers to have insurance so corporations that do not have insurance incur higher borrowing costs. *Id.* at 64. Similarly, when a company is confronting a crisis that creates an uncertain future due to, for example, a catastrophe such as a flood, the company's ability to raise capital is limited and insurance provides a ready source of funds to address such situations. *Id.* at 65. Some companies also purchase insurance for the loss-prevention expertise of insurers that the companies themselves lack. *Id.* at 66. Finally, insurance protects the shareholders' investments in the company by lowering the volatility of a company's share price by smoothing the company's profits and losses that otherwise would be impacted by the payments of settlements and judgments. *Id.* at 67.

6. See, e.g., JERRY & RICHMOND, *supra* note 5 (describing how many people would prefer to lose one dollar with certainty rather than take a one in ten thousand chance of losing ten thousand dollars); JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 14 (2010) (describing the concept of insurance in operation as a person or entity willing to exchange a small, certain loss to avoid a larger, uncertain loss).

7. See, e.g., JERRY & RICHMOND, *supra* note 5, at 255–58 (exploring the origins and purpose of the insurable interest requirement).

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happening. As described by one court, a person who buys insurance is attempting to “buy financial protection and peace of mind against [un]fortuitous losses.”⁸

The entity that accepts the risk of loss typically spreads the risk of loss across a large number of policyholders.⁹ Although it is expected that some people will suffer losses, only a subset of the total pool of people insured will actually incur losses. This concept is known as the “law of large numbers.”¹⁰ In essence, the large percentage of fortunate people that pay for insurance but do not suffer a loss receive peace of mind through their purchase of insurance and their premiums subsidize the unfortunate few people who do suffer losses.¹¹ In short, everyone pays a premium to create a pool of funds from which the unfortunate few that suffer losses will be paid. Under this concept of insurance, if some people do not participate in the risk pool, whether by choice or exclusion, then the fulfillment of the purpose of insurance is reduced.¹²

In a non-profit context, the insurer simply functions as an intermediary that facilitates this transfer of risk from the individual to the group. For some lines of insurance, such as auto insurance, the insurance industry can predict with great accuracy the likelihood and extent of the actual risk of loss that is transferred because it has collected very detailed and accurate information regarding the likelihood and severity of injuries with respect to various risk classifications. For example, insurers know that on average: (1) there will be 21 fatalities for every 1000 licensed drivers, (2) a driver aged 21 to 24 is almost three times as likely to be involved in a fatal crash while intoxicated as a driver 55 to 64 years old, and (3) the average collision repair cost for all cars is \$3131.¹³ Knowing what each policyholder pays in premiums and the amount of the losses, the insurer is able to predict with great accuracy the expected return it will receive for accepting the transfer of risk.

8. FEINMAN, *supra* note 6, at 19 (quoting *Campbell v. State Farm Mut. Auto Ins. Co.*, 98 P.3d 409, 415 (Utah 2004)).

9. FEINMAN, *supra* note 6, at 14.

10. Omri Ben-Shahar and Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 203 (2012); Cummins, *supra* note 4.

11. See Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 377 (2003) (explaining how insurance is predicated on the existence of a large number of fortunate members' premiums paying for the losses of the unfortunate few); Deborah A. Stone, *Beyond Moral Hazard: Insurance As Moral Opportunity*, 6 CONN. INS. L.J. 11, 16 (1999) (noting how the basic premise of insurance is collective responsibility for harms that befall individuals).

12. See Baker, *supra* note 11, at 378 (stating that the reduction of the ability of the insurance pool to spread risk has an adverse effect on the insurance pool).

13. FEINMAN, *supra* note 6.

As discussed more fully below in Part II. C, for-profit, publicly traded stock companies, which are operating for the benefit of their shareholders rather than as third party intermediaries for the benefit of pools of policyholders, use claims data and risk classifications to charge different premium rates to the people in the various risk classifications or to refuse to insure certain people or risks they deem unprofitable or inadequately profitable.

B. *The Origins of Insurance and the Demise of Mutual Insurance Companies*

Insurance traces its roots back to Babylonian maritime traders as early as 2250 B.C. The Babylonians developed what were known as contracts of “bottomry,” under which investors would loan money or goods to a merchant at a high interest rate with the understanding that the borrower’s obligation to pay the interest or the debt would be eliminated if the vessel carrying the goods sank or was pirated.¹⁴ The Phoenicians, Greeks, and Romans subsequently used contracts of bottomry.¹⁵ Centuries later, bottomry contracts evolved into what we know today as insurance contracts with Lloyd’s of London being the first formal insurer of vessels and cargo in the late seventeenth century.¹⁶ Following the Great Fire of London in 1666, insurers also began selling insurance to cover fire losses for non-marine properties.¹⁷

In the United States, insurance initially developed as community projects for fire insurance in which members of a community contributed to a pool of money from which a member would be paid if his property were destroyed by a fire.¹⁸ The first one of these “mutual” companies was called the “Philadelphia Contributorship for Insuring Houses from Loss by Fire” and was established in Philadelphia in 1752, with Ben Franklin as one of its first directors.¹⁹ Similar mutual companies subsequently were formed throughout the country to protect people and businesses against fire losses.²⁰ Thus, through the collective actions of communities and groups of businesses, mutual insurance pools were developed as social safety nets for

14. See, e.g., JERRY & RICHMOND, *supra* note 5, at 16 (finding the earliest traces of risk transference resembling insurance within ancient Babylonian society).

15. *Id.* at 16–17.

16. *Id.*

17. *Id.* at 16–18.

18. *Id.* at 18; see also FEINMAN, *supra* note 6, at 21 (noting how early insurance companies, including lumbermen insurance companies, were keenly aware of their responsibility to pay claims since they were initially formed to share losses).

19. FEINMAN, *supra* note 6, at 21.

20. *Id.*

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individuals and businesses through which a community or group as a whole acted for the benefit of the unlucky few who suffered losses.²¹

In mutual companies, the members who contribute to the pool of funds used to pay for losses own the company, and they are insured under the pool.²² In contrast, in a for-profit, publically traded stock company, shareholders contribute capital to the company, but they are not insured by it; their interest in the company is limited to maximizing the return on their investments.²³ Thus, the collective interests of a mutual insurance company's owners and policyholders are aligned, while a for-profit, publicly traded stock insurance company's owners' and policyholders' interests are not. Indeed, as will be discussed more fully in Part II.C, there is a significant conflict of interest between corporate shareholders and policyholders when it comes to paying policyholders' claims.

Mutual companies, however, are a dying corporate form for companies in most lines of insurance. Although it was the dominant corporate form when insurance companies were first created hundreds of years ago for the purpose of allowing a community or group of businesses to pool their assets together to protect the unlucky few that suffered losses, competition for insurance premium dollars and capital largely has driven mutual companies out of the market for most lines of insurance.²⁴ There was a dramatic shift from the mutual company form to for-profit, publicly traded stock companies in the 1990s.²⁵ The primary justification given for the change is that stock companies can raise capital and diversify into other lines of insurance more easily than mutual companies.²⁶ Mutual companies' primary means of raising capital is by generating and retaining earnings, unlike stock companies, which can simply issue new shares.²⁷ Other justifications for the switch from the mutual form to stock form include the claim that stock companies can attract better employees and

21. *Id.* at 22–23.

22. *See, e.g.*, JERRY & RICHMOND, *supra* note 5, at 47–48 (noting that mutual companies are not designed for profit, but instead to provide insurance to the members of the company); James A. Smallenberger, *Restructuring Mutual Life Insurance Companies: A Practical Guide Through The Process*, 49 DRAKE L. REV. 513, 516 (2001) (defining mutual insurance company).

23. Smallenberger, *supra* note 22.

24. FEINMAN, *supra* note 6, at 48.

25. Otgontsetseg Erhemjamts & J. Tyler Leverty, *The Demise of The Mutual Organizational Form: An Investigation of the Life Insurance Industry*, 42 J. MONEY, CREDIT & BANKING 1011, 1011 (2010).

26. *See, e.g.*, Smallenberger, *supra* note 22, at 518 (detailing competitive market advantages); Henry Hansmann, *The Organization of Insurance Companies: Mutual versus Stock*, 1 J.L. ECON. & ORG. 125, 138 (1985) (explaining corporate fundraising via bond issuance).

27. Hansmann, *supra* note 26.

managers by offering stock options, as well as the changes to the federal income tax laws in the 1980s that resulted in the elimination of the favorable tax treatment that mutual insurance companies had been receiving.²⁸

C. *Insurance's Essential Role in Society*

Today, insurance's role in society has become far larger than it was in the 1700s. One insurance law scholar describes insurance as a "social instrument" because of its important and socially desirable role of protecting the limited assets of individuals and business owners against catastrophic losses by spreading and transferring the risk of such losses to well-capitalized insurers.²⁹ Indeed, insurance has become integral to people's lives and the conduct of business in developed countries such as America.³⁰ Without insurance, people and businesses simply could not function in today's world. For example, anyone who wants to purchase a house using a bank to finance a mortgage is required to have homeowners insurance in an amount adequate to cover the mortgage.³¹ Anyone who wants to drive a car must have auto insurance.³² Almost all states require businesses to have workers' compensation insurance.³³ In many business

28. Hansmann, *supra* note 26; Smallenberger, *supra* note 22, at 518.

29. Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1489 (2010). See also Erik S. Knutsen, *Auto Insurance as Social Contract: Solving Automobile Insurance Coverage Disputes Through a Public Regulatory Framework*, 48 ALBERTA L. REV. 715, 716 (2011) (noting that because auto insurance is mandatory in order to ensure that victims are compensated and policyholders have no ability to change the policy language, the terms used in auto policies should not be interpreted strictly without regard to the social purpose underlying the policies); Stone, *supra* note 11, at 26–29 ("Because virtually every adult citizen participates in various forms of mandatory insurance, from automobile liability insurance to unemployment insurance, old-age pensions and disability insurance, everyone is exposed to two of the moral assumptions of these programs: collective responsibility for the well-being of individuals and individual responsibility for the well-being of others.").

30. Stempel, *supra* note 29, at 1497.

31. *Id.* See also MARTIN F. GRACE ET AL., CATASTROPHE INSURANCE: CONSUMER DEMAND, MARKETS AND REGULATION 83 (2003) (stating that "homeowners insurance . . . is essentially mandatory" in discussing the demand for homeowners insurance).

32. Stempel, *supra* note 29, at 1497–98. See also MARK S. DORFMAN, INTRODUCTION TO RISK MANAGEMENT AND INSURANCE 222 (8th ed. 2005) (discussing the financial responsibility laws that require drivers to purchase insurance); EMMETT J. VAUGHAN & THERESE VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 539–41 (8th ed. 1999) (conducting a 50-state survey of compulsory automobile liability insurance laws).

33. Stempel, *supra* note 29, at 1498. See also GEORGE E. REJDA, PRINCIPLES OF RISK MANAGEMENT AND INSURANCE 556 (9th ed. 2005) (noting that "[a]ll states today have workers compensation laws").

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transactions, such as construction contracts, one party typically is required to maintain insurance to cover the project.³⁴ In short, because insurance fills an important need in modern society, it has become a necessity in many respects.

In addition, aside from mandatory insurance, if someone lives or does business in areas prone to disasters such as hurricanes, tornadoes, or floods, they need insurance to protect their homes and businesses. Without it, they risk bankruptcy with each passing storm. Of course, if the insurers from whom the policies are purchased do not pay the full value of the actual losses when they arise due to exclusions or aggressive claims payment practices, then the purpose of the insurance is frustrated because the risk of loss was not truly transferred from the policyholder to the insurer. The net result in situations where a person is uninsured or is underpaid for his losses is that both the person and society are in a worse position because the person or its business could be financially devastated by the losses.

Another reason that insurance has become central to our lives is the concern that innocent victims will go uncompensated in the absence of insurance if they are injured.³⁵ Many injured people would not be able to pay their medical bills or recover lost wages in the absence of insurance because tortfeasors often do not have sufficient assets to adequately compensate the people they injure.³⁶ Indeed, ensuring that innocent victims will be compensated is the primary reason automobile insurance is mandatory in this country.³⁷

34. Stempel, *supra* note 29, at 1499, 1505 (discussing construction contracts that require the builder to maintain various types of liability insurance and Amtrak's insistence that the State of Rhode Island "buy \$200 million in liability insurance if it wants to extend commuter rail service to Warwick and South County") (internal quotations omitted).

35. See, e.g., Leland R. Gallaspy, *Breland v. Schilling: Louisiana's Approach to "Injuries Expected or Intended from the Standpoint of the Insured"*, 52 LA. L. REV. 199, 200 (1991) (detailing the public policy rationale for providing insurance in the case of tort victims); Karen Cuttler, *Liability Insurance for Intentional Torts—Subrogation of the Insurer to the Victim's Rights Against the Insured: Ambassador Insurance Co. v. Montes*, 32 RUTGERS L. REV. 155, 157 (1979) (describing the deterrent effect of financial responsibility on potential tortfeasors' decisions); see also *Yousuf v. Cohlma*, 718 F. Supp. 2d 1279, 1288 (N.D. Okla. 2010) (stating that compensating a wrongdoer's innocent victims would outweigh the concern that the wrongdoer would unjustly benefit); *St. Paul Fire & Marine Ins. Co. v. Jacobson*, 826 F. Supp. 155, 163–64 (E.D. Va. 1993) (the public policy of compensating innocent victims outweighs the public policy of not permitting coverage of intentional action); *Vigilant Ins. Co. v. Kambly*, 319 N.W.2d 382, 385 (Mich. Ct. App. 1982) ("[T]here is great public interest in protecting the interests of the injured party.").

36. See generally Stephen G. Gilles, *The Judgment-Proof Society*, 63 WASH. & LEE L. REV. 603, 607 (2006) (noting how commonplace being judgment-proof is as a result of the laws).

37. See, e.g., Stempel, *supra* note 29, at 1498 (noting how every state effectively requires auto insurance in order to license a car); *JERRY & RICHMOND, supra* note 5, at 924–

Because of its importance to society today, insurance has become a huge industry with global premiums exceeding \$4 trillion with the United States alone accounting for 28% of that amount.³⁸ Accounting for 7% of the world's gross domestic product, the insurance industry has grown to become one of the largest and most important industries in the world.³⁹

So, what has happened now that insurance has become one of the largest and most important industries in the world and is dominated by publicly traded stock companies? As is discussed in the next two parts, insurers, as all publicly traded stock companies strive to do, have dedicated themselves to increasing their profits for the benefit of their shareholders. They have done so by: (1) reducing the coverage that is provided under their broadest policy forms; (2) refusing to insure the people and entities for which they cannot charge premiums high enough to meet their target profit margins; and (3) reducing their primary expenses—the amounts they pay for their policyholders' losses. All of these actions are in conflict with the purpose of insurance.

III. INSURERS' REFUSAL TO INSURE RISKS OR ENTITIES THAT DO NOT PRODUCE CONSISTENT PROFITS IN BOTH THE SHORT TERM AND LONG TERM

In this part, to illustrate how the profit imperative has impacted insurers' behavior, several examples of insurers' reduction of the scope of coverage provided under the broadest forms of commercial liability and property policies sold is discussed first. Then, insurers' claims handling conduct under both consumer and commercial lines of insurance is addressed.

A. *Insurers' Contraction of Coverage Provided Under Comprehensive General Liability Policies*

A prime example of insurers systematically reducing the coverage their policies provide in pursuit of profits can be seen when one reviews the history of the Comprehensive General Liability (CGL) policy. The CGL policy, which was renamed the "Commercial" General Liability insurance policy by insurers in 1986 in order to avoid the broad coverage implications of the word "comprehensive," was first created in the 1940s.⁴⁰

25 (stating that the obvious purpose of such mandatory coverage is to provide victims of automobile accidents with access to funds to cover their losses).

38. JERRY & RICHMOND, *supra* note 5, at 18.

39. *Id.*

40. Jeffrey W. Stempel, *Assessing The Coverage Carnage: Asbestos Liability And*

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Although the first CGL policy was sold in 1941, the policy form that became widely used was first issued in 1943.⁴¹ The two rating bureaus that initially created the CGL policy eventually merged and became the Insurance Services Office, Inc. (ISO).⁴²

Prior to 1943, there were numerous different lines of liability insurance available to cover specific risks such as Public Liability Insurance and Premises Operations Insurance that were issued by various insurers with varying policy language.⁴³ Due to the numerous specific lines of insurance available, policyholders were able to purchase only the specific lines of insurance they needed, which meant insurers had a customer base of only policyholders who believed they had a meaningful risk of loss under each of the selected lines of insurance.⁴⁴ The CGL policy was created to broaden the insurance pool and to address other problems associated with splintered lines of coverage such as insurers' use of differing terms and conditions in their policies.⁴⁵ As is still the case today with almost all insurance policies, the terms of CGL policies were drafted by insurers, set forth in lengthy, complex contracts of adhesion, and then sold on a take-it-or-leave-it basis.⁴⁶

Insurance After Three Decades Of Dispute, 12 Conn. Ins. L. J. 349, 355 (2006); see, e.g., E. W. SAWYER, COMPREHENSIVE LIABILITY INSURANCE, Chs. 2–3 (1943) (describing the merger of the Mutual Insurance Rating Bureau (MIRB) and National Bureau of Casualty and Surety Underwriters (NBCSU) to form the Insurance Services Office (ISO)). Sawyer was an attorney for the NBSCU.

41. Stempel, *supra* note 40, at 355.

42. *Id.* ISO is an influential organization within the insurance industry that promulgates standard form insurance policies, including CGL policies that insurers across the country use to conduct their business. *U.S. Fire Ins. Co. v. J.S.U.B., Inc.*, 979 So. 2d 871, 879 n.6 (Fla. 2007). In particular, the organization develops its own standard policy forms and makes them available to its member insurers, which then adopt them and present them to state insurance regulators for approval. See *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 772 (1993) (discussing the ISO's role in crafting traditional CGL insurance). ISO is comprised of approximately 1400 property and casualty insurers and "is the almost exclusive source of support services in this country for CGL insurance." *Id.* As a result, "most CGL insurance written in the United States is written on [ISO] forms." *Id.*

43. Stempel, *supra* note 40, at 356; Sawyer, *supra* note 40, at 11–17.

44. Stempel, *supra* note 40, at 356; Sawyer, *supra* note 40, at 12–18.

45. Stempel, *supra* note 40, at 356; Sawyer, *supra* note 40, at 16.

46. See, e.g., JEFFREY W. STEMPEL, 1 LAW OF INSURANCE CONTRACT DISPUTES § 4.06[b] at 4–37 (Aspen 2d ed. 1999) ("In a sense, the typical insurance contract is one of 'super-adhesion' in that the contract is completely standardized and not even reviewed prior to contract formation."); Michelle Boardman, *Insuring Understanding: The Tested Language Defense*, 95 IOWA L. REV. 1072, 1091 (2010) (describing the "hyperstandardization" of insurance policies); James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation? Text versus Context*, 24 ARIZ. ST. L.J. 995, 996 (1992) ("The only part of the standard policy that is generally customized to the consumer-insured is the Declarations Sheet . . . [T]here is little, if any, freedom to

When created, the CGL policy became the broadest form of liability coverage that could be purchased because the insurer agrees under CGL policies to pay “all sums” for which the policyholder becomes liable for “bodily injuries” or “property damage” caused by an accident.⁴⁷ Despite the expansive coverage grant, insurers embraced the CGL policy because they were able to charge higher premiums and could avoid situations where policyholders only purchased the lines of coverage under which the policyholders thought they most likely would have claims.⁴⁸ In addition, because insurers often would not have to pay claims until many years after the premiums for such policies had been paid, insurers would be able to earn investment income on the premiums until funds were needed to pay claims.⁴⁹ The insurers’ profits created by this delay are referred to as the “float.” Warren Buffet has famously acknowledged that Berkshire-Hathaway earns most of its profits from the “float,” as opposed to underwriting profits (i.e., the amount of premiums collected that exceed the amount paid for claims).⁵⁰ Indeed, in 2007, for example, insurers made \$58 billion in investment income.⁵¹

Under the CGL policy forms used between 1943 and 1966, the

negotiate the standardized language of the insurance contract that determines the scope of coverage.”); Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 125 (2007) (“[I]n some lines of insurance, all insurance companies provide identical coverage on the same take-it-or-leave-it basis.”); Daniel Schwarcz, *Reevaluating Standardized Policies*, 78 U. CHI. L. REV. 1263 (2011) (citing sources that discuss the standardization of insurance policies and then arguing homeowners insurance policies are not as standardized as other lines of insurance); Kent D. Syverud, *The Duty to Settle*, 76 VA. L. REV. 1113, 1153 (1990) (“[P]roperty owner’s liability insurance contracts are standardized across insurers in a form few insureds have the power or experience to bargain around.”).

47. Stempel, *supra* note 40, at 358.

48. Stempel, *supra* note 40, at 358; Sawyer, *supra* note 40, at 115; John H. Eglof, *Liability Insurance, The Outside* 42 BEST’S FIRE AND CASUALTY NEWS 19 (May 1941) (arguing that the bundling of different lines of liability insurance into a comprehensive policy would enable insurers to obtain higher premiums because they would not need to sell different lines of liability insurance). Eglof was the Supervisor of the Agency Field Service of the Travelers Insurance Company.

49. See, e.g., MARK R. GREEN, *RISK AND INSURANCE* 147 (4th ed. 1977) (“In property and liability insurance, investment income has accounted for a very substantial portion of total profits and has served to offset frequent underwriting losses.”); Eliot Martin Blake, *Rumors of Crisis: Considering the Insurance Crisis and Tort Reform in an Information Vacuum*, 37 EMORY L.J. 401, 422–23 (1988) (“Insurers do not simply hang onto premiums, of course; they invest them for the time period between payment of premiums and payment of losses The role of investment income in the [insurance] industry is particularly important. Studies have concluded that investment income allows the industry to remain profitable as a whole even with significant negative underwriting losses.”).

50. Stempel, *supra* note 40, at 357, n. 18; FEINMAN, *supra* note 6, at 16.

51. FEINMAN, *supra* note 6, at 16.

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policies covered liabilities “caused by accident.”⁵² The term “accident” was not defined, and thus courts were left to determine what constituted an “accident.”⁵³ As the case law developed, courts increasingly concluded that “accidents” were not confined in time and space to a single event and could include injury-producing events that took place over longer spans of time.⁵⁴

As a result of the judicial trend in the case law, among other reasons, the CGL policy form was revised in 1966 to substitute the term “occurrence” for the term “accident.”⁵⁵ The term “occurrence” was defined as “an accident, including continuous or repeated exposure to conditions which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”⁵⁶ Significantly, the change to the “occurrence” form meant that it became undisputed that insurance coverage was provided not only for events, but also for gradual, ongoing or continuous injury situations. Indeed, according to one insurer representative, the change to the “occurrence” policy form made it clear that:

The definition [of “occurrence”] embraces an injurious exposure to conditions which results in injury. Thus, it is no longer necessary that the event causing the injury be sudden in character. In most cases, the injury will be simultaneous with the exposure. However, in some other cases, injuries will take place over a long period of time before they become manifest. The slow ingestion of foreign matters and inhalation of noxious fumes are examples of injuries of this kind. The definition serves to identify the time of loss for application of coverage in these cases, viz, the injury must take place during the policy period. This means that in exposure-type cases, cases involving cumulative injuries, more than one policy contract may come into

52. Stempel, *supra* note 40, at 363.

53. *Id.* at 363–64.

54. Compare *Jackson v. Employers Liab. Ass. Co.*, 248 N.Y.S. 207 (N.Y. Sup. Ct. 1931), *aff’d*, 259 N.Y. 559 (1932) (an “accident” must be confined in time and space) with *Shipman v. Employers Mut. Liab. Ins. Co.*, 125 SE. 2d 72, 75–76 (Ga. Ct. App. 1962) (an “accident” may take place over time). See also ROWLAND H. LONG, *THE LAW OF LIABILITY INSURANCE* §1.22, 1–91 (1985) (“[t]he insurance industry concluded that insurance should be afforded to the public on certain kinds of risk which would cover injuries resulting from exposure to harmful conditions over a period of time”; Stempel, *supra* note 40, at 363 (“when the asbestos mass tort arrived, the basic contractual and legal framework of coverage determination combined with the peculiarities of asbestos to require coverage beyond that anticipated by insurers when they first accepted the risk”).

55. John J. Tarpey, *The New Comprehensive Policy: Some of the Changes*, 33 INS. COUNS. J. 223, 223 (1966) (“The principal reason given for revision of the policies [from the 1955 form to the 1966 form] was adverse court decisions.”); Stempel, *supra* note 40, at 364.

56. *Id.* (quoting a leading insurance company representative).

play in determining coverage and its extent under each policy.⁵⁷

In short, coverage was triggered if an injury or damage took place during the policy period whether or not the “accident” causing the injury or damage occurred at that time.

At the time the 1966 CGL policy form was adopted, a CGL workbook used by a major property/casualty insurer gave the following example of an “occurrence” that would be covered under the policy:

Wilson Chemical Company, the named insured, occupies the second floor of a commercial building owned by West End Cleaners. The West End operation occupies the entire first floor. Wilson Chemical used acid as a raw material. The acid is stored in 100 gallon drums on the second floor. One storage drum developed a leak allowing acid to drip onto the floor. This eventually caused extensive damage to several structural supports of the building and caused a partial collapse which destroyed much of West End’s equipment. West End Cleaners brought a suit against Wilson Chemical for the replacement of their equipment. Would Wilson’s CGL policy pay?

Yes. This situation would meet the second part of the definition of occurrence, as the slow leak of acid constitutes a continuous or repeated exposure to conditions.⁵⁸

Thus, under the 1966 CGL policy form, insurers understood that long-tail claims such as environmental claims were covered regardless of whether the damage occurred gradually over time (e.g., due to “continuous or repeated exposure to conditions”) or abruptly (e.g., due to a spill) so long as the damage was not expected or intended by the policyholder.⁵⁹

Another significant feature of CGL policies at this time was the fact that such policies generally did not have aggregate limits except for “products” and “completed operations.”⁶⁰ Without an aggregate limit, an insurer could be required to pay the maximum per occurrence limit in the

57. Stempel, *supra* note 40, at 368 (quoting Norman Nachman, *The New Policy Provisions for General Liability Insurance*, 10 CPCU ANNALS 196, 199–200 (1965) (Nachman was the manager of non-automobile casualty insurance and multiple lines insurance at the National Bureau of Casualty Underwriters)).

58. Stempel, *supra* note 40, at 372 (quoting THE COMPREHENSIVE GENERAL LIABILITY POLICY WORKBOOK 11–12 (1973)) (title caps eliminated).

59. See, e.g., *Morton International, Inc. v. General Acc. Ins. Co.*, 629 A.2d 831, 849–71 (N.J. 1993) (discussing in great detail the evidence, commentators’ views and case law regarding the issue of whether the 1966 CGL policy form covered environmental contamination).

60. See, e.g., Stempel, *supra* note 40, at 376, 381–85 (discussing the absence of an aggregate limit for general operations coverage under the CGL).

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policy over and over again. Thus, an insurer with, for example, a \$1 million per occurrence limit could be required to pay tens of millions of dollars in claims under a single policy if multiple occurrences gave rise to the liabilities.

1. Insurers' Creation of "Pollution" Exclusions to Avoid Covering Environmental Damage

Because policyholders' potential exposure for environmental liabilities was extremely limited in the late 1960s under the existing laws when the new "occurrence" CGL policy was created,⁶¹ insurers aggressively marketed the policy on the basis that it provided coverage for unintentional environmental damage.⁶² For example, in explaining whether the 1966 CGL policy form covered unintentional, gradual environmental damage, Gilbert Bean, a former executive of a major insurer and a member of the General Liability Rating Committee that was in charge of reviewing and drafting policy language, wrote:

Manufacturing risks producing insecticides, plant foods, fertilizers, weed killers, paints, chemicals, thermostats or other regulatory devices, to name a few, have severe gradual [property damage] exposure. They need this protection and should legitimately expect to be able to buy it, so we have included it.⁶³

In another insurance industry paper, Mr. Bean stated the following with respect to the issue of whether the new CGL policy form covered environmental claims:

[There is] coverage for gradual [bodily injury] or gradual [property damage] resulting over a period of time from exposure to the insured's waste disposal. Examples would be gradual adverse effect of smoke, fumes, air or stream pollution,

61. See, e.g., DONALD STERVER, *LAW OF CHEMICAL REGULATION AND HAZARDOUS WASTE* §5.1, at 5–7 (1988) (noting that, prior to the passage of Resource Conservation and Recovery Act of 1976, there was little regulation of hazardous wastes).

62. See *Just v. Land Reclamation, Ltd.*, 456 N.W. 2d 570, 574 (Wis. 1990) ("At least with respect to environmental claims, contemporaneous industry commentary on the 1966 CGL policy indicates that there was no intent to avoid coverage for unexpected or unintended pollution."). See also Thomas Reiter, David Strasser, and William Pohlman, *The Pollution Exclusion Under Ohio Law: Staying The Course*, 59 U. CIN. L. REV. 1165, 1191–93 (1991) (discussing the scope of coverage under "occurrence" CGL policies).

63. Gilbert Bean, *New Comprehensive General and Automobile Program, The Effect on Manufacturing Risks*, presented at Mutual Insurance Technical Conference (Nov. 15–18, 1965), quoted in Robert Saylor & David Zolensky, *Pollution Coverage and the Intent of the CGL Drafters: The Effect of Living Backwards*, 1 Mealey's Litig. Rep. (Ins.) 4425, 4432 (1987).

contamination of water supply or vegetation. We are all aware of cases such as contamination of oyster beds, lint in the water intake of downstream industrial sites, the Donora, Pa. atmospheric contamination, and the like.⁶⁴

The insurers' championing of the 1966 CGL policy form on the basis that it provided coverage for unintentional, gradual environmental damage did not, however, last long. With the adoption by most states of strict liability under §402A of the Restatement (Second) of Torts in 1965,⁶⁵ followed by the enactment of the Federal Water Quality Improvement Act of 1970,⁶⁶ which imposed strict liability for certain discharges into bodies of water, a new regime of environmental regulation and liability was on the horizon. These legal developments, combined with several significant environmental incidents such as the Torrey Canyon disaster and the Santa Barbara offshore oil spill in the same time period,⁶⁷ prompted the insurance industry in the late 1960s to draft a specific exclusion for offshore oil contamination incidents⁶⁸ and a qualified pollution exclusion for CGL policies in order to project a public image that insurers did not protect intentional polluters.⁶⁹

The qualified pollution exclusion, which also is known as the "sudden and accidental" pollution exclusion, was first introduced in 1970 as an endorsement and then became part of the CGL policy form itself in 1973.⁷⁰

64. Gilbert Bean, *Summary of Broadened Coverage Under New CGL Policies With Necessary Limitation To Make This Broadening Possible*, Paper (1966), quoted in Saylor & Zolensky, *supra* note 63, at 4438 n. 34.

65. WILLIAM PROSSER & W. PAGE KEETON ON TORTS §98, at 692–94 (5th ed. 1984).

66. Pub. L. No. 91-224, §102, 84 Stat. 91 (1970) (formerly codified at 33 U.S.C. §1161) (superseded by Federal Water Pollution Control Act Amendments of 1972, §2, Pub. L. No. 92-500, 88 Stat. 816 (1972)).

67. See, e.g., James Hourihan, *Insurance Coverage for Environmental Damage Claims*, 15 FORUM 551, 553 (1980) ("Pollution claims burst on the insurance scene following the Torrey Canyon disaster and the Santa Barbara offshore-drilling oil spills in 1969."); Warren Brockmeier, *Pollution—The Risk and Insurance Problem*, 12 FOR THE DEFENSE 77, 77–78 (1971) (discussing changes to CGL coverage after 1960s disasters).

68. See Brockmeier, *supra* note 67, at 78 (noting that the General Liability Governing Committee of the Insurance Rating Board adopted an exclusion for oil contamination of water on October 28, 1969); ROWLAND LONG, LAW OF LIABILITY INSURANCE §10A.04(2) (Bender ed. 1990) (quoting the wording of the exclusion).

69. See, e.g., Letter from David E. Kuizenga, Secretary, Mutual Insurance Rating Bureau, to Samuel H. Weese, West Virginia Insurance Commissioner (July 30, 1970), quoted in Bradbury, *Original Intent, Revisionism and the Meaning of the CGL Policies*, 1 ENVTL. CLAIMS J. 279, 286–87 (1988) ("It is in the public interest that willful pollution of any type be stopped If the insurance industry were to support continued pollution by providing coverage . . . it would be considered as aiding and abetting these polluters, thereby placing the insurance industry in public disfavor.").

70. See, e.g., Reiter et al., *supra* note 62, at 1196–1200 (discussing the sudden and

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It was worded as follows:

This insurance does not apply. . . . (f) to bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon land, the atmosphere or any water course or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental⁷¹

When the qualified pollution exclusion was first introduced and insurers sought regulatory approval for its use in the early 1970s, insurers represented to state insurance regulators that it was not a restriction on the existing coverage for environmental damage under the CGL policy form.⁷² And, as discussed above, it was undisputed that the existing policy language covered gradual pollution if it was unexpected and unintended.⁷³ Consequently, insurers did not reduce the premium rates charged for CGL policies when they added the qualified pollution exclusion to them.⁷⁴

Insurers' position regarding the scope and meaning of the qualified pollution exclusion changed, however, following the enactment of the Resource Conservation and Recovery Act (RCRA)⁷⁵ in 1976, the Comprehensive Environmental Response Compensation and Liability Act of 1980 (CERCLA), and the Superfund Amendments and Reauthorization Act of 1986 (SARA) (collectively known as the "Superfund" laws).⁷⁶ The Superfund laws imposed retroactive, strict, and joint and several liability for the remediation of environmental damage on any entity that was: (1) the current owner and operator of the disposal facility, (2) the owner or

accidental" pollution exclusion); INS. SERVS. OFFICE, INC., FORM NO. GL 00 02 01 73, COMMERCIAL GENERAL LIABILITY COVERAGE FORM, Exclusion (f) (1973), *reprinted in* DONALD S. MALECKI, COMMERCIAL GENERAL LIABILITY COVERAGE GUIDE, App. A (9th ed. 2011).

71. INS. SERVS. OFFICE, INC., FORM NO. GL 00 02 01 73, COMMERCIAL GENERAL LIABILITY COVERAGE FORM, Exclusion (f) (1973), *reprinted in* MALECKI, *supra* note 70, at App. A.

72. *See, e.g.*, Reiter et al., *supra* note 62, at 1200–05 (discussing insurance industry representations regarding the qualified pollution exclusion); *Morton*, 629 A.2d at 848–53 (discussing insurance industry's explanatory memoranda of the pollution exclusion clause); *Joy Technologies*, 421 S.E. 2d at 498–99 (discussing the IRB's explanatory memorandum of the pollution exclusion clause).

73. *See supra* notes 57–59, 62–64, and the accompanying text.

74. *See, e.g.*, Reiter et al., *supra* note 62, at 1202; *Morton*, 629 A.2d at 848, 853.

75. *Solid Waste Disposal Act Amendments*, 94 Stat. 2334 (1980); *Hazardous and Solid Waste Act Amendments*, 98 Stat. 3224 (1984) (current versions of both amendments are at 42 U.S.C. §§690–6992 (1988)).

76. 42 U.S.C. §§960–9675 (1988).

operator of the disposal facility at the time of the disposal, (3) the entity that arranged for the disposal or treatment of a hazardous substance, or (4) the transporter of a hazardous substance even if the entity handled the chemicals and wastes in accordance with all of the historical laws and industry standards.⁷⁷

With the enactment of Superfund, policyholders were faced with a total cleanup bill of several hundred billion dollars.⁷⁸ When policyholders turned to their CGL insurers to request payment of such liabilities, insurers' response was multipronged: (1) notwithstanding the drafting history of the qualified pollution exclusion and their representations to state insurance regulators regarding the impact the exclusion had on coverage, they took the position that the exclusion precluded coverage for any and all environmental liabilities unless such liabilities resulted from an "abrupt" release of contaminants;⁷⁹ (2) after losing a number of cases regarding the meaning of the qualified pollution exclusion, they promptly drafted a new "absolute" pollution exclusion that was intended to preclude coverage for all environmental liabilities regardless of whether the environmental damage was unexpected and unintended or caused by abrupt releases;⁸⁰ and (3) they litigated every other defense they could conceive in an all-out war with their policyholders to avoid covering their policyholders' environmental liabilities.⁸¹ The battle between insurers and their policyholders regarding coverage for environmental claims lasted many

77. See, e.g., *United States v. Stringfellow*, 661 F. Supp. 1053, 1060, 1062 (C.D. Cal. 1987) (discussing CERCLA's imposition of strict and joint and several liability); *O'Neil v. Picillo*, 883 F.2d 176, 178 (1st Cir. 1989) (discussing CERCLA's retroactive and joint and several liability); *United States v. R.W. Meyer, Inc.*, 889 F.2d 1497, 1506 (6th Cir. 1989) (discussing the same).

78. See, e.g., *Reiter et al.*, *supra* note 62, at 1171 (citing estimated industry liability for cleanup of \$150 billion to \$700 billion).

79. See, e.g., *Reiter et al.*, *supra* note 62, at 1174 (noting that insurers generally argue that "sudden" means "abrupt."); *Morton*, 629 A.2d at 852 (noting that insurers in litigation excepted from the pollution exclusion clause discharge of pollutants that was "sudden" or abrupt).

80. *INS. SERVS. OFFICE, INC.*, FORM NO. CG 00 01 11 85, COMMERCIAL GENERAL LIABILITY COVERAGE FORM, Exclusion (f) (1986), reprinted in *MALECKI*, *supra* note 70, at App. B; Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the "Absolute" Exclusion in Context and in Accord with Its Purpose and Party Expectations*, 34 *TORT & INS. L. J.* 1, 2, 5-6 (1998).

81. See, e.g., PETER J. KALIS, THOMAS M. REITER & JAMES R. SEGERDAHL, *POLICYHOLDER'S GUIDE TO THE LAW OF INSURANCE COVERAGE* §§ 3.02, 3.03, 5.02, 5.03, 10.03, 10.04 (1st ed. 1997 & Supp. 2013) (discussing insurers' arguments and the resulting case law regarding insurers' defenses to coverage based upon the "other insurance" clause, allocation, number of "occurrences," the terms "legally obligated to pay" and "damages," the "owned property" exclusion and the qualified pollution exclusion in environmental insurance coverage disputes).

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years⁸² and resulted in the creation of an extensive body of common law regarding numerous issues and provisions contained in CGL policies due to the breadth of the defenses insurers asserted to coverage.⁸³ In short, when faced with billions of dollars of liabilities that insurers previously had stated were of a type covered by their policies, the profit imperative drove insurers to add an exclusion for such claims going forward and to contest the payment of the existing claims with all available means and resources.

2. Insurers' Creation of an "Asbestos" Exclusion to Avoid Covering Asbestos Liabilities

A similar story can be told regarding insurers' response to policyholders' presentation of claims for liabilities related to asbestos. As is discussed in the preceding section, when the insurance industry adopted the "occurrence"-based CGL policy form in 1966, insurers understood that they were agreeing to insure bodily injuries and property damage that took place gradually over time.⁸⁴ Insurers accepted this increased risk exposure because of the higher premiums and profits that they could earn.⁸⁵

Because tort liabilities are one of the most common types of claims that indisputably are covered under CGL policies, however, insurers were not well positioned to successfully deny that they were responsible for

82. This battle resulted in dozens of law review articles being written regarding the meaning and origins of the qualified pollution exclusion. *See generally* Nancy Ballard and Peter Manus, *Clearing Muddy Waters: Anatomy of the Comprehensive General Liability Pollution Exclusion*, 75 CORNELL L. REV. 610 (1990) (discussing the meanings and applications of "sudden" and "accidental"); Scott C. Stirling, *Reasonable Expectations of Insurance Coverage and the Problem of Environmental Liabilities*, 22 ARIZ. ST. L. J. 395 (1990) (discussing CGL insurance liability and consumer reasonable expectations); Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942 (1988) (exploring the ways in which environmental liability has produced more severe and enduring effects than those produced by the liability insurance crisis of 1985 and 1986); Robert Chesler et. al., *Patterns of Judicial Interpretation of Insurance Coverage for Hazardous Waste Site Liability*, 18 RUTGERS L.J. 9 (1986) (examining, in the hopes of forecasting the outcome of future disputes, liability that arises out of pollution in insurance coverage litigation); Richard Hunter, *The Pollution Exclusion in the Comprehensive General Liability Insurance Policy*, 1986 U. ILL. L. REV. 897 (examining the general principals of insurance law that apply to the pollution exclusion as well as providing a history of the exclusion and the CGL policy language that courts have relied on in construing the exclusion); E. Joshua Rosenkranz, Note, *The Pollution Exclusion Through the Looking Glass*, 74 GEO. L. J. 1237 (1986) (introducing a new method for judicial analysis of whether insurance covers pollution related losses).

83. *See* KALIS ET. AL., *supra* note 81, at § 3 (discussing the insurance law related to various coverage issues).

84. *See supra* notes 57–59.

85. Stempel, *supra* note 40, at 375.

paying their policyholders' asbestos liabilities when asbestos claims began being submitted in the 1970s and 1980s. Consequently, in an attempt to minimize their coverage obligations in order to preserve profits for their shareholders when faced with what ultimately became billions of dollars of liabilities that the insurers had agreed to pay under the policies they drafted,⁸⁶ insurers initially engaged in battles in which each insurer challenged whether the injuries at issue occurred during its policy period and, if so, how much of the liabilities it, as opposed to other insurers, should pay. This litigation led to the development of the common law regarding issues now commonly known as "trigger," "allocation" and "number of occurrences."⁸⁷

Once it became clear, however, that such battles simply had the effect of shifting asbestos liabilities from one insurer to another without actually decreasing the financial obligations of the insurance industry as a whole for such liabilities, the insurance industry did the same thing it did with respect to environmental claims—it drafted and adopted an asbestos exclusion that initially was used as an endorsement and then became part of the standard CGL policy form in 1986.⁸⁸

Following the coverage wars between insurers and their policyholders and the adoption of the asbestos exclusion, more than seventy policyholders went bankrupt as a result of asbestos claims, but there was only a 1 to 3% drag on insurers' earnings and only a handful of insurer insolvencies.⁸⁹ To add insult to injury after first fighting with and then abandoning their policyholders with respect to asbestos liabilities, some insurers even objected to their policyholders' bankruptcy reorganization plans because insurers would be required to pay claims promptly under such plans, thereby depriving the insurers of the "float" income they generated by holding onto the policyholders' premiums for as long as possible and paying claims slowly over time.⁹⁰ Such actions by insurers

86. See, e.g., Stempel, *supra* note 40, at 351 (discussing the billions of dollars in costs to insurers from asbestos claims).

87. See, e.g., *Insurance Company of North America v. Forty-Eight Insulation, Inc.*, 633 F.2d 1212 (6th Cir. 1980) (analyzing when the injury occurs in asbestos cases (i.e., trigger) and how much each insurer whose policy is triggered by the injury should pay (i.e., allocation)); *Keene Corporation v. Insurance Co. of North America*, 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied*, 455 U.S. 1007 (1982) (discussing the same). For a discussion regarding the complexities involved in determining the amount each insurer should be obligated to pay when a claim, such as an asbestos claim, triggers coverage in multiple years and multiple layers of coverage, see Christopher C. French, *The "Non-Cumulation Clause": An "Other Insurance" Clause by Another Name*, 60 U. KAN. L. REV. 375, 378–85 (2011).

88. See, e.g., Stempel, *supra* note 40, at 464 (discussing asbestos exclusions in the CGL policy form).

89. Stempel, *supra* note 40, at 416–17.

90. Stempel, *supra* note 40, at 432–33.

were dictated by the profit imperative.

3. Insurers' Creation of Additional Exclusions to Avoid Paying Losses

Educated by their experiences with asbestos and environmental liabilities, insurers have drafted and adopted exclusions for CGL policies to eliminate coverage for any risks they anticipate could be unprofitable to insure. Today, the CGL policy form, the broadest form of liability insurance that can be purchased, contains the following exclusions: (1) expected or intended injury; (2) contractual liability; (3) liquor liability; (4) workers' compensation claims; (5) employer liability; (6) pollution; (7) aircraft, auto and watercraft; (8) mobile equipment; (9) war; (10) owned property; (11) damage to your product; (12) damage to your work; (13) damage to impaired property; (14) product recall; (15) personal and advertising injury; (16) electronic data; and (17) distribution of material in violation of statutes.⁹¹ In short, the profit imperative has driven insurers to restrict the coverage provided today under a policy form originally entitled "Comprehensive General Liability Insurance" so substantially that the coverage provided under the policy form is no longer even named or described as "comprehensive."

B. *Insurers' Contraction of Coverage Provided Under "All Risk" Property Policies*

A similar story can be told regarding the profit imperative and property insurance. Like CGL policies, which originally were intended to provide coverage for all types of liability claims, insurers also sell property and homeowners policies that purport to cover "all risks" except for specific risks that are expressly excluded.⁹² In much the same way that CGL policies were a consolidation of multiple lines of liability insurance, "all risk" property policies evolved from "named peril" policies. Historically, "named peril" policies covered one specified peril. The earliest non-marine "named peril" policy was the fire policy, which originated in London following the Great Fire of 1666.⁹³

In the 1940s and 1950s, insurers began to bundle coverage for certain

91. Ins. Servs. Office, Inc., *supra* note 70, FORM NO. CG 00 01 12 07, at App. J.

92. See, e.g., Jeff Katofsky, *Subsiding Away: Can California Homeowners Recover from their Insurer for Subsidence Damages to their Homes?*, 20 PAC. L.J. 783, 785 (1989) ("In an 'all-risk' policy, all losses except those specifically excluded are covered. This is the broadest form of coverage and has been so interpreted by the courts.").

93. KALIS ET AL., *supra* note 81, at § 13.02[A][1].

named perils together under one policy. These policies became known as “multi-peril” policies. Under “named peril” or “multi-peril” policies, any perils that were not expressly listed as covered were excluded.⁹⁴

“All risk” policies were then developed from “multi-peril” policies.⁹⁵ Unlike “multi-peril” policies, however, “all risk” policies cover all perils unless a peril is specifically excluded.⁹⁶

Yet, as was the case with CGL policies, the coverage provided by “all risk” policies has eroded over the years as insurers learned that insuring certain risks or policyholders were not as profitable as the profit imperative demanded. A few examples of this phenomenon are discussed below.

1. Insurers’ Creation of an “Earth Movement” Exclusion to Avoid Covering Earthquake Damage

Insurers have been refusing to cover earthquakes since even before “all risk” policies were first created.⁹⁷ As discussed above, “named peril” and “multi-peril” policies only covered perils that were expressly listed so there was no coverage for earthquakes under those policies. Similarly, standard form “all risk” homeowners policies⁹⁸ and commercial property policies⁹⁹ historically have expressly excluded coverage for earthquakes.

Consequently, in California, a state in which residents acutely need earthquake coverage, the state legislature enacted a statute that required insurers that sold homeowners insurance in the state to also offer coverage

94. *Id.* § 13.02[A].

95. *Id.* § 13.02[B].

96. See 5 John Alan Appleman & Jean Appleman, *Insurance Law and Practice with Forms* § 3092 (4th prt., rev. vol. 1987) (providing a background regarding “all risk” policies); 3 New Appleman *Insurance Law Practice Guide* § 31.06[2][d] (Jeffrey E. Thomas et al. eds., 2011) (explaining the difference between a “named perils” policy and an “all risks policy”; 10A Lee R. Russ & Thomas F. Segulla, *Couch on Insurance* § 148:50 (3d ed. 1996) (discussing the increasing use of “all risk” policies).

97. See, e.g., Christopher C. French, *The “Ensuing Loss” Clause in Insurance Policies: The Forgotten and Misunderstood Antidote to Anti-Concurrent Causation Exclusions*, 13 NEV. L.J. 215, 216 (2012) (“[In 1906], most property [insurance] policies in the U.S. covered losses caused by fire, but also contained an ‘anti-concurrent causation’ exclusion that barred coverage for losses caused ‘directly or indirectly’ by earthquakes.”).

98. See, e.g., Brian Mattis, *Earth Movement Claims Under All Risk Insurance: The Rules Have Changed in California*, 31 SANTA CLARA L. REV. 29, 36–37 (1990) (citing State Farm Fire & Cas. Co.’s Homeowners Policy Special Form 3, p. 7, Form FP-7103).

99. See, e.g., INS. SERVS. OFFICE, INC., FORM NO. CP 10 20 06 07, COMMERCIAL PROPERTY BROAD FORM, EXCLUSION (B) (2007), reprinted in BRUCE J. HILLMAN, COMMERCIAL PROPERTY, 404–05 (Susan Massmann, 4th ed. 201009) (“[w]e will not pay for loss or damage caused directly or indirectly by . . . [an] [e]arthquake, including any earth sinking, rising or shifting related to such event”).

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for earthquakes.¹⁰⁰ So long as there were no earthquakes that resulted in significant losses, insurers were willing to accept that requirement.

That, of course, changed in 1994 following the Northridge earthquake. In less than a minute on January 17, 1994, insurers incurred over \$12 billion in losses due to the Northridge earthquake in Southern California.¹⁰¹ In response, 93% of homeowners insurers in California either stopped writing homeowners insurance or imposed strict limits on the policies that they were willing to sell.¹⁰² And the insurers that did not completely abandon California demanded significantly higher premium rates.¹⁰³ For example, State Farm requested a 97.2% rate increase.¹⁰⁴ Due to insurers' refusal to accept the risk of losses for earthquakes in California because they did not view homeowners insurance as an adequately profitable line of insurance for them in the short term if they could not exclude coverage for earthquake losses, the State of California was forced to assume the primary responsibility for insuring earthquake losses in most parts of the state.¹⁰⁵

As discussed further below in Part III.B, insurers justify their refusal to insure catastrophic risks such as earthquakes on the basis that the losses are essentially "uninsurable" because the risks of loss are highly correlated (i.e., they happen in concentrated areas and thus, insurers are not able to adequately spread the risk of loss across a large enough pool of policyholders to cover the losses when they occur).¹⁰⁶ Although such losses are correlated, that does not necessarily mean they are uninsurable. Indeed, regardless of the merits of such arguments in past decades, this justification is fading today due to reinsurance and catastrophe bonds. Reinsurance is now a worldwide business in which global reinsurers actually insure all or portions of another insurer's portfolio of business (known as "treaty" reinsurance),¹⁰⁷ which means that the risk of an earthquake loss in California, for example, is spread across policyholders located not only in California, but also in distant places such as Australia

100. See Cal. Ins. Code § 10081 (West, Westlaw through 2014 Sess.) (requiring earthquake coverage in residential property insurance issued in California).

101. Daniel L. Keller, *Insurance; earthquake insurance—availability*, 27 PAC. L.J. 867 (1996).

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

103. *Id.* at 215.

104. *Id.*

105. See Véronique Bruggeman, Michael Faure, and Tobias Heldt, *Insurance Against Catastrophe: Government Stimulation of Insurance Markets for Catastrophic Events*, 23 DUKE ENVTL. L. & POL'Y F. 185, 195–96 (2012) (describing government intervention in insurance through California's CEA, which bears the primary earthquake risk in California).

106. See, e.g., Cummins, *supra* note 4, at 342–43; Bruggeman et al., *supra* note 105, at 187.

107. *Id.*

and Europe. Further, catastrophes do not regularly recur in the exact same location so insurers collect many years, if not decades, of premiums from policyholders in a location ultimately impacted by a catastrophe before the catastrophe occurs.¹⁰⁸ Insurers today also can further spread the risk of loss through the sale of catastrophe bonds, pursuant to which insurers sell bonds for specific types of catastrophes such as earthquakes and hurricanes to investors who receive interest payments on the bonds and the return of their principal at the end of the bond term unless the specified catastrophe occurs, in which case the insurer keeps the principal and ceases to make interest payments on the bonds. Since 1996, insurers have spread their risks through the issuance of \$51 billion in catastrophe bonds, with only \$682 million in losses or only 1.3% of the amount issued.¹⁰⁹ Thus, in order to tenably advance the argument that the risk of losses caused by earthquakes in California cannot be spread across a large enough pool of policyholders to be actuarially sound at the allowable premium rates, one must take a narrow view of both the relevant time period in which to evaluate the profitability of the premiums and investment income earned versus the losses paid and discount the risk spreading impact that reinsurance and catastrophe bonds have on the relevant pool of policyholders and investors across which the risk of loss is spread.

Nonetheless, regardless of the strength of the argument that catastrophic losses such as earthquakes are “uninsurable” due to the highly correlated nature of the losses, the fact remains that most private insurers do not want to sell insurance to cover earthquake losses so states, such as California, that want their citizens to have coverage for such losses generally must provide it themselves.

2. Insurers’ Creation of a “Flood” Exclusion to Avoid Covering Flood Damage

The insurance industry’s refusal to insure the risk of loss due to floods is another tale of profits over purpose. Largely due to waterways historically serving as a means of transportation, this country developed along waterways, with the largest cities and population centers being located on the coasts or along rivers. With water, however, comes periodic flooding despite humans’ best efforts to prevent it. Indeed, the plain states are fertile farming lands due to the fact that rivers, such as the Mississippi

108. See, e.g., Jaffee & Russell, *supra* note 102, at 206, 208.

109. See Al Yoon and Leslie Scism, *Yield Hunt’s Latest Twist: ‘Catastrophe Bonds’*, WALL ST. J., Apr. 24, 2014, at C2 (“Natural disasters have saddled cat bonds with \$682 million in losses since 1996, or 1.3% of the \$51 billion issued . . .”).

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River, enrich the soil in the surrounding areas by periodically flooding.¹¹⁰

Historically, the risk of loss due to flooding was not excluded under “all risk” homeowners and commercial property policies.¹¹¹ The losses caused by floods over the years, however, have been extraordinary and cause billions of dollars a year in damages.¹¹² Indeed, nine out of ten catastrophes in the United States each year are due to flooding.¹¹³

As is revealed by the preceding discussion regarding environmental, asbestos and earthquake losses, when the damages associated with a potential risk of loss are high, insurers lose their appetites for insuring such risks. Consequently, by the 1960s, insurers had seen enough of flood losses that they decided insuring losses due to flooding generally was not a risk they wanted to accept for several reasons: (1) the near certainty of losses in some areas; (2) the ruinous, widespread nature of flooding events; and (3) the propensity of entities most likely to suffer from flooding losses to purchase coverage for flooding while those unlikely to suffer such losses decline to purchase such coverage.¹¹⁴ As a result, despite selling “all risk” homeowners and commercial property policies, insurers almost uniformly have refused to insure flood losses since the 1960s.¹¹⁵

Thus, the government again was left to fill the void created by

110. See Christine A. Klein & Sandra B. Zellmer, *Mississippi River Stories: Lessons from a Century of Unnatural Disasters*, 60 SMU L. REV. 1471, 1477 (2007) (“As on many rivers, seasonal floods are natural, life-giving occurrences on the Mississippi River. Periodic flooding allows the river to deposit rich soils outside its channel”); Adam F. Scales, *A Nation of Policyholders: Governmental and Market Failure in Flood Insurance*, 26 MISS. C. L. REV. 3, 6 (2007) (“The fertile soils of the alluvial plain constituted a tremendous resource”); Edward V.A. Kussy, *Wetland and Floodplain Protection and the Federal-Aid Highway Program*, 13 ENVTL. L. 161, 176 (1982) (discussing the positive role flooding has in fertilizing wetlands).

111. See, e.g., Scales, *supra* note 110, at 7 (explaining the historic practice of including flood losses in “all risk” policies).

112. See, e.g., Scales, *supra* note 110, at 6 (explaining the extent of the losses due to flooding); Oliver A. Houck, *Rising Water: The National Flood Insurance Program and Louisiana*, 60 TUL. L. REV. 61, 63, 66 (1985).

113. Houck, *supra* note 112, at 62.

114. Warren Kriesel and Craig Landry, *Participation in the National Flood Insurance Program: An Empirical Analysis for Coastal Properties*, 71 J. RISK & INS. 405, 405 (2004); See Scales, *supra* note 110, at 8–9 (explaining the contributing factors to the market failure for flood insurance).

115. Kriesel and Landry, *supra* note 114, at 405. Contrary to the conventional wisdom that no private insurers will provide coverage for the risk of flooding, for the right price and for the right policyholders, there are some insurers that are still willing to provide limited coverage under commercial property policies for floods. See, e.g., *Penford Corp. v. Nat’l Union Fire Ins. Co. of Pittsburgh, PA*, 662 F.3d 497 (8th Cir. 2011), *reh’g denied* (Dec. 19, 2011) (litigating whether the policyholder, whose manufacturing facility was located on the banks of the Cedar River, had \$50 million or \$20 million in coverage for flood losses under an “all risk” commercial property policy issued by AIG and ACE).

insurers' refusal to cover flood losses. In this instance, the void has been filled by the federal government through the National Flood Insurance Program (NFIP) that was initiated through the National Flood Insurance Act of 1968.¹¹⁶ Unfortunately, the NFIP has not been a model for success. Historically, it has suffered from low participation rates and has been subject to widespread criticism due to problems such as the subsidization of premium rates, outdated flood maps, periods of insolvency and inadequate compensation amounts for losses due to the poor coverage provided under the NFIP policy and the \$250,000 liability cap under the program.¹¹⁷ The recently passed Biggert-Waters Flood Insurance Reform Act of 2012 was intended to address these problems.¹¹⁸ Only time will tell if the 2012 amendments to the Act will be effective, but it is clear that the profit imperative is the reason private insurers refuse to cover flood losses.

3. Insurers' Attempts to Refuse to Cover Hurricanes/Windstorms

What about hurricanes? In light of insurers' history of exiting lines of insurance for risks that have or may result in substantial claims, hurricanes would certainly seem to be the type of risk that insurers would prefer not to insure. There were \$23 billion in losses caused by Hurricane Andrew in 1992.¹¹⁹ Hurricane Katrina caused \$43 billion in losses in 2005.¹²⁰ Also in 2005, Hurricane Wilma caused \$23 billion in losses.¹²¹

Not surprisingly, even though insurers already exclude coverage for the "flood" portion of damage caused by hurricanes,¹²² insurers also have sought, with some success, to completely exit the insurance market for wind damage caused by hurricanes.¹²³ Indeed, when state insurance

116. 42 U.S.C.A. § 4001 *et seq.* (2012).

117. *See, e.g.*, Kriesel and Landry, *supra* note 114, at 406–07; Cummins, *supra* note 4, at 358; Beth A. Dickhaus and Darrin N. Sacks, *Recent Developments in Insurance Regulation*, 42 TORT TRIAL & INS. PRAC. L.J. 571, 582 (2007).

118. *See* Pub. L. 112–141, Div. F, Title II, § 100249, July 6, 2012, 126 Stat. 969 (amending 42 U.S.C. § 4001 *et seq.*). It remains to be seen whether actuarially sound premium rates will ever be charged because several coastal states successfully lobbied against the new premium rates that would be charged to their residents such that Congress recently passed the Homeowner Flood Insurance Affordability Act of 2014, which delays the full implementation of actuarially sound premium rates mandated by Biggert-Waters Flood Insurance Reform Act of 2012. *See* Pub. L. 113–89, § 2, Mar. 21, 2014, 128 Stat. 1020 (amending 42 U.S.C. § 4001 *et seq.*).

119. Cassandra R. Cole, *et. al.*, *The Use of Post-Loss Financing of Catastrophic Risk*, 14 RISK MGMT. & INS. REV. 265, 266 (2011).

120. *Id.*

121. *Id.*

122. *See*, Part II.B.2, *supra* (highlighting the flood exclusions in insurance policies).

123. *See, e.g.*, Donald T. Hornstein, *Natural Disasters and the Financing of Fat Tails:*

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commissioners have refused to approve the premium rates that insurers claim they need in order to meet their profit margin goals in coastal states, insurers have simply refused to sell the insurance, unless the government intervenes to prevent them from doing so.¹²⁴ In Florida, for example, insurers attempted to exit the market for hurricane coverage after Hurricane Andrew in 1992, but legislation was passed to temporarily prevent them from doing so.¹²⁵ More recently, after the legislative prohibition expired, most major private insurers have been refusing to insure coastal properties.¹²⁶ Consequently, Citizens Property Insurance Corporation, a state sponsored insurance company, is by far the largest property insurer in Florida.¹²⁷

Like Florida, the states of Alabama, Louisiana, North Carolina, Mississippi, South Carolina, and Texas also have been forced to create hurricane insurance plans due to the lack of availability of affordable insurance coverage from private insurers.¹²⁸ Insurers typically are required to contribute to such plans as a condition to being allowed to sell insurance in the state.¹²⁹ Thus, although states have taken steps to slow or prevent insurers from refusing to cover the wind portion of damage caused by hurricanes, it is clear that insurers would not cover any portion of hurricane losses in coastal areas if not for legislative requirements.

Finally, what about tornadoes? Since 1950, almost 58,000 tornadoes have been observed.¹³⁰ The average annual losses caused by tornadoes between 1950 and 2013 were \$5.9 billion.¹³¹ In recent years, however,

Lessons from the Economics and Political Economy of Weather-Related Insurance, p. 4, 6 (2013), available at <http://ssrn.com/abstract=2249904>; Elisabeth A. Onda, *Testing the Waters: The South Carolina Coastal Captive Insurance Act As Part of A Multifaceted Approach to the Coastal Insurance Conundrum*, 59 S.C. L. REV. 599, 600 (2008) (explaining instances where insurers have succeeded and failed at exiting the market).

124. Hornstein, *supra* note 123, at 4 (describing Allstate's, Farmers Insurance's and Farm Bureau's withdrawal from the insurance markets in Florida and North Carolina when they did not obtain regulatory approval for their requested premium rate increases despite the fact that premium rates already had been increased by 77% in Florida between 2001 and 2006).

125. 1993 Fla. Laws, ch. 93-401; Jonathan Brennan Butler, *Insurers Under Fire: Assessing the Constitutionality of Florida's Residential Property Insurance Moratorium After Hurricane Andrew*, 22 FLA. ST. U. L. REV. 731, 770 (1995); Jaffee and Russell, *supra* note 102, at 206.

126. Bradley G. Bodiford, *Florida's Unnatural Disaster: Who Will Pay for the Next Hurricane?*, 21 U. FLA. J.L. & PUB. POL'Y 147, 149, 161-62 (2010).

127. *Id.* at 160.

128. Hornstein, *supra* note 123, at 2, 6; Onda, *supra* note 123, at 601, 605-07.

129. Hornstein, *supra* note 123, at 6.

130. Roger A. Pielke, Jr., *The Decline of Tornado Devastation*, WALL ST. J., Apr. 25, 2014, at A13.

131. *Id.*

tornadoes have caused even more staggering devastation, particularly in the “Hurricane Alley” states of Alabama, Arkansas, Louisiana, Kansas, Missouri, Oklahoma and Texas. In 2011, for example, tornadoes killed 550 people and caused \$28 billion in property damage.¹³²

Thus far, insurers have continued to cover tornado losses. Yet, in light of the impact that the profit imperative had on insurers’ response to claims for environmental, asbestos, flood, earthquake, and hurricane losses, how long can we expect that insurers will voluntarily continue to cover damages caused by tornadoes?

4. Insurers’ Creation of Additional Exclusions to Avoid Covering Other Risks as They Have Appeared

Now, insurers waste little time contemplating how to respond to new risks of loss that could impair their profit margins when they appear. Instead, ISO quickly drafts exclusions that are immediately added to policies to avoid insuring potentially unprofitable risks of loss. For example, as the year 2000 approached, there was wide spread concern regarding potential computer crashes because computers had not been programmed to turn from 1999 to 2000. Instead of assuring policyholders that they would be covered under their policies in the event of losses due to crashing computers, ISO drafted an exclusion for Y2K claims that was added by endorsement to property policies well before the ball dropped in Times Square on New Year’s Eve of 2000.¹³³

Similarly, the first case in which a policyholder was awarded substantial damages by a jury for mold contamination occurred in 2001.¹³⁴ Within a year, ISO had drafted a new mold exclusion for “all risk” homeowners and other types of property policies in an attempt to avoid paying any claims related to mold in the future.¹³⁵

Just a year later in 2002, with the 9/11 terrorist attack losses projected to be in the range of \$30 to \$100 billion,¹³⁶ ISO quickly drafted and added a

132. Kevin M. Simmons, Daniel Sutter, and Roger Pielke, *Normalized Tornado Damage in the United States: 1950–2011*, Environmental Hazards, 1 (2012).

133. Stempel, *supra* note 40, at 465.

134. See *Ballard v. Fire Ins. Exchange*, No. 99-05252, 2001 WL 883550 (Tex. Dist. Ct. Aug. 1, 2001) (a homeowner successfully sued her insurer for bad faith handling of a claim for mold contamination and was awarded \$32 million in total by the jury). See generally Brian Lake, *The Empire Strikes Back: The Insurance Industry Battles Toxic Mold*, 33 WM. MITCHELL L. REV. 1527 (2007) (explaining the insurance industry’s response to the explosion in mold litigation); Julie Elmer, *A Fungus Among Us: The New Epidemic of Mold Claims*, 64 ALA. L. REV. 109 (2003) (providing a general overview of mold litigation).

135. Stempel, *supra* note 40, at 466.

136. Saul Levmore & Kyle D. Logue, *Insuring Against Terrorism—and Crime*, 102

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terrorism exclusion to insurers' policies.¹³⁷ To fill the vacuum created by insurers' refusal to cover terrorism losses, and to calm a justifiably shaken country, Congress intervened by passing the American Terrorism Risk Insurance Act of 2002 under which insurers are required to offer terrorism coverage, but the federal government provides free reinsurance subject to a \$5 million, per occurrence deductible.¹³⁸

Today, in addition to excluding coverage for earthquakes, floods and mold, ISO's standard form "all risk" homeowners policy also contains exclusions for losses caused by: (1) collapse; (2) frozen pipes; (3) wear and tear; (4) mechanical breakdown; (5) corrosion or dry rot; (6) settling; (7) birds, vermin, rodents or insects; (8) ordinance or law; (9) power failure; (10) neglect; (11) war; (12) nuclear hazard; (13) intentional loss; and (14) governmental action.¹³⁹ In short, as is the case with CGL policies, the profit imperative has reshaped the "all risk" property policy sold by insurers to homeowners today so that such policies cover quite a bit less than "all" risks.

C. *The Impact of the Profit Imperative on Insurers' Payment of Claims*

Although insurers' introduction of exclusions and refusal to insure certain risks are examples of the profit imperative overriding the purpose of insurance, perhaps the clearest manifestation of this phenomenon today can be seen in the way insurers have approached reducing their principal expenses—the amounts paid for their policyholders' losses. In essence, due to the profit imperative, when it comes to paying claims, insurers and their policyholders are adversaries. In the words of one scholar, when it comes to paying their policyholders' losses, insurers do not act like "a good neighbor" and policyholders are not in "good hands".¹⁴⁰ When a claim is presented, the insurer and the policyholder become adversaries.¹⁴¹ The reason is simple: every dollar an insurer pays on a claim is a dollar that does not go to the insurer's profits. The payment of claims is a zero-sum

MICH. L. REV. 268, 269 (2003).

137. See, e.g., Michelle E. Boardman, *Known Unknowns: The Illusion of Terrorism Insurance*, 93 GEO. L.J. 783, 787, 803 (2005); Levmore & Logue, *supra* note 136, at 276, 296.

138. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, 116 Stat. 2322 (2002) (codified as amended in various sections of 15 U.S.C.); Boardman, *supra* note 137, at 788–89; Bruggeman et al., *supra* note 105, at 230.

139. INS. SERVS. OFFICE, INC., FORM NO. HO 00 03 10 00, HOMEOWNERS POLICY FORM, EXCLUSIONS (1999), reprinted in Kenneth S. Abraham, *Insurance Law & Regulation*, at 202–06 (5th ed. 2010).

140. FEINMAN, *supra* note 6, at 190.

141. *Id.*

game for insurers and policyholders. Thus, insurers and policyholders are competing for the same dollars.

As the insurance industry became increasingly dominated by publicly traded stock companies in the 1990s, insurers did what all successful for-profit businesses do. They closely analyzed their revenues and costs, looking for ways to increase revenues and to decrease costs. What insurers and their management consultants discovered when they looked at insurers' expenses in the 1990s was that seventy-two cents of every premium dollar collected was paid out in claims.¹⁴² Consequently, they concluded that in order to increase their profits, they had to decrease the amounts paid in claims.¹⁴³ As the Chairman of one insurer explained to its employees in 1997:

In the long run, if we don't win on the claim side of this business we don't win. Because that's where all the leverage is. Three-quarters of every dollar that leaves this company goes to pay claims. So we have to build a long-term, sustainable competitive advantage in claims. It's as simple as that.¹⁴⁴

The Vice President of Claims at another insurer described his company's approach to claims payments as follows:

[W]hat I'm talking about is the loss ratio, because that's the difference between profits and loss And if our competition settles claims for less money than we do, we stand a good chance of being non-competitive Now you all know losses are a function of frequency and severity. You can't do a whole lot about the frequency but severity is strictly in our ballpark.¹⁴⁵

In short, the profit imperative drove insurers to settle claims for less money and to build a "sustainable competitive advantage in claims."¹⁴⁶

The insurance industry's focus on reducing the amounts it paid in claims in order to increase profitability was successful, as demonstrated by the industry's loss ratio, which is the amount paid in claims divided by the amount collected in premiums. The loss ratio went from 67% in 1987 to 56% in 2007.¹⁴⁷ Richard Stewart, the former Superintendent of Insurance for New York and President of the National Association of Insurance Commissioners, described the transformation that occurred in the insurance

142. *Id.* at 58.

143. *Id.*

144. *Id.* at 63 (*quoting Allstate Now*, 24 (January 1997)).

145. *Id.* at 64 (*quoting State Farm Divisional Claim Superintendents Conference* (1986)).

146. *Id.* at 63.

147. *Id.* at 15.

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industry regarding the emphasis placed on driving down the amounts paid on claims as a shift “from orientation toward policyholders to orientation toward stockholders”¹⁴⁸ The end result, of course, is that the “stockholders get the benefit of what is not paid out for claims.”¹⁴⁹

1. Insurers’ Claims Payment Practices under Consumer Lines of Insurance

In practice, when it came to implementing the insurers’ focus on profitability under consumer lines of insurance, such as auto insurance, the basic instruction to claims handlers was to “deny everything you can.”¹⁵⁰ In addition, claims handlers were no longer evaluated on the basis of how accurately claims were being valued or how satisfied policyholders were with the claims adjustment process, but rather, “based on the average amount we paid out in claims.”¹⁵¹ Claims handlers were instructed “to close a set percentage of claims without payment” and “to estimate the condition of damaged vehicles at or below the national average to minimize indemnity payments,” which, of course, meant the claims handlers were being instructed to deny some claims and lower the amount paid on other claims without regard to the true value of the claims.¹⁵² Claims handlers were also instructed to try to settle claims before the policyholder retained counsel because policyholders represented by counsel recovered 90% more than unrepresented policyholders.¹⁵³

With respect to some soft tissue injuries, such as whiplash, which generally were viewed with suspicion by insurers, one insurer adopted a policy of “forcing soft tissue cases through arbitration and trial for the purpose of sending a message to claimants, their attorneys, and the public in general, that it is simply not profitable to pursue a soft tissue case when [we are] the insurer.”¹⁵⁴ The insurer’s policy was effective because the average amount it paid on whiplash claims declined by 38%, from \$4,500 to \$2,783.¹⁵⁵ The cumulative effect on the insurer’s bottom line was dramatic, with the insurer’s profits increasing by over \$100 million.¹⁵⁶

Insurers also began using computer programs to value claims instead

148. FEINMAN, *supra* note 6, at 47–48 (quoting Richard E. Stewart and Barbara D. Stewart, *The Loss of the Certainty Effect*, RISK MGMT. & INS. REV. 4, 29 (2001)).

149. *Id.*

150. *Id.* at 77 (quoting Declaration of William R. Hurst, (December 29, 2003)).

151. *Id.*

152. *Id.* at 79.

153. *Id.* at 88.

154. *Id.* at 97 (quoting Affidavit of Grace Hess (March 12, 1998)).

155. *Id.* at 100.

156. *Id.*

of trained people. As with any computer program, it could be programmed to consider whatever data was input. With the profit imperative in mind, one insurer programmed the system to omit jury verdicts and settlements that exceeded \$50,000 when valuing claims because “profits would go up” by lowering the average claim payments and executives would receive significant bonuses as a result.¹⁵⁷ Another insurer decided to pay only 80% of the value of claims as calculated by the computer program.¹⁵⁸

In addition, the profit imperative also has encouraged insurers to delay the payment of losses they agreed to pay or were forced to pay for as long as possible. Because of the “float”—the investment income earned on premiums before the premiums are used to pay claims—it is now the standard operating procedure for insurers to hold onto the money for as long as possible before paying.¹⁵⁹

2. Insurers’ Claims Payment Practices under Commercial Lines of Insurance

The profit imperative has driven insurers to behave similarly with respect to commercial lines of insurance. The biggest differences, however, are that the amounts at issue are often larger and corporate policyholders, unlike consumers, frequently have the financial resources to fight when insurers refuse to pay claims or attempt to settle claims for pennies on the dollar.

Unlike individual consumers, corporate policyholders typically have liability and property insurance programs that have multiple layers of coverage which total tens or hundreds of millions of dollars of coverage in each policy year, and some of their claims are worth tens or hundreds of millions of dollars.¹⁶⁰ Consider, for example, long-tail claims such as environmental and asbestos liabilities discussed above in Part II.A. Because the losses at issue totaled billions of dollars in the aggregate, insurers fought their policyholders over every dollar using every legal

157. *Id.* at 117 (quoting Affidavit of Maureen Reed (April 12, 2003)).

158. *Id.* at 118.

159. *See supra* notes 50, 51, 90 (explaining “float” and its use by insurers). *See also* FEINMAN, *supra* note 6, at 16, 28, 32 (explaining risk aversion in the insurance industry).

160. French, *supra* note 87, at 378–79 (discussing the structure of corporate policyholders’ insurance programs); Christopher C. French, *Segmented Settlements Are Not the Answer: A Response to Professor Squire’s Article, How Collective Settlements Camouflage the Costs of Shareholder Lawsuits*, 7 VA. L. & BUS. REV. 589, 611–13 (2013) (same); Michael M. Marick, *Excess Insurance: An Overview of General Principles and Current Issues*, 24 TORT & INS. L.J. 715, 718 (1989) (“Most major corporations purchase multiple layers of excess insurance to cover losses potentially aggregating in the millions of dollars.”).

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procedure and defense they could conceive, keeping in mind that every dollar they paid to their policyholders was a dollar that could not be paid in profits to their shareholders. And in cases where the policyholders successfully defeated the literally dozens of defenses that insurers typically asserted, insurers then forced their policyholders to litigate issues such as “trigger,” “number of occurrences,” “allocation,” and “other insurance,” in an attempt to avoid or minimize the amounts they were obligated to pay.¹⁶¹

One case I handled regarding a long-tail product liability claim with over \$200 million in damages, for example, involved dozens of insurers, took over a decade to litigate, and required two trips to the Supreme Court of Delaware before it was finally resolved.¹⁶² The final hold-out insurer, aptly named Stonewall Insurance Company, was ordered to pay almost as much in pre-judgment interest as the amount of its policy’s limits after its scorched earth defense of the case, which included more than thirty affirmative defenses, was litigated and finally tried more than ten years after the case was commenced.¹⁶³

The outcomes of such battles are very dependent upon which state’s laws apply and in which court the fight is litigated.¹⁶⁴ This is not a secret. Consequently, as a final example of insurers’ commitment to increasing their profits at the expense of their policyholders, insurers have added choice of law and forum selection provisions to some of their policies in order to tilt the battle field in their favor by forcing their policyholders to try to collect for their losses only in the forums, and only under the laws, most favorable to insurers.¹⁶⁵

III. MINIMIZING THE IMPACT OF THE PROFIT IMPERATIVE ON THE RELATIONSHIP BETWEEN INSURERS AND POLICYHOLDERS

How can, or should, the role the profit imperative plays in risk management be minimized or otherwise addressed? The answer to that question is very complex and cannot be adequately covered in the context of a single law review article. With that said, set forth below are a few

161. See, e.g., French, *supra* note 87, at 380–85, 404 (discussing the different types of triggers that courts have adopted); KALIS ET AL., *supra* note 81, at § 3 (discussing insurers’ various defenses).

162. French, *supra* note 160, at 614–15; Stonewall Ins. Co. v. E.I. Du Pont de Nemours & Co., 996 A.2d 1254 (Del. 2010).

163. *Stonewall*, 996 A.2d at 1256.

164. KALIS ET AL., *supra* note 81, at §26.03.

165. See, e.g., Stempel, *supra* note 40, at 469 (discussing the use of arbitration clauses, forum selection clauses, and choice of law clauses in commercial insurance forms).

ideas to begin the discussion.

A. *Penalties Should Be Created to Incentivize Insurers to Pay Losses Timely and in Full*

Under the current laws, there is no downside risk for insurers that do not pay their policyholders' claims timely and in full. To the contrary, unless the policyholder can prove the insurer acted in bad faith,¹⁶⁶ which is quite difficult to do under most states' laws,¹⁶⁷ an insurer that wrongfully denies its policyholder's claim, delays payment of the claim, or underpays the claim is only liable for the amount underpaid plus some nominal interest on that amount.¹⁶⁸ Because there is no penalty for being wrong or

166. The standards for proving bad faith vary widely in jurisdictions throughout America. Some jurisdictions require that the policyholder prove that the insurer acted egregiously or with a dishonest intent, while others require the policyholder to prove that the insurer acted "unreasonably" with respect to the handling or payment of a claim and that the insurer knew or had reason to know that its behavior was unreasonable. *See, e.g.,* JERRY & RICHMOND, *supra* note 5, at 165–70 (explaining how the determination of bad faith often centers around the unreasonableness of the insurer's conduct but varies across jurisdictions); Douglas R. Richmond, *An Overview of Insurance Bad Faith Law and Litigation*, 25 SETON HALL L. REV. 74, 96–103 (1994) (discussing what constitutes bad faith and looking at various standards set forth by the courts). With respect to decisions to deny coverage, many courts apply a "fairly debatable" standard, which means there cannot be a finding of bad faith unless it is so clear that the claim is covered that it is not even fairly debatable. *See* JERRY & RICHMOND, *supra* note 5, at 166 (discussing the "fairly debatable" standard).

167. Many jurisdictions require that the insurer's bad faith conduct be proven by the policyholder with "clear and convincing evidence." *See, e.g.,* JERRY & RICHMOND, *supra* note 5, at 167 (explaining how some courts require the plaintiff to provide proof of bad faith by "clear and convincing evidence"). Indeed, in most of the cases in which the policyholder successfully proves the insurer acted in bad faith, the insurer's misconduct involved much more than, for example, the simple refusal to pay under a liability policy a reasonable amount within policy limits to settle a claim asserted against the policyholder. *See, e.g.,* Crisci v. Sec. Ins. Co., 426 P.2d 173 (Cal. 1967) (affirming a jury verdict of bad faith where the insurer, in addition to refusing to accept a settlement demand within policy limits, refused to settle even though the policyholder, a 70-year old widow, offered to contribute to the settlement and ultimately attempting suicide after becoming indigent while attempting to satisfy the judgment in excess of the policy's limits entered against her); Birth Ctr. v. St. Paul Cos., 787 A.2d 376 (Pa. 2001) (affirming a jury verdict of bad faith in a medical malpractice case involving an injured baby where the insurer refused to settle within policy limits due to its corporate practice of trying, instead of settling, all "bad baby cases," despite the insurer-appointed defense counsel recommending settlement and the presiding trial judge informing the insurer that it was acting in bad faith by refusing to settle).

168. *See, e.g.,* JERRY & RICHMOND, *supra* note 5, at 161 (explaining that bad faith remedies were created due to the "apparent inadequacy of contract remedies to compensate insureds and deter insurers from elevating their own interests above their insureds."). In order to actually be awarded a penalty such as punitive damages, however, in many

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treating their policyholders poorly, insurers currently have little incentive to pay claims timely or in full. To the contrary, the profit imperative actually dictates that insurers delay claims payments as long as possible to take advantage of the “float,” pay as little as possible for even legitimate claims, and contest the payment of claims so long as the costs of doing so are lower than the payment amounts being sought and there is not a significant chance of being held liable for acting in bad faith.¹⁶⁹ And, as discussed above in Part II.C, this is exactly what insurers do.

To change the risk/benefit equation for insurers regarding the payment of claims, penalties need to be created to incentivize insurers to pay timely and in full. There are so many ways in which to do so that it could and should be the subject of a separate article. However, here is one idea: a law should be created to the effect that if the fact finder determines that the value of a claim is greater than the amount paid or offered by the insurer, then the insurer would be liable not only for the difference, but also for a penalty, interest above market rates, and attorneys’ fees.¹⁷⁰ For example, if a loss is determined to be worth \$1000 but the insurer only paid or offered to pay \$700, then the insurer would be liable for: (1) the additional \$300 owed, (2) a 20% penalty on the unpaid \$300,¹⁷¹ (3) interest on the unpaid \$300 calculated at the prime rate plus 5% from the date of the loss until the date of final payment, and (4) the policyholder’s attorneys’ fees. The prospect of being held liable for amounts significantly greater than their existing contractual obligations in the absence of a finding of bad faith should discourage insurers from: (1) collecting “float” income by delaying the payment of claims and (2) forcing their policyholders to sue in order to recover the full value of their losses.

jurisdictions the policyholder must prove by clear and convincing evidence that the insurer engaged in egregious, wanton misconduct. *Id.* at 167, 169.

169. *See supra* Part II.C. (explaining why insurers delay payments as long as possible).

170. I am not the only person to suggest that insurers should be penalized for failing to pay the full value of claims timely. *See, e.g.*, 2 ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 9:24 (6th ed. 2012) (“There are, in short, sound public policy reasons for allowing an insured some type of ‘extra’ award when an insurance company unreasonably refuses to . . . indemnify the insured, forcing him or her to go to the expense of establishing the company’s error by means of litigation The most appropriate relief, therefore, when an insurance company has acted unreasonably, is an award of attorney’s fees.”). Indeed, some states have enacted statutes that impose penalties on insurers that fail to pay their policyholders’ claims timely and in full under certain lines of insurance. *See, e.g.*, RUSS & SEGULLA, *supra* note 96, at § 207:75 (citing Minnesota, Georgia, and Louisiana cases and statutes).

171. Although I am proposing a 20% penalty in this Article as an illustration of how a penalty system would work, it is notable that 20% is the penalty the United States imposes on people who substantially underpay their taxes over the course of a tax year. 26 U.S.C.A. § 6662. If there is a gross underpayment, then the penalty is 40%. *Id.*

B. *Certain Exclusions Should Be Eliminated from Policies and Insurers' Ability to Refuse to Insure Certain Entities and People Should Be Reduced*

The hollowing out of coverage provided under socially critical lines of insurance, such as property insurance through the addition of exclusions for catastrophic and other risks that interfere with insurers' fulfillment of the profit imperative that has occurred over the past 40 years also should be reversed. For example, homeowners policies, which are a social necessity today, should be required to cover losses caused by floods and hurricanes. The losses caused by these types of disasters are exactly the types of losses that should be covered under such policies. Removing coverage for the very types of losses that are most common and have the most devastating impact on people, businesses, and communities is antithetical to the risk transferring purpose of insurance.¹⁷² Insurers simply should not be allowed to avoid fulfilling the purpose of insurance solely in the name of profits.

Thus, each of the numerous lines of insurance that currently exist should be analyzed by state insurance commissioners to determine how critical the line is to society. To that end, a task force could be created by the National Association of Insurance Commissioners with representatives from the insurance industry, legislatures, and consumer advocates to examine the various lines of insurance. If a line of insurance is determined to be a socially critical line of insurance, then insurers' use of exclusions to hollow out the coverage actually being provided should be closely examined and each exclusion should be eliminated or narrowed as appropriate.

Similarly, insurers' ability to refuse to insure people or entities that they have concluded are not adequately profitable because they are "bad risks" also should be reduced or eliminated for socially critical lines of insurance. In the absence of such controls on insurers, reverse adverse selection has been employed by insurers such that only the most profitable people and businesses can purchase insurance under many important lines of insurance while the least profitable or unprofitable have been left uninsured.¹⁷³ These uninsured people and businesses are often the ones

172. See *supra* Part I (explaining the dangers of excluding crucial risks).

173. Simply stated, adverse selection is "the disproportionate tendency of those who are more likely to suffer losses to seek insurance against those losses." Kenneth S. Abraham & Lance Liebman, *Private Insurance, Social Insurance, and Tort Reform: Toward a New Vision of Compensation for Illness and Injury*, 93 COLUM. L. REV. 75, 102 n.82 (1993); see also Baker, *supra* note 11, at 373, 375 (discussing how adverse selection results in high risk individuals being disproportionately represented in insurance pools). Some critics of the concept of adverse selection have argued that insurers' alleged concerns regarding the

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who need insurance the most. There is no tenable defense for such a result. Consequently, the restrictions placed on insurers' ability to refuse to insure certain people or businesses should be expanded beyond the few limitations that currently exist for each line of insurance determined to be socially critical.

Although not being done in a coordinated or comprehensive way, in recent years we have begun to see some legislatures moving in the direction of this proposal. For example, with respect to health insurance, the Affordable Care Act has: (1) removed insurers' ability to refuse to insure certain people, (2) removed insurers' ability to cancel insurance for people who become sick and (3) reduced insurers' ability to use reverse adverse selection to charge certain risk classifications prohibitively expensive premiums.¹⁷⁴ Similarly, in a more limited way, it also has happened for auto insurance in the sense that even drivers who private

impact that adverse selection has on policyholders' behavior are overblown. *See, e.g.*, Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1225 (2004) (arguing that while adverse selection in insurance markets is a possibility, it is not as serious of a problem as some people suggest). The role adverse selection has on insurers' behavior, however, is quite significant. Insurers use adverse selection—or more accurately, reverse adverse selection—to improve their profit margins. Insurers use decades' worth of claims data related to each line of insurance collected by the entire insurance industry through ISO, detailed information regarding each prospective policyholder that is collected through property reviews and applications for insurance, and actuaries to create a risk profile for each prospective insured. *See, e.g.*, FEINMAN, *supra* note 6, at 14 (explaining how insurers use claims data); Siegelman, *supra*, at 1245, 1248–49, 1251–52, 1263 (discussing the sources of informational asymmetry between insurers and insureds); Ben-Shahar & Logue, *supra* note 10, at 206, 209–11 (examining how insurers gain information during the underwriting process and insurers' informational advantages); Baker, *supra* note 11, at 381 (describing an alternative approach where risk-based pricing and underwriting would be limited or prohibited and the purchase of insurance would not be required). Then, subject to some limited laws regarding discrimination based upon protected categories, such as race, gender and genetics, insurers decide whether to insure the person or business at all and if so, what premium to charge. *See, e.g.*, Ben-Shahar & Logue, *supra* note 10, at 204, 206 (discussing how insurers can adjust premiums based on individual policyholder's characteristics, ongoing behavior, and loss experience); ABRAHAM, *supra* note 139, at 144–156 (discussing the various laws that prevent certain types of discrimination in establishing rates or insuring people); Baker, *supra* note 11, at 377–79, 392 (discussing discrimination against battered women in the late 1980s and noting that although risk classification is one of the most powerful competitive tools, it can create reverse adverse selection). Indeed, if not for laws prohibiting it, insurers would, for example, refuse to sell life, health and disability insurance to battered women because they are more likely to suffer injuries and thus, are viewed as unprofitable, bad risks. *Id.* at 393. Insurers also would use genetic profiling to avoid insuring certain people if it were not prohibited. *Id.* at 394, n.53.

174. *See* KENNETH S. ABRAHAM & DANIEL SCHWARZ, ABRAHAM'S INSURANCE LAW & REGULATION, HEALTH CARE SUPPLEMENT, at 20 (5th ed. 2010) (explaining the effect of the Affordable Care Act on insurers).

insurers refuse to insure because insurers do not consider them adequately profitable generally can still get a minimum amount of liability coverage through state residual risk insurance pools.¹⁷⁵

C. *State Sponsored Insurance Programs Could Be Created for Socially Critical Lines of Insurance that Private Insurers Refuse to Sell*

If the proposals set forth in Parts III.A and III.B were implemented, would private insurers still sell the impacted lines of insurance? Maybe not. So what then? As discussed below, that may not be a bad result because state sponsored insurance programs could be created to fill the voids and state sponsored insurance programs can fulfill the purpose of insurance in ways that private insurers currently do not due to the profit imperative, the nature of the risks involved and the current laws.

1. *Mutual Insurance Companies Are Not the Solution Even Though They Theoretically Could Be Able to Fulfill the Purpose of Insurance for Some Lines of Coverage*

If the profit imperative is the primary source of conflict in risk management today, is the solution to the profits over purpose conflict simply to restrict the sale of insurance to only non-profit mutual companies? Unfortunately, no.

Although the profit imperative does not impede mutual insurance companies in the way that it does publicly traded stock companies, mutual companies are hamstrung by their inability to raise capital quickly and to accumulate it.¹⁷⁶ Consequently, although it might be possible over a very long period of time to accumulate the capital necessary to insure

175. See ABRAHAM, *supra* note 139, at 771–73. There are numerous additional examples of legislatures enacting statutes to override policy exclusions. One example is that most states have passed statutes that nullify the innocent co-insured exclusion insurers added to property policies in an attempt to prevent innocent co-insureds from recovering under policies for losses that were expected or intended by another insured. See, e.g., JERRY & RICHMOND, *supra* note 5, at 425–26 (noting that five states have adopted The National Association of Insurance Commissioners’ model statute regarding innocent co-insureds and at least 36 other states have their own statutes). Another example is the State of California’s refusal to enforce exclusions that would exclude coverage for a loss that is concurrently caused by both an excluded peril and a covered peril where the efficient proximate cause of the loss is a covered peril. See West’s Ann. Cal. Ins. Code § 530 (not allowing anti-concurrent causation exclusions to remove coverage where the efficient proximate cause of a loss is covered); *Garvey v. State Farm Fire & Casualty Co.*, 770 P.2d 704 (Cal. 1989) (holding that the facts at issue required the jury to conduct an efficient proximate cause analysis to determine liability).

176. Jaffee & Russell, *supra* note 102, at 216–17.

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catastrophic risks such as floods, earthquakes and hurricanes, it would be difficult for most mutual companies to earn and retain the necessary capital needed to insure such risks. That inability to quickly and easily raise capital was one of the primary drivers of the shift from mutual insurance companies to publicly traded stock insurance companies.¹⁷⁷

In addition, many members (i.e., policyholders) of mutual companies who are not likely to suffer a catastrophic loss prefer premium reductions or dividends if the company has surplus capital so even mutual companies have pressures that impede their ability to accumulate the large amounts of capital needed to cover catastrophic losses.¹⁷⁸ Thus, although the mutual company form theoretically may be fine for some lines of insurance such as automobile and life insurance, which have high frequency but low loss values and thus do not need large capital reserves to pay claims, mutual companies are not a good vehicle through which to insure catastrophic risks despite the availability of catastrophe bonds and reinsurance for some portions of their risk portfolios.¹⁷⁹

Putting aside the issue of adequate capitalization, however, why would mutual companies be the answer to the conflict between the profit imperative and the purpose of insurance in risk management for any lines of insurance in light of the fact that mutual companies currently behave quite similarly to publicly traded stock companies with respect to the payment of claims and the use of exclusions and adverse selection to avoid covering certain risks and people?¹⁸⁰ One possible answer is that, in order to compete with publicly traded stock companies, mutual companies have been forced to behave like publicly traded stock companies. Thus, if mutual companies did not have to compete with publicly traded stock companies, then mutual companies theoretically could return to their original purpose of serving as a social safety net by acting as an intermediary on behalf of a group of businesses or people by creating and managing a pool of money created by the group in order to pay the losses of the unfortunate few.

177. See *supra* Part I.B. (explaining the rise of publically traded stock insurance companies).

178. Jaffee & Russell, *supra* note 102, at 214.

179. There is some uncertainty as to whether the reinsurance market has the capacity to completely reinsure the amounts necessary to ensure proper capitalization for some catastrophic risks. See Jaffee & Russell, *supra* note 102, at 217, 223 (discussing the uncertain capacity of the reinsurance market and three states' approaches to help remedy the problem).

180. See, e.g., FEINMAN, *supra* note 6, at 64, 97, 106–09, 138–40, 145, 158, 163 (describing the claims payment practices of State Farm, a mutual insurance company and one of the largest insurers in America, and concluding that it does not act “like a good neighbor”).

As things currently stand, however, in order to compete with publicly traded stock companies for business, mutual insurance companies must spend enormous sums on advertising just like publicly traded stock companies do. They also must charge competitive premium rates because that is the only means by which consumers currently can compare insurers. Purchasers of insurance today cannot effectively compare insurers on anything other than premium rates due to: (1) the proliferation of ISO's standardized insurance policy forms which both mutual companies and publicly traded stock companies use¹⁸¹ and (2) insurers' effective concealment of their claims payment practices because the insurance industry's powerful lobbyists thus far have convinced state insurance commissioners not to make such information publicly available based upon the argument that such information is confidential, propriety business information.¹⁸² As discussed above in Part II.C, premiums are based primarily upon the projected claims payments because the amounts paid on claims are by far insurers' greatest expenses. Consequently, in order to compete with for-profit insurance companies, mutual insurance companies have been forced to adopt similar claims payment practices in order to keep their costs down to allow them to charge competitive premium rates. In the words of one mutual company's Vice President of Claims, "if our competition settles claims for less money than we do, we stand a good chance of being non-competitive"¹⁸³ The same competitive premium rate pressures also force mutual companies to refuse to insure high-risk people because the overall premium rates for the entire risk pool would go up if they did.

In short, competition with publicly traded stock companies has forced mutual companies to behave like publicly traded stock companies in a race to the bottom with respect to the amounts paid for claims and the availability of coverage for higher risk people and certain perils. If mutual companies did not have to compete with publicly traded stock companies for customers and individual insurers' claims payment practices were disclosed to the public, then one would expect that mutual companies could and would change their practices such that they could be part of the answer

181. See *supra* note 46, and accompanying text.

182. See, e.g., FEINMAN, *supra* note 6, at 38–40 (discussing how insurance companies closely guard data on lawsuits for unfair claims practices); Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394, 415–20 (2014) (discussing the need for the disclosure of insurers' claims payment practices in order to allow consumers to make more informed insurance purchasing decisions).

183. G. Robert Mecherle, Vice President of Claims, State Farm, Remarks at the State Farm Divisional Claim Superintendents Conference (1986), *quoted in* FEINMAN, *supra* note 6, at 64.

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to the profits over purpose problem at least with respect to some lines of insurance.

2. Correlated Risk Concerns and the Profit Imperative Result in Insurers Taking a Narrow View of the Relevant Time Horizon and Geographic Area in Which to Measure the Profitability of Insuring Certain Risks

It should not be unexpected that insurers may refuse to sell insurance that is required to cover all types of catastrophes, including floods, earthquakes and hurricanes, because insurers contend such catastrophic risks cannot be insured profitably because they are highly correlated risks that occur in geographically localized areas.¹⁸⁴ Thus, insurers contend that they are unable to adequately spread the risk of loss across enough policyholders because most or all of the policyholders in an affected area suffer similar losses at the same time and, due to adverse selection, people or businesses that are not located in areas prone to such risks will not purchase insurance so there are not enough “fortunate” policyholders that pay premiums to cover the losses of the “unfortunate” policyholders.¹⁸⁵

In using this justification, however, insurers largely must ignore the fact that they now have much larger geographic footprints than they did decades ago and they have reinsurance to cover a portion or all of the losses of their entire portfolios of business (i.e., all of the losses of their policyholders in the impacted area as well as non-impacted areas). The reinsurance market today is dominated by companies that insure other insurers on a global basis, which means the localized risk of a flood impacting an underlying insurer in one area of the world is actually spread across people and businesses throughout the entire world.¹⁸⁶ Insurers today also can further spread the risk of loss through the sale of catastrophe bonds. Thus, unlike years ago when insurers’ businesses were much more localized, the correlated risk of loss in a local area today is in many respects overstated because the “fortunate” majority of policyholders that pay premiums to cover the losses of the “unfortunate” few policyholders are actually spread across the entire world.¹⁸⁷ Nonetheless, because reinsurance and catastrophe bonds may not be viewed by insurers as a

184. See Cummins, *supra* note 4, at 343 (discussing how risks that are locally dependent may be globally independent).

185. See, e.g., Cummins, *supra* note 4, at 342–43 (describing an insurance statistical model and its relation to the law of large numbers); Bruggeman et al., *supra* note 105, at 187 (discussing the role of reinsurance in funding insurance losses for catastrophes).

186. Cummins, *supra* note 4, at 343.

187. *Id.*

complete answer to the correlated risk problem (e.g., reinsurers may refuse to cover insurers that insure catastrophic risks or markets for catastrophe bonds may be weak in years following catastrophes), insurers may refuse to sell insurance if they are not allowed to exclude coverage for catastrophic risks.

Even if the correlated risk problem did not dissuade insurers from selling insurance that is required to cover catastrophic risks, insurers still may decline to sell such insurance because their shareholders demand profitability in both the short-term and long-term. Paying losses caused by catastrophes results in uneven earnings for insurers. Thus, profitability cannot be ensured in the short-term and, instead, it is likely there will be periods of unprofitability.¹⁸⁸

Yet, the fact that catastrophes may result in periods of short-term unprofitability does not necessarily mean that catastrophic risks cannot or should not be insured. To determine the financial feasibility of insuring catastrophes, one should not consider the profitability of such lines of insurance during just the narrow time period immediately following a catastrophe.¹⁸⁹ Hurricanes, for example, happen infrequently in the same exact geographic location. Indeed, despite the fact that hurricanes are coming ashore somewhere every year, insurers have been collecting insurance premiums from people and businesses that are located in the afflicted areas for many years, if not decades, before a hurricane hits the area. Insurers collected thirty-six years of premiums from New Orleans residents between Hurricane Camille and Hurricane Katrina.¹⁹⁰ Consequently, in measuring the financial viability of property insurance that covers hurricanes, instead of considering the profitability of the insurance during just the time period immediately following the date when a hurricane hits, one should consider the profits and losses of the line of insurance over the course of the many decades in which insurers received premiums and investment income from those premiums before and after

188. Indeed, undercapitalized insurers that cover catastrophic losses can suffer such devastating losses in the short-term that they can become insolvent. For example, several undercapitalized insurers became insolvent following Hurricane Andrew in 1992. Cole et al., *supra* note 119, at 266.

189. See, e.g., Jaffee & Russell, *supra* note 102, at 206, 208 (discussing how dynamic premium strategies based on only a few years of experience will lead to highly variable loss ratios in some years in the context of insuring catastrophes).

190. Insurers' claims regarding the alleged lack of profitability of insuring catastrophes are demonstrably overstated. Even in 2005, the year of Hurricane Katrina, property/casualty insurance companies had record profits of \$48.8 billion and \$68.1 billion the following year. See FEINMAN, *supra* note 6, at 149 (citing Testimony of J. Robert Hunter before the Committee on Commerce, Science, and Transportation of the United States Senate, p. 11 (April 11, 2007)).

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the hurricane hit. If one did so, one just might find that selling property insurance in New Orleans during the past fifty years actually was profitable.

Nonetheless, the profit imperative and shareholder pressures discourage private insurers from covering catastrophic risks for the reasons discussed above. Consequently, it should be expected that insurers may decline to sell insurance that is required to cover catastrophes.

3. The Current Laws Create Financial Disincentives for Private Insurers to Fulfill the Purpose of Insurance that Would Not Apply to State Sponsored Insurance Programs

In addition to shareholders' myopic focus on profitability in the short-term and the correlated risk problem associated with catastrophes, it is difficult for many insurers to accumulate and maintain the capital necessary to handle large-scale catastrophes under the current laws. First, the current tax laws effectively discourage insurers from accumulating capital to pay future losses. The income generated by insurers that could be set aside to pay future losses is taxed.¹⁹¹ Then, if that income is not paid to shareholders in the form of dividends, the income generated by the money set aside for future unrealized losses is taxed as well.¹⁹² Second, companies that have accumulated surplus capital, which is what insurance companies need to do in order to cover the losses associated with catastrophes, become takeover targets for corporate raiders that think the capital has a better use than simply sitting there unused while being taxed.¹⁹³ Third, the accounting rules do not allow insurers to set aside reserves for the payment of future claims if the losses giving rise to the claims have not yet occurred.¹⁹⁴ Consequently, the cumulative result of these laws is that the surplus earnings of insurers are paid to shareholders as dividends or to managers as bonuses, so the companies may not have adequate surplus capital to cover catastrophic losses, which is another reason it should be expected that insurers may decline to sell insurance that is required to cover

191. See, e.g., Jaffee & Russell, *supra* note 102, at 212, 222 (explaining why insurance companies are not incentivized to accumulate funds for catastrophes); Cummins, *supra* note 4, at 371.

192. *Id.*

193. See, e.g., Jaffee & Russell, *supra* note 102, at 212–13 (discussing how other companies can purchase a cash rich insurance company, use the cash reserve and then shut down the insurance company).

194. See, e.g., Jaffee & Russell, *supra* note 102, at 209, 222 (discussing Financial Accounting Standards Board (FASB) Statement No. 5 Accounting for Contingencies, which precludes an insurance company from earmarking capital surplus to pay for future catastrophic losses that have not yet occurred); Cummins, *supra* note 4, at 371–72.

catastrophes.¹⁹⁵

If private insurers were to refuse to sell socially critical lines of insurance in a legal regime in which: (1) the insurance sold was required to cover catastrophic risks, (2) insurers could not refuse to insure people or businesses that are able to pay premiums, and (3) insurers would be subject to penalties for failing to pay the full value of losses timely, then state sponsored insurance programs may need to be created to fill the voids. Instead of being a negative outcome, however, this might actually be a good result because state sponsored insurance programs could be a better vehicle for providing insurance for some lines of insurance than mutual or stock companies.

For example, state sponsored insurance programs would be good for insuring catastrophic risks. Because premium income would not be paid to shareholders in the form of dividends or stock repurchases, state sponsored insurance programs could accumulate the capital needed to pay large catastrophic losses caused by disasters such as floods, hurricanes and earthquakes. And, the accumulation of capital would not make state sponsored insurance programs takeover targets because such programs would not, of course, be available for purchase by corporate raiders. Further, state sponsored insurance programs also would not be subject to the tax and accounting rules that discourage publicly traded stock companies and mutual companies from accumulating capital. Thus, state sponsored insurance programs would not be subject to many of the legal impediments that private insurers currently must overcome in order to cover catastrophic risks.

4. State Sponsored Insurance Programs Could Reduce Moral Hazard and Adverse Selection Concerns

State sponsored insurance programs also can address adverse selection and moral hazard¹⁹⁶ concerns more efficiently than private insurers can.

195. Jaffee & Russell, *supra* note 102, at 212.

196. The concept of moral hazard captures the intuitive idea that a policyholder will have a “tendency to take fewer precautions in the presence of insurance.” Adam F. Scales, *The Chicken and the Egg: Kenneth S. Abraham’s “The Liability Century,”* 94 VA. L. REV. 1259, 1263 (2008) (book review) (reviewing and citing KENNETH S. ABRAHAM, *THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11* 45–48 (2008)). Judge Easterbrook has described the theory underlying the concept by stating that “once a person has insurance, he will take more risks than before because he bears less of the cost of his conduct.” *W. Cas. & Sur. Co. v. W. World Ins. Co.*, 769 F.2d 381, 385 (7th Cir. 1985). The term “moral hazard” also generally encompasses situations where “[a] person . . . deliberately causes a loss . . . [or] exaggerates the size of a claim to defraud an insurer.” DORFMAN, *INTRODUCTION TO RISK MANAGEMENT AND INSURANCE* 480 (8th ed.

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For example, states have the power and incentive to make insurance mandatory to ensure satisfactory participation rates. Thus, to the extent adverse selection is a concern, by making the insurance mandatory, that concern could be eliminated.¹⁹⁷ The Affordable Care Act is an example of this.¹⁹⁸

Similarly, state sponsored insurance programs should have more power and ability to regulate policyholders' behavior than private insurers do. Thus, states could either mandate or reward policyholders to take specified loss-prevention activities.¹⁹⁹ An example of this on the federal level is the Biggert-Waters Flood Insurance Reform Act of 2012, which incentivizes policyholders who are covered under the NFIP program to rebuild their homes above flood heights by charging them significantly lower premiums if they do so.²⁰⁰ Although private insurers can regulate policyholders' behavior in some ways,²⁰¹ one advantage state sponsored insurance programs have over private insurers on this point is that future owners of the property also would benefit from premium reductions for preventative measures taken by prior owners. Unless the subsequent owner purchases insurance from the same insurer as the previous owner, that may or may not be true because private insurers do not have uniform premium

2005). Numerous scholars have written articles regarding moral hazard and offered similar descriptions of the concept. See, e.g., Gary T. Schwartz, *The Ethics and Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313, 338 n.117 (1990) ("Moral hazard" is sometimes distinguished from 'morale hazard', the former referring to deliberate acts like arson, the latter to the mere relaxation of the defendant's discipline of carefulness.") (citing C. ARTHUR WILLIAMS, JR. & RICHARD M. HEINS, *RISK MANAGEMENT AND INSURANCE* 217 (4th ed. 1981); Scott E. Harrington, *Prices and Profits in the Liability Insurance Market*, in *LIABILITY: PERSPECTIVES AND POLICY*, 42, 47 (Robert E. Litan & Clifford Winston eds., 1988) ("Moral hazard is the tendency for the presence and characteristics of insurance coverage to produce inefficient changes in buyers' loss prevention activities, including carelessness and fraud . . ."); JERRY & RICHMOND, *supra* note 5, at 12 ("The existence of insurance could have the perverse effect of increasing the probability of loss . . . This phenomenon is called moral hazard."); George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1547 (1987) ("Moral hazard refers to the effect of the existence of insurance itself on the level of insurance claims made by the insured . . . Ex ante moral hazard is the reduction in precautions taken by the insured to prevent the loss, because of the existence of insurance.").

197. Bruggeman et al., *supra* note 105, at 211, 217.

198. See ABRAHAM & SCHWARCZ *supra* note 174 (explaining the effect of the Affordable Care Act on insurers).

199. *Id.*; Bruggeman et al., *supra* note 105, at 217.

200. 42 U.S.C.A. § 4015; See also National Flood Insurance Program, *Can We Afford to Rebuild Higher? Can We Afford Not To?*, FEMA, available at http://www.fema.gov/media-library-data/20130726-1910-25045-7987/fema_datasheet_rebuild_aezone05.pdf (explaining the link between National Flood Insurance Program premiums and flood risk).

201. See Ben-Shahar & Logue, *supra* note 10 (explaining the ways insurers can regulate and shape the behavior of their policyholders).

guidelines so the premium discounts that one insurer provides may not be provided by another.²⁰²

In short, state sponsored insurance plans can address moral hazard and adverse selection concerns in ways that private insurers cannot.

5. State Sponsored Insurance Programs Should Have Lower Premiums

Another advantage that should result from the creation of state sponsored insurance programs is lower premiums. Because private insurers compete for business, a significant portion of the premiums collected by both publicly traded stock companies and mutual companies goes to sales commissions for insurance agents.²⁰³ Indeed, it has been reported that insurers currently pay as much as 20% of the premiums they collect in sales commissions.²⁰⁴

Insurers also currently spend significant amounts of the premiums they collect on advertising.²⁰⁵ Who has not seen the TV commercials that run over and over again in high priced ad slots during prime time in which GEICO claims that “spending 15 minutes could save you 15% or more on car insurance” or Progressive’s ads intended to help policyholders save on premiums by avoiding “rate suckers” (depicted by people jumping on vehicles and sucking on them) or Flo, the bubbly Progressive salesperson, exhorting customers to try a “snapshot” or to save money by “bundling”? In fact, the fifty largest insurers spend approximately \$2.5 billion a year on advertising.²⁰⁶

Once a person has been induced to apply for insurance due to ads and insurance salesmen plying for the person’s business, insurers then spend significant amounts of money in the underwriting process in an attempt to weed out the “bad risks” (i.e., the people most likely to have claims).²⁰⁷ If insurance were mandatory and it were sold by state sponsored programs, then very little money would need to be spent on underwriting efforts designed to avoid selling insurance to bad risks because the bad risks would be included in the insurance pool.

State sponsored insurance programs also should result in lower

202. Thomas von Ungern-Sternberg, *The Benefits of Introducing a Mandatory State Hurricane Insurance Scheme in Florida* 14 (HEC Working Papers in Economics, 2009).

203. Ungern-Sternberg, *supra* note 202, at 10. Cole et al., *supra* note 119, at 271.

204. Ungern-Sternberg, *supra* note 202, at 10.

205. Ungern-Sternberg, *supra* note 202, at 11, 17; Cole et al., *supra* note 119, at 271.

206. FEINMAN, *supra* note 6, at 54.

207. Ungern-Sternberg, *supra* note 202, at 13, 17; Cole et al., *supra* note 119, at 271; Bruggeman et al., *supra* note 105, at 211, 217.

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premiums because they would not need to spend as much money investigating and litigating their policyholders' claims in order to maximize profits for shareholders. Insurers spend approximately 12% of the premiums they collect investigating, contesting and litigating claims.²⁰⁸ Fighting claims makes good business sense for publicly traded stock insurance companies because every dollar insurers can avoid paying on claims increases insurers' profitability.²⁰⁹ That would not be the case for state sponsored insurance programs because they would not be governed by the profit imperative and instead would only need to verify the validity of a claim before paying it.

In sum, if insurance were sold by state sponsored programs, then all of the money private insurers currently spend on sales commissions, high priced ads, underwriting and aggressive claims handling would be unnecessary. Those savings could be directly passed on to policyholders in the form of lower premiums.

6. European State Sponsored Insurance Programs as Models for America

Although unlikely to be a source of inspiration in light of Europe's current economic climate in which many countries in Europe are still in a recession and several European countries' financial solvency remains in question, in order to understand what a successful state sponsored insurance program would look like, one can look to Europe. Switzerland, Spain, France and Germany are examples of countries that successfully have implemented state sponsored insurance programs.²¹⁰

For example, Spain has a state sponsored insurance program known as "the Consorcio."²¹¹ The Consorcio insures all properties in Spain against a wide range of catastrophes.²¹² The Consorcio covers both natural catastrophes and unnatural catastrophes such as terrorist attacks.²¹³ The insurance is mandatory and the policy issued is standardized.²¹⁴ The total administrative costs of the program for sales, underwriting and claims

208. Ungern-Sternberg, *supra* note 202, at 11.

209. See FEINMAN, *supra* note 6, at 2, 5. Insurers' aggressive claims investigation and payment practices do not hurt their bottom lines in the form of lost customers caused by gaining a reputation for unfair claims payment practices because the information regarding insurers claims payment practices is not disclosed to the public. *Id.* at 7, 39–40.

210. Ungern-Sternberg, *supra* note 202, at 4.

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

administration are only 10% of the premiums collected.²¹⁵

Under European state sponsored insurance programs, the policyholder and insurer are not adversaries when it comes to the payment of claims because the insurer does not have shareholders pushing for increased dividend distributions which can be achieved only if the insurer nickels and dimes its policyholders when it comes to paying claims. Consequently, empirical studies have shown that European citizens have a high degree of customer satisfaction regarding the amount and timeliness of the payment of their claims.²¹⁶

In contrast, in the United States, policyholders and their insurers spend millions of dollars engaged in endless litigation whenever catastrophes hit. For example, whenever a hurricane comes ashore and brings flooding with it, litigation ensues regarding whether the damage to homes was caused by flooding (an excluded peril) versus wind (a covered peril).²¹⁷ More than 6,600 lawsuits were filed in federal court in New Orleans in connection with Hurricane Katrina.²¹⁸ In Mississippi, one insurer involved in the Hurricane Katrina litigation filed a motion to transfer the lawsuits out of Mississippi on the basis of a survey that showed that 49% of the people in southern Mississippi “believe that insurance executives are on the same level as child molesters.”²¹⁹ The Louisiana Department of Insurance received 20,000 complaints per month during the six-month period following the storm.²²⁰ Thus, it is an understatement to say there is a high degree of dissatisfaction with insurers’ handling and payment of claims in

215. *Id.* at 4, 10, 11.

216. *Id.* at 13.

217. *Id.* at 14; French, *supra* note 97, at 243 (discussing the “ensuing loss” clause’s potential impact on wind versus water disputes for hurricane claims); Erik S. Knutsen, *Confusion About Causation in Insurance: Solutions for Catastrophic Losses*, 61 ALA. L. REV. 957, 959–60 (2010) (discussing concurrent causation with respect to, among other issues, wind versus water damage caused by hurricanes). *See also* Leonard v. Nationwide Mut. Ins. Co., 499 F.3d 419, 430–31 (5th Cir. 2007) (analyzing an anti-concurrent causation exclusion in a wind versus water dispute following Hurricane Katrina); Corban v. United Servs. Auto. Ass’n, 20 So. 3d 601, 617–18 (Miss. 2009) (same). Notably, because private insurers handle claims under the National Flood Insurance Program on behalf of the federal government, many insurers that issued homeowners policies were responsible for estimating the repair costs for both the federal flood policies under the NFIP program and the insurers’ homeowners policies. When estimating the cost to remove and replace drywall, for example, the profit imperative drove one insurer to calculate the cost at \$0.76 per square foot when the costs would be charged to its homeowners policy and \$3.31 per square foot when it would be charged to the federal flood program. *See* FEINMAN, *supra* note 6, at 165 (describing risk aversion in insurance).

218. FEINMAN, *supra* note 6, at 147.

219. *Id.* at 145 (quoting Benick, *The Flood After the Storm: The Hurricane Katrina Homeowners’ Insurance Litigation*, 4 BUS. L. BRIEF (Am. U.) 51 (Fall 2007)).

220. *Id.* at 147.

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the United States.²²¹ If American state sponsored insurance programs could duplicate the success of European state sponsored programs with respect to the handling and payment of claims, then policyholders in America would have a much higher satisfaction rate than they currently do with respect to the payment of losses.

D. *Impediments to the Reforms Necessary to Address the Conflict between the Profit Imperative and the Purpose of Insurance in Risk Management*

The impediments to the implementation of the reforms to insurance law discussed in this Article are considerable. First, imposing penalties on an insurer that breaches its contract of insurance by failing to pay the full amount of a policyholder's loss in a timely manner without a finding that the insurer acted in bad faith is simply inconsistent with existing law regarding damages for breach of contract, which generally does not provide for an award of penalties or extra contractual damages.²²² Thus, in order for legislatures to embrace this extra-contractual damage award, there would need to be a broader recognition that insurance policies are not simply contracts, but rather, they occupy a role of great social importance as social safety nets and they are not actually "negotiated" contracts by two parties to accommodate the desires of the parties regarding the transfer of risk.²²³ Until that happens, it will be difficult to convince legislatures to create disincentives for insurers to pursue the fulfillment of the profit imperative by paying as little as possible on their policyholders' losses as late as possible.

Second, because it is widely believed that the losses caused by catastrophes are correlated risks that cannot be insured profitably,²²⁴ it will be difficult to overcome the powerful insurance industry lobbyists'

221. Ungern-Sternberg, *supra* note 202, at 14. Although insurers collect and report information regarding the complaints they receive with respect to their claims handling practices to state insurance commissioners, the full extent of consumer dissatisfaction with insurers' claims handling practices is unknown because insurers refuse to disclose such information, and thus far, they have convinced state insurance commissioners not to disclose such information either. *See, e.g.*, FEINMAN, *supra* note 6, at 216–17; Schwarcz, *supra* note 182, at 415–420 (discussing the need for transparency in claims handling practices).

222. *See, e.g.*, *Mannheimer Bros. v. Kansas Cas. & Sur. Co.*, 184 N.W. 189, 191 (1921) ("the general rule [is] that the measure of damages for breach of a contract for the payment of money is the amount agreed to be paid with interest"); Restatement (Second), Contracts, §§346-56 (1979) (addressing the various damages available for breach of contract, which do not include penalties).

223. *See supra* Part I (highlighting the social importance of insurance).

224. *See supra* Parts II.B.1 and III.C.2 (explaining the belief of insurers that insuring catastrophic events is not profitable).

opposition to the elimination of exclusions for such risks. Similarly, insurers likely will cite freedom of contract and the purported unprofitability of insuring certain risks to support the continued use of exclusions for other non-catastrophic risks of loss such as environmental damages and asbestos liabilities. Insurance regulators generally have accepted such arguments in the past, as evidenced by the fact that the ISO policy forms that contain such exclusions have been widely approved.²²⁵

Third, the creation of state sponsored insurance programs in America for socially critical lines of insurance likely would face immense political opposition in many states. Many Americans highly value freedom of choice and capitalism, and if people think they will be left with only state sponsored insurance programs if the laws were changed along the lines discussed in this Article, then such a regime likely would face significant opposition. Indeed, look at what has happened with the Affordable Care Act. It was passed only when Congress was heavily Democratic and has been subjected to dozens of efforts to repeal it since Republicans obtained a majority in the House of Representatives. If something as important as ensuring that sick people are able to obtain health care in this country has been met with so much political resistance, then there is little reason for optimism that the political will exists at this juncture for legislation to be passed that might result in private insurers leaving certain insurance markets.

Fourth, another major objection to state sponsored insurance programs is that capitalism generally allocates resources in the most efficient manner through competition and incentives to eliminate waste. Indeed, to prove why governments should not be selling insurance in the United States, one only needs to consider the National Flood Insurance Program. The NFIP has been a poster-child example of why government should not be in the business of insurance. The NFIP historically used outdated floodplain maps due to a lack of funds needed to create accurate ones so in many instances the wrong homes were insured or uninsured.²²⁶ The NFIP also has been actuarially unsound, which has led to frequent periods of insolvency.²²⁷ In addition, because the program is voluntary, participation has been poor, and it also has been noted that many homes covered under the program get flooded repeatedly and the homeowners do not take steps to prevent flood damage.²²⁸ Consequently, if insurance were only about the

225. See *supra* Part II (highlighting the freedom of contract argument frequently made by insurers).

226. See *supra* Part II.B.2 and accompanying notes (highlighting problems with the government acting as an insurer).

227. *Id.*

228. *Id.*

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most efficient allocation of resources and administration of a profitable business, then the case for private insurers selling insurance instead of governments could be made simply by saying “NFIP.”

Perhaps, with the changes to the NFIP made by the Biggert-Waters Flood Reform Act of 2012 that were designed to address such problems, in time the NFIP will be a model government insurance program instead of a justification for private insurance. For now, however, its past failures decrease the chances that state sponsored insurance programs on a national scale will be embraced.²²⁹ Thus, because America’s history with government sponsored insurance programs generally has been poor, one should not expect that state sponsored insurance programs would be warmly embraced despite the benefits of such programs and the numerous shortcomings of private insurance that are discussed in this Article.

CONCLUSION

The profit imperative has undermined the role of insurance in risk management in recent years. Insurance originally was intended to serve as a social safety net to ensure that people who cannot afford to bear the financial risk of disasters could transfer and spread that risk across a community of people or businesses in exchange for the payment of a certain loss, a premium. That purpose cannot be fulfilled when the goal of insurers—entities that originally in America were only administrators of the pools of premium money created by policyholders for the benefit of the unfortunate few in the policyholders’ communities—is the maximization of profits for their shareholders with little regard for the policyholders’ or society’s interests.

As the insurance industry has become dominated by publicly traded

229. One response to the opponents of state sponsored insurance programs who will point to the NFIP when explaining why government sponsored insurance programs are a bad idea in America is that there are existing examples of successful state sponsored insurance programs. One such example, and this is not to suggest that the program is either flawless or above criticism, is Florida’s property insurance program that is administered by Citizens Property Insurance Corporation. It offers property insurance to homeowners in Florida at premium rates significantly lower than the private market because: (1) it does not need to provide an adequate return to investors; (2) it is tax exempt; (3) it does not need to raise excessive amounts of capital to pre-fund losses because it has the ability to do post-loss assessments; and (4) it is reinsured by a state sponsored reinsurer, the Florida Hurricane Catastrophe Fund. *See, e.g.,* Cole et al., *supra* note 119, at 267–71 (discussing the advantages and disadvantages of post loss catastrophe financing). Despite problems in the past and the fact that the State of Florida has been pounded by hurricanes year after year, the program continues to successfully provide property insurance to the state’s residents where private insurers, both publicly traded stock companies and mutual companies, generally have refused to do so or failed.

stock companies, the profit imperative has dictated that insurers refuse to insure members of society and risks that do not satisfy their profit margin goals. The profit imperative also has forced insurers and their policyholders to be adversaries when it comes to paying the policyholders' losses because any amounts paid for losses are amounts that cannot be paid to shareholders as profits.

There is no tenable reason why insurance cannot fulfill its intended purpose and role in risk management today as it originally was intended when it was first introduced in America. Three changes to the law could accomplish this goal. One, penalties should be allowed to be imposed on insurers that do not pay losses timely and in full to overcome the profit imperative's mandate to pay as little as possible for losses and to delay payment as long as possible because there currently is no downside to doing so under the existing laws. Two, for socially critical lines of insurance, insurers' ability to refuse insure people, businesses or risks they deem to be inadequately profitable should be reduced or eliminated. Three, if insurers are unwilling to sell insurance subject to these first two changes, then state sponsored insurance programs for socially critical lines of insurance should be created to fill the void.

State sponsored insurance programs may actually be a better source for socially critical lines of insurance than private insurers. State sponsored insurance programs would not need to spend billions of dollars annually on advertising, sales commissions, underwriting, investigating and contesting claims; thus, the cost of such insurance should be lower. State sponsored insurance programs also could accumulate capital tax-free to pay catastrophic losses without reprisals from shareholders or attacks by corporate raiders. Finally, and perhaps most importantly, under state sponsored insurance programs the claims adjustment process should not be as adversarial because such programs would not be driven by the profit imperative which forces insurers to fight with their policyholders regarding the payment of losses because each dollar paid for losses is a dollar that cannot be paid to shareholders or managers as dividends or bonuses. Thus, instead of fighting with their insurers over money in the wake of catastrophes, policyholders could focus their energy on rebuilding and moving on with their lives.