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ARTICLE

FOUR CONCEPTIONS OF INSURANCE

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This Article identifies four conceptions of insurance that have operated in the debates about insurance law in recent decades, analyzes these conceptions, and examines the normative agendas that drive them. These are the contract, public utility/regulated industry, product, and governance conceptions. Although these conceptions adopt very different perspectives, each is a way of struggling with the two fundamental questions that modern insurance law has continually faced. The first question involves the extent to which the language of an insurance policy should determine its legal effect. This is the insurance law version of the age-old question concerning the validity of one-sided provisions in contracts of adhesion. Because virtually all insurance policies, including high-end corporate insurance

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policies, are standard-forms, it is a question at the core, not the periphery, of insurance law. The second question involves the proper influence of what are sometimes called “public law” values on the scope of private insurance coverage. This is a question with which much of modern private law struggles. To what extent should private law be about doing justice between two contracting parties, and to what extent should it also be concerned with other, more nearly public law matters? Public law matters such as the impact of litigation outcomes on the future behavior of other parties or the equal treatment of similarly situated policyholders. Ultimately, the Article argues, adopting a particular conception of insurance is no substitute for making or rejecting the normative choices that each conception entails. It is not our concepts, but our political, economic, and social values that underlie and underwrite legal doctrines and practices. Nonetheless, sometimes we do not see through our conceptual structures but instead are led around by them. This is part of what is taking place in the contests among different conceptions of insurance. In such circumstances, the kind of critical analysis this Article undertakes is required to expose the normative agendas that are doing the actual work within each conceptual structure.

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INTRODUCTION

One of the ways that contests over the proper content of a body of legal rules take place is through competing descriptions of the subject matter that the rules address. When we “describe” a subject—when we create a conception of a subject by explaining, giving an account of, or making sense of it—the description is likely to have normative implications. It is easy enough to get an “ought” from an “is”¹ when a particular subject or phenomenon typically has distinctive norms associated with it.

This is an Article about different descriptions of insurance and the features of insurance law that might flow from them. In recent years, the contest often has been among different ways of describing insurance in terms of something else. The contest, that is, has been over competing metaphors and analogies. Each metaphor creates, develops, or calls upon a different conception of insurance in service of a particular view of what insurance law should be or do. Thus, normative agendas have driven the choice of metaphor.

My goal in this Article is to identify four different conceptions of insurance that I have discerned in the debates about insurance and insurance law in recent decades, to analyze these conceptions, and to examine the normative agendas that drive them. Ultimately, in my view, adopting a particular conception of insurance is no substitute for making or rejecting the normative choices that each conception entails. Going back at least to the legal realists we have understood that it is not our concepts, but our political, economic, and social values that underlie and underwrite legal doctrines and practices.² Nonetheless, sometimes we do not see through our conceptual structures but instead are led around by them. This is part of what is taking place in the contests among different conceptions of insurance. In such circumstances, critical analysis is required in order to expose the normative agenda that is doing the actual work within a conceptual structure.

To accomplish this, at points I must extrapolate from the existing case law, scholarly literature, and policy statements of actors in the field, because the four conceptions of insurance are not equally coherent, developed, or systematic. In addition, some of their features are obviously directed at legal doctrine, but some make no claim to have express implications for doctrine. Nevertheless, conceptions that purport to describe aspects of

¹ See John R. Searle, *How to Derive “Ought” from “Is,”* 73 PHIL. REV. 43, 56-58 (1964) (arguing that descriptive statements of fact can give rise to normative statements).

² See Emerson H. Tiller & Frank B. Cross, *What is Legal Doctrine?*, 100 NW. U. L. REV. 517, 519 (2006) (describing the legal realist view that judges resolve disputes based on subjective ideological preferences rather than objective legal doctrine).

insurance or insurance law necessarily have implications for insurance law doctrine. This does not mean that the conceptions are comparable in every regard. Rather, they attempt to confront or criticize different features of insurance. None of the four conceptions is (and probably could not be) a full-blown model of insurance. Instead, they compete for overlapping, but not wholly coincident, territory, and none of them attempts to capture all of insurance or all of insurance law.

Each, however, is a way of struggling with the two fundamental questions that modern insurance law continually has faced. The first question involves the extent to which the language of an insurance policy should determine its legal effect. This is the insurance law version of the age-old question concerning the validity of one-sided provisions in contracts of adhesion.³ Because virtually all property-casualty insurance policies, including high-end corporate insurance policies, are standard-forms used by most insurers,⁴ it is a question at the core, not the periphery, of the law of insurance. The second question involves the proper influence of what are sometimes called “public law” values on the scope of private insurance coverage. This is a version of the question with which much of modern private law struggles.⁵ To what extent should private law focus on doing justice between two contracting parties, and to what extent should it be concerned with other, more nearly public law matters, such as the impact of litigation outcomes on the future behavior of other parties or equal treatment of similarly situated policyholders? The very idea of insurance involves a group of individuals or entities in an indirect relationship, without any contract specifying the terms of that relationship. Concerns that involve public law values, such as discouraging moral hazard or ensuring the equal treatment of policyholders, naturally arise when no contract specifies the rights and obligations of the parties to an indirect relationship. And because insurance is a device that is used in other legal regimes that

³ See e.g., Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 632-33 (1943) (describing the conflict courts face when enforcing harsh terms in standardized contracts between parties with unequal bargaining power).

⁴ See KENNETH S. ABRAHAM, *INSURANCE LAW AND REGULATION* 31 (5th ed. 2010).

⁵ See, e.g., John C. P. Goldberg, *Twentieth-Century Tort Theory*, 91 GEO. L.J. 513, 524-25 (2003) (criticizing certain theorists’ view of tort law as a de facto administrative agency designed to “regulate behavior on a forward-looking basis”); David Rosenberg, *The Causal Connection in Mass Exposure Cases: A “Public Law” Vision of the Tort System*, 97 HARV. L. REV. 849, 905-08 (1984) (arguing that costs for mass exposure litigation should be decreased to enable the tort system to act as a “public law mechanism[]”).

openly pursue public law values—tort⁶ and corporate law,⁷ for example—it is almost inevitable that insurance law will be asked to support these pursuits.

These two fundamental questions are of course related. The greater the influence of public law values on the interpretation of insurance policy language, the less determinative of an insurance policy's legal effect the language of the policy is likely to be. But public law values influence more than just the legal effect given to insurance policies; these values may influence the coverage that insurance policies provide in the first instance and the prices different policyholders pay.

It is worthwhile at the outset to briefly summarize the four conceptions. The *contract conception*⁸ understands insurance as a voluntary agreement between an individual policyholder and an insurer, subject to the constraints and rules of construction that are ordinarily placed on such agreements by the law of contracts. This conception supplies the “literal” view of insurance to which the other conceptions, understood as metaphors or analogies, contrast themselves. Under the *public utility/regulated industry conception*,⁹ contract is a mere tool for bringing the regulated relationship into existence. On this view, insurance is a cartelized industry selling a good sufficiently essential that it requires government regulation in the public interest. The *product conception*¹⁰ sees insurance more as a tangible good than a promise to perform financial services, and therefore appropriately subject to rules analogous to those that govern defectively designed products. Tort, rather than contract, is the core paradigm in this conception. Finally, the *governance conception*¹¹ views insurance as a surrogate for government in controlling behavior and protecting against misfortune, as well as an organizational arrangement among policyholders. These governance relationships create the risk of abuse by the insurer for its own ends, and for the ends of the majority of policyholders at the expense of the minority. Insurance law rules, analogous to those that protect the populace against government and the minority of the populace against overreaching by the majority, are therefore desirable.

⁶ See KENNETH S. ABRAHAM, *THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11*, at 193-97 (2008) (exploring how both first-party and liability insurance influenced the development of tort liability).

⁷ See TOM BAKER & SEAN GRIFFITH, *ENSURING CORPORATE MISCONDUCT* 44-51 (2010) (examining the role of directors' and officers' liability insurance in corporate liability).

⁸ See *infra* Part I.

⁹ See *infra* Part II.

¹⁰ See *infra* Part III.

¹¹ See *infra* Part IV.

I. THE CONTRACT CONCEPTION

The traditional and dominant conception of insurance is that it is a contract transferring a risk of loss to a party whose business is selling such contracts, rather than as an incident of another transaction.¹² The language of an insurance contract, an insurance policy, is the agreement of parties.

The contract conception is the dominant way of understanding insurance for good reason. Private insurance comes into being through, and is largely embodied in, contracts. The contract conception is the most accurate description of what insurance is; it is also the way insurance law most often treats insurance. Most judicial decisions, and most insurance law scholarship (my own included), unselfconsciously employ or reflect the contract conception. Indeed, the other conceptions are in a sense metaphorical precisely because of their relation to this conception. They define insurance in terms of something else, and in some measure by reference to their differences from the contract conception.

A. *Tensions in the Core Conception*

The contract conception has a powerful gravitational pull. In coverage disputes, insurers often simply point to the language of the policy at issue in support of their denial of coverage. Such a move is not so much an argument as it is an assertion of the contract conception. In contrast, a policyholder seeking to avoid the language of the policy must fit himself within one of the circumscribed exceptions to the prime axiom of the contract conception that the language of the contract governs. Courts commonly remind the parties that an insurance policy is, after all, a contract, and that departures from the contract must be limited if the contract is to have any meaning.¹³

The contract conception also heavily influences insurance law scholars. It is the basis for arguments against the expansion of policyholder rights

¹² See ABRAHAM, *supra* note 4, at 3 (describing insurance as a “*risk-transfer* from comparatively risk-averse to less risk-averse or risk-neutral parties”).

¹³ See, e.g., *Smith v. Am. Family Life Assurance Co. of Columbus*, 584 F.3d 212, 215 (5th Cir. 2009) (“[A]n insurance policy is a contract between the parties”); *Adams v. Reliance Standard Life Ins. Co.*, 225 F.3d 1179, 1185 (10th Cir. 2000) (“[A]n insurance policy is a contract, and the general rules of contract construction apply to insurance agreements.”); *TNT Speed & Sport Ctr., Inc. v. Am. States Ins. Co.*, 114 F.3d 731, 732 (8th Cir. 1997) (“An insurance policy is a contract and the rules of contract construction apply.”); *Park-Ohio Indus., Inc. v. Home Indem. Co.*, 975 F.2d 1215, 1218 (6th Cir. 1992) (“[A]n insurance policy is a contract, and the parties’ rights under the policy are purely contractual in nature.”).

and protections,¹⁴ and it is the necessary target of criticism for arguments favoring the expansion of these rights and protections. Scholarly analyses identify the purposes and justifications of policy language that limits coverage, citing, for example, the threats of adverse selection and moral hazard to explain why adherence to policy language seeking to combat these threats is desirable.¹⁵ Critics then attack these analyses on the ground that the threats are exaggerated and coverage exclusions overbroad.¹⁶ This scholarly debate takes place on the playing field that the contract conception has created.

One of the difficulties with the contract conception as a description of insurance, however, is that it trades on the way the law treats insurance. It is a conception of insurance law, and only through that conception of law is it a conception of insurance. To the extent that the law treats insurance transactions as contracts, that is what they are. But if we set aside the applicable legal regime, the contract conception becomes contestable. To put this point another way, the accuracy of the contract conception depends on what a contract is.

If what we understood to be the insurance contract were only the terms to which the parties subjectively assented, then the contract conception would ordinarily be deeply flawed, for there would be almost no such contract. It is true that some insurance comes into being as a result of knowing, voluntary agreement by the parties regarding the actual terms of their contract. But as scholars have repeatedly noted, most actual insurance transactions do not involve subjective assent to many of the provisions in an

¹⁴ See, e.g., Roger C. Henderson, *Insurance Protection for Products Liability and Completed Operations—What Every Lawyer Should Know*, 50 NEB. L. REV. 415, 441 (1971) (stating that products liability insurance exclusions preclude coverage for damage to the insured's own product because they cover tort liability for physical damage to others, not contractual liability for economic loss); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171, 194 (1995) ("While insurance contracts contain mainly optimal terms, the ambiguity rule interprets such terms inefficiently."); Alan O. Sykes, "Bad Faith" Refusal to Settle by Liability Insurers: Some Implications of the Judgment-Proof Problem, 23 J. LEGAL STUD. 77, 84 (1994) (noting the argument that "the delegation of settlement authority to the insurer is often optimal for parties to an insurance contract and that lawsuits after the fact by disappointed insureds represent an effort to renege on an implicit bargain").

¹⁵ See, e.g., Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942, 946 (1988) (suggesting that adverse selection and moral hazard create asymmetrical uncertainty, where the insured has more information than the insurer, and that this impedes insurance from working efficiently).

¹⁶ See, e.g., Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 276-77 (1996) (questioning some of the assumptions underlying the moral hazard concern and arguing that it should play less of a role in legal and policy analysis); Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1240 (2004) (criticizing the adverse selection model due to its "serious empirical and theoretical problems").

insurance policy.¹⁷ First, because most insurance policies are written on standard forms, the insurer is highly familiar with the terms of the policies it sells. But most individuals know little about what they are purchasing. They purchase insurance through intermediaries such as agents and the amount of explanation they typically receive regarding the terms of coverage is minimal. For virtually all individuals, insurance policies are complex documents with terms they neither read nor understand.¹⁸

Second, there are structural obstacles to giving informed assent to the terms of an insurance policy. Insurance policies are offered on a take-it-or-leave-it basis, thus reducing a policyholder's incentive to study the terms being offered. Moreover, these contracts are not merely adhesive, but super-adhesive. For instance, health insurance is often employment-based group coverage, the terms of which are negotiated by the employer.¹⁹ And, more importantly, in property-casualty lines of insurance—where standard-form policies are the norm—all insurers offer the same standard policy on the same take-it-or-leave-it basis.²⁰ Comparison of the terms offered by different insurers, except for price differences, is therefore pointless. In any event, ordinarily the policyholder does not receive the policy containing the terms in question until weeks or months after the purchase, at which point the parties are bound. Thus, any knowledge of the terms that the occasional policyholder gains by reading the policy at that point has no bearing on the policyholder's intent at the time of purchase.

For sizable businesses and other institutions, contractual intent and understanding are potentially more plausible and meaningful notions. These entities have access to attorneys and insurance brokers to advise them. Some have personnel with insurance expertise and responsibility. Part of these entities' business planning involves making decisions about the insurance they wish to purchase. Even for these entities and their insurers, however, the notion of contractual intent is often problematic. In my experience,

¹⁷ See, e.g., Wayne R. Barnes, *Toward a Fairer Model of Consumer Assent to Standard Form Contracts: In Defense of Restatement Subsection 211(3)*, 82 WASH. L. REV. 227, 242 (2007) (“[T]he consumer’s subjective assent to each and every term in the standard form is not necessary in order for there to be an operative manifestation of assent.”).

¹⁸ See ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 6.3(a)(4) (1988) (“Relatively few policyholders ever examine their insurance policies with the care that would be required for even moderately detailed understanding of coverage limitations.”).

¹⁹ The employee may receive a certificate of insurance, but the actual master insurance “policy”—typically a document of considerable length—is maintained somewhere in the files of the employer.

²⁰ ABRAHAM, *supra* note 4, at 31. *But see* Daniel Schwarcz, *Reevaluating Standard Insurance Policies*, 78 U. CHI. L. REV. 1263, 1277-1308 (2011) (demonstrating that the terms of consumer homeowners’ insurance policies vary across carriers).

commercial policyholders' own "experts" frequently are not conversant with many of the terms of the numerous insurance policies that their employers or clients purchase.

As in contract law generally, the fault lines in insurance law reveal the tension between all these facts on the ground and the way contract law treats them. Writing nearly seventy years ago, Friedrich Kessler identified the assumptions underlying the contract conception. "A person is supposed to know the contract that he makes. . . . Either party is supposed to look out for his own interests and his own protection. Oppressive bargains can be avoided by careful shopping around. Everyone has complete freedom of choice with regard to his partner in contract"²¹

Thus, the very notion of contractual intent presupposes that the parties know the terms of their agreement and have the capacity to bargain about those terms. When these conditions are not present there may still be intent to be bound,²² but there will also be uncertainty over whether the content of that intent can be inferred from the fact of agreement itself. Courts often say that the purpose of interpretation of the terms of insurance policies is to ascertain the intent of the parties, as expressed in the policy.²³ But in insurance, this must ordinarily be objective intent, which is something of an oxymoron. The objective theory of contract must accommodate the law of insurance contracts to the reality of actual insurance transactions. The objective theory holds that assent to a contract constitutes assent to all of its terms, whether or not they are understood or subjectively agreed to, and whether or not they are standard-form or individually negotiated. Exceptions to these presuppositions are necessarily narrow²⁴: otherwise, the whole

²¹ Kessler, *supra* note 3, at 630.

²² See Randy E. Barnett, *Consenting to Form Contracts*, 71 *FORDHAM L. REV.* 627, 634-35 (2002) (contending that under the consent theory of contract, the assent that is "critical" is not the promise to do something, "but the manifested assent to be legally bound to do so").

²³ See, e.g., *Middlesex Ins. Co. v. Mara*, 699 F. Supp. 2d 439, 446 (D. Conn. 2010) ("In Connecticut, insurance policies are construed according to general rules of contract interpretation. They are thus enforced in accordance with the parties' intent, as derived from the plain and ordinary meaning of the policy's terms." (citations and internal quotation marks omitted)); *Nautilus Ins. Co. v. Nicky & Claire's Day Care, Inc.*, 630 F. Supp. 2d 727, 734 (W.D. Tex. 2009) ("Courts must interpret policies 'to ascertain the true intent of the parties as expressed in the instrument.'" (quoting *Nat'l Union Fire Ins. Co. v. CBI Indus., Inc.*, 907 S.W.2d 517, 520 (Tex. 1995))); *NorFab Corp. v. Travelers Indem. Co.*, 555 F. Supp. 2d 505, 509 (E.D. Pa. 2008) ("The court's 'task is to ascertain the intent of the parties as manifested by the terms used in the written insurance policy.'" (quoting *401 Fourth St., Inc. v. Investors Ins. Grp.*, 879 A.2d 166, 171 (Pa. 2005))); *John S. Clark Co. v. United Nat'l Ins. Co.*, 304 F. Supp. 2d 758, 764 (M.D.N.C. 2004) ("Because the intent of the parties is derived from the language in the policy, the language of the policy necessarily controls the interpretation of the policy." (citations omitted)).

²⁴ See Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 *HARV. L. REV.* 1173, 1185 (1983) (noting that exceptions are available only under narrow circumstances).

contract conception would be called into question. This is the Achilles heel of the contract conception.

Moreover, even if there were actual, meaningful intent, the standard-form nature of insurance would render the contract conception problematic. Certain features of standard-form insurance policies are drafted at a level of generality and with an issue-postponing vagueness that renders them incompletely specified. This characteristic affects many kinds of contracts, but it has a special significance in insurance. For instance, different policyholders may have different intentions or expectations regarding the scope of coverage that policy language incompletely addresses. Gap-filling interpretative methods that look to the intentions of the particular parties to an insurance policy would therefore threaten to undermine the standard-form character of the policy. In practice, standard policy language would then have a set of nonstandard meanings. So the subjective intent of any given commercial policyholder, even if it existed, ordinarily must be irrelevant.²⁵ For this reason, the contract conception must presuppose something like a uniform intent on the part of all policyholders. But a uniform intent comes close to being no intent at all, and without any intent it is difficult to see what is left of the contract conception other than the words on the page. If these are not to be both the beginning and the end of the matter, then something beyond the contract conception is necessary to capture the full significance of the insurance transaction.

B. *Administrative and Judicial Regulation of Insurance Contracting*

Insurance law has developed two devices that adjust to the differences between the pure contract conception of insurance and the realities of the insurance marketplace. These devices, which regulate the market in which insurance contracts come into existence, imply that insurance law regards the contract conception as inaccurate. One device operates *ex ante* and the other operates *ex post*.

First, state administrative regulation requires premarket approval of the terms of insurance policies. Insurers licensed to do business in a state must first secure approval from the state's insurance commissioner or other official of any policy they wish to sell or of any amendment to the terms of

²⁵ See RESTATEMENT (SECOND) OF CONTRACTS § 212 cmt. a (1981) (stating that a party's intent is what is manifested in the agreement, not any subjective, undisclosed intention); Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1110 (2006) (arguing that courts subordinate the meaning an individual party may attach to contract language to the goals of "fairness and future clarity, and, in the insurance context, the 'reasonable expectations' of the policyholder").

a policy already being sold in that state.²⁶ In addition, under traditional insurance regulation, premium rates also require regulatory approval.²⁷ This consumer protection function is designed to neutralize insurers' asymmetric expertise and to counterbalance the structural obstacles that prevent ordinary individuals from understanding their policy's terms.²⁸ Ideally, the insurance commissioner stands in the shoes of potential policyholders, disapproving policy terms that would be unacceptable to purchasers if they were in a position to understand, bargain about, or reject them.

In practice, however, authority to regulate policy forms and premium rates is only lightly exercised, except for occasional forays into the high-volume consumer auto and homeowners lines of insurance. One reason is that regulatory resources are extremely limited, given the sheer volume of policy form and rate filings.²⁹ Realistically, regulators can scrutinize only a small percentage of filings. They tend to focus where scrutiny will have the most impact.³⁰ But as Daniel Schwarcz has recently shown, in the field of homeowners insurance there are variations in policy language from the standard-form industry-wide policy that are disadvantageous to policyholders.³¹ This has come as a surprise to some observers, probably including the regulators. It is a significant regulatory failure.

Another reason for limited insurance regulation, at least in the regulation of premium rates, is that price competition, one of the classic features of a contract regime, has become more common in recent decades.³² Competition thus often regulates rates without the need for governmental intervention. Nevertheless, the fact that policy language and premium rates

²⁶ See ABRAHAM, *supra* note 4, at 119 (discussing the authority of state insurance commissioners).

²⁷ See KEETON & WIDISS, *supra* note 18, § 8.4(a) (overviewing the goals and potential methods of premium rate regulation).

²⁸ See *id.* § 8.2(a) & nn.1-2 (listing the avoidance of insurers' overreaching as one of the main goals of insurance regulation).

²⁹ See ABRAHAM, *supra* note 4, at 142 (noting variation in the resources and effectiveness of state insurance departments).

³⁰ See *id.* at 142-43 (surveying the rationales insurance commissioners may use to target their resources to specific goals or problems).

³¹ See Schwarcz, *supra* note 20, at 1314-317 (concluding that such discrepancies could result in "consumer exploitation").

³² Premium rates charged by the entire industry sometimes move abruptly in the same direction, however. This phenomenon is known as the underwriting cycle. See Kenneth S. Abraham, *Making Sense of the Liability Insurance Crisis*, 48 OHIO ST. L.J. 399, 400-01 (1987) (discussing the causes of the underwriting cycle and how it could explain industry-wide changes in premium rates in past decades); Kyle D. Logue, *Toward A Tax-Based Explanation of the Liability Insurance Crisis*, 82 VA. L. REV. 895, 907-12 (1996) (explaining the insurance-cycle theory as a way of understanding changes in product-liability market rates).

are subject to governmental regulation, even if they frequently are not actually regulated, is difficult to square with the contract conception.

The second device that adjusts the contract conception to the realities of the market is judicial regulation of the terms of insurance policies, which takes place largely, though not entirely, by means of interpretation. The maxim *contra proferentem* directs that ambiguities in a contract be construed against its drafter.³³ Nowhere is this maxim invoked more frequently than in insurance disputes, where the drafter is virtually always the insurer.³⁴ As a consequence, ambiguous policy provisions—those that are susceptible to more than one reasonable interpretation—are construed in favor of the policyholder. Robert Keeton and Alan Widiss note, however,

[t]here are literally thousands of judicial opinions resolving insurance coverage disputes in favor of claimants on the basis that a provision of the insurance policy at issue was ambiguous and therefore should be construed against the insurer. There are also numerous judicial opinions that predicate the result on the theory of resolving an ambiguity against an insurer in situations which clearly appear to be beyond what seem to be the reasonable bounds for applications of the ambiguity theory. In many of these cases . . . the conclusion is almost inescapable that the courts found an ambiguity where none existed.³⁵

The courts thus often use *contra proferentem* as a method of trumping, rather than interpreting, policy language. The contract conception cannot easily coexist with this practice.

Courts in a minority of states are more open about judicial regulation. These courts apply a doctrine requiring them to honor the policyholder's objectively reasonable expectation of coverage, even when unambiguous policy language would otherwise exclude or limit coverage.³⁶ If it were given full reign, the expectations principle would constitute an open break with the contract conception. But the principle appears to be applied somewhat selectively even in the handful of jurisdictions that have adopted

³³ Boardman, *supra* note 25, at 1110 n.15.

³⁴ To be precise, in property-casualty insurance the drafter typically is the Insurance Services Office (ISO), a nominally independent entity that was once completely controlled by the property-casualty industry and is still heavily influenced by it. See ABRAHAM, *supra* note 4, at 34, 142 (narrating a brief history of the ISO and describing the potential for industry capture). The maxim *contra proferentem*, however, actually means "against the offeror." *Id.* at 37. Thus, although the drafter of standard-form language usually is the ISO, the offeror is still the individual insurer issuing the policy. *Contra proferentem* is therefore properly applied to insurers who have not drafted the policies they issue.

³⁵ KEETON & WIDISS, *supra* note 18, § 6.3(a)(2) (citations omitted).

³⁶ See *id.* § 6.3(a)(3) (describing the expectations principle and its justifications).

it.³⁷ Therefore, in practice, the expectations principle, like its analog the unconscionability doctrine, does not wholly displace the contract conception, but operates in uneasy tension with it.

Finally, a number of insurance policy provisions address complex problems in such simple language that they are necessarily incomplete. Liability insurance policies, for example, typically impose on the insurer a duty to defend suits seeking damages covered by the policy and afford the insurer a privilege to settle suits against the insured. In the course of elaborating the implications of the duty to defend and the privilege to settle, courts have adopted what amount to regulatory rules governing them. For example, a liability insurer that defends its policyholder without reserving its right to contest coverage is estopped from doing so,³⁸ and a liability insurer that rejects a reasonable offer to settle a claim against its policyholder for an amount less than the policy limits is liable for the full amount of any judgment in excess of the policy limits.³⁹ To describe these rules as “interpretation” would stretch the meaning of that term beyond recognition.

Of course, judicial gap-filling occurs in many contract disputes. And there is some debate about precisely what criteria the courts should use to interpret incomplete contracts.⁴⁰ But the judicially created rules regarding liability insurers’ defense and settlement of suits against policyholders arguably go beyond any of these criteria. These rules are regulatory in

³⁷ Cf. *id.* (cautioning that there are meaningful differences in the ways that various jurisdictions apply the rule).

³⁸ Perhaps the seminal case on the issue is *Gray v. Zurich Insurance Co.*, 419 P.2d 168, 179 (Cal. 1966).

³⁹ See, e.g., *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 177 (Cal. 1967) (“[A]n insurer should not be permitted to further its own interests by rejecting opportunities to settle within the policy limits unless it is also willing to absorb losses which may result from its failure to settle.”).

⁴⁰ See, e.g., Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87, 106-07 (1989) (arguing that courts should use penalty defaults, rather than the defaults parties would have wanted, where penalty defaults encourage information sharing and clearer contracts); Ian Ayres & Robert Gertner, *Strategic Contractual Inefficiency and the Optimal Choice of Legal Rules*, 101 YALE L.J. 729, 765-66 (1992) (advocating an “efficient contract rule” as a default rule to combat strategic behavior by parties to incomplete contracts); Charles J. Goetz & Robert E. Scott, *The Limits of Expanded Choice: An Analysis of the Interactions Between Express and Implied Contract Terms*, 73 CALIF. L. REV. 261, 320 (1985) (criticizing the current rules of contract interpretation and suggesting that the state should provide better options from which parties could choose *ex ante*); Robert E. Scott, *A Relational Theory of Default Rules for Commercial Contracts*, 19 J. LEGAL STUD. 597, 615 (1990) (suggesting that a rigid interpretation of default rules would discourage compliance with informal social rules that promote cooperation); *Symposium on Default Rules and Contractual Consent*, 3 S. CAL. INTERDISC. L.J. 1 (1993) (debating the utility of default rules and how, if at all, to improve their use in contract law); see also Richard Craswell, *Contract Law, Default Rules, and the Philosophy of Promising*, 88 MICH. L. REV. 489, 504 (1989) (claiming that philosophical theories of contract do not adequately discuss the implications of default rules in contract).

character. The failure of insurers to alter these rules by redrafting their contracts is some evidence that insurers have accepted such judicially created rules, rather than that the rules have been imposed on them.⁴¹

But perhaps the most important feature of the judicial regulation of insurance—the feature that makes it more like regulation than mere adjudication—is that such judicial decisions have uniform and broad application. To be ambiguous, a policy provision must be susceptible to more than one “reasonable” interpretation; an objective standard is thus part of the test for ambiguity.⁴² And it is precisely the ambiguity of standard-form policy language that is usually at issue.⁴³ Consequently, when a court holds that a policy provision is ambiguous and interprets it in favor of coverage, the holding applies to everyone whose policy contains that provision.⁴⁴ By virtue of *stare decisis*, the holding declares the meaning of that standard-form policy provision, not merely the rights of the particular policyholder whose claim is before the court. Judicial holdings honoring the “objectively reasonable” expectations of the policyholder as to coverage, notwithstanding contrary policy language, tend to have the same effect, for analogous reasons. What is objectively reasonable for one policyholder to expect is usually objectively reasonable for all who are covered by the same, standard-form policy. Similarly, rules governing the liability insurer’s policy-based duty to defend and settle are just that—*rules* that apply across the board to all

⁴¹ On the other hand, in connection with the duty to defend, insurers have persistently asserted positions designed to circumvent the rules. For example, insurers have asserted the right to recoup defense costs from policyholders when the insurer has defended without an obligation to do so. Some courts have accepted these arguments and some courts have rejected them. See ABRAHAM, *supra* note 4, at 648-49. I doubt that regulators would approve an express, policy-based right to recoup in the manner that insurers have argued for in the courts. Auto and homeowners liability insurance policyholders are ordinary consumers without the funds to defend most suits against them. One of the main benefits of their insurance is that it provides them with a defense against suits that would fall within the terms of coverage. KEETON & WIDISS, *supra* note 18, § 9.1(a). Regulators would not approve the prospect that these ordinary consumers could be defended by their insurer but then sent a bill for tens of thousands of dollars for the insurer’s defense of a suit that the insurer claimed it had no duty to defend. So in this instance insurers have signaled some dissatisfaction with judicially created rules, though insurers are also attempting to avoid the constraints that administrative regulation would likely impose, by selectively obtaining judicial modification of prior judicial regulation.

⁴² See, e.g., *A.Y. McDonald Indus. v. Ins. Co. of N. Am.*, 475 N.W.2d 607, 618-19 (Iowa 1991).

⁴³ See, e.g., ABRAHAM, *supra* note 4, at 624 (noting “an explosion of litigation over the duty to defend,” partly because “insurance policies state the duty in only general terms”).

⁴⁴ It is true that a court occasionally rules that an insurance policy provision is ambiguous in context or ambiguous as applied to the particular claim at issue. The contexts in which such rulings are made, however, tend not to be at all unique. Rather, the holdings in such instances apply to whole categories of claims and therefore are uniform in the sense described in the text. See, e.g., *A.Y. McDonald Indus.*, 475 N.W.2d at 618-19 (holding that the term “damages”—used in a variety of consumer and commercial liability insurance policies—is ambiguous).

policyholders whose policies contain the same incomplete language governing defense and settlement.⁴⁵

In short, recognizing the breadth of administrative and judicial regulation of insurance provides a striking contrast to the contract conception. Regulation combats asymmetric expertise and structural obstacles to the development of individual contractual intent by substituting the single judgment of an administrative agency or a court about the contents of an insurance policy for that of a disparate group of policyholders. But regulation cannot fully rehabilitate contract in this field. Despite their potentially differing preferences, all policyholders still are offered standard-form coverage on a take-it-or-leave-it basis. Regulation thus affects the content of the standard-form, but it typically does not mandate any greater opportunity for individual choice than insurers already provide their policyholders in the absence of regulation. Indeed, in the case of judicial regulation, insurers are free to modify offending provisions in their policies. As a result, insurers can repeatedly try to achieve the result they desire, by using language that has a greater chance of being found unambiguous.

Judicial regulation, however, occurs only when enough is at stake in a dispute to warrant litigation, and courts do not have the same kind of expertise as insurance commissioners. They are ill-equipped, for example, to determine what different policyholders want or would be willing to pay for. On the other hand, the threat of each of these forms of regulation probably acts as a disciplining force that leverages the effect of regulation. Insurers may provide more coverage than they would if left to their own devices, with the hope of staving off administrative or judicial regulation that would require even more coverage. This inconsistency of the contract conception with the forms of regulation to which insurance contracts are subject, along with the perceived ineffectiveness of insurance law's regulatory adjustments

⁴⁵ Moreover, consumers and commercial policyholders are, to a large extent, each others' beneficiaries when it comes to judicial regulation. A standard-form policy provision usually is accorded the same meaning regardless of whether it is in an individual or a commercial policy. As such, when policies contain the same standard-form provision, judicial regulation—designed to protect individual policyholders—tends to benefit commercial policyholders as well. Correspondingly, commercial policyholders may litigate coverage disputes and establish pro-coverage interpretations of standard-form provisions that no individual policyholder would find worthwhile, or could afford, to litigate. Individual policyholders are the beneficiaries of this litigation. The occasional exception to this parallel treatment of commercial and individual policyholders finds expression in the “sophisticated insured” doctrine adopted by a few courts. Under this doctrine, large corporations are precluded from taking advantage of *contra proferentem*. See, e.g., *McNeilab, Inc. v. N. River Ins. Co.*, 645 F. Supp. 525, 547 (D.N.J. 1986) (holding that a subsidiary of Johnson & Johnson, a Fortune 500 company, could not take advantage of the *contra proferentem* doctrine because it was a sophisticated party).

to that inconsistency, help give rise to the alternative conceptions that I discuss next.

II. THE PUBLIC UTILITY/REGULATED INDUSTRY CONCEPTION

A second conception sees insurance as something like a public utility or regulated industry. The classic, technical definition of a public utility involves the provision of a good or service where there is a “natural” private monopoly that makes it impossible or impractical for more than one seller of the good or service to operate.⁴⁶ Common carriers, providers of water and electricity, and operators of highways tend to be public utilities in this sense. Insurance is not.

On the other hand, insurance has many of the same characteristics of public utilities and other highly regulated industries. Proponents of this view argue that insurance is affected with the public interest as an important good.⁴⁷ Moreover, the insurance industry operates under cartel-like market conditions⁴⁸ with a grant of immunity from the U.S. antitrust laws.⁴⁹ Therefore, the proponents of this view argue that the terms and conditions under which insurance is sold,⁵⁰ as well as the price charged for insurance,⁵¹ must be subject to regulation to serve the public interest.⁵²

⁴⁶ See RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* § 12.1 (7th ed. 2007).

⁴⁷ “Water and power are essential for life,” Mrs. Feinstein said. “So they are heavily regulated, and rate increases must be approved. Health insurance is also vital for life. It too should be strictly regulated so that people can afford this basic need.” Robert Pear, *Senate Democrats Lay Out a Plan to Regulate Health Insurance Premiums*, N.Y. TIMES, Apr. 21, 2010, at A15; see also Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 523 (1961) (describing insurance as “crucial to the social fabric”).

⁴⁸ See *The McCarran-Ferguson Act: Implications of Repealing the Insurers’ Antitrust Exemption: Hearing on S. 557 Before the S. Comm. on the Judiciary*, 109th Cong. 79 (2006) (testimony of J. Robert Hunter, Dir. of Ins., Consumer Fed’n of Am.) (asserting that anticompetitive behavior by the insurance industry caused a homeowners insurance crisis along America’s coastlines); *Oversight Hearing on Insurance Brokerage Practices, Including Potential Conflicts of Interest and the Adequacy of the Current Regulatory Framework: Hearing on S. 736 Before the Subcomm. on Fin. Mgmt., the Budget, and Int’l Sec. of the S. Comm. on Governmental Affairs*, 108th Cong. 66, 71 (2004) (testimony of Eliot Spitzer, N.Y. Att’y Gen.) (asserting that a “network of insurance brokers and insurance carriers essentially creates a secret cartel based on hidden payments and preferential treatment” and calling for more federal regulation); Jay Angoff, *Insurance Against Competition: How the McCarran-Ferguson Act Raises Prices and Profits in the Property-Casualty Insurance Industry*, 5 YALE J. ON REG. 397, 404 (1988) (asserting that industry conduct indicates the existence of collusion in price-setting).

⁴⁹ See *The McCarran-Ferguson Act*, 15 U.S.C. §§ 1011–1015 (2006) (exempting the business of insurance in a state from federal antitrust laws provided that a state regulates the industry).

⁵⁰ See Susan Randall, *Freedom of Contract in Insurance*, 14 CONN. INS. L.J. 107, 146–47 (2008) (arguing that, to determine the meaning of insurance policies, courts should emphasize regulatory goals and strategies rather than freedom of contract and the parties’ intentions).

⁵¹ See *Why is Regulation of Insurance Necessary?: Before the Task Force on Long-Term Solutions For Florida’s Hurricane Insurance Market* 5 (2005) (statement of J. Robert Hunter, Dir. of Ins.,

In some significant ways the formal structure of insurance regulation in the United States conforms to the public utility/regulated industry conception. The insurance industry is exempt from the reach of U.S. antitrust laws under the McCarran-Ferguson Act to the extent that insurance is regulated by state law.⁵³ The states in turn permit certain arguably anticompetitive practices such as industry-wide preparation of property-casualty insurance policy forms and the pooling of data on loss and claims experience.⁵⁴ But in return for this federal and state antitrust immunity, the states retain authority to disapprove of policy forms and to regulate premium rates in a way that permits a fair rate of return but is suspicious of excess profits.⁵⁵ States also have promulgated special investment and accounting standards designed to help ensure the solvency of insurance companies.⁵⁶

Beyond these formalities, the accuracy of the public utility/regulated industry conception varies with the type of insurance. The most accurate statement of this conception would be that, because insurance is embodied in a complex and difficult-to-understand document, heavy regulation is warranted when it involves a form of coverage that is close to essential for individual well-being. This rationale for regulation is less like the rationale

Consumer Fed'n of Am.), available at <http://www.myfloridacfo.com/hurricaneinsurancetaskforce/TaskforceRS2/Appendix5/9aFloridaStatementWhyisRegulationofInsuranceNecessary.pdf> (“We question the entire foundation behind the assumption that virtually no front-end regulation of insurance rates and terms coupled with more back-end (market conduct) regulation is better for consumers.”); *id.* at 9 (arguing that “[a]ll consumers should have access to adequate coverage”); *id.* at 14 (asserting that “insurance is an essential public good”).

⁵² “The law requires businesses affected with a public interest—notably public utilities and common carriers—to contract with all comers on nondiscriminatory and reasonable terms.” Rakoff, *supra* note 24, at 1193 n.73 (citations omitted) (internal quotation marks omitted); see also *Shavers v. Kelley*, 267 N.W.2d 72, 87 (Mich. 1978) (holding that, because the purchase of no-fault auto insurance is required by state law, drivers have a constitutionally protected property interest in the availability of insurance at fair and equitable rates); Matthew O. Tobriner & Joseph R. Grodin, *The Individual and the Public Service Enterprise in the New Industrial State*, 55 CALIF. L. REV. 1247, 1249, 1273 (1967) (noting that businesses such as insurance companies are “affected with the public interest” and that courts in interpreting insurance contracts have looked to the relationship of the policyholder to the insurer rather than to the consensual transaction itself (citations omitted)).

⁵³ 15 U.S.C. §§ 1011–1015.

⁵⁴ See ABRAHAM, *supra* note 4, at 34, 118–19.

⁵⁵ See, e.g., *North Carolina ex rel. Comm’r of Ins. v. N.C. Fire Ins. Rating Bureau*, 234 S.E.2d 720, 725, 730 (N.C. 1977) (stating that the state insurance commissioner must approve all changes in “rating method, schedule, classification, underwriting rule, bylaw, or regulations” and that homeowner insurers may charge rates that leave them “a fair and reasonable profit and no more” (citations and internal quotation marks omitted)).

⁵⁶ See ABRAHAM, *supra* note 4, at 118–27 (outlining the roles that the states, insurance commissioners, and the National Association of Insurance Commissioners play in assuring the solvency of insurers through regulation and licensing).

for regulating public utilities and more like the rationale for regulating food and drugs, whose dangers are difficult to detect, but which are essential for individual well-being.

A number of features of health insurance, for example, fit this conception. Along with food and shelter, access to medical care is one of the basic goods most essential to individual well-being. In our system, health insurance is the principal vehicle through which access to medical care becomes available. The argument for regulating the terms and conditions under which health insurance operates is therefore strong, and the actual scope of regulation tends to reflect the importance of health insurance.

There have long been state-mandated benefits laws that require certain forms of coverage—maternity benefits, for example—to be included in all health insurance policies.⁵⁷ At the federal level, for over a dozen years the Health Insurance Portability and Accountability Act (HIPAA) has addressed the problem of preexisting condition limitations that would otherwise affect the job mobility of those with group health insurance.⁵⁸ And some states have their own, broader restrictions on preexisting condition limitations.⁵⁹ Regulatory provisions such as these, specifying what must be sold and under what conditions, are typical of those that apply to heavily regulated industries.

Of course, the strongest example of the treatment of health insurance as a heavily regulated industry is the Patient Protection and Affordable Care Act (Affordable Care Act)—the federal health care reform legislation that will take full effect in 2014. Beginning in 2014, it will be mandatory for health insurers to take all comers,⁶⁰ preexisting condition limitations will be prohibited,⁶¹ and the federal government will effectively dictate the minimum acceptable terms of coverage for all policies except those sold in the

⁵⁷ See, e.g., MINN. STAT. § 62A.041 (2012) (requiring maternity coverage for all women regardless of marital status).

⁵⁸ Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, §§ 701, 2701, 110 Stat. 1936, 1939-45, 1955-61 (codified at 29 U.S.C. § 1181 and 42 U.S.C. § 300gg).

⁵⁹ See HENRY J. KAISER FAMILY FOUND., HEALTH INSURANCE MARKET REFORMS: PRE-EXISTING CONDITION EXCLUSIONS 3-4 (2012), available at <http://www.kff.org/healthreform/upload/8356.pdf> (stating that the states' approaches to limits on preexisting conditions exclusions vary, and providing a fifty-state survey).

⁶⁰ See Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 156 (to be codified at 42 U.S.C. § 300gg) (requiring every health insurance issuer to accept all applicants during limited "open or special enrollment" periods and to "renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable").

⁶¹ See *id.* § 1201, 124 Stat. at 154 (prohibiting preexisting condition exclusions and other discrimination based on health status).

large group market.⁶² Once this occurs, traces of the contract conception will hardly be discernible at all in health insurance. Health insurance will then be treated much like a public utility or heavily regulated industry. The vehicle for providing most people with health insurance will be a contract, but neither party will determine the content of most of the contract's terms.

Perhaps next in importance, given the incidence of auto accidents and the way the tort system handles them, is auto liability insurance. In all but urban areas where there is adequate mass transit, driving is an essential feature of daily life. Having auto liability insurance is not only a practical necessity for anyone with assets worth protecting, but also legally mandatory in virtually all states.⁶³ Ensuring access to auto liability insurance on reasonable conditions and for a tolerable cost is then necessary if individuals are not to be deprived of the right to drive.

The considerable regulation of auto liability insurance resembles what occurs in the public utility/regulated industries field. In addition to the requirement in virtually all states that drivers be covered by liability insurance, certain key policy provisions are also mandated by statute.⁶⁴ State statutes consistently provide for a residual insurance market, which ensures that all who are authorized to drive can meet the statutory insurance requirement.⁶⁵ As in health insurance, the specification of what must be sold and under what conditions—a characteristic of public utility regulation—also occurs in auto liability insurance.

In both health and auto insurance however, an additional factor distinguishes them from public utilities and regulated industries: prices are regulated in a manner that is partly redistributive. After the Affordable Care Act takes effect, there will be only very limited bases upon which health insurers will be able to charge high-risk applicants higher premiums than low-risk applicants.⁶⁶ In auto insurance the matter is more complicated, but there is still considerable redistribution. Auto liability insurers are permitted considerable room to charge high-risk drivers more than low-risk

⁶² See *id.* § 1302(a), 124 Stat. at 163 (defining the “essential health benefits package” and authorizing the Secretary of Health and Human Services to further define the package).

⁶³ ABRAHAM, *supra* note 4, at 702.

⁶⁴ See *e.g.*, N.Y. INS. LAW § 3420 (McKinney 2012) (specifying standard provisions that must be included in various kinds of insurance policies, including specified provisions for auto insurance policies).

⁶⁵ See ABRAHAM, *supra* note 4, at 771-73 (describing the residual market for auto liability insurance, under which applicants who are unable to obtain insurance in the ordinary market are offered coverage from a government-mandated or government-operated market in which private insurance must participate).

⁶⁶ See Patient Protection and Affordable Care Act § 1201 (forbidding discrimination in pricing coverage on the basis of any characteristic other than age, family status, rating area, or tobacco use).

drivers for their coverage.⁶⁷ Statutes in every state give insurance commissioners authority to regulate rates so as to ensure (among other things) that they are not “unfairly discriminatory,”⁶⁸ but the categories used by insurers are lightly regulated, with the exception of a few salient prohibited characteristics such as race and religion.⁶⁹ On the other hand, the states maintain residual markets for those who cannot obtain auto insurance in the conventional market.⁷⁰ Typically these are the highest-risk drivers, or at least those whom insurers perceive to be highest-risk. Auto insurers in the state share revenue shortfalls that occur in the residual market, and such shortfalls are not uncommon. Any shortfall assessed against an insurer is either a credit against premium taxes or may be surcharged to the insurers’ policyholders. In effect, when there are shortfalls, the higher-risk drivers are subsidized by all other drivers.⁷¹

In short, health insurance will soon share some of the characteristics of other highly regulated industries, as does auto insurance already. Auto insurance for high-risk drivers is also a disguised risk-distribution scheme that works like a tax and transfer regime, and health insurance is about to follow the same path. This is not a characteristic of the typical public utility or regulated industry.

Moreover, as soon as one moves beyond health and auto insurance, the resemblance becomes even more attenuated. The importance of most other forms of insurance pales in comparison to health and auto liability insurance. Other forms of liability insurance, as well as life and disability insurance, for example, are far less important to individual well-being and economic security. Non-auto-related personal tort liability exposure is very limited. The limited amount of life and disability insurance in force suggests that most people believe they either do not need or simply cannot afford significant amounts of either form of coverage, however fairly priced it may be.⁷²

⁶⁷ State premium rate regulation was once a much more vigorous enterprise, despite the calls of some advocates for even more regulation. See ABRAHAM, *supra* note 4, at 142-43. Thus, in this respect, the public utility/regulated industry conception was more accurate in the past than it is today.

⁶⁸ *Id.* at 119.

⁶⁹ See generally Ronen Avraham, Kyle D. Logue & Daniel Schwarcz, *The Anatomy of Insurance Anti-Discrimination Laws* 20-21 (Univ. of Mich. Law Sch. Pub. Law & Legal Theory Research Paper Series, Paper No. 289, 2012), available at <http://ssrn.com/abstract=2135800> (explaining potential rationales for prohibiting insurers from discriminating based on socially suspect characteristics).

⁷⁰ See *supra* note 65 and accompanying text.

⁷¹ ABRAHAM, *supra* note 4, at 779.

⁷² See *id.* at 306 (indicating that the average life insurance policy purchased in 2007 provided only \$175,000 of insurance); *id.* at 429 (indicating that only twenty-five percent of the American population is covered by private short-term disability insurance and only ten percent is covered by private long-term disability insurance).

And in my view, the number of coverage disputes in these forms of insurance, which would be some evidence of the need for regulatory intervention, seems comparatively small.

Exactly as would be expected, therefore, beyond health and auto liability insurance regulation, the public utility/regulated industry model becomes even less accurate. Market concentrations and the intensity of competition vary greatly depending on the state and on the line of insurance involved.⁷³ In many settings the insurance market is highly competitive, and in any event certainly does not resemble the classic natural monopoly that characterizes traditional public utilities. When this is the case it is competition, not a regulatory agency, that is the effective regulator of premium rates. The existence of standard-form policies enhances competition by facilitating the comparison of prices offered by different insurers.⁷⁴ Finally, outside of health and auto liability insurance there is not the take-all-comers requirement that applies to the sellers of electricity, water, and other public utilities. Insurers generally are permitted to reject applications for coverage. In short, in the very areas of insurance that are most essential to individual well-being, insurance regulation bears some resemblance to the public utility/regulated industry conception. But beyond these areas of insurance, this conception is a far less accurate description of what occurs.

III. THE PRODUCT CONCEPTION

My discussion of the contract conception revealed that there is a long tradition in contract law scholarship addressing the distinctive features of contracts of adhesion.⁷⁵ It is only a slight oversimplification to say that the burden of this scholarship is that the terms of contracts of adhesion should not necessarily be binding because parties have not bargained for them and

⁷³ See Robert W. Klein, *The Insurance Industry and Its Regulation*, in *THE FUTURE OF INSURANCE REGULATION IN THE UNITED STATES* 13, 18 tbl.2-2 (Martin F. Grace & Robert W. Klein eds., 2009) (providing market concentration data for various lines of insurance).

⁷⁴ Life and disability insurers do not prepare industry-wide standard forms or pool data on loss experience. Property-casualty insurers do engage in these practices, but under modern antitrust law, the practices probably would not violate federal or state antitrust laws even in the absence of the statutory immunity granted to the industry. Under the state-action doctrine originating in *Parker v. Brown*, 317 U.S. 341, 350-51 (1943), practices that would otherwise violate the federal antitrust laws are exempt if they are actively supervised by a state. And it is now well-established that intra-industry sharing of cost data is not necessarily a U.S. antitrust violation. See, e.g., *Maple Flooring Mfrs. Ass'n v. United States*, 268 U.S. 563, 586 (1925) (permitting trade associations and corporations to disseminate cost data as long as they do not attempt to set prices or restrain competition).

⁷⁵ Cf. Kessler, *supra* note 3, at 631-32 (discussing the emergence of standard-form contracts); Rakoff, *supra* note 24, at 1177 (delineating the seven key features of contracts of adhesion).

because the promisee (here, the policyholder) is not aware of these terms and certainly does not understand many of them.⁷⁶ The dilemma that then arises is how to determine which such terms are binding and which are not.

Under the contract conception, the provisions of an insurance policy are presumptively valid. To invalidate, or at least to trump, a policy provision, the policyholder must show that a particular provision falls outside the bounds of freedom of contract because it is ambiguous, conflicts with the policyholder's objectively reasonable expectations, is unconscionable, or violates public policy in some way.⁷⁷ Only under these unusual circumstances can the policyholder question the applicability of the plain language of the insurance contract. In the absence of one of these situations, the provisions of the policy are treated as if they were specifically agreed to. The language of policy provisions is placed in the foreground and considerations governing the validity of these provisions are kept in the background. As I noted above, however, policyholders usually do not read their policies or have a meaningful choice about the coverage provisions these policies contain. So, in a sense, policyholders are not agreeing to a set of contract terms. Rather, they are buying a commodity—insurance—in the hope that it will provide them with what they need.

A number of commentators have reacted to this tension within the contract conception by arguing that conceiving of the policy as a contract is not entirely accurate if the adhesive terms of an insurance policy are not necessarily binding on the policyholder. Rather, insurance policies are more like commodities—products or things.⁷⁸ Buyers often purchase commodities

⁷⁶ See, e.g., Rakoff, *supra* note 24, at 1242 (“Once placed in its proper context as a matter primarily implicating the ordering of power and freedom in our society, the general rule that contracts of adhesion are presumptively enforceable cannot be upheld.”).

⁷⁷ See, e.g., Hartford Cas. Ins. Co. v. Powell, 19 F. Supp. 2d 678, 693-94 (N.D. Tex. 1998) (holding that insurance against liability for punitive damages is against public policy); W. David Slawson, *Standard Form Contracts and Democratic Control of Lawmaking Power*, 84 HARV. L. REV. 529, 540-44 (1971) (arguing that the test for validity of insurance policies should be whether a provision satisfies the standards to which private lawmaking, such as contracting, is subject).

⁷⁸ See Daniel Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389, 1405-06 (2007) (discussing how “the various base forms and endorsements” insurance companies offer consumers “are analogous to differentiated products”); Jeffrey W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813, 818 (2009) [hereinafter, Stempel, *The Insurance Policy as Thing*] (discussing how insurance “is more a product or good than it is a contract”); see also Eugene R. Anderson & James J. Fournier, *Why Courts Enforce Insurance Policyholders’ Objectively Reasonable Expectations of Insurance Coverage*, 5 CONN. INS. L.J. 335, 419-23 (1998) (arguing that insurance policies are defective products in light of the discrepancy between insurer advertising and the scope of coverage actually provided); Slawson, *supra* note 77, at 546 (describing the process of entering into a standard form contract as buying a promise). Another piece by Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489, 1495 (2010) [hereinafter Stempel, *The*

subject to a set of mandatory rules regarding the seller's obligations. When a car is sold, for example, although the sale takes place through a contract, the seller also has obligations that sound in tort. Thus, according to the proponents of the product conception of insurance, insurers should be liable if the insurance policies they sell are defective, just as the sale of goods is ordinarily subject to an implied warranty of merchantability and just as product manufacturers are liable in tort for injuries resulting from product defects.

The product conception is an effort both to describe the actual character of insurance and to expressly identify its normative implications for insurance law. Under a product conception, background considerations governing the legal acceptability of the provisions of the policy are moved into the foreground. For proponents of the product conception, policy provisions should not be binding unless they satisfy a standard governing their suitability.⁷⁹ The locus of coverage disputes would therefore shift under a product conception. Under a contract conception, coverage disputes center on the *meaning* of applicable policy provisions.⁸⁰ Under the product conception, disputes center on the *validity* of these provisions.

Conceiving of insurance policies as products circumvents some of the dilemmas that contract theory faces in dealing with contracts of adhesion. The product conception underscores one of the two fundamental questions that any conception of insurance inevitably must confront: how to determine which of the policy provisions that insurers include in their policies to limit or preclude coverage are enforceable, and which are not. In my opinion, the product conception is a more accurate description of the nature and function of insurance policies—especially personal insurance policies sold to consumers—than the contract conception.

In practice, however, the product conception would be a flawed basis for assessing the validity of insurance policy provisions. A product can rarely be designed so that it is perfectly safe, yet also useful and affordable. Therefore, courts do not impose liability for many designs that are not perfectly safe, but sometimes cause harm. Rather, tort law imposes liability on the seller of a product for injuries resulting from its design only if the product is “defective in design.”⁸¹ The problem is that “defectiveness,” whether in a product or an insurance policy provision, is difficult to define and even

Insurance Policy as Social Instrument], might also be thought to fall into the product conception, although in my view it more comfortably fits in the governance conception.

⁷⁹ See, e.g., *infra* note 83 (discussing Professor Schwarcz's proposed test for the enforceability of insurance provisions).

⁸⁰ See *supra* Section I.A.

⁸¹ RESTATEMENT (THIRD) OF TORTS: PRODS. LIAB. § 2(b) (1998).

more difficult to apply. For a number of reasons, the concept does not easily lend itself to adjudication.

A. *The Deficiencies of the Cost-Benefit Approach*

The dominant test for product defects is whether the risks posed by the product's design outweigh its utility.⁸² Assessing the utility of a product design, however, is a difficult, open-ended inquiry. A product design has implications not only for safety, but also for cost, appearance, and functionality. It is not clear how to weigh the safety risks a product's design poses against the cost, appearance, and functionality considerations that bear on the design's utility.

Applying a risk-utility test—or what amounts to the same thing, a cost-benefit test—to determine the validity of insurance policy provisions would pose at least as many difficulties as in the product context, and probably more. When it comes to determine whether the risk a policy provision posed outweighs its utility, the product conception necessarily must rely on some notion of the purpose of a policy provision.⁸³ The only standard by which one can judge the utility of a policy provision is to determine how effectively the provision serves its purpose. But a provision's purpose is rarely self-evident; it must be constructed, either through judicial reasoning, evidence, or some combination of the two. And there is little reason to think that the adjudicative construction of purpose will be any less open-ended than the assessment of the utility of product designs.

For example, consider a standard homeowners policy provision that requires the policyholder to complete the repair or rebuilding of damaged or destroyed property before receiving the full replacement cost of the repairs or rebuilding. If the homeowner does not rebuild, the insurer pays only the (usually lower) actual cash value of the damaged property. Professor Daniel Schwarcz, one of the two main proponents of the product conception, cites this provision as a prime example of a clause that does not satisfactorily serve its “underwriting purpose.”⁸⁴ Schwarcz argues that the underwriting purpose of such a limitation on coverage is to combat moral hazard,

⁸² *Id.* § 2, cmt. d.

⁸³ See Schwarcz, *supra* note 78, at 1448-49 (discussing the purpose of a replacement cost endorsement); Stempel, *The Insurance Policy as Thing*, *supra* note 78, at 847-53 (discussing the purposes of burglary insurance and pollution exclusions). Professor Schwarcz would engage in a two-step process, under which the first step would be a determination of whether a policy provision served a legitimate underwriting purpose. Schwarcz, *supra* note 78, at 1445-46. If it did not, then it would be defective if it failed “a cost-benefit, reasonable-alternative-design test.” *Id.*

⁸⁴ Schwarcz, *supra* note 78, at 1449.

“prevent[ing] insurance fraud[] because . . . insureds looking to move could potentially profit by destroying their home and collecting insurance rather than selling the house” for less than its replacement cost.⁸⁵

I do not doubt that one of the purposes of such provisions is to combat this moral hazard.⁸⁶ And I do not doubt that insurers could redraft the provision to achieve this purpose and still cover the policyholder who could, and would, rebuild if only the insurer would first pay the policyholder the full replacement cost.⁸⁷ But the provision could have a second purpose: to keep premiums at an optimum level by discouraging the inefficient reconstruction of damaged or destroyed property. When reconstructed property would have a market value at least equal to the cost of reconstruction, policyholders in a normal credit market should be able to obtain construction loans even if their insurance proceeds are not payable until replacement is completed. Construction loans for the full cost of replacement will be unavailable, however, when the reconstructed property would not be worth its replacement or reconstruction cost. In such a case, the mortgage provided as security for the loan will not be fully secured. By paying replacement cost only after rebuilding, the rebuilding requirement both separates inefficient from efficient reconstruction and avoids cross subsidization of inefficient reconstructors by all other policyholders.

Thus, the rebuilding requirement not only combats *ex ante* moral hazard, but also discourages inefficient reconstruction (in effect, *ex post* moral hazard), by making full replacement cost available only to policyholders who can obtain construction loans, which occurs only when reconstruction is not inefficient. On this view, the coverage limitation in question serves two underwriting purposes, not just one. It thus satisfies the cost-benefit test and is not defective.

How could courts apply the defectiveness test to the rebuilding clause to determine whether it has the two purposes I have hypothesized, or only the one purpose that Schwarcz identified? Schwarcz analyzes the issue as if it were a pure question of law, perhaps analogous to a question of policy interpretation.⁸⁸ In his view, apparently only the purpose of the insurer is relevant. On the other hand, Professor Jeffrey Stempel, the other major proponent of the product conception, appears to believe that the intentions

⁸⁵ *Id.*

⁸⁶ ABRAHAM, *supra* note 4, at 271.

⁸⁷ *See* Schwarcz, *supra* note 78, at 1455 n.287.

⁸⁸ *See id.* at 1448 (suggesting a court inquire “whether the insurer has any legitimate *underwriting purpose* for not insuring against the *specific loss* that befell the insured”).

of both the insurer and the insured are relevant to a policy provision's purpose.⁸⁹

Whichever approach one takes, the perils of seeking to determine purpose abound. For example, it is not clear what would be involved in determining purpose as a matter of law. Drafting history may shed light on underwriting intent. But since we are concerned mainly with industry-drafted, property-casualty insurance standard-form provisions, the intent of the drafters may not be the same as that of the particular insurer selling the policy. Additionally, insurers may become aware of, or come to consider important, additional functions that a particular policy provision performs only after they have used the provision for a while. If these functions count as part of the underwriting "purpose" of the policy, then some method of identifying them for the court must be employed. One can easily picture the rise of extended discovery into industry drafting history and individual insurers' separate intentions complicating what previously would have been simple, straightforward policy interpretation disputes.⁹⁰

The conceptual and practical difficulties of determining a policyholder's intention would be even greater. Most policyholders do not have a crystallized "intent" about the scope of coverage. They have at most a general purpose—to obtain coverage of a particular risk, such as fire damage to a home or liability for automobile "accidents." Such an intent will rarely be specific enough to resolve disputes over the proper scope and application of particular policy provisions under distinct factual circumstances.

Some other workable touchstone for determining the specific scope of coverage would therefore be necessary, but a risk-utility or cost-benefit test has difficulty providing it. Schwarcz acknowledges that even if a policy provision fails his cost-benefit test, the provision is not defective if the desirability of avoiding "juridical" risk justifies its exclusionary breadth.⁹¹ For example, wordings of exclusionary provisions that are highly fact-

⁸⁹ See Stempel, *The Insurance Policy as Thing*, *supra* note 78, at 847-48.

⁹⁰ Schwarcz acknowledges these and other potential difficulties, and therefore stops short of recommending immediate adoption of the defectiveness approach. See Schwarcz, *supra* note 78, at 1462 (noting that the products liability model "should serve as a the starting point for further discussion, rather than the end point for a new doctrine of insurance law").

⁹¹ *Id.* at 1448 (noting that clauses designed to minimize juridical hazard "should not be considered an insurance harm, because they serve a legitimate and important underwriting function that often enhances the overall efficiency of the insurance arrangement"); see also *id.* (explaining that juridical hazard "encompasses the transaction costs to insurers of deciding whether to pay a claim, which includes the costs of fact gathering and legal fees").

dependent tend to have higher adjudication costs than wordings that are more exclusionary but less fact-dependent.⁹²

This consideration of juridical risk is sensible. But it is one thing to acknowledge the relevance of juridical costs, and quite another to weigh them against the risk that the policy provision will exclude claims consistent with its underwriting purpose in an effort to reduce juridical costs.⁹³ This balancing is traditionally a regulatory judgment. Schwarcz, however, would have courts take this approach, despite the fact that they almost inevitably lack both the necessary expertise and the access to “legislative facts” on which regulators theoretically base their decisions. In effect, Schwarcz wants the courts to redesign insurance policy provisions in order to determine the suitability of a provision under scrutiny, just as the cost-benefit test asks juries to redesign products in order to determine whether they are defective.⁹⁴

B. *Atwater Creamery and Preference Diversity*

One of the canonical cases involving a broad, and therefore arguably “defective,” limitation on coverage is *Atwater Creamery Co. v. Western National Mutual Insurance Co.*⁹⁵ In *Atwater*, a burglary policy precluded coverage unless there were visible marks of forced entry on external doors and windows.⁹⁶ The court held that one purpose of this limitation was to ensure that coverage existed only for actual third-party burglaries and not “inside jobs.”⁹⁷ Schwarcz apparently thinks that this clause is not defective.⁹⁸ In his view, the utility of this clause—reducing the juridical risk entailed in litigating whether each loss resulted from an inside job—outweighs the risk associated with the denial of coverage for losses that do not result from inside jobs but also do not leave visible marks of entry.⁹⁹ On the other hand, Stempel thinks the clause does not pass muster under a

⁹² See *id.* (“[I]nsurance policies are written using bright-line rules that imperfectly facilitate legitimate underwriting purposes . . . because they are easy to apply after an insured has incurred a loss.”).

⁹³ For Schwarcz, apparently either the cost of adjudicating the application of a policy provision is relevant to whether the benefits of a particular wording outweigh its costs, or there is some other, unspecified test for determining whether an otherwise defective provision can be saved because of the juridical costs entailed in applying a less exclusionary provision. *Id.* at 1445-49.

⁹⁴ See *id.* at 1454-55 (suggesting that courts determine the existence of harm in the insurance context “by applying a marginal cost-benefit test premised on reasonable alternative designs”).

⁹⁵ 366 N.W.2d 271 (Minn. 1985) (en banc).

⁹⁶ *Id.* at 274.

⁹⁷ *Id.* at 276.

⁹⁸ See Schwarcz, *supra* note 78, at 1452 (noting that the “clause served a legitimate underwriting purpose”).

⁹⁹ *Id.*

defectiveness test.¹⁰⁰ He acknowledges that there will be juridical costs if the visible marks requirement is not determinative in *Atwater*, but asserts that “these additional costs are likely to be minor.”¹⁰¹

Thus, the two major proponents of the product conception cannot agree on the result that it would dictate in one of the leading cases that they contend would have been better handled by this conception. Their disagreement suggests how unpredictable and variable any assessment of the utility of otherwise overbroad policy provisions would be.

1. A “Reasonable Alternative Design” Test?

Nor would proof of the availability of a reasonable alternative design—in this case, a more suitable policy provision—provide a way around the challenge of assessing the utility of a particular policy provision in light of its purpose. In products liability, proof of a reasonable alternative design is an additional requirement for defectiveness beyond the risk-utility test and not an alternative test for whether a defect exists.¹⁰²

There is good reason for the two separate requirements. If a court could find a product defective based purely on the availability of a reasonable alternative design—even if it satisfied the risk-utility test—then, in effect, there would be a defect whenever the product could be better designed. One would be liable for adopting anything but the best possible design. By analogy, a policy provision would be considered defective whenever there was a “more reasonable” alternative. Insurers, therefore, would be required to have the best provisions possible, and would be liable even if the provisions they used were satisfactory. None of the proponents of the product conception seem to think, or at least expressly state, that insurance policy provisions should be required to satisfy this exacting requirement. But that would be the implication of a test that hinged exclusively on whether there were a reasonable alternative to the challenged policy language.

In any event, even if the test for a defect were whether there was a reasonable alternative policy provision, this would simply shift the locus of the problem entailed in assessing utility. Whether proposed alternative language was reasonable would depend in part on an assessment of its utility—thus implicating the same unpredictability and variability concerns that would

¹⁰⁰ Stempel, *The Insurance Policy as Thing*, *supra* note 78, at 848-49.

¹⁰¹ *Id.* at 848.

¹⁰² See RESTATEMENT (THIRD) OF TORTS: PRODS. LIAB. § 2(b) (1998) (“[A product] is defective in design when the foreseeable risks of harm posed by the product could have been reduced or avoided by the adoption of a reasonable alternative design . . . and the omission of the alternative design renders the product not reasonably safe.”).

trouble an assessment of the provision to which this alternative would be compared.¹⁰³

2. The Problem of Preference Diversity

The cost-benefit test has yet another flaw. It has difficulty accommodating differences in preferences—whether in taste, risk-aversion, or otherwise—among purchasers of a product. Even if a particular risk-utility tradeoff is satisfactory for a majority of purchasers, others may prefer a different tradeoff. In the case of complex products, this concern becomes even more important because individual purchasers will rarely have sufficient information—especially regarding risk—to determine their optimal tradeoff. Therefore, since the market for safety is imperfect, the law must apply a standard that attempts to capture the presumed preferences, or anticipate best interests, of the majority.¹⁰⁴ When it is not feasible to offer alternative products with different degrees of quality, courts employ a one-size-fits-all legal standard. Such a standard almost inevitably fails to track the preferences or interests of some portion of those it purports to protect. Those who would prefer to buy a less safe, less expensive product, for instance, might be precluded from doing so.

The same would be true if a product conception were applied to the assessment of insurance policy provisions. The cost-benefit test would treat all policyholders as if they had the same preferences. Yet this assumption would often be untrue. Schwarcz attempts to accommodate this possibility by requiring that there be a strong likelihood that a provision resulted from a market failure¹⁰⁵—implying that if only one approach is feasible, it cannot be defective. But Schwarcz’s test for market failure is whether there is uncertainty¹⁰⁶ “about whether the underwriting purposes of the applicable policy exclusion warrant not covering the loss at issue.”¹⁰⁷

¹⁰³ I have argued elsewhere that the availability of a clearer expression of the insurer’s contended meaning of a policy provision often is an argument for labeling such a provision ambiguous. Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 540-44 (1996). But that contention concerns linguistic clarity, not juridical utility.

¹⁰⁴ See *infra* Section IV.B.

¹⁰⁵ Schwarcz, *supra* note 78, at 1447.

¹⁰⁶ Instead of the term “uncertainty,” he uses the term “ambiguity.” *Id.* at 1447. The choice is unfortunate in this context because of the term’s close association with issues regarding the meaning of policy language. See *id.* at 1452 n.274 (listing cases where courts considered ambiguity regarding coverage). Here, the issue is whether a provision, ambiguous or not, serves its underwriting purpose.

¹⁰⁷ *Id.* at 1448.

Insurance market failures result, however, not only when an insurer is in a monopoly-like position, but also when transaction costs prevent an insurer from offering a range of coverage options to reflect the different preferences of policyholders. For example, burglary coverage of the sort involved in *Atwater* can be either broad or narrow, requiring visible marks of entry or not requiring them. Some policyholders will want broader coverage at a higher premium, whereas others will want narrower coverage at a lower premium. If it is not cost-effective for insurers to offer this choice because of transaction costs, they must offer only one of the options. Some policyholders will then receive the coverage they want, but others will have to settle for more or less coverage than they prefer, depending on the coverage offered.

Under these circumstances, asking about the underwriting purpose of the visible marks of entry provision is not very meaningful.¹⁰⁸ The provision's purpose is to provide the coverage that the majority of potential policyholders prefer. Of course, it is also possible—likely, in this instance—that most policyholders are not aware of the visible marks provision. This lack of knowledge may be why it is not cost-effective to offer policyholders a choice of broad or narrow coverage—too much explanation is required given the minimal increase in premium revenue that offering a choice of coverage would generate.

The only question that a defectiveness test could then answer is whether the coverage the insurer provides is satisfactory to the majority of its policyholders. However, it is unclear how a court could make such a determination in most instances. Only in the few cases in which it is obvious *as a matter of law* that most policyholders would want more coverage than was provided and would be willing to pay for it would a court be able to make this determination with confidence. In other cases, it is possible that the majority would prefer (and be willing to pay for) broader coverage, but there is no reliable way to adjudicate this question. Majority preferences would depend not only on the combination of coverage and prices offered, but also on the different degrees of risk aversion of potential policyholders. Those factors are not matters that are easily susceptible to fact-finding in insurance coverage litigation. Even insurance regulators have trouble answering detailed questions about policyholder preferences like these.

In short, the product conception of insurance would face the same problem that design-defect litigation faces in products liability itself. Ideally, market forces would present product purchasers with different combinations of safety, cost, and other product qualities, thereby satisfying different preferences. In

¹⁰⁸ See *supra* notes 95-101 and accompanying text.

practice, however, product purchasers are not always sufficiently knowledgeable about safety risks—and cannot become sufficiently knowledgeable in a cost-effective manner—for market forces to offer reliable optimal safety levels for individuals with varying preferences.

The same is true for insurance coverage. In practice, policyholders usually are not sufficiently knowledgeable, and the market is not sufficiently supple, to offer policyholders with different preferences the type and amount of coverage that would be optimal for them. But courts and juries are also not well-suited to make such product-optimizing or coverage-optimizing calculations. Even if they were, such calculations would at best only satisfy the preferences of the majority of product purchasers or policyholders, not minority preferences.

This predicament is the same one that much safety regulation faces. Reconfiguring the test for the validity of insurance policy provisions does not avoid this quandary. Rather, reconfiguration changes only the terms in which the debate about when and how to regulate, and who should regulate, is carried on without changing the problems that regulation must confront: When is a regulator's conclusion superior to that of the market, and how should a regulator deal with minority preferences when it is only feasible to satisfy one set of preferences?

IV. THE GOVERNANCE CONCEPTION

Each of the first three conceptions regard insurance as some sort of bilateral transaction between the insurer and the policyholder: a more or less traditional contract (the contract conception),¹⁰⁹ the sale of an essential good requiring regulation (the public utility conception),¹¹⁰ or the sale of a product subject to liability rules governing the quality of the product (the product conception).¹¹¹

A different way of looking at insurance is to understand it as a relationship in which the insurer “governs” its policyholders.¹¹² The proponents of

¹⁰⁹ See *supra* Part I.

¹¹⁰ See *supra* Part II.

¹¹¹ See *supra* Part III.

¹¹² Probably the seminal work in this field is RICHARD V. ERICSON ET AL., *INSURANCE AS GOVERNANCE* (2003), which asserts that insurance governs in nine ways: it objectifies risks into “degrees of chance and harm,” converts risks into costs and probabilities, creates a pool of people interested in minimizing loss, protects against loss of capital against which the insurer offers indemnification, manages risk “through surveillance and audit,” makes risk “subject to contract and adjudication,” offers a cultural framework for conceptions such as responsibility, offers “a social technology of justice,” and “combin[es] aspects of collective well-being and individual liberty.” *Id.* at 47-49.

this conception have been selective in their use of it, mainly citing those practices with which the conception fits and only partially working through the potential implications of this conception for insurance law.

Descriptive and explanatory treatments of this governance conception, for example, identify the ways in which governments and insurers exercise analogous powers.¹¹³ The argument is that, in some settings, insurance functions like government by influencing policyholders' conduct and protecting them against misfortune. This view appears to conceive of insurance as a surrogate for government. The question is just how far to carry this analogy.

In contrast, normative treatments tend to focus on the potential of insurance, like government, to promote solidarity and community among policyholders.¹¹⁴ The implication appears to be that each policyholder has ongoing responsibilities and rights that insurers' obligations should reflect. This view incorporates an organizational conception of governance. However, because policyholders are not necessarily homogeneous, their interests will not always coincide—just as the interests of citizens under a government do not always coincide. In insurance, the interests of the majority and the minority of policyholders may be in conflict. Simply recognizing that a question of governance is involved can neither reconcile these interests nor lead to a choice to favor one set of interests over the other. Principles of governance are required to do that. Consequently, there are complications in the notion of insurance as government—whether as a surrogate for government or as an organization uniting policyholders with conflicting interests—that need to be unpacked. Several aspects of these notions are worth exploring further.

¹¹³ See, e.g., *id.* at 52-58 (discussing ways that insurance industry regulatory techniques mirror those used by the government).

¹¹⁴ See François Ewald, *The Return of Descartes's Malicious Demon: An Outline of a Philosophy of Precaution* (Stephen Utz trans.), in *EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY* 273, 277 (Tom Baker & Jonathan Simon eds., 2002) [hereinafter *EMBRACING RISK*] (indicating that insurance is one of the main nongovernmental instruments for promoting "solidarity" among individuals); Deborah Stone, *Beyond Moral Hazard: Insurance as Moral Opportunity*, in *EMBRACING RISK*, *supra*, at 52, 54 (describing insurance as a system of "collective responsibility" for the harms faced by others). Politicians also often follow this conception. See, e.g., 155 CONG. REC. S7941 (daily ed. July 22, 2009) (statement of Sen. Christopher Dodd) ("In the United States of America, we believe in shared risk and shared responsibility."). Jeffrey Stempel's argument in *The Insurance Policy as Social Instrument* also seems to fit comfortably within the insurance as governance conception. See Stempel, *The Insurance Policy as Social Instrument*, *supra* note 78, at 1495 ("The concept I am advancing could accurately be termed the insurance policy as social instrument, . . . public policy instrument, or even political instrument.").

A. Insurance as Surrogate Government

One of the principal insights of the insurance-as-governance scholars is that, in the modern state, insurers often perform quasi-governmental, behavior-control functions.¹¹⁵ For example, because liability insurance is a precondition to registering a car, auto insurers help to control who drives lawfully and what it costs to drive.¹¹⁶ Similarly, since physicians and others in the medical profession are granted hospital-admitting privileges only if they have malpractice insurance, malpractice insurers determine which physicians get these privileges.¹¹⁷ The practical effect is that insurers decide who can practice medicine in public and private hospitals, where most medical treatment occurs. Likewise, to combat moral hazard, property and liability insurers often charge experience-rated premiums. Experience-rating premiums influences the behavior of policyholders by creating incentives for them to behave more carefully than they would otherwise behave.¹¹⁸

In the behavior-control story that proponents of the governance conception tell, insurers are seen as coercing or influencing individuals to behave in ways that government also sometimes coerces.¹¹⁹ Government in effect relies on insurers to perform some functions that government could legitimately perform but does not.

There is a second surrogate governance function that the proponents of insurance as government sometimes do not emphasize, but that insurance performs in significant fashion. This function is the provision of the equivalent of governmental “entitlements.”¹²⁰ Insurers are the vehicle

¹¹⁵ See Tom Baker & Jonathan Simon, *Embracing Risk*, in *EMBRACING RISK*, *supra* note 114, at 1, 13 (“Whether obtained as a result of compulsion or simple prudence, insurance is a form of regulation.”); Carol A. Heimer, *Insuring More, Ensuring Less: The Costs and Benefits of Private Regulation Through Insurance*, in *EMBRACING RISK*, *supra* note 114, at 116, 125-28 (describing the manner in which the need for insurance regulates access to activities, from home buying to renting cars); Stempel, *The Insurance Policy as Social Instrument*, *supra* note 78, at 1498-1501 (describing the various forms of insurance that are effectively required as a condition of doing business or engaging in ordinary activities).

¹¹⁶ See Baker & Simon, *supra* note 115, at 12-13 (noting that insurance is necessary to own a home and drive a car, and is thus “one of the greatest sources of regulatory authority over private life”).

¹¹⁷ See Heimer, *supra* note 115, at 127 (explaining how malpractice insurance is required to practice midwifery or specialized medicine at hospitals).

¹¹⁸ For a further discussion of experience rating’s effect on the incentives of policyholders, see KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 72-74 (1986).

¹¹⁹ See Baker & Simon, *supra* note 115, at 13 (noting that insurance can be “a crucial form of delegated state power”).

¹²⁰ Insurance-as-governance theorists actually emphasize that government and insurance are providing less protection against risk and more nearly “embrace” risk-taking than in the past. *Id.* at 3-4.

through which the protection against risk, one of the hallmarks of the modern state, is delivered. Life, health, disability, and property insurance all perform this function. In effect, insurance is a means of supporting the social welfare of policyholders who purchase coverage, sometimes voluntarily, but also often without much choice.¹²¹

One possible implication of the governance conception is that insurers should be subject to some of the obligations that are imposed on government because the relationship between insurers and their policyholders falls somewhere between the public relationship of government to its citizens and the private relationship between contracting parties. Governments owe individual citizens (and often noncitizens) obligations that ordinary private entities do not owe to those with whom they contract. Correlatively, individual citizens have both positive and negative rights against government that they do not have against private entities. To the extent that insurance engages in the behavior-control and risk-protection functions that are characteristic of governance, we might expect to see insurance law treat insurers less like private entities and more like government. In any event, we might consider the extent to which insurance should be treated like government. Two examples of such possible treatment are the insurance law analogues to government's obligation to provide procedural due process and equal protection.

1. Insurance "Due Process"

Ordinary contracting parties are entitled to waive their contract rights selectively, whether or not doing so is arbitrary or capricious. If I contract to sell you my car and then have second thoughts about the deal, I am liable to you for the value of the car in damages. This conclusion holds true whether I breach in good faith because I want to keep the car or in bad faith because I have discovered that I do not like your wife. Similarly, a car dealer is free to provide a complimentary replacement part to an owner whose vehicle's warranty expired the week before, on the ground that the owner has always been a good customer, while denying such treatment to those who have bought their cars from other dealers in the past.¹²² Indeed,

¹²¹ See ABRAHAM, *supra* note 118, at 3 ("Some features of the insurance market are left to individual choice, but others are regulated.").

¹²² Through the use of standard-form contract provisions that limit its obligations, a firm can selectively waive those limits and thereby "build a reputation for allowing customers substantial recourse in matters of return, repair, or alteration without committing itself to maintain the policy in any particular case." Rakoff, *supra* note 24, at 1221. By so doing, "the firm gains the discretion to

nascent contracts literature suggests that one of the efficiencies of standard-form contracts is that they permit what Professor Jason Johnston has called “tailored forgiveness.”¹²³ They enable sellers to selectively waive standard performance requirements post-contract and thereby to favor comparatively reliable and nonopportunistic customers whom they could not easily identify in advance.¹²⁴ In insurance terms, this method would consist of identifying and differentially treating parties who have adversely selected, but doing so *ex post* rather than in the typical manner of combating adverse selection *ex ante*.

Government, in contrast, does not have the luxury of this form of discretion. For example, the government is not free to grant benefits to certain applicants who do not qualify for them while denying benefits to other unqualified applicants. I suspect that, in addition to violating the applicable statutory scheme, most observers would consider this sort of treatment to deny the latter group due process of law.

To what extent might a governance conception of insurance subject insurers to an analogous obligation to treat their policyholders with a measure of due process? In many states, insurers are liable to their insureds for “bad faith” denial of valid claims.¹²⁵ When there is such a denial, the insured is entitled to recover not only what is due under the insurance policy, but also extra-contractual damages, compensatory and sometimes punitive, above and beyond what was due under the policy. But in fact there is no requirement that the insured prove the insurer’s subjective bad faith. Rather, the dominant test to determine that a denial was legitimate is simply whether the insured’s claim for coverage was “fairly debatable.”¹²⁶

follow or ignore its practice in any given instance; the consequence, in time of dispute, is to make the adherent a supplicant for relief that the firm usually grants freely.” *Id.* at 1275.

¹²³ Jason Scott Johnston, *The Return of Bargain: An Economic Theory of How Standard-Form Contracts Enable Cooperative Negotiation between Businesses and Consumers*, 104 MICH. L. REV. 857, 879 (2006).

¹²⁴ *See id.* (explaining the function of “tailored forgiveness” in exposing hidden customer types who have signed standard-form contracts); *see also* Lucian A. Bebchuk & Richard A. Posner, *One-Sided Contracts in Competitive Consumer Markets*, 104 MICH. L. REV. 827, 834 (2006) (describing how hotels use check-out rules in a way that is consistent with tailored forgiveness).

¹²⁵ *See infra* note 126.

¹²⁶ *See, e.g.*, *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 995 P.2d 276, 279 (Ariz. 2000) (holding that an automobile insurance company “must exercise reasonable care and good faith” in defending a “fairly debatable” claim); *LeRette v. Am. Med. Sec., Inc.*, 705 N.W.2d 41, 44, 50 (Neb. 2005) (applying the “fairly debatable” standard to uphold an insurance company’s denial of plaintiff’s precertification request for a claim based on an upcoming hysterectomy); *Trinity Evangelical Lutheran Church & Sch.-Freistadt v. Tower Ins. Co.*, 661 N.W.2d 789, 795 (Wis. 2003) (holding that an automobile insurance company may not deny a claim without a reasonable basis for believing that the claim is “fairly debatable”).

Although this standard is nominally substantive, the threat that liability may be a multiple of what is due under the policy itself provides the insurer with the incentive to ensure that it does not deny valid claims. The result is a de facto right to a fairer process of consideration than might otherwise be provided. Moreover, in many of the bad-faith cases, there has been evidence of insurer misbehavior collateral to the claim itself that would probably raise due process concerns if it were committed by a government actor.¹²⁷ The lesson I draw from the cases is that a bad-faith claim has a much better chance of succeeding if the process the insurer followed involved more than merely a mistaken denial of a claim that was not fairly debatable. Following an unfair process matters.¹²⁸

In addition to this common law duty, insurers have a variety of statutory duties reflecting their enhanced obligation to provide fair process. For example, a number of states require that health insurers provide beneficiaries with the right to an administrative appeal of coverage denials.¹²⁹ And most states have also enacted the Model Unfair Insurance Practices Act, which authorizes insurance commissioners to regulate unfair or deceptive practices.¹³⁰

But insurance law provides little right to due process beyond common law liability for bad faith and the limited statutory duties to provide fair process, and probably would find it difficult to do so. Consider a typical situation in which an ordinary contracting party would have no obligation to provide fair process, but the government would have to provide due process. One might think that a conception of insurance as surrogate governance would lead to an insurance law obligation that fell somewhere in between these two extremes. For example, suppose that a policyholder completes an application for coverage and the insurer issues a policy in reliance on the facts stated in the application. The policyholder subsequently suffers a loss and makes a claim, and in the course of investigation the insurer begins to suspect the policyholder is engaging in the most egregious form of adverse selection: he knowingly misrepresented facts about the risks he posed on his insurance application. But the insurer is never able to secure proof of the fraud. Instead, the insurer denies the coverage claim on grounds it would not apply to policyholders whom it does not suspect of

¹²⁷ See ABRAHAM, *supra* note 4, at 452-53 (suggesting that many of the cases have this feature).

¹²⁸ *Id.* at 453.

¹²⁹ See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 361 (2002) (analyzing an Illinois law that requires independent medical review of denied claims that are appealed).

¹³⁰ See UNFAIR CLAIMS SETTLEMENT PRACTICES ACT, at ST-900-1 to -6 (Nat'l Ass'n of Ins. Comm'rs 2012); see also ABRAHAM, *supra* note 4, at 119 (explaining the various powers states typically give to insurance commissioners).

fraud.¹³¹ A similar hypothetical involving the most egregious form of suspected moral hazard—arson, for example—could also be constructed.

However, no doctrine in insurance law precludes the insurer with an ulterior motive from using this type of subterfuge if in fact the validity of the insured's claim was otherwise "fairly debatable," the test for bad-faith denial of a claim in most states.¹³² The insurer is free to insist on or waive its rights to deny coverage as it sees fit, asserting its defense to some policyholders' claims but waiving the defense to claims by others under the same circumstances.¹³³ The insurer thus has discretion to insist upon or waive its contract rights in the same way that the car dealer in my earlier hypothetical is free to insist on or waive the provisions of its automobile warranties.

The absence of any affirmative legal obligation for insurers to apply the same standards to all claims is considerable evidence that the reach of the private government conception is limited. While insurers have an obligation to provide their insureds with certain features of fair process, this obligation does not extend to applying the same substantive standards to all claims. But should they be under such an obligation?

The arguments in favor of such an obligation might follow directly from the very notion of insurance as surrogate governance. Insurance is a good that is important—if not essential—to individual and business well-being. Given the role that insurance and insurers play in furthering such well-being, candid and disinterested claim-processing, rather than self-interested conduct, could be made obligatory. And as in other long-term relationships where exiting is difficult or costly—such as membership in a labor union or certain kinds of employment—there is a need for procedural protections against opportunistic behavior by the dominant party. A requirement that

¹³¹ See, e.g., *Heller v. Equitable Life Assurance Soc'y*, 833 F.2d 1253, 1257 (7th Cir. 1987). In *Heller*, a disability insurance policy covered lost income resulting from the "complete inability of the Insured, because of injury or sickness, to engage in the Insured's regular occupation." *Id.* at 1255. The policyholder was a cardiologist who specialized in invasive procedures and contracted carpal tunnel syndrome, a condition affecting the dexterity of his hand and fingers, months after he purchased the policy. *Id.* at 1254-55. The insurer denied coverage because the insured refused to undergo an elective surgery, which could have allowed the insured to return to practice. *Id.* at 1255. A second potential ground for denial of coverage, however, could have been that the insured was still able to "engage" in his "regular occupation." *Id.* The insurer's stated basis for denying coverage was so likely to fail that the alternative of suspected fraud is a far more plausible explanation for the insurer's decision to fight the claim all the way to its unsuccessful appeal to the Seventh Circuit.

¹³² See *supra* note 126.

¹³³ State unfair-insurance-practices laws conceivably would reach such behavior through their prohibition of "[f]ailing to provide promptly a reasonable explanation of the basis relied on in the insurance policy . . . for the denial of a claim" when "perform[ed] with such frequency as to indicate a general business practice." CAL. INS. CODE § 790.03(h)(13) (West 2005).

insurers provide claimants the real rationale for denying a claim, and act only on that reason, could help satisfy that need. In contrast, giving insurers the right to engage in subterfuge increases the risk that they will deny valid claims that they incorrectly believe are the products of adverse selection or undue moral hazard. Some claimants will in effect face silent accusations of such behavior without ever having the opportunity to disprove the insurer's suspicion—indeed, often without even knowing of the suspicion or that it is the insurer's actual reason for denying the claim.

Two arguments against recognizing a due process-like obligation of candid disclosure, however, put the case for it seriously in doubt. First, as I will argue below, any conception of insurance as governance should recognize that government often acts for the benefit of the majority of its constituents. Insurance claimants who are guilty of fraud or arson seek unjustifiably to obtain payment of funds that would otherwise be devoted to the payment of valid claims. Ultimately, this is a cost to current or future policyholders, whose premiums must rise if invalid claims are paid. Most honest policyholders probably do not want to pay premiums that will sometimes pay fraudulent policyholders, even if this means that the occasional policyholder who is incorrectly suspected of fraud is denied coverage.¹³⁴

Second, expressly recognizing a due process-like obligation might be an empty gesture. One reason that there is no law on this issue may be that a policyholder would have difficulty raising the issue effectively. Just to pose the issue, a policyholder would have to obtain evidence that (1) the insurer suspected the insured of adverse selection or moral hazard which, if proved, would be a valid basis for denying the claim; and (2) in the absence of its suspicions, the insurer would not have denied the claim on the same basis that it actually asserted for denying it. Proving only condition (1) would be insufficient, because otherwise the existence of the insurer's suspicions would have no causal connection to the denial of the claim. However, obtaining evidence of (2)—evidence of causation—would require discovery into and the compilation of a vast amount of data from an insurer's files. In my view, courts would probably exercise their discretion not to permit such discovery: the files might not always reveal the insurer's putative suspicions, and the cost of obtaining and then analyzing data would likely be prohibitive except on a class-wide basis or in connection with claims involving very high potential recovery. It is no surprise, then, that in over thirty years of studying insurance law, I have never encountered a case making such a

¹³⁴ Cf. *supra* notes 96-101 and accompanying text.

claim. Moreover, few courts would even want to entertain the possibility of such litigation.

For these reasons, there probably never has been a meaningful opportunity for policyholders to attempt to develop a right to due process–like treatment from their insurers. The extent to which the courts would recognize such a right, and thereby make law that further reflects the private government conception, is therefore not clear. Instead, the interest of insureds as a group in the candid disclosure of the insurer’s actual reasons for denying claims is partially protected by the threat of liability for the bad-faith denial of claims.¹³⁵ If the insurer suspects an insured of fraud or arson, but cannot prove it and denies a claim on the basis of a defense that is not even fairly debatable, the insurer is liable for extra-contractual damages.¹³⁶ The number of other cases in which the basis for denial of the claim is fairly debatable, but is not the insurer’s actual reason for denying the claim, may not be large. If so, then the absence of an express remedy for this kind of subterfuge may not be significant.

2. Insurance “Equal Protection”

Insurance law provides some protection against the unequal treatment of policyholders. However, most of this protection is provided for by statute or regulation rather than the common law, and the protection is limited. At the state level, both legislative and regulatory directives prohibit the use of certain classification variables in setting premium rates,¹³⁷ even if the rate classes produced would be actuarially sound. Insurance commissioners in every state have the authority to prohibit rates that are “unfairly discriminatory,”¹³⁸ and state statutes sometimes single out particular variables for prohibition in connection with certain forms of insurance. For example, a Hawaii statute prohibits auto insurance companies from basing standards or rating plans on “race, creed, ethnic extraction, age, sex, length of driving experience, credit bureau rating, marital status, or physical handicap.”¹³⁹ Certain forms of classification based on genetics are also regulated. At the federal level, the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits health insurers from requesting or using individuals’

¹³⁵ See *supra* note 126.

¹³⁶ See *supra* text accompanying notes 125-26.

¹³⁷ See *infra* note 139.

¹³⁸ See ABRAHAM, *supra* note 4, at 119.

¹³⁹ HAW. REV. STAT. § 431:10C-207 (2005).

personal genetic information in underwriting or risk-classification.¹⁴⁰ Moreover, “over half the states have enacted legislation that prohibits or in some way limits insurers from requiring genetic testing of applicants or from asking for the results of testing done independently.”¹⁴¹

There is no single factor common to all of insurance law’s efforts to promote equality, any more than a single factor is common to all the equality protections afforded by the U.S. Constitution or other sources of legal authority. However, one factor common to a substantial subset of these equality efforts in insurance law involves uncontrollable causes of loss. Many of these protections rule out the consideration of characteristics over which policyholders have no control—mental health, gender, race, genetic makeup, etc.¹⁴² It is as if insurance law has decided that at least some of the risks associated with what Rawls termed “the natural lottery”¹⁴³ should be shared by all policyholders, rather than advantaging some and disadvantaging others. Thus, a norm of equal treatment of uncontrollable risks seems to be at the heart of many of insurance law mandates that resemble equal protection.

What about the possibility of going further and placing even stronger limits on the extent of an insurer’s authority to vary premiums based on the degree of risk posed by the insured? After all, government “charges” everyone the same rate for Social Security and Medicare insurance.¹⁴⁴ Unfortunately, providing an answer requires more than merely shifting from a contract to a governance conception of insurance. This is because adopting a governance conception does not itself dictate to what kind of theory of government one subscribes. Governance, after all, can be either

¹⁴⁰ Pub. L. No. 110-233, § 101–104, 122 Stat. 881, 883–903 (codified in scattered sections of 26, 29 & 42 U.S.C.).

¹⁴¹ ABRAHAM, *supra* note 4, at 153–54.

¹⁴² See *supra* note 139 and accompanying text.

¹⁴³ JOHN RAWLS, A THEORY OF JUSTICE 75 (1971).

¹⁴⁴ In fact, the way in which government charges everyone the same rate for these forms of public insurance is more complicated than this rhetorical question implies. When government pays for services out of general revenues and these revenues are raised primarily through progressive income taxes, everyone is not charged the same rate for these services. The wealthy pay more for the same service than the less wealthy. We may make up the difference in practice by providing the wealthy with greater access to federal farm subsidies, Department of Commerce services, better local policing, or garbage removal services, but, at least formally, the wealthy pay more for these services because they are financed by progressive taxation. In contrast, the decision to finance Social Security and Medicare through flat-rate income taxation with a comparatively low income-ceiling—relative to financing them out of general revenues—is actually a regressive approach. It may charge everyone the same rate based on their risk levels, but doing so costs the poor a higher percentage of their income than the wealthy. In effect, there is very broad sharing of the cost of general government services—because they are financed by progressive taxation—but less sharing of the cost of Social Security and Medicare between the poor and the wealthy. The poor bear a cost burden that is greater for them than it is for the wealthy.

heavily or lightly egalitarian. Therefore, conceiving of insurance rate classification as posing an equal protection–like issue does not tell us how to resolve the issue.

Perhaps the strongest explanation for insurance law's apparent reluctance to regulate insurance classification in a more egalitarian manner is that doing so could create more adverse selection and cross-subsidization than most people would find acceptable. In general, there is little prohibition of rate classification based on controllable characteristics. For example, liability insurers, including auto liability insurers, are permitted to base their rates in part on the insured's past loss experience.¹⁴⁵ It is true that the risk of adverse selection has sometimes been exaggerated.¹⁴⁶ However, the fact that the risk has been exaggerated does not make it nonexistent. If experience rating were not permitted, higher risk drivers would tend to buy more coverage than they would otherwise, and yet they would not have paid premiums commensurate with the rate of claims that they would make. Average and low-risk drivers—by definition the majority of drivers—would in effect be subsidizing the riskier driving minority. These drivers would not want to do that.

Insurance law could nonetheless require that this minority benefit at the expense of the majority, but that would involve an allocation of resources to the minority where the justification for such an allocation would be uncertain. In fact, it is this sort of conflict between the majority and the minority that is characteristic of the governance of organizations. This conflict is in turn reflected in the second conception of insurance as governance.

B. *Insurance as Organization: The Relationship Between the Majority and Minority of Policyholders*

In addition to the conception of insurance as surrogate government, the governance conception might see insurance as a set of relationships among policyholders. Under this conception the insurer would be more like an agent or trustee, serving the purposes of its policyholder-principals, with profits (when permitted) earned by the payment of fees to the insurer for this service.¹⁴⁷ Individual insurer-policyholder contracts would be seen as

¹⁴⁵ E.g., *Your Choice Auto Insurance Options*, ALLSTATE, <http://www.allstate.com/auto-insurance/auto-insurance-features.aspx> (last visited Jan. 11, 2013) (safe-driving bonus).

¹⁴⁶ See, e.g., Siegelman, *supra* note 16, at 1244 (noting that theoretical models and empirical studies failed to support the importance of adverse selection in insurance markets).

¹⁴⁷ Mutual insurance companies come closer in legal form to this conception than stock companies because their policyholders own mutual insurers. Yet since mutual insurance policyholders

merely serving as the legal mechanism for bringing the institution of insurance into being. Insurers would be understood as the intermediary through which individuals, motivated by concern for themselves, become part of an enterprise that transforms selfish concern into altruism.¹⁴⁸

In considering insurance as surrogate government, as I did in the preceding section, a single policyholder could properly be understood to stand for all the policyholders. However, in considering the relationship between the majority and minority of policyholders, we cannot indulge in this assumption. One impact of looking at insurance as a set of relationships within an organization is that, for certain purposes, the insurer is set off to the side, and the relationship among those who are governed—the policyholders—is placed into sharper focus. Certain practices that might otherwise appear to be advantage-taking by the insurer may then be seen as market reactions to demand by the majority of policyholders.

For example, sellers in a market have an incentive to try to satisfy the preferences of even a minority of consumers. In fact, markets are often superior to politics at dealing with conflicts between the interests of the majority and the minority.¹⁴⁹ Yet there comes a point at which all demand cannot be satisfied at an acceptable price. A minority of consumers want a product or service that is not cost-effective for sellers to provide because of the lack of demand. Shoe manufacturers make shoes in half-sizes, even though a few consumers would like them made in quarter-sizes, because most people find half-sizes acceptable and would not pay the additional cost entailed in obtaining a more perfect fit. Similarly, limitations on coverage for mental health care in health insurance arguably reflect the preferences of the majority (whether these preferences are in the majority's long-term self-interest is a separate question) for greater coverage—other things being equal—for physical rather than for mental health care. Limitations on burglary insurance to losses evidenced by “visible marks on the exterior of the building” that operated in *Atwater Creamery*¹⁵⁰ may reflect the preference of the majority for avoiding additional premiums that would be

rarely exercise control of or influence over management, the difference between mutual and stock insurance companies is more apparent in theory than reality.

¹⁴⁸ Cf. Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 518 (1983) (noting that controversies about insurance classification “reveal the strain produced by the opposition of individual autonomy and intragroup solidarity”); Kimball, *supra* note 47, at 491-98 (suggesting that the purposes of insurance law include promoting reasonableness between the insurer and its policyholders as well as promoting equity among policyholders).

¹⁴⁹ HENRY HANSMANN, *THE OWNERSHIP OF ENTERPRISE* 288 (1996).

¹⁵⁰ *Atwater Creamery Co. v. W. Nat'l Mut. Ins. Co.*, 366 N.W.2d 271, 278 (Minn. 1985); see also *supra* notes 95-100 and accompanying text.

involved in case-by-case inquiries into whether a loss was the result of an actual burglary or an inside job. On this view, much of the criticism aimed at insurers may actually reflect insurers' responses to majority preferences.

However, it is also true that once we begin to conceive of insurance as organizational governance, these phenomena may take on a different valence. It may well matter if we think of the minority, not as a set of people with idiosyncratic tastes that they cannot afford to satisfy, but as members of a community whose interests conflict with those of the majority. Then the question would be whether and when insurance law, as a tool by which policyholders "govern" themselves, should prescribe rules that trump the market's tendency to satisfy majority rather than minority preferences.

As I noted above in discussing insurance "equal protection," insurance law as it currently stands has chosen to protect policyholder minorities mainly against disadvantages resulting from uncontrollable characteristics—race, religion, gender, and genetics, for example. Different versions of insurance as governance might choose an even more egalitarian, or a far less egalitarian (or even libertarian) approach.

But one of the controllable characteristics that insurance law typically has chosen to make the responsibility of each policyholder, rather than to share among all policyholders, is the decision to engage in opportunistic behavior. Two major threats that opportunism poses for the insurance function are adverse selection¹⁵¹ and moral hazard.¹⁵² Restrictions on coverage

¹⁵¹ Adverse selection is the greater tendency of those who are at above average risk of suffering a loss to seek coverage of the risk of loss. ABRAHAM, *supra* note 4, at 6. Insurers attempt to combat adverse selection through a number of methods. With the exception of prohibitions on rate classifications based on uncontrollable characteristics, regulators typically permit insurers to use these methods of combating adverse selection. For example, insurers may seek risk-related information from applicants for coverage and then base the premiums they charge on the level of risk that this information reveals. *Id.* at 7. Insurers may also include limitations in their policies designed to preclude coverage of losses that, if covered, would be particularly likely to generate adverse selection. *Id.* Thus, homeowners policies place dollar ceilings on the amount of coverage provided for jewelry losses, and life insurance policies limit coverage of loss resulting from suicide within one year of the date of the issuance. *Id.* at 197-98, 312.

¹⁵² Moral hazard is "the tendency of any insured party to exercise less care to avoid an insured loss than would be exercised if the loss were not insured." *Id.* at 7. Insurers attempt to combat moral hazard by basing premiums in part on past losses, thereby creating an incentive for policyholders to exercise care to avoid loss even though they are insured, in order to reduce premiums in subsequent policy periods. *Id.* In addition, insurers include limitations on coverage in their policies designed, directly or indirectly, to combat moral hazard. For example, all liability insurance policies exclude coverage of loss that is "expected or intended" or caused intentionally by the insured. *Id.* at 533. And Commercial General Liability (CGL) insurance policies purchased by most businesses in the United States exclude coverage of liability for injury or damage caused by pollution. *Id.* at 467-68. In my view, this decision is based at least in part on the ground that

and legal doctrines designed to combat these threats are sometimes seen as the product of overreaching by insurers.¹⁵³ There are certainly a number of examples of insurer overreaching in the name of protecting against these threats. But it is also plausible to understand many efforts by insurers to combat adverse selection and moral hazard as methods of preventing the minority of applicants and policyholders from taking advantage of the majority.

If high-risk applicants for insurance could obtain coverage that did not take into account the degree of risk they posed, then adverse selection could result as lower-risk applicants disproportionately failed to purchase coverage, purchased less coverage than they would otherwise purchase, or continued to purchase coverage, in effect cross-subsidizing higher-risk applicants. Permitting insurers to combat this tendency allows the majority to protect itself against the minority of adverse selectors; placing restrictions on insurers' use of devices that combat adverse selection creates "minority rights."

Similarly, if no policy provisions or insurer practices combated moral hazard, then some policyholders would behave less carefully than they would have behaved in the absence of coverage, disadvantaging others who did not relax the degree of care they exercised. Permitting insurers to use these policy provisions and follow these practices protects the majority from the behavior of the minority; placing restrictions on insurers' use of devices that combat moral hazard creates "minority rights."

I have heard insurers invoke this kind of rationale for certain of their practices. They argue, for example, that it would be unfair to safe drivers if insurers did not surcharge the premiums of drivers who had made claims in the prior policy year. And, in the past, insurers contended that prohibiting preexisting-condition limitations in individual, voluntarily-purchased health insurance would encourage people to wait until they became ill to purchase insurance, thus taking advantage of those who had purchased insurance while they were healthy. Behavior by a minority of policyholders that imposes a cost on the majority, however, infringes on the rights of that majority only if the majority has no duty to the minority regarding that behavior. If people have a right to health insurance, whether or not they

gradual pollution is likely to be somewhat controllable by policyholder precautions that the insurer is unable to observe.

¹⁵³ See, e.g., Baker, *supra* note 16, at 249; Siegelman, *supra* note 16, at 1232 (noting one commentator's view "that expanded tort liability led to a series of adverse selection death spirals . . . leading ultimately to a complete collapse of certain segments of the liability insurance market").

have purchased it before they become ill, then preexisting-condition limitations violate the rights of the minority, not the majority.

That is, the governance conception helps us to understand insurance rights and obligations as running not only *de jure* between insurers and policyholders, but also *de facto* among policyholders. The governance conception, however, cannot tell us the substance of these rights. It cannot tell us what rights the majority should have against the minority, or what rights the minority should have against the majority. It takes a theory of substantive insurance rights and obligations to do that. For example, such a theory might be that only certain uncontrollable characteristics should be prohibited from use in rate classification. A classification based on gender might be acceptable in pricing life insurance and annuities because, although the former distinction disadvantages women, the latter advantages them. Or the theory might hold that classification in auto liability insurance should be heavily based on the number of miles driven, in order to encourage use of alternative, energy-conserving forms of transportation.¹⁵⁴ In short, under the governance conception decisions about the rights and obligations of policyholders among themselves are political. If the law is to trump or supplant what the market would provide about these rights and obligations, it must do so not only based on the notion that insurance is governance, but based on a *particular theory* regarding the duties of the majority to the minority. Without such a theory, we have a framework for analyzing the question, but no basis for answering it.

CONCLUSION

The lesson of this Article is that employing different conceptions of insurance may help us see the entirety of insurance and insurance law more clearly, and may highlight certain normative possibilities that other conceptions hide or underemphasize. Having different conceptions of insurance may shed additional light on the two fundamental questions insurance law perpetually faces: how binding the language of insurance policies should be, and what role public law values should play in insurance law.

Thus, the contract conception reflects the importance of policy language and highlights the potential importance of fine differences in coverage, but it does not adequately account for policyholder rights that are at variance

¹⁵⁴ Cf. Jennifer B. Wriggins, *Automobile Injuries as Injuries with Remedies: Driving, Insurance, Torts, and Changing the "Choice Architecture" of Auto Insurance Pricing*, 44 LOY. L.A. L. REV. 69, 82-84 (2010) (arguing that auto insurance laws imprudently encourage driving despite "the huge public health problems, environment degradation, and other costs caused by cars").

with policy language. The public utility/regulated industry conception captures the way that insurance law reflects the essential importance of health and auto liability insurance, but does not accurately depict the way insurance law treats other areas of insurance. The product conception may accurately describe the sense in which insurance is a product, rather than a contract, for most ordinary consumers, but it has not developed a suitable test for evaluating the validity of the insurance product's design. And the governance conception may be better than the others at explaining certain features of insurance law—the cause of action for bad-faith breach, restrictions on risk classification based on uncontrollable characteristics, and the treatment of policy provisions combating adverse selection and moral hazard—but there are large areas of insurance and insurance law about which it has little to say.

Moreover, when we turn from the descriptive to the normative features of these conceptions, none can by itself resolve the issues over which they contest. To use the now standard cliché, each paints a different view of the cathedral, and from that painting normative implications follow.¹⁵⁵ The combined descriptive and normative exercise produces a more rounded and complete picture than the contract conception alone. However, we should not suppose—as the proponents of particular conceptions sometimes seem to do—that developing a conception can itself tell us how insurance should change, or what insurance law should be. The exercise can bring into the foreground what the contract conception sometimes relegates to the background. But the particular lens through which we view insurance law cannot tell us what principles should govern or what policy choices to make. The way we look at insurance law can only bring to our attention the availability of choices that the dominant conceptual structure had previously camouflaged. We still have to make the actual choices ourselves.

¹⁵⁵ For the origins of this metaphor, see Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1089-90 n.2 (1972).