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## EXCUSING NONOCCURRENCE OF INSURANCE POLICY CONDITIONS IN ORDER TO AVOID DISPROPORTIONATE FORFEITURE: CLAIMS-MADE FORMATS AS A TEST CASE

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# EXCUSING NONOCCURRENCE OF INSURANCE POLICY CONDITIONS IN ORDER TO AVOID DISPROPORTIONATE FORFEITURE: CLAIMS– MADE FORMATS AS A TEST CASE

*Bob Works\**

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## INTRODUCTION

Claims-made liability insurance coverage, the New York State Insurance Department told us more than a decade ago, "is generally inferior to occurrence coverage."<sup>1</sup> For a time developments regularly chronicled in the trade press seemed to confirm that judgment. Industry efforts to introduce a claims-made format for commercial general liability policies were flatly rejected by most sophisticated buyers.<sup>2</sup> Some jurisdictions instituted

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1. *New York State Insurance Department Opinion and Decision on Issues Raised by Insurance Services Office on Commercial General Liability Claims-Made Form*, 4 J. INS. REG. 39, 41 (1986). See also Reg. No. 121, N.Y. COMP. CODES R. & REGS. tit. 11, § 73 (1993) (minimum standards for approval of claims-made forms).

In a "pure" occurrence format, the trigger that activates liability insurance coverage usually is bodily injury or property damage allegedly caused by a tortious act; less frequently, in professional liability and other settings where determining the time of the injury may be difficult, the occurrence trigger may be the negligent act or omission itself. In a "pure" claims-made format, the trigger that activates liability insurance coverage is a claim for damages made by an injured party against the insured during the policy period. As we shall see, such generalizations often obscure more than they reveal.

2. See, e.g., *In re Insurance Antitrust Litig.*, 938 F.2d 919, 923 (9th Cir. 1991) (policyholder resistance to claims-made formats), *aff'd in part, rev'd in part by* Hartford Fire Ins. Co. v. California, 509 U.S. 764 (1993). Compare INSURANCE SERVICES OFFICE, COMMERCIAL GENERAL LIABILITY INSURANCE: ISO MAKES THE CASE FOR THE CGL (1985) (reciting advantages of claims-made formats) with John F. Fitzgerald, *Claims-Made and the Agent*, BESTS REV. — PROP. & CASUALTY INS. ED., Jan, 1988, p. 48 ("Claims-made is a bust, an overreaction, a dead issue."). See

regulatory restrictions on the use of claims-made formats.<sup>3</sup> Defense lawyers complained that courts both in this country<sup>4</sup> and abroad<sup>5</sup> improperly were converting claims-made policies into occurrence policies, and were in turn denounced as having mounted a crusade to "rig the common law" to prevent such heresies from taking root.<sup>6</sup> And, perhaps most visibly to the casual observer, major players in the insurance industry found themselves defending high profile antitrust litigation alleging that they had employed illegal boycotts in an effort to force an unwanted format on unwilling buyers.<sup>7</sup>

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also Alison Kittrell, *Risk Managers Accept Claims-Made Reluctantly*, BUS. INS., Oct. 13, 1986, at 1, col. 2 (survey indicates more than 50% forced to use claims-made policies); Robert A. Finlayson, *Insurers Restricting Use of Claims-Made CGL Form*, BUS. INS., Feb. 9, 1987, at 1, col. 2 (insurers insisting on claims-made format only for long tail exposures). The best generally accessible guides to the current use of claims-made formats are the publications of the International Risk Management Association. See INTERNATIONAL RISK MANAGEMENT INSTITUTE, INC., PROFESSIONAL LIABILITY INSURANCE VIII.C.3 (1995) (hereinafter "IRMI, PROFESSIONAL LIABILITY INSURANCE"); INTERNATIONAL RISK MANAGEMENT INSTITUTE, INC., COMMERCIAL LIABILITY INSURANCE II.C.5 (1995) (hereinafter "IRMI, COMMERCIAL LIABILITY INSURANCE").

3. See, e.g., ARK. CODE ANN. §§ 23-79-306 to 307 (Michie 1992); COLO. REV. STAT. § 10-4-419 (1998); CONN. ADMIN. CODE Title 38a §§ 327-1 to 327-6 (1990); N.Y. COMP. CODES R. & REGS. title 11, § 73 (1993); N.C. GEN. STAT. § 58-40-140 (1994).

4. See *infra* notes 50-68, 88 and accompanying text.

5. See generally Jorge Angell, *Claims Made Policies or Occurrence Policies in Civil Liability Insurance: A Spanish Judicial Perspective*, INT'L J. INS. L. 112 (1994); Jorge Angell, *Claims Made Policies or Occurrence Policies in Civil Liability Insurance in Spain: Announced Legislative Changes*, INT'L J. INS. L. 191 (1994); Marcel Fontaine, *Claims Made Policies Under Belgian Law*, INT'L J. INS. L. 128 (1994); Tim Griffiths, *Time-Limits in Claims Made Insurance in Australia and New Zealand*, 5 INT'L INS. L. REV. 85 (1997); Mikaël Hagopian, *France: The Supreme Court Rules that "Claims-Made" Coverage Is a Nullity*, INT'L J. INS. L. 52 (1994); Susan Hankey, *Claims Made Policies and Choice of Law in the European Union*, 2 INT'L INS. L. REV. 267 (1994); Mark Sheller, *"Claims Made": The Australian Experience*, INT'L J. INS. L. 188 (1994). For more accessible summary treatment of the European developments, see Sarah Goddard, *Directives Command Change in Europe: Claims Made Policies Under Fire*, BUS. INS., Oct. 9, 1995, at 75.

6. See *infra* notes 50-71 and accompanying text.

7. See generally ABA SECTION OF ANTITRUST LAW, THE INSURANCE ANTITRUST HANDBOOK 28-30 (1995); Ian Ayres & Peter Siegelman, *The Economics of the Insurance Antitrust Suits: Toward an Exclusionary Theory*, 63 TUL. L. REV. 971

But in recent years that apparently settled history has required some rewriting. Claims-made policies constitute a growing presence in the liability insurance marketplace. University finance departments assure us that "the claims-made form represents a preferred form of contracting under conditions of non independence between insurable risks."<sup>8</sup> Judicial unease

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(1989); George L. Priest, *The Antitrust Suits and the Public Understanding of Insurance*, 63 TUL. L. REV. 999 (1989). In 1988, nineteen states and a number of private plaintiffs filed complaints in federal district court alleging that some domestic primary and reinsurance companies, a reinsurance broker, and London-based reinsurers had conspired to force the Insurance Services Office to make changes in its CGL program, to include, especially, claims-made policy triggers. Later that year ten other states joined the litigation, and a similar action was filed in Texas state court. In 1991, the Texas suit was settled for \$6.6 million. See Michael Bradford, *Final Defendants Settle Texas Antitrust Litigation*, BUS. INS., Apr. 1, 1991, at 2.

The federal suit was dismissed on summary judgment in September, 1989, but the United States Court of Appeals for the Ninth Circuit reversed in a decision that defined boycott to mean a "use of economic power of a third party to force the boycott victim to agree to the boycott beneficiary's terms." *In re Insurance Antitrust Litigation*, 938 F.2d 919, 930 (9th Cir. 1991). The United States Supreme Court reversed; the five to four decision held that allegations that the defendants tried to limit liability coverage to claims-made fell within the boycott exception to the McCarran-Ferguson exemption, but in the process defined boycott much more narrowly than had the Ninth Circuit. See *Hartford Fire Ins. Co. v. California*, 509 U.S. 764 (1993). The suit was finally settled in 1994 by an agreement that industry dominance of the ISO board of directors would be ended, and that the defendants would pay the plaintiffs' legal fees and contribute more than \$26 million to establish a public entity data base and a "Public Entity Risk Institute." See generally Judy Greenwald, *Antitrust Settlement to Alter ISO, Industry*, BUS. INS., Oct. 10, 1994, at 1.

The suits by the attorneys general were preceded by *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978), in which the only four insurers selling medical malpractice insurance in the market were accused of conspiring to boycott prospective purchasers of medical malpractice insurance in order to force them to accede to a change from occurrence formats to claims-made formats; the complaint alleged that St. Paul and the other three insurers agreed that St. Paul would offer only claims-made coverage, and that the other three would refuse to write medical malpractice insurance on any terms. The Supreme Court held that the boycott exception to the McCarran-Ferguson exemption from antitrust laws included boycotts that were not aimed at harming competitors.

8. Neil A. Doherty, *The Design of Insurance Contracts when Liability Rules are Unstable*, 58 J. RISK & INS. 227, 243 (1991). In Doherty's view, the emergence of claims-made forms "helped to revive a flagging market" and "challenges the basis of recent antitrust suits brought against the industry which suggests that introduction

about claims-made coverage seems on the wane, and a variety of legal voices can be heard confirming that “the advantages of the claims-made form over occurrence policies for professional and commercial liability risks are now well documented.”<sup>9</sup>

So which is it? Are claims-made formats “generally inferior,” or a “preferred form of contracting” whose “advantages . . . [are] well

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of the claims made policy is harmful to consumers”). *Id.* at 243, 244. *See also infra* notes 302–304 and accompanying text.

9. Harry W.R. Chamberlain II, *Claims-Made Policies Are Enforceable in California: Trends after Burns v. International Insurance Company*, 28 TORT & INS. L.J. 90, 92 (1992). *See also* W.F. Young, *Is Insurance A Niche Business? Reflections on Information as an Insurance Product*, 1 CONN. INS. L.J. 1, 29 (1995) (seeing no sharp dichotomy between “occurrence” and “claims-made” coverages: “The two are roughly equivalent, so long as the enterprise insured throws off claims that are even over time in frequency and magnitude.”); Kathleen E. Wherthey, *New Life for The Claims-Made Liability Policy in Maryland*, 53 MD. L. REV. 948, 949 (1994) (celebrating Maryland’s joining “the national trend toward continuing the viability of the claims-made form of coverage, a cost-effective innovation, which, if drafted with reasonable clarity, benefits both insurers and policyholders”). Not all agree that the systemic effects are so benign. *See, e.g.*, KENNETH S. ABRAHAM, *DISTRIBUTING RISK* 49–51, 58–59 (1986) (claims-made coverages make cost-internalization more difficult).

A claims-made pricing system forces insured enterprises to internalize some costs. But they are mainly not the future costs of today’s activities; they are the costs incurred this year as a result of activities that took place in the past. In effect, claims-made premiums are installment payments for coverage against losses caused by past activities.

*Id.* at 50. Others recognize some of the greater risks individual insureds are forced to bear. *See, e.g.*, ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* § 5.10(d)(1) & (3) at 599 (1988) (“[O]ne of the principal disadvantages . . . is that the policyholder is left to bear much of the burden of uncertainty about future claims costs and the premiums which will have to be paid to cover the continuing risk that new claims may be asserted for activities that occurred years earlier”); Eugene R. Anderson, *Current Issues in Claims-Made Insurance Policies*, ALI-ABA COURSE MATERIALS J., Oct. 1989, at 57; Jeanine Dumont, *What Every Professional Should Know before Buying Claims-Made Liability Insurance*, 35 FED. INS. COUNSEL Q. 363 (1985); Lee Roy Pierce Jr., *Professional Liability Insurance: The Claims Made and Reported Trap*, 19 W. ST. U. L. REV. 165 (1991).

documented?" And why has that question provoked so much explicit attention from lawyers and judges whose conceptions of their professional roles rarely permit any overt examination of the adequacy of contractual exchanges? Most observers agree that liability insurance markets seem to have settled into a relatively stable pattern in which most coverage is written on an "occurrence" basis and "claims-made" coverage is employed chiefly for the more troublesome long-tail exposures. Why not conclude that with liability insurance formats, as with apples and oranges, such questions of relative value may best be left to individual consumers, some of whom may have chosen to purchase a less comprehensive and thus less costly product? After all, as Judge Richard Posner recently reassured us, with claims-made formats "the coverage is less, but so, therefore, is the cost."<sup>10</sup>

But is rolling out the standard Rosetta Stone of applied price theory really a useful way to decipher the Babel that continues to infect the law and literature of claims-made insurance? Is the coverage provided by a claims-made policy less in the same sense that an insured under a personal auto policy has less coverage than if she had purchased collision coverage to go with the other coverages she did buy, or in the sense that the coverage provided by a homeowner's policy is less because the policy excludes liabilities arising out of business activities, or requires that notice of accidents be given within a reasonable time? Of course, in some formal and ultimately trivial sense these limitations on coverage are all the same. In the simple black letter law of contracts, they are all conditions, and the insurer has no obligation to perform unless all conditions are fully satisfied. And in the simple analytics of applied price theory, they are all reductions in coverage that operate to reduce the cost of insurance to insureds, and thus redound to the benefit of all insureds except the unfortunate few who actually get caught by the limitations. But in this article I will argue that there is more to concerns about claims-made formats, and more, both to law and to economics, than that.

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10. *National Union Fire Ins. Co. v. Baker & McKenzie*, 997 F.2d 305, 306 (7th Cir. 1993). The refrain is a familiar one. *See, e.g., Livingston Parish Sch. Bd. v. Fireman's Fund Am. Ins. Co.*, 282 So.2d 478, 483 (La. 1973) ("[T]he insured received what [it] paid for by the present policy, with premiums presumably reduced to reflect the limited coverage."); *Ferguson v. Phoenix Assur. Co.*, 370 P.2d 379, 481 (Kan. 1962) (dissenting opinion) ("In this day and age a person gets just about what he pays for—whether it be insurance protection or anything else—and that is what happened here.").

Put simply, claims-made triggers sometimes operate to allocate to insureds risks that are different in kind from those assigned by more familiar insurance policy coverage restrictions. Because many “claims-made” policies are structured and interpreted to include “claims-made-and-reported” triggers or “potential-claim-discovered-and-reported” triggers, they create the potential that in some circumstances even an insured who maintains continuous unaltered coverage with the same insurer may find that fortuities of timing of some of the events in the tort liability sequence mean that none of those policies has been triggered even when those same fortuities of timing do not affect the burdens borne by the insurer. And, even more fundamentally, because they make the triggers for determining whether a particular insurer is potentially obligated operate late in the liability claim sequence, claims-made policies create the potential that “preexisting circumstances” will become known and render the insured effectively uninsurable in a way not usually encountered outside of medical expense insurance.

Unfortunately, these characteristics of claims-made policies—what I will call the “forfeiture risk” and the “classification risk”—though familiar to the professional risk managers who led the resistance to adopting claims-made triggers for commercial general liability policies, have not received the attention they deserve. There are several reasons. First, these particular devils are in the details, and the details of claims-made policies are far from standardized and often devilishly complicated. Rather than fight through these complexities, too many discussions settle for stylized characterizations of the differences between idealized “pure” versions of occurrence and claims-made formats, and thus fail to train scrutiny on the ways claims-made formats can create occasions for insurer opportunism and encourage forfeitures. Second, though the failure of claims-made triggers to take root in commercial general liability insurance may be an especially useful example of how even a thin margin of informed buyers can protect a larger group of unsophisticated, not all parts of the liability insurance buying market seem to have produced such leaders, and only sometimes are both claims-made and occurrence formats available in the same markets for the same risks. In medical malpractice, legal malpractice, products liability, environmental impairment and a host of specialty product lines, occurrence coverage simply is not an available option for most buyers, and the separation of buyer from insurer by intermediaries like bar and medical associations, managing partners, and brokers may prevent many of those most affected from appreciating the differences. Third, the last decade has been a period of



extraordinarily soft markets in which renewals come easily; we simply have not yet seen the hard markets that would push these concerns to the forefront. But there is another reason as well. Even when the multiple-event trigger and preexisting circumstances problems are squarely presented, the neo-classical habits of thought still dominant in both the law and the economics of insurance provide few tools to help lawyers to understand the problems posed by “forfeiture risk” and “classification risk” and to construct ways to ameliorate them.

Thus, this article has two principal ambitions. The first is to rescue understanding of the operation of claims-made liability formats from the stylized and often misleading descriptions found in the insurance decisions and much of the professional commentary. In this, my effort is not to root out all errors nor to provide a complete systematics of claims-made formats, but rather to suggest a conceptual structure and vocabulary that will permit a more nuanced examination of the very real issues posed by various claims-made formats. The second is to suggest that our understanding of the problems posed by claims-made policies and of the legal responses that may be possible will be enhanced by drawing on the literatures of neo-institutional economics and relational contracting. Neo-classical economic and legal models that use spot market transactions as their paradigm, and that regard each insurance policy as a fully-presentiated contract that speaks clearly to dictate a specific allocation of risks for a specific term, operate from much different premises than the new institutional models grounded in behavioral assumptions concerning “bounded rationality” and “opportunism” and informed by a methodological sensitivity to the vulnerabilities that sequential performances and transaction-specific investments can create. In the neo-classical tradition, a condition is a condition, and there is no reason to inquire why it was included in a contract, why one party failed to satisfy it, or whether the other party was adversely affected by the failure. In this world, defense lawyers understandably regard any unhappy judicial decision as a “refusal to enforce” the policy by a court that has strayed into efforts to “rewrite the contract,” and lawyers representing insureds, struggling to find an explanation for why failure to satisfy a policy condition should not be fatal to their client’s claim, end up casting their challenges as broad-gauge assertions that claims-made forms contravene public policy or violate the reasonable expectations of insureds. By contrast, neo-institutional economics and its legal analogs permit the focus to move from whether claims-made forms on balance are a good thing or a bad thing to how they operate in a particular context, and offer a conceptually coherent explanation for judicial

policing of the application of claims-made formats that the neo-classical tradition simply cannot provide.

The organization of this essay mirrors this agenda. Part I begins with a brief field guide to insurance policy triggers, the variety of triggers to be found in nominally “claims-made” policy formats, and recent claims-made litigation; here we encounter insurance policy exotica so dense that legal taxonomy using traditional classification tools can only hint at the problems claims-made insureds encounter with their claims-made formats and the problems their attorneys encounter with the inadequate doctrinal tools insurance law puts at their disposal. Part II follows with a primer on the law of insurance policy conditions, with particular attention to differences between dominant *ex ante* perspectives summarized by traditional insurance law efforts to vindicate the hypothetical objective reasonable expectations of insureds and subterranean *ex post* policing designed to excuse nonoccurrence of conditions to avoid disproportionate forfeitures; here we seek to identify a fuller array of tools than usually will be found in the insurance lawyer’s kitbag. Part III then offers a preliminary exploration of how these doctrinal tools might operate if applied to some of the peculiar challenges of claims-made formats.

The result is an academic’s exercise, part polemic decrying continued debasements of insurance law by uncritical application of the acontextual formalisms of neo-classical economics and contracts, part homiletic preaching that contextualization requires us to acknowledge that both bounded rationality and opportunism contribute to the special challenges of insurance law, and part speculative meditation about what the problems posed by claims-made formats might tell us about how such an enriched version of insurance law might work in practice. Thus it should not surprise that the focus throughout is less about who should prevail in specific disputes in this small slice of the insurance market than about the different habits of mind that constrain and channel the rhetorical resources that can be brought to bear in controversies throughout insurance.

#### I. A SHORT FIELD GUIDE TO CLAIMS-MADE POLICY TRIGGERS AND CLAIMS-MADE TRIGGER LITIGATION

We seldom worry about insurance policy triggers. If my teenage daughter negligently backs our insured automobile into my neighbors’ recreational vehicle, the insurer that issued our family automobile policy quickly will see that the damaged vehicle is repaired. What “triggered” that obligation? In a fundamental legal sense, the insurer’s present active duty to

pay rests on satisfaction of all of the conditions precedent to that duty: my daughter was an "insured" within the policy definitions, the premiums had been paid, the damage was not something my daughter "expected or intended," she was not engaged in business activities, she gave timely notice to the insurer and cooperated in its investigation of the accident, and so on throughout the multi-page litany of conditions that establish the limitations of the family auto insurer's obligations. But that is not what insurance lawyers mean when they speak of policy triggers. They mean that before we can set about determining whether all a policy's conditions have been satisfied, we first must determine which policy is applicable to the particular insurance story.<sup>11</sup>

Of course, there is no mystery about what insurance policy was triggered by my daughter's accident. Family automobile policies are "occurrence" policies, and so the policy triggered was the one in effect at the time the RV suffered physical damage. Do we care? In this case we do not, because everything that we are likely to consider an element of my daughter's accident, from her initial inadvertence to the insurer's payments to the neighbors, seems likely to be conveniently packed within a single policy period. But what if the sequence takes longer? What if we decompose a liability insurance story into constituent elements and stretch that story over several policy periods? If my 1990 landscaping efforts include negligently leaving a large rock perched on the precipice at the edge of my property, but the rock does not actually crush my neighbor's perambulator until 1991, and the neighbor's claim is not settled until 1992, do we care whether my homeowner's insurer regards the problem as attributable to the 1990, 1991, or 1992 policy years? Usually we do not, so long as I maintained the same homeowner's coverage with the same insurer for each of the years in question. But what if a renewal policy differs in some material way from the policy it replaced, or I changed insurers part way through the sequence, or other claims have exhausted some or all of the policy limits for a particular year? Then we would care, for knowing that the physical damage is the policy trigger tells us which insurer will be obligated to perform if all of its policy conditions are satisfied.

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11. In Professor Fischer's felicitous metaphor, "the trigger concept . . . acts as a gatekeeper, matching particular claims with particular periods of time and hence particular insurance policies." James M. Fischer, *Insurance Coverage for Mass Exposure Tort Claims: The Debate over the Appropriate Trigger Rule*, 45 *DRAKE L. REV.* 625, 631 (1997).

### *A. Choosing a Policy Trigger*

Why would a liability insurer choose one trigger over another? Ease of application is one major factor. We know when the rock crushed the perambulator, but can we confidently locate in one and only one policy year my failure to use reasonable care in planning, executing, and maintaining my landscaping? In that setting an occurrence trigger has obvious advantages over a negligence trigger.<sup>12</sup> But though occurrence triggers often will be satisfied by unambiguous scenes of crumpled metal and bleeding bodies, sometimes they too prove difficult in ways that over the last decades have kept legions of lawyers fully employed. If the perambulator was full of triplets, all of whom were injured, has there been one occurrence, or three (or four)?<sup>13</sup> Does it matter if the triplets were old enough to be walking single file down the sidewalk, and were hit seriatim by the negligently driven car? Because liability insurance usually is written with limits per occurrence, the answer to that question can matter a great deal. If an insured sells livestock feed contaminated with polybrominated biphenyl so that 28,679 cattle, 4,612 swine, 1,399 sheep, and over 6,000 chickens and other farm animals must be destroyed, do we count the mistakes, or count the injuries, or count the farmers bringing suit?<sup>14</sup> If an asbestos manufacturer in operation since the 1940's should have foreseen an unreasonable danger of asbestosis to both its workers and users of its products, should we treat the resulting injuries as having occurred when the victims first inhaled the asbestos fibers, when the fibers became resident in the victims' lungs, when scarring of the lungs could

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12. Of course, the ease-of-application factor can cut the other way. Before the advent of claims-made policies made them obsolete, "occurrence" professional liability policies often were triggered when the professional services were rendered—and the negligent act or omission allegedly occurred—rather than when the client was injured. For a discussion of the difficulties encountered in trying to locate the time of injury in lawyer's malpractice litigation, see RONALD E. MALLIN & JEFFREY M. SMITH, 4 *LEGAL MALPRACTICE* § 33.9–33.11 (4th ed. 1996).

13. Don't forget the perambulator.

14. See *Michigam Chem. Corp. v. American Home Assur. Co.*, 728 F.2d 374 (6th Cir. 1984). Probably most courts agree that "[t]he general rule is that an occurrence is determined by the cause or causes of the resulting injury. . . . [T]he court asks if there was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages." *Id.* at 379, n.5. See also *Bartholomew v. Appalachian Ins. Co.*, 655 F.2d 27 (1st Cir. 1981).

have been discovered, when the scarring actually was discovered, when medical treatment was required, or all of the above?<sup>15</sup>

Of course, such familiar lawyers' concerns about ease of application are not the only important criteria for selecting a policy trigger. Other things being equal, the insurer's financial people will want to employ a policy trigger that falls later in the sequence rather than earlier, in order to shorten the time between when a policy obligation is priced and when the extent of that obligation is determined. Statistical models of insurance pools that help inform insurance underwriting and pricing decisions depend in part on the quality of the loss frequency and severity estimations they employ.<sup>16</sup> Consequently, the longer the period for which one must "develop" immature historical loss data in order to estimate ultimate loss costs for policies written in the past, and the longer into the future one must peer in an effort to trend those estimates of past loss costs in order to make predictions about future loss costs for new policies, the greater the likelihood for error. In the 1970's and 1980's, as insurers wrestled with newly reported claims implicating occurrence policies priced and underwritten (and triggered) decades earlier,<sup>17</sup> many became convinced that the best way to shorten the "tail" on liability insurance policies was to choose a policy trigger that would operate later in the tort liability sequence. How much better, the argument ran, if a claim made against an insured in 1985 based upon a latent injury that "occurred" in 1945 could have been treated as triggering the 1985 policy rather than the 1945 policy; with the benefit of forty additional years of experience to reflect the correlated changes in inflation, loss frequency, legal doctrine, medical

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15. See generally John P. Arness & Randall D. Eliason, *Insurance Coverage for "Property Damage" in Asbestos and Other Toxic Tort Cases*, 72 VA. L. REV. 943 (1986); Stephen V. Gimigliano, Note, *The Calculus of Insurer Liability in Asbestos-Related Disease Litigation: Manifestation + Injurious Exposure = Continuous Trigger*, 23 B.C. L. REV. 1141 (1982). For more recent surveys of the field after attention moved from asbestos-related claims to other progressive injury and progressive damage claims, see Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942 (1988); Tung Yin, *Nailing Jello to a Wall: A Uniform Approach for Adjudicating Insurance Coverage Disputes in Products Liability Cases with Delayed Manifestation Injuries and Damages*, 83 CAL. L. REV. 1243 (1985).

16. See generally David Cummins, *Statistical and Financial Models of Insurance Pricing and the Insurance Firm*, 58 J. RISK & INS. 261 (1991).

17. See, e.g., *Boyce Thompson Inst. for Plant Research v. Insurance Co. of N. Am.*, 751 F. Supp. 1137 (S.D.N.Y. 1990) (in 1988, insurer tendered defense of claims based on activities that occurred between 1924 and 1969).

technology, and jury attitudes over that period, the best pricing guesses for 1985 must necessarily be superior to the best pricing guesses for 1945. Though it was too late to rewrite history to replace occurrence coverage with claims-made coverage for already triggered policies, a change to claims-made formats for future years would assure that future tails would not be so long, and that the uncertainties to which insurers would be exposed by future policies would not be so great.

Thus, claims-made formats could seem to offer a way for liability insurers to avoid at least some of the problems that have so occupied their recent pasts. If the policy trigger no longer must be the injury, but instead could be the claim, many of the nasty lawyer problems involved in determining when an occurrence occurred disappear, and the guesswork involved in determining a price for future liability coverage can be made less daunting. There is little reason to try to change my family auto and homeowners policies to a claims-made format, for the claim by my unhappy neighbors is likely to follow closely behind the sound of an unambiguous crash. But for other settings, where the potentials for multiple or progressive injuries and for long tails seem more threatening, making the policy trigger a claim against the insured could promise insurers an attractive way to avoid some of the problems posed by occurrence triggers.

However, for insureds, the move from an occurrence trigger to a claims-made trigger could prove much less attractive, for two principal reasons. First, claims-made triggers themselves present real lawyer problems. But, unlike the uncertainties of application associated with the "occurrence" trigger, where much of the litigation involved which among several insurers' policies should be deemed to have been triggered,<sup>18</sup> the burden of uncertainties associated with determining when a claims-made policy has been triggered fall most heavily on insureds. And second, the uncertainties the insurer avoids by pushing the trigger deeper into the tort claim sequence do not go away; they are shifted to insureds, and claims-made policies are structured in such a way that the insurer may be empowered to make those risks fall on an individual insured, rather than on the entire pool of insureds. These two ways in which claims-made policies can result in coverage gaps for insureds are at the core of the claims-made problems addressed in this article.

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18. See generally Kenneth S. Abraham, *Allocation of Settlements in Multi-Insurer Coverage Disputes*, 48 FED. INS. & CORP. COUNSEL Q. 427 (1998); Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257 (1997).

*B. Beyond "Pure" Occurrence and "Pure" Claims-Made Policy Triggers*

In the conventional telling, then, liability insurance comes in two flavors: occurrence, and claims-made. As explained by Gerald and Sol Kroll, the most influential of the early prophets of claims-made formats:

At present two types of insurance policies are offered in the professional liability field: the "claims made" (or "discovery") policy and the "occurrence" policy. A "claims made" policy is one whereby the carrier agrees to assume liability for any errors, including those made prior to the inception of the policy, as long as a claim is made within the policy period. On the other hand, an "occurrence" policy provides coverage for any acts or omissions that arise during the policy period, regardless of when claims are made.<sup>19</sup>

Thus:

The major distinction between the "occurrence" policy and the "claims made" policy constitutes the difference between the peril insured. In the "occurrence" policy, the peril insured is the "occurrence" itself. Once the "occurrence" takes place, coverage attaches even though the claim may not be made for some time thereafter. While in the "claims made" policy, it is the making of the claim which is the event and peril being insured and, subject to policy language, regardless of when the occurrence took place.<sup>20</sup>

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19. Gerald Kroll, *The "Claims-Made" Dilemma in Professional Liability Insurance*, 22 UCLA L. REV. 925, 925-26 (1975) (footnote omitted). Numerous courts and commentators have relied on Kroll's simple dichotomy in explaining "claims-made" policy formats, even where the characterization does not fit the policy format in question. See, e.g., *Hasbrouck v. St. Paul Fire & Marine Ins. Co.*, 511 N.W.2d 364, 366 (Iowa 1993). The two-kingdoms vision of the liability insurance world also holds sway from the other side of the divide. See, e.g., *Montrose Chem. Corp. v. Admiral Ins. Co.*, 913 P.2d 878, 904 (Cal. 1995) (to adopt "manifestation" interpretation of occurrence trigger would be same as "transforming the broader and more expensive occurrence-based CGL policy into a claims made policy").

20. Sol Kroll, *The Professional Liability Policy "Claims Made,"* 13 FORUM 842, 843 (1978). For many courts this passage has become the short-hand description of

As described by the Krolls and most commentators, nothing could be simpler.<sup>21</sup> The reality is much more complex. If we decompose liability insurance stories into their constituent elements, beginning with the act or omission by the insured and running all the way through to the final payment by the insurer, we will generate a list likely to include at least the following potential stages in the evolution of liability insurance claims:

#### **Exhibit 1: Potential Stages in the Evolution of Liability Insurance Claims**

allegedly tortious act or omission by insured
exposure of potential victims
injury in fact
manifestation of victim's injury
insured should have discovered circumstances that may give rise to a claim
insured discovers circumstances that may give rise to a claim
insured discovers specific acts or omissions that may give rise to a claim
insured reports to insurer circumstances that may give rise to a claim
insured reports to insurer specific acts or omissions that may give rise to a claim
claim for compensation by victim against insured
insured reports claim to insurer
victim files suit against insured
investigation by insurer
defense and reserving decisions by insurer
negotiations between insurer and victim
judgment or settlement
payment to victim

the difference between occurrence and claims-made policies. *See, e.g., American Cas. Co. v. Continisio*, 17 F.3d 62, 68 (3d Cir. 1994); *Truck Ins. Exch. v. Ashland Oil, Inc.*, 951 F.2d 787, 790 (7th Cir. 1992); *Insurance Corp. of America v. Dillon, Hardamon & Cohen*, 725 F. Supp. 1461, 1469 (N.D. Ind. 1988); *Sherlock v. Perry*, 605 F. Supp. 1001, 1004 (E.D. Mich. 1985). *See also* Sol Kroll, "Claims Made" — *Industry's Alternative: "Pay As You Go" Products Liability Insurance*, 1976 INS. L.J. 63.

21. *See, e.g.,* JEAN LUCEY, *INSURING AND MANAGING THE PROFESSIONAL RISK* 32 (1993) ("How encouraging it is to find terms which accurately express intent and meaning: in this case, claims-made policies provide coverage for *claims which are made* during the policy period."); 1 ALLAN D. WINDT, *INSURANCE CLAIMS & DISPUTES* § 1.07, at 29 (3d ed. 1995) (discussing "the standard claims-made policy"); Fischer, *supra* note 11, at 636 ("Under an occurrence policy, the insured risk covered bodily injury or covered property damage *happening* within the policy period. Under a claims-made policy, the insured risk was a covered claim *being asserted* against the policyholder during the policy period.").



The exercise of exploding liability insurance stories into their constituent parts can serve to remind us of a number of things that will help us to understand the structure and operation of claims-made formats. First, and perhaps most obviously, there is the question of pace: sometimes, as in my daughter's simple auto accident, the entire sequence will play out in a few days; sometimes, as with some insidious disease, products liability, and professional malpractice exposures, the sequence—or even portions of it—can extend over many decades. Second, there is the question of order: though we can imagine liability insurance stories that follow the sequence outlined in Exhibit 1, we also can imagine stories that do not. Discovery by the insured of circumstances that may give rise to a claim, for example, may occur at various places in the sequence, and may not happen at all; if it occurs before a policy has been triggered, the insured may or may not report that information to the insurer. Third, there is the question of when to cut off the sequence: though insurers' rhetoric tends to focus on their desire to avoid uncertainties associated with liabilities that have been incurred but not reported by the end of the policy period (the "IBNR" tail), and academic models often assume that all claims are paid at the end of the policy year, in fact tail problems do not end with tender of the defense to the insurer; even after a claim has been reported to the insurer, the claims-adjustment process still may involve many continuing sources of uncertainty concerning the ultimate impact of the claim on the insurer's treasury.<sup>22</sup>

But the most salient consequence of decomposing liability insurance stories into constituent parts is that it forces recognition that "occurrence" and "claims-made" are not the only possible policy triggers, and that neither is free from troublesome questions of application. The fierce battles over the last two decades about how to apply "occurrence" triggers have resulted in

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22. *See generally* ROBERT J. PRAHL ET AL., *LIABILITY CLAIM CONCEPTS AND PRACTICES* 458–75 (1985) (emphasizing difference between "settlement value" of claim at time of initial report and "ultimate probable cost"); RUTH E. SALZMANN, *ESTIMATED LIABILITIES FOR LOSSES & LOSS ADJUSTMENT EXPENSES* (1984) (emphasizing role of judgment in making and revising reserving decisions). *See also* INSURANCE SERVICES OFFICE, *CLOSED CLAIM SURVEY FOR COMMERCIAL GENERAL LIABILITY: SURVEY RESULTS* 4–5 (1991) (for "large claims of \$75,000 or more that drive the costs of the liability insurance system," average elapsed time between date of report and date of final judgment or settlement more than three times averaged elapsed time from date of accident to date of report); FRANK A. SLOAN ET AL., *INSURING MEDICAL MALPRACTICE* 125 (1991) (only 21.1% of medical malpractice claims made and reported during policy year had been paid by end of three additional years; only 77.5% by end of six years).

decisions that locate the occurrence trigger at several different, sometimes overlapping, points on the continuum: some courts have been willing to say that “exposure to harm” satisfies an occurrence trigger; some say there has been no occurrence until manifestation; still others recognize a continuous trigger.<sup>23</sup>

The concept of a “claims-made” trigger also proves slippery, even about such fundamental questions as whether we mean a “claim made by the victim against the insured,” or a “claim made by the insured against the insurer.”<sup>24</sup> And what does our exploded sequence tell us about the now-nearly-standard characterization of “claims-made” policies as “discovery” policies,<sup>25</sup> and about the judicial refrain that “claims-made or discovery policies are essentially reporting policies?”<sup>26</sup> Claims made by whom against whom?

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23. See generally 1 EUGENE R. ANDERSON ET AL., INSURANCE COVERAGE LITIGATION §§ 4.1 – 4.24 (1997); 2 WINDT, *supra* note 21, §§ 11.04 – 11.05; Fischer, *supra* note 11, at 629 n.10 (collecting citations).

24. See *infra* notes 28–36 and accompanying text.

25. See, e.g., *Jones v. Continental Cas. Co.*, 303 A.2d 91, 93 (N.J. 1973) (quoting *Zarpas v. Morrow*, 215 F. Supp. 887, 888 (D.N.J. 1963)):

The type of policy in question has been termed a discovery policy. . . . “In a ‘discovery’ policy the coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurance company during the period of the policy, no matter when the act occurred. In an occurrence policy, the coverage is effective if the negligent or omitted act occurred during the period of the policy, whatever the date of discovery.”

The second sentence made it into *Appleman*, from whence it metastasized. See, e.g., *Merrill & Seeley, Inc. v. Admiral Ins. Co.*, 275 Cal. Rptr. 280, 282 (1990) (“By way of background, we note that the two common types of insurance policies offered in the professional liability field are the ‘claims made’ (or discovery) policy and the ‘occurrence’ policy”); *James J. Brogger & Assocs., Inc. v. American Motorists Ins. Co.*, 595 P.2d 1063, 1064 (Colo. App. 1979) (“The policy is generally described as a ‘discovery’ or ‘claims made’ insurance agreement. See 7 *J. Appleman, Insurance Law & Practice* § 4262 (Cum. Supp. 1972)”).

26. See, e.g., *Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 920 (Ariz. 1994):

The “claims made” policy differs from an “occurrence” policy in several important aspects. Because it triggers coverage, transmittal of the notice of the claim to the insurer is the most important aspect

Discovery of what by whom? Reports of what by whom to whom? We can imagine pure reporting policies in which the policy trigger would be a report, to the insurer, of *something*, by *someone*: it could be a report of a claim by the injured person against the insured, or a report of an injury, or a report of an act or omission that creates a risk of injury. And, of course, given the insurer's concerns about lags between the time the policy is priced and the time the insurer's liability is finally determined, we could imagine moving the trigger still deeper into the sequence: much of what we think of as "health" insurance is really "medical expense" insurance in which coverage is not triggered, no matter how long-standing the exposure or injury or disease and no matter how much the insurer knows about those things, until actual medical expense is incurred.

So, the possible triggers are many. What do insurers actually use as triggers in "claims-made" forms? A lawyer looking only in reported opinions will encounter at least those identified in Exhibit 2.<sup>27</sup>

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of the claims made policy. A claims made policy extends coverage if "the negligent or omitted act is discovered and brought to the attention of the insurer within the policy term." *Id.* (quoting 7A John Alan Appleman, Insurance Law and Practice § 4504.01, at 312 (Berdal ed. 1979)). "The timing of the making of the claim in such policies stands in equal importance with the error or omission as the insured event." [citation omitted] Notice to the insurer of a claim made against the insured is generally required to be given during the policy period or within a specified amount of time after the policy period. "The essence, then, of a claims-made policy is notice to the carrier within the policy period."

27. The events designated with a "?" — exposure and manifestation—are not, so far as I know, explicitly identified as triggers in any claims-made formats; however, following the practice for "occurrence" triggers, both exposure and manifestation might be adopted as the standard for when the injury in fact occurs.

The event designated with a "!" — payment to the victim—is not, so far as I know, a trigger in any reported decision, but the appearance of "claims-paid" medical malpractice policies has been chronicled in Ilene Davidson Johnson, *Occurrence vs Claims-Made Medical Professional Liability Insurance Policies: Fundamental Differences in the Concept of Coverage*, 266 JAMA 1570, 1571 (1991). For a discussion of some of the implications of such a trigger, see *infra* notes 313–15 and accompanying text.

**Exhibit 2: Triggers Employed in Claims-Made Liability Formats**

<b>allegedly tortious act or omission by insured</b>	<b>T</b>
<b>exposure of potential victims</b>	<b>?</b>
<b>injury in fact</b>	<b>T</b>
<b>manifestation of victim's injury</b>	<b>?</b>
<b>insured should have discovered circumstances that may give rise to a claim</b>	<b>T</b>
<b>insured discovers circumstances that may give rise to a claim</b>	<b>T</b>
<b>insured discovers specific acts or omissions that may give rise to a claim</b>	<b>T</b>
<b>insured reports to insurer circumstances that may give rise to a claim insured</b>	<b>T</b>
<b>reports to insurer specific acts or omissions that may give rise to a claim</b>	<b>T</b>
<b>claim for compensation by victim against insured</b>	<b>T</b>
<b>insured reports claim to insurer</b>	<b>T</b>
<b>victim files suit against insured</b>	
<b>investigation by insurer</b>	
<b>defense and reserving decisions by insurer</b>	
<b>negotiations between insurer and victim</b>	
<b>judgment and settlement</b>	
<b>payment to victim</b>	<b>!</b>

Why do we find such triggers lurking beneath face-page warnings that the policy is a "claims-made" policy and that "the coverage of this policy is limited generally to liability for only those claims that are first made against the insured while the policy is in force?"<sup>28</sup> Sometimes policy definitions attempt at least a rhetorical reconciliation: thus, for example, one prominent medical malpractice insurer begins by requiring that "[t]he claim must . . . first be made while this agreement is in effect," but then creates a reporting trigger by declaring: "A claim is made on the date you first report an incident

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28. The quoted warning is drawn from the notice required by CAL. INS. CODE § 11580.01(c) (West 1988) (applicable to a professional liability policy "which generally limits the coverage thereof to liability for only those claims that are first made while the policy is in force"):

Each such policy . . . shall contain on the face page thereof a prominent and conspicuous legend or statement substantially to the following effect:

**NOTICE**

"Except to such extent as may otherwise be provided herein, the coverage of this policy is limited generally to liability for only those claims that are first made against the insured while the policy is in force. Please review the policy carefully and discuss the coverage thereunder with your agent or broker."

or injury to us or our agent.”<sup>29</sup> However, most of the variety of policy triggers in nominally claims-made policies are not the product of such semantic legerdemain; we will find no occurrence policies sailing under

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29. For example, a medical malpractice policy employed by St. Paul Fire & Marine Insurance Company uses the following language:

When you are covered.

To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also first be made while this agreement is in effect.

When is a claim made?

A claim is made on the date you first report an incident or injury to us or our agent. You must include the following information:

- \*Date, time and place of the incident.
- \*What happened and what professional services you performed.
- \*Type of claim you anticipate.
- \*Name and address of injured party.
- \*Name and address of any witness.

For a telling criticism of the two different ways in which “claim” is employed in this policy, see *Thoracic Cardiovascular Assoc., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 924–25 (Ariz. 1994) (dissenting opinion). Compare *Skandia America Reinsurance Corp. v. St. Paul Fire & Marine Ins. Co.*, 951 F.2d 362 (9th Cir. 1991) (policy not ambiguous; “claim” means claim against insurer) with *St. Paul Fire & Marine Ins. Co. v. House*, 554 A.2d 404 (Md. 1989) (policy ambiguous as to whether trigger is claim made against insured or claim made to insurer). See also *Driskill v. El Jamie Marine, Inc.*, 1988 WL 93606, at \*1 (E.D. La. 1988) (policy specifying trigger as a claim made against an insured but defining a claim as having been made “when notice of such claim is received and recorded by any insured or by [the insurer], whichever comes first”). For what is arguably another way to create a pure reporting trigger, see *Helfand v. National Union Fire Ins. Co.*, 10 Cal. App. 4th 869, 886 (Cal. App. 1992) (insurer promises to pay for loss arising from claims first made against the insured during the policy period, but then says that “[t]he time when a loss shall be incurred within the meaning of this policy shall be the date on which . . . Insureds shall give written notice to the Insurer as hereafter provided”).

“claims-made” flags.<sup>30</sup> Rather, the reason nominally claims-made policies employ such a variety of policy triggers is that many of what we call “claims-made” policies in fact employ “multiple-event triggers” —triggers requiring that two or more events must happen within a particular policy period—or “alternative-event triggers” —triggers identifying two or more events some of which must happen within a particular policy period.

Thus, as we shall see, many “claims-made” forms in fact are multiple-event-trigger “claims-made-and-reported” or “potential-claim-discovered-and-reported” policies that require that at least two things must happen during a particular policy period in order to trigger the policy: with a “claims-made-and-reported” format, the injured party must assert a claim against the insured during the policy period, and the insured must report that claim to the insurer during the policy period;<sup>31</sup> with a “potential-claims-discovered-and-reported” format, the insured must both discover circumstances that might ripen into a claim during the policy period and report that discovery to the insurer during the policy period.<sup>32</sup> Moreover, many nominally “claims-

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30. Sometimes hybrids may appear. Thus, CGL policies written on an occurrence basis may nonetheless have claims-made riders for certain exposures. Nominally claims-made formats that include a “circumstances-discovered-and-reported” trigger, or that include some form of extended reporting period, sometimes will operate by virtue of such provisions much as would an “occurrence” policy. And, of course, insurers and insureds continue to experiment with other triggering mechanisms. See, e.g., Kate Tilley, *Australian Liability Form Has Different Trigger*, BUS. INS., Oct. 24, 1994, p. 37 (reporting growing use of “claims-occurring” coverage in Australia and some European markets).

31. For example, a lawyers’ professional liability policy issued by Home Insurance Company contains the following insuring clause:

To pay on behalf of the Insured all sums in excess of the deductible amount . . . which the insured shall become legally obligated to pay as damages as a result of CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD caused by any act, error or omission for which the insured is legally responsible, and arising out of the rendering or failure to render professional services for others in the insured’s capacity as a lawyer or notary public.

32. “Potential-claim-discovered-and-reported” provisions, often misleadingly called “discovery” or “awareness” provisions, or more-usefully “notice of potential claim,” “claim substitute,” “claims-after-termination” or “occurrence first reported”

made” policies also include a “retroactive date” after which the injury to the victim or the negligent act or omission must have happened;<sup>33</sup> some more liberal “retro date” provisions provide “prior acts” coverage for negligence or injuries prior to the retro date if the insured neither knew nor should have

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provisions, permit an insured to lock in coverage before a claim has been made by reporting to the insurer circumstances that may ripen into a claim. Often the reporting requirements are quite detailed, demanding identification of specific acts or omissions or specific injuries that have been or may be suffered by potential claimants; in some policy formats, however, a more general notice is all that is required. The differences and their implications have been explored in a series of decisions arising out of efforts by the FDIC and FSLIC as receivers of failed financial institutions to recover on director’s and officer’s liability policies issued to the failed institutions. *Compare, e.g.,* FDIC v. Caplan, 838 F. Supp. 1125 (W.D. La. 1993) (report insufficient because if failed to identify specific wrongful acts and specific directors and officers); FDIC v. St. Paul Fire & Marine Ins. Co., 783 F. Supp. 1176 (D. Minn. 1991) (detailed information about potential claims in renewal application did not satisfy potential claim reporting provision); RTC v. Artley, 24 F.3d 1363 (11th Cir. 1994) (forwarding to insurer detailed information of improper lending practices did not satisfy potential claim reporting provision) *with* RTC v. American Cas. Co., 874 F. Supp. 961 (E.D. Mo. 1995) (general identification of potential claimant and circumstances enough to satisfy potential claim reported provision that did not require specificity); FSLIC v. Heidrick, 774 F. Supp. 352 (D. Md. 1991) (same). For treatment of the considerations that should go into deciding whether to take advantage of such a provision, see IRMI, PROFESSIONAL LIABILITY INSURANCE, *supra* note 2, at VIII.C.9 – VII.C.12 (detailing “Advantageous Uses” and “Catch-22 Aspects” of use of such provisions); Laird Campbell, *The Claims Made Policy — A Trap for the Unwary Lawyer*, 18 COLO. LAW. 1121 (1989); Robert Knowles, *The Reporting of “Potential Claims” under a Claims-Made Policy*, FOR THE DEFENSE, July, 1993, p. 23.

33. The standard explanation for retro dates is that they are a necessary protection against adverse selection; without them, a prospective insured could wait until a claim is imminent before first buying claims-made coverage. *See, e.g.,* LUCEY, *supra* note 21, at 34. The literature of adverse selection is vast. Three classics are George A. Akerlof, *The Market for “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488 (1970); Georges Dionne & Neil Doherty, *Adverse Selection in Insurance Markets: A Selective Survey*, in CONTRIBUTIONS TO INSURANCE ECONOMICS (G. Dionne, ed., 1992); Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: The Economics of Markets with Imperfect Information*, 90 Q. J. ECON. 629 (1976). More nuanced explanations recognize that retro dates can be used as a blunt alternative to laser exclusions for avoiding known risks, and to avoid problems associated with adjusting “stale” claims. *See* IRMI, PROFESSIONAL LIABILITY INSURANCE, *supra* note 2, at VIII.C.3; IRMI, COMMERCIAL LIABILITY INSURANCE *supra* note 2, at II.C.5.

known of those circumstances at the time of the retro date.<sup>34</sup> And, as we shall see, some “claims-made” and “claims-made-and-reported” policies include an alternative “discovery” trigger that allows the insured to trigger coverage by reporting circumstances that might give rise to a claim to the insurer during the policy period during which the circumstances were first discovered, even though the victim’s claim against the insured may not come until well after the end of the policy period.<sup>35</sup> Finally, claims-made formats

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34. For example:

PROVIDED ALWAYS THAT such act, error or omission happens:

- a) during the policy period; or,
- b) prior to the policy period, provided that prior to the [start of continuous coverage from this insurer]:
  - 1) The insured did not give notice to any prior insurer of any such act or error, and
  - 2) The [insureds] had no reasonable basis to believe that the insured had breached a professional duty or to foresee that a claim would be made against the insured; and
  - 3) There is no prior policy or policies which provide insurance for such liability or claim, unless the applicable limits of such prior policy or policies are insufficient to pay any liability or claim, in which event this policy will be excess over any such prior coverage . . . .

The retro date provision quoted above is relatively liberal, for it at least holds out the possibility of “nose” coverage for acts prior to the period covered by the current insurer; some claims made policies establish an absolute retroactive date at the beginning of the insuring relation, or even at the beginning of the particular coverage period.

35. For example:

If, during the policy [or any tail coverage] . . . the insured first becomes aware that an insured has committed a specific act, error or omission in professional services for which coverage is otherwise provided hereunder, and if the insured shall during the [policy period or tail period] . . . give notice to the Company of:

- a) the specific act, error or omission; and
- b) the injury or damage which has or may result from such act, error or omission; and



often provide or permit the purchase of "extended reporting" coverage that applies the last policy period's coverage limits to the tail of claims made, or reported, or both, after the end of the policy period.<sup>36</sup>

*C. The Trouble(s) with Claims-Made Formats*

We may now feel ready for our first explorations into deepest claims-made land. There we encounter an insured who has purchased identical calendar-year claims-made professional liability policies continuously from the same insurer during the years 1985 to 1995. In 1994 a client for the first time makes a malpractice claim against him. Which, if any, of his ten policies has been triggered?

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c) the circumstances by which the insured first becomes aware of such act, error or omission then any claim that may subsequently be made against the insured arising out of such act or omission shall be deemed for the purpose of this insurance to have been made within [the coverage period].

36. Some "claims-made" policies contain "extended reporting" or "tail" coverage provisions that guarantee a right to purchase (for an additional premium) a limited extension of the coverage for future claims arising out of acts or omissions committed prior to the termination of the coverage. In effect, "tail" coverage is "occurrence" coverage for occurrences within the policy period producing claims within the specified extended reporting period. Such tail coverage may be "one way" —i.e., available for a price if the insurer cancels or nonrenews, but not if the insured terminates the relationship with the insurer—or, more infrequently, "two-way" —i.e., available for a price even if the insured terminates the relationship; the practice apparently varies with the kind of professional liability being insured. See IRMI, PROFESSIONAL LIABILITY INSURANCE, *supra* note 2, at VIII.D.6. The same professional liability policy may carry two tail options, one for terminations of coverage while professional activities continue, another to provide coverage for a "non-practicing tail." Some forms provide an automatic extension of the reporting date; thus, a nominally "claims-made-and-reported" policy for calendar 1996 might in fact require that for the policy to be triggered the claim be made during calendar 1996 but permit the report to the insurer of the claim to be made during calendar 1996 or in the first sixty days of 1997. See *generally id.* at VIII.C.8.

Two factors may limit the value of tail coverage: 1) the premiums for the optional tail coverage may be left to negotiation at the time the tail coverage is purchased, or fixed for only the first few years of the tail coverage; 2) usually tail coverage only extends the last policy period's policy limits over the last policy period and the tail period, so that claims made in the last policy year may deplete the limits available during the tail period.

Presented in this fashion, the process for determining the answer may appear easy. We simply determine what each policy identifies as the trigger or triggers for coverage, and then determine whether the trigger or triggers were satisfied. If the policy employs a “pure” claims-made trigger like that summarized in Exhibit 3, the only thing that matters is the timing of the first claim. If that happened in 1994, the 1994 policy has been triggered.

**Exhibit 3: Pure Claims-Made Trigger**

A policy is triggered if, during the policy period, the victim first makes a claim against the insured

If the policy employs a pure “reporting” claims-made trigger like that summarized in Exhibit 4, the only thing that matters is when the insured reported a claim to the insurer. Equally simple. If the policy employs a “pure” claims-made trigger with a retro date like that summarized in Exhibit 5, we must determine not only whether the claim was first made during the policy period, but also whether the allegedly

**Exhibit 4: Pure Reporting Trigger**

A policy is triggered if, during the policy period, the insured first reports to the insurer that a victim has made a claim against the insured.

**Exhibit 5: Claims-Made Trigger with Retro Date**

A policy is triggered if:

1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and

2) during the policy period, the victim first made a claim against the insured.

negligent act or omission that prompted the claim (or, in some policies, the injury to the victim) occurred after the retro date. In our case, if the retro date established in the 1994 policy (the policy covering the year in which the claim was first made) is a date prior to the insured’s alleged negligence (or, where relevant, the injury), then the 1994 policy has been triggered; if the insured’s negligence occurred prior to that retro date, then the 1994 policy has not been triggered.

If the policy employs a “reported potential claim” trigger with a retro date like that summarized in Exhibit 6, then the timing of the claim by the victim against the insured is irrelevant; the policy will only be triggered if the insured reports to the insurer during the policy year that the insured has discovered circumstances that may ripen into a claim, and if the retro date is satisfied.

If the insured’s policy employs a multiple-event “claims-made-and-reported” trigger with a retro date, like that summarized in Exhibit 7, then our inquiry becomes three-pronged. To trigger such a policy, the alleged negligence must have occurred after the applicable retro date, and both the first claim by the victim against the insured and the report of the claim by the insured to the insurer must have occurred during the policy period.

If the insured’s policy employs the combination of dual and alternative triggers summarized in Exhibit 8, we in effect go through the process twice. Did the alleged negligence occur after the retro date and did the insured give notice to the insurer of circumstances that might give rise to a claim in the policy period in which the insured first became aware of those circumstances? If so, then the policy in effect at the time of the notice has been triggered. If no policy was triggered by that method, then we investigate the second possibility. Did the alleged negligence occur after the retro date and during a single policy period did the victim make a claim against the insured and the insured report the claim to the insurer? If so, then the policy in effect at the time the claim was made and reported has been triggered. Detailed perhaps, but still simple enough.

#### **Exhibit 6: Potential–Claim–Reported Trigger with Retro Date**

A policy is triggered if:

- 1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and
- 2) during the policy year, the insured reported to the insurer [a specific wrongful act] [circumstances] that might give rise to a claim.

#### **Exhibit 7: Claims–Made–and–Reported**

A policy is triggered if:

- 1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and
- 2) during the policy period,
  - a) the victim made a claim against the insured; and
  - b) the insured reported the claim to the insurer.

But what is it about this exercise that makes it so (tediously) simple? The answer is that we have assumed away all the juicy questions. We assumed that we knew the policy

triggers, and we assumed that we knew the facts necessary to apply those policy triggers. In the claims-made thicket, things are not so simple. Might not an insured professional who each year tucks her prominently-labeled "claims - made" renewal policy into her safety deposit box feel aggrieved to learn that her insurer denies any obligation to defend or indemnify her because she really has a "claims-made-and-reported" policy, and the claim made against her on Friday fell in one policy year and her report

the following Monday fell in a second policy year? And might not an insured who knows exactly what his claims-made-and-reported policy says and who conscientiously reports a suit against him on the same day he is served feel aggrieved to learn that the multiple-event "claims-made-and-reported" trigger was not satisfied because a billing dispute or a regulatory inquiry in an earlier year is deemed a "claim" that was first made then but went unreported until the victim's suit against the insured prompted action? They might indeed, and yearn for a world of simple hypotheticals where triggers are unequivocal and well understood, and events necessary to satisfy those triggers come with labels neatly attached. And then they might consult their lawyers.

The exercise is artificially simple for another reason as well. It evinces no interest in when the insured first became aware that she might have committed an act or omission that could give rise to a claim. But insurers are interested, and claims-made policies and marketing practices are designed to assure that, when the insured knows or should know of circumstances that may give rise to a claim, the insurer soon will have that information too.

**Exhibit 8: Claims-Made-and-Reported/  
Potential-Claim-Discovered-  
and-Reported Triggers with  
Retro Date**

**A policy is triggered if:**

**1) the [allegedly tortious act, error or omission] [injury to the victim] occurred after the applicable retro date; and**

**2) during the policy period, EITHER**

**A) the victim made a claim against the insured; and the insured reported the claim to the insurer; OR**

**B) the insured first discovered [a specific wrongful act] [circumstances] that might give rise to a claim; and the insured notified the insurer of [a specific wrongful act] [circumstances] that might give rise to a claim.**

Sometimes, of course, pre-trigger knowledge by the insured is not an issue. Sometimes the first inkling an insured has that something has gone wrong comes when a claim is filed against her. But often the insured will receive warning signals that she may have committed an act or omission that could give rise to a claim in the future, and if she does, "notice"<sup>37</sup> provisions in the policy and renewal application questions are supposed to assure that the insurer soon will have access to that information as well. Where does that leave the insured? Identified to the insurer as especially likely to have a claim in the future, thus inviting the insurer to advance the retro date, or to use a laser exclusion to carve the identified source of potential liability out of policy coverage, or to raise the price of future coverage, or even to refuse to renew coverage for the future. For insurers, these devices are only commonplace manifestations of their desire to avoid adverse selection when making underwriting decisions. For insureds, however, the conjunction of annual renewal underwriting with policy triggers that operate late in the tort insurance claim sequence means that the insured may be subjected to serious problems of "classification risk." Might not claims-made insureds feel aggrieved to learn that a change from an occurrence to a claims-made trigger means not only that insureds rather than insurers will bear the risk of increased costs due to correlated changes during the IBNR period, but also that insurers have been empowered to shift to individual insureds the burden of bearing the liability costs that become both inevitable and known during a coverage period but before any policy has been triggered? They might indeed. And then they might consult their lawyers.

#### *D. Lawyering in a Claims-Made World*

And what will their lawyers tell them? The news will not be good. Consider, for example, the lessons to be learned from the battle between Dolan, Fertig & Curtis, a Florida law firm, and its claims-made insurers. The Dolan firm purchased a claims-made errors and omissions policy from Gulf Insurance Company for the period from November 20, 1978 to November 20, 1979. In fact, the policy was a triple-event-trigger claims-made-and-

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37. In some policies, the insured is only required to give prompt notice of a claim, a requirement that adds little to the "reporting" requirement of the insuring clause. But in some policies, the insurer's liability is conditioned on notice if the insured becomes aware of an act or omission that might reasonably be expected to ripen into a claim covered by the policy, even if there is as yet no claim to report, and even if there is no "discovery" clause to make the notice operate as a trigger of coverage.

reported policy with a retro date of November 20, 1978; thus, by its terms, the Gulf policy would be triggered only if 1) a claim was made against the law firm in the 1978–79 policy year, 2) the claim was reported to insurer during the 1978–79 policy year, and 3) the claim was based upon professional activities during the 1978–79 policy year. Toward the end of the policy year the Dolan firm contracted with a second insurer, Lawyers Professional Liability Insurance Company (LPLIC), to provide liability coverage for the period from November 20, 1979 to November 20, 1980. The LPLIC policy was a claims-made-and-reported policy with a retro date of November 20, 1977, but it expressly excepted from coverage

any claim arising out of acts or omissions occurring prior to the effective date of this policy if the insured at the effective date knew or could have reasonably foreseen that such acts or omissions might be expected to be the basis of a claim or suit.

Thus, by its terms the LPLIC policy would be triggered only if 1) a claim was made against the law firm in the 1979–80 policy year, 2) the claim was reported to the insurer during the 1979–80 policy year, and 3) the claim was based upon professional activities after November 20, 1977, and the insured on November 20, 1979, was not chargeable with knowledge of a potential claim based on such professional activities.

On November 19, 1979, the final day of the Gulf policy period, the law firm received a letter from a client claiming that the law firm had been negligent in the provision of legal services during the period after the policies' retro dates. The law firm reported the claim to LPLIC on December 6, 1979; after being informed by LPLIC that two of the three triggers for LPLIC coverage had not been satisfied, the law firm on February 12, 1980, reported the claim to Gulf. Gulf too denied coverage; although two of its three triggers had been satisfied, the third—report of claim within the policy period—had not. By early 1988 the Florida courts had confirmed the obvious. In the straight-forward world of the conventional insurance law syllogism, all of a policy's conditions must be fully satisfied if an insurer is to have a duty to perform, the reporting condition in the Gulf policy and the retro date and claim conditions in the LPLIC policy were not satisfied, and therefore neither insurer had a duty to perform.<sup>38</sup>

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38. *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512 (Fla. 1983); *Lawyers Prof. Liab. Ins. Co. v. Dolan, Fertig & Curtis*, 524 So. 2d 677 (Fla. App. 1988).

**Exhibit 9: *Dolan Case: Claims-Made-and-Reported Policies with Retro Dates; Different Insurers***

1978-79 Gulf Ins. Co.	1979-80 LPLIC
<b>CONDITIONS:</b> 1) Neg after 11/20/78 2) Claim in 78-79 3) Report in 78-79	<b>CONDITIONS:</b> 1) Neg after 11/20/78 2) Claim in 79-80 3) Report to LPLIC in 79-80
<b>FACTS:</b> Neg in 78-79; Claim in 78-79; Reports in 79-80	

For a lawyer in search of a way to escape the simple force of these catechetical understandings, the choices may seem dauntingly few. Absent facts sufficient to support equitable doctrines of waiver, estoppel, or reformation,<sup>39</sup> rummaging through the standard-issue lawyers' kitbag of neo-classical insurance law is likely to produce little more than what is often a litany of last resorts: Is the policy ambiguous so that it can be construed against the insurer? Does it violate the objective reasonable expectations of the insured? Is there something about it that makes it contrary to public policy? Usually, of course, the answers are "no," "no," and "no."

Still, in the early days of claims-made formats, a few lawyers did manage to guide their insureds along these routes. Thus, for example, in *Gyler v. Mission Insurance Company*, careless drafting that obligated a professional liability insurer to respond to "claims for breach of professional duty as Lawyers which may be made" during the policy period provided an opening for a court to declare itself uncertain as to "whether coverage is limited to claims asserted during the policy period or extends to claims maturing during the policy period but not asserted until later," and so to invoke *contra proferentem* rules of construction to assure that what the insurer thought was a claims-made-and-reported form would operate in that instance as an occurrence form.<sup>40</sup> And, at a time when claims-made formats could seem

39. See, e.g., *Cornell, Howland, Hayes & Merryfield, Inc. v. Continental Cas. Co.*, 465 F.2d 22 (9th Cir. 1972) (second insurer precluded from invoking retro date provision against insured by express assurances that coverage would be provided for a known circumstance); *Stein, Hinkle, Dawe & Assoc., Inc. v. Continental Cas. Co.*, 313 N.W.2d 299 (Mich. App. 1981) (agent's failure to recommend prior acts endorsement precludes insurer from denying coverage for prior acts).

40. *Gyler v. Mission Ins. Co.*, 514 P.2d 1219 (Cal. 1973). See also *Chamberlin v. Smith*, 72 Cal. App. 3d 835 (1977) (construing same language as in *Gyler*); *J.G. Link & Co. v. Continental Cas. Co.*, 470 F.2d 1133 (9th Cir. 1972), *cert. denied*, 414

as strange to some judges as to the insureds seeking to escape them, a few decisions concluded that particular claims-made formats were unconscionable or contrary to public policy or violations of reasonable expectations of insureds because they did not provide either the prospective coverage of a pure occurrence policy or the retrospective coverage of a pure claims-made policy.

Thus, in one briefly-famous decision, *Brown-Spalding & Assoc. v. International Surplus Lines Ins. Co.*,<sup>41</sup> a California Court of Appeals held a reporting requirement contrary to public policy and a violation of reasonable expectations of insureds:

A claims made policy which requires the insurer to be notified during the policy period severely limits the scope of coverage so that the objectively reasonable expectations of the purchaser of professional liability coverage are not met. . . . [T]he reporting requirement effectively precludes coverage for claims made toward the end of the policy period which cannot reasonably be reported until after expiration.<sup>42</sup>

And in one much-criticized 1985 decision, *Sparks v. St. Paul Ins. Co.*,<sup>43</sup> the New Jersey Supreme Court rescued a claims-made-and-reported insured who had failed to report a claim within the policy period by giving canonical status to an idealized characterization of a “pure” claims-made trigger providing unlimited retrospective coverage, and then refusing to enforce the policy because the presence of a retro date meant that the policy failed to live up to that unlikely ideal.

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U.S. 829 (1973) (ambiguous as to whether policy requiring both negligent act and report of negligence act within policy period provided claims-made or occurrence coverage). For a recent example along the margins, see *St. Paul Fire & Marine Ins. Co v. MetPath Inc.*, No. 3-96-703, 1998 U.S. Dist. LEXIS 2264 (D. Minn. Jan. 26, 1998) (exclusion of known prior acts ambiguous as applied to acts prior to acquisition of company by insured).

41. 254 Cal. Rptr. 192 (Cal. Ct. App. 1988).

42. 254 Cal. Rptr. at 195. The opinion was later decertified by the California Supreme Court. See *infra* note 60.

43. 100 N.J. 325, 495 A.2d 406 (N.J. 1985).



[T]he policy at issue here is substantially different from the standard "claims made" policy. Indeed, St. Paul's policy combines the worst features of "occurrence" and "claims made" policies and the best of neither. It provides neither the prospective coverage typical of an "occurrence" policy, nor the "retroactive" coverage typical of a "claims made" policy.

....

[A] policy that defines the scope of coverage so narrowly is incompatible with the objectively reasonable expectations of purchasers of professional liability coverage. We assume that there are vast numbers of professionals covered by "claims made" policies who are unaware of the basic distinction between their policies and the traditional "occurrence" policy. However, those professionals covered by "claims made" policies who do understand how their policies differ from "occurrence" policies would expect that in return for the loss of prospective coverage provided by "occurrence" policies, they would be afforded reasonable retroactive coverage by their "claims made" policies. A leading proponent of "claims made" coverage has characterized this quid pro quo—the relinquishment of prospective coverage in return for retroactive coverage—as "the essential trade-off inherent in the concept of 'claims-made' insurance."<sup>44</sup>

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44. *Id.* at 339–40, 495 A.2d at 414–15 (citation omitted). The "leading proponent," of course, was Sol Kroll. *See supra* note 20. In a companion case, *Zuckerman v. National Union Fire Ins. Co.*, 495 A.2d 395 (N.J. 1985), a similar failure to satisfy a reporting condition was fatal to the insured's claim because the policy contained no retro date and thus provided the "retroactive coverage" the court demanded. However, the force of the distinction was less than might appear. The *Sparks* decision indicated that multiple-event triggers would be permitted to truncate both "prospective" and "retroactive" coverage if the limitations were "specifically understood and bargained for" by the insured, 495 A.2d at 416 n.6, and the insured did not need coverage for pre-issuance activities because a newly-minted professional or covered by earlier occurrence coverage. *Id.* at 416 n.4. On remand, the insurer was able to convince the trial court that these conditions had been satisfied, and the Appellate Division affirmed. *Sparks v. St. Paul Ins. Co.*, A-3213-85T8 (App. Div. Feb. 3, 1987). *See generally* Kenneth F. Oettle & Davis J. Howard, *Zuckerman and Sparks: The Validity of "Claims Made" Insurance Policies as a*

In similar fashion, a lower court in New Jersey declared contrary to public policy a retro date provision that provided coverage for earlier errors and omissions only if the same insurer had provided coverage in the earlier years,<sup>45</sup> and a lower court in New York refused to enforce as unconscionable a condition requiring the claim to be made in a policy year when the insurer refused to renew for subsequent years because it knew the insured had suffered an explosion almost certain to produce claims after the end of the policy period.<sup>46</sup> But such apostasies could easily be distinguished or ignored, and would pose little long-term threat to the prevailing orthodoxy. In the conventional understanding, modern claims-made formats are too well-established, and the buyers look too sophisticated, for the forms to fall prey to arguments that they offend public policy<sup>47</sup> or are unconscionable or violate the reasonable expectations of insureds.<sup>48</sup>

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*Function of Retroactive Coverage*, 21 TORT & INS. L.J. 659 (1986); Richard D. Catenacci, *Sparks Revisited: Sparks v. St. Paul Insurance Co.*, 23 TORT & INS. L.J. 707 (1988). For a more supportive view of the *Sparks* decision and an argument that courts should use the doctrine of reasonable expectations to abrogate retro date provisions, see Carolyn M. Frame, Note, "Claims-Made" Liability Insurance: Closing the Gaps with Retroactive Coverage, 60 TEMPLE L.Q. 165 (1987).

45. *Jones v. Continental Cas. Co.*, 303 A.2d 91 (N.J. Ch. 1973) (prior acts liberalization of retro provision contrary to public policy and reasonable expectations of insured because limited to prior acts while insured with the same insurer).

46. *Heen & Flint Assoc. v. Travelers Indem. Co.*, 400 N.Y.S.2d 994, 998-99 (N.Y. Sup. Ct. 1977).

It is my determination that a provision in a "claims made" policy that permits an insurer, where it has notice of a potential claim, to refuse to renew that policy, is unconscionable. Such a provision allows an insurer to avoid the risk of serious potential claims arising from accidents committed within the policy period, and leaves the insured without coverage after the expiration of the policy, since no other insurer will be willing to accept the known risk and thus buy its way into a potential lawsuit.

I, therefore, limit the provision of the Travelers' policy that requires a claim to be made against the insured during the policy period, to instances where continued coverage is available from the same or from some other insurer . . . .

47. See, e.g., *James & Hackworth v. Continental Cas. Co.*, 522 F. Supp. 785 (N.D. Ala. 1980) (reporting trigger not contrary to state statute prohibiting shortening

Still, there was one argument that might seem to commend itself to a lawyer in search of escape from the failure of her client to satisfy the conditions of a dual-trigger claims-made-and-reported policy. By the time that claims-made disputes began making their way into court in significant numbers many jurisdictions had "adopted" a "notice-prejudice rule" that, in the conventional understanding, alters the strict common law rule governing some failures of condition. If, for example, an insured involved in an auto accident fails to give the timely notice required by her personal automobile policy, the "notice-prejudice rule" permits the insurer a defense only if the failure of condition "prejudiced" the insurer.<sup>49</sup> Why not apply the "notice-prejudice rule" to liability coverage where the trigger is a claim in the same way it is applied when the trigger is an occurrence?

Why not indeed, some courts responded. In California,<sup>50</sup> Michigan,<sup>51</sup> Massachusetts,<sup>52</sup> Maine,<sup>53</sup> Minnesota,<sup>54</sup> and perhaps Maryland,<sup>55</sup> courts

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of statutes of limitations); *James J. Brogger & Assoc., Inc. v. American Motorists Ins. Co.*, 595 P.2d 1063 (Colo. App. 1979) (claims-made format not anticompetitive tying arrangement because insured free to move to other insurers). *Cf. Home Ins. Co. v. Adco Oil Co.*, 987 F. Supp. 1057 (N.D. Ill. 1997), *rev'd*, 154 F.3d 739 (7th Cir. 1998) (Illinois public policy means insured's intentional failure to report claim to insurer could not defeat victim's vested rights against insurer); *Murray v. City of Bunkie*, 686 So. 2d 45 (La. Ct. App. 1996) (direct action statute gives victim vested rights against insurer that cannot be lost by insured's failure to report claim within policy period).

48. *See, e.g.,* ROBERT H. JERRY, II UNDERSTANDING INSURANCE LAW 289 (1987) ("As long as consumers understand the limitations inherent in claims-made coverage and alternative occurrence coverage is available, no good reason exists for not having claims-made coverage available to consumers."). *See generally* Martin J. McMahon, *Event Triggering Liability Insurance Coverage as Occurring within Period of Time Covered by Liability Insurance Policy where Injury or Damage is Delayed—Modern Cases*, 14 A.L.R. 5th 695 (1997).

49. In Georgia, Maryland, Massachusetts, Texas and Wisconsin, the "notice-prejudice rule is a [statutory/administrative] creation; most other states have announced the rule judicially." Charles C. Marvel, Annot., *Modern Status of Rules Requiring Liability Insurer to Show Prejudice to Escape Liability Because of Insured's Failure or Delay in Giving Notice of Accident or Claim, or in Forwarding Suit Papers*, 32 A.L.R. 4th 141 (1984). For a recent survey of "late notice rules by state," see ANDERSON ET AL., *supra* note 23, at § 5.9 (1997). *See also* WINDT, *supra* note 21, at § 1.04.

50. *Northwestern Title Ins. Co. v. Flack*, 6 Cal. App. 3d 134 (1970); *Mt. Hawley Ins. Co. v. Federal Sav. & Loan Ins. Corp.*, 695 F. Supp. 469 (C.D. Cal. 1987).

allowed the effect of failure to report a claim to the insurer within the policy period to turn on whether the insurer was prejudiced by that failure.<sup>56</sup>

The industry counter-attack was swift, mounted on several concurrent fronts, and strikingly effective. Did a panel of the United States Court of Appeals for the 9th Circuit apply the California prejudice rule to a reporting condition in a claims-made policy?<sup>57</sup> Then take advantage of the happy circumstance that both parties to the litigation were insurers and settle the litigation with a stipulation that the parties would join in a request that the decisions be vacated and the opinions withdrawn from publication; surely the court would go along.<sup>58</sup> Did a division of the California Court of Appeals

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51. *Wood v. Duckworth*, 401 N.W.2d 258 (Mich. App. 1986) (prejudice shown); *Sherlock v. Perry*, 605 F. Supp. 1001 (E.D. Mich. 1985); *Stine v. Continental Cas. Co.*, 349 N.W.2d 127 (Mich. 1984) (dictum concerning application of statute excusing late notice when compliance impracticable).

52. *Johnson Controls, Inc. v. Bowes*, 409 N.E.2d 185 (Mass. 1980).

53. *American Home Assur. Co. v. Ingeneri*, 479 A.2d 897 (Me. 1984).

54. *Reliance Ins. Co. v. St. Paul Ins. Cos.*, 239 N.W.2d 922 (Minn. 1976).

55. *St. Paul Fire & Marine Ins. Co. v. House*, 554 A.2d 404 (Md. 1989) (dictum). The court backed away in *T.H.E. Ins. Co. v. P.T.P. Inc.*, 628 A.2d 223 (Md. 1993). *See generally* Whertley, *supra* note 9.

56. New Zealand and Australia also applied statutory prejudice requirements to failures to satisfy some claims-made triggers. *See Sinclair Horder O'Malley & Co. v. National Ins. Co. of N.Z. Ltd*, 2 N.Z.L.R. 257 (1995) (applying prejudice requirement of § 9 of NEW ZEALAND INSURANCE LAW REFORM ACT 1977 to a potential-claim-discovered-and-reported condition); *Bradley West Clarke List and Anor v. Keeman and Ors*, 9 ANZ Ins. Cas. 76,742 (1997) (applying prejudice requirement to claims-made-and-reported policy); *East End Real Estate Pty Ltd v. C.E. Heath Cas. & Gen. Ins. Ltd.*, 7 ANZ Ins. Cas. 61,092 (Ct. App. N.S.W. 1992)(effect of failure to report claim governed by § 54 of Insurance Contracts Act 1984 (Cth)); *FAI Gen. Ins. Co. Ltd. v. Perry*, 7 ANZ Ins. Cas. 61,164 (Ct. App. N.S.W. 1993) (failure to report potential claim governed by § 54).

57. *New England Reins. Corp. v. National Union Fire Ins. Co.*, 822 F.2d 887 (9th Cir. 1987), *rev'g* 654 F. Supp. 742 (C.D. Cal. 1986).

58. *New England Reins. Corp. v. National Union Fire Ins. Co.*, 829 F.2d 840 (9th Cir. 1987) (vacating earlier decision). Policyholder Attorney Eugene Anderson, quoted in Roger Parloff, *Rigging the Common Law*, *The American Lawyer*, March 1992, p.74, said of the original court of appeals decision in *New England Reinsurance*: "That was a great case for us. . . . A few days later, zingo. It was gone." Not completely, however; though unavailable in the reporter systems, and on Westlaw and Lexis, the opinion still can be found at 1987 CCH Fire & Cas. Cases.

hold that a dual trigger claims-made-and-reported policy violated the reasonable expectations of insureds?<sup>59</sup> Get that opinion decertified too.<sup>60</sup> Did another division of the California Court of Appeals apply the prejudice rule to a claims-made-and-reported policy?<sup>61</sup> Then settle after oral argument contingent upon no opinion being filed in the case.<sup>62</sup> When the court refuses “[t]o bow to this pressure” and files its opinion<sup>63</sup> applying the

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407 and on Anderson’s “Vacatur” web site. See Anderson Kill & Olick, *infra* note 60.

59. Brown–Spaulding & Assoc., Inc. v. International Surplus Lines Ins. Co., et al, 254 Cal. Rptr. 192 (Cal. Ct. App. 1988).

60. The *Brown–Spaulding* opinion was decertified on March 16, 1989, pursuant to CAL. CT. RULE 979. See 206 Cal. App. 3d 1580 (1989) (acknowledging deletion of opinion). Application of the “notice–prejudice rule” to claims-made-and-reported policies prompted “a massive letter–writing campaign” by insurers, according to one attorney for insureds, Stacy Gordon, *Only California Allows Justices to “Depublish,”* BUS. INS., June 15, 1992, p.14, and provoked howls that the industry was turning the courts into a “system of private justice,” Stacy Gordon, *Vanishing Precedents: Policyholders Can Get Better Deal—if Rulings Are Erased,* BUS. INS., June 15, 1992, p. 1 (“A system of private justice is emerging nationwide. Insurers are agreeing not to press appeals of pro–policyholder decisions and are even paying policyholders more than courts have awarded if policyholders help persuade judges to vacate their opinions.”).

Eugene Anderson has been especially critical of the practices involved in *New England Reinsurance* and *Brown–Spaulding*: “You see brief after brief where [the insurance lawyers] say, ‘The weight of authority is . . .’ or ‘most of the cases hold that . . .’ The fact that they can manipulate the goddamn numbers is beyond belief.” See Parloff, *supra* note 58, at 76. Anderson’s campaign against disappearing authority now includes a web site clearing house. See Anderson Kill & Olick, *Vacatur Center*, <<http://www.andersonkill.com/vacatur.htm>>. For a rebuttal, see Fred F. Gregory, *Letters*, THE AMERICAN LAWYER, June 1992, p. 18. Cf. Roberto Cenicerros, *Decision Will Keep Rulings on the Books*, BUS. INS., Nov. 14, 1994, p. 1 (reporting reactions to U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership, 513 U.S. 18, 115 S.Ct. 386 (1994) (party to federal litigation cannot request that defeat in lower court be erased by settlement)).

61. Village Escrow Co., Inc. v. National Union Fire Ins. Co., 248 Cal. Rptr. 687 (Cal. Ct. App. 1988).

62. Stacy Adler, *Ruling Transforms Claims–Made Cover into Occurrence*, BUS. INS., July 25, 1988, p. 1.

63. The court noted that the case was of first impression in the United States, recited the terms of the proposed settlement, and refused to go along:

prejudice rule, organize a letter-writing campaign to the California Supreme Court and get the offending decision decertified.<sup>64</sup> Eventually a court would hold that the California notice-prejudice rule should not be applied to reporting conditions in claims-made policies.<sup>65</sup> In the meantime, flood the

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To bow to this pressure and refrain from filing our opinion would do disservice not only to the public interest implicated in this case but to the proper functioning of the appellate courts in future cases. For it would send a message to other appellants and respondents that they can wait until oral argument and, if they sense the probability or possibility the appellate court will rule against them, buy their way out of an unfavorable precedent often at the relatively cheap price asked by the single opponent they face in that appeal. This would tend to inhibit appellate judges from asking the tough questions at oral argument which might suggest the direction of their thinking. It would result in the squandering of public resources on the research, analysis and writing of opinions which never get filed even though they resolve issues of great public import. And it could even distort the law by allowing parties who possess ample means to prevent the filing of adverse precedents while those without means are unable to do so.

Village Escrow Co., Inc. v. National Union Fire Ins. Co., 248 Cal. Rptr. 687, 694-96 (Cal. Ct. App. 1988).

64. The American Insurance Association and eight insurers asked the Supreme Court to decertify that decision, even before the court decided whether to grant review. Stacy Adler, *Court Asked to Decertify Claims-Made Ruling*, BUS. INS., Mar. 6, 1989, p. 43. Less than three months later, the decision was decertified, Stacy Adler, *Ruling on Claims-Made Decertified in California*, BUS. INS., Nov. 28, 1988, p. 2, making it not available for citation in California and in practice — elsewhere. For a demonstration of the effects of decertification even outside the jurisdiction, see *Civic Assocs., Inc. v. Security Ins. Co. of Hartford*, 749 F. Supp. 1076, 1080 (D. Kan. 1990).

65. In *Burns v. International Ins. Co.*, 929 F.2d 1422 (9th Cir. 1991), the Court of Appeals reviewed the split in the California courts of appeal, read the tea leaves strewn by the California Supreme Court in *Village Escrow* and *Brown-Spalding*, and concluded that to apply the prejudice rule to a claims-made-and-reported policy would be to “extend coverage.” *Id.* at 1425. By the time a California court, in *Pacific Employers Ins. Co. v. The Superior Court of Los Angeles County*, 270 Cal. Rptr. 779 (Cal. Ct. App. 1990), for the first time held that the insurer position should prevail, the three decisions that had applied the notice-prejudice rule to disputes arising in California had all but disappeared from the official records. Almost, but not completely. In *Slater v. Lawyers’ Mut. Ins. Co.*, 278 Cal. Rptr. 479 (Cal. Ct. App.

trade press with complaints that courts are “refusing to enforce” claims-made forms and are “converting claims-made policies into occurrence policies.”<sup>66</sup> And throughout, insist as an article of the insurers’ faith that reporting conditions in claims-made liability policies are fundamentally different than notice conditions in an occurrence policy. *Gulf Insurance Company v. Dolan, Fertig & Curtis*<sup>67</sup> would supply one of the canonical texts:

A claims-made policy is a policy “wherein the coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurer within the policy term.” 7A Appleman at 312 . . . . The essence, then, of a claims-made policy is notice to the carrier within the policy period.”

. . . .

Notice within an occurrence policy is not the critical and distinguishing feature of that policy type. . . . Coverage depends on when the negligent act or omission occurred and not when the claim was asserted. . . . The giving of notice is only a condition of the policy, and in no manner is it an extension of coverage itself. It does not matter when the

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1991), a summary judgment in favor of the insurer was affirmed even though the insurer had canceled the policy at the end of the policy year and even though the insured had not learned of the claim against him until months later. His anger palpable, Judge Johnson wrote a stinging dissent, *id.* at 1428–29, 278 Cal. Rptr. at 487–88, that essentially repeated his decertified *Village Escrow* opinion. Finally, in *Helfand v. National Union Fire Ins. Co. of Pittsburgh*, 13 Cal. Rptr. 2d 295 (Cal. Ct. App. 1992), the First District refused to apply the “notice-prejudice rule” even to a claims-made policy that was not explicitly “claims-made-and-reported.”

66. See, e.g., Stacy Adler, *Ruling Transforms Claims-Made Cover into Occurrence*, *supra* note 62, at 28 (discussing *Village Escrow*); Stephen Tarnoff, *Claims Made: Court Grants Coverage Despite Late Reporting*, BUS. INS., Aug 31, 1987, p. 1, 76 (quoting American Insurance Association official: “I don’t think it is unreasonable to say that the effect is to turn the claims-made policy into an occurrence-based policy.”). This characterization, though patently inaccurate, has become so much a part of the conventional wisdom that it is blithely repeated even in technical manuals. See, e.g., IRMI, PROFESSIONAL LIABILITY INSURANCE, *supra* note 2, § VIII.C.1 (“[L]ate reports of claims made it more difficult for underwriters to project ultimate claim liabilities (which defeated the purpose of the claims-made coverage trigger) and, in effect, transformed the policies into occurrence forms.”).

67. 433 So. 2d 512 (Fla. 1983) (discussed *supra* note 38 and accompanying text).

insurer is notified of the claim by the insured, so long as the notification is within a reasonable time and so long as the negligent act or omission occurred within the policy period itself.

. . . .

With claims-made policies, . . . coverage depends on the claim being made and reported to the insurer during the policy period. Claims-made or discovery policies are essentially reporting policies. If the claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches. If a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained. This extension of coverage, by the court, so very different from a mere condition of the policy, in effect rewrites the contract between two parties. This we cannot and will not do.<sup>68</sup>

Thus, by the early 1990s, the notice-prejudice heresy in California had been extirpated and the offending texts mostly purged. One by one other pockets of apostasy recanted,<sup>69</sup> and the growing orthodoxy was swelled by new adherents who made it clear that they brooked no uncertainties about the correctness of their position: the notice-prejudice rule should not be applicable to reporting conditions in claims-made liability insurance policies.<sup>70</sup> And that, so far as most cases and commentators were concerned, was that.<sup>71</sup>

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68. *Id.* at 514–16.

69. *See, e.g.*, T.H.E. Ins. Co. v. P.T.P. Inc., et al, 628 A.2d 223 (Md. 1993) (repudiating dicta in *St. Paul Fire & Marine Ins. Co. v. House*, et al, 554 A.2d 404 (Md. 1989)); *Chas. T. Main v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28 (Mass. 1990) (backing away from *Johnson Controls, Inc. v. Bowes*, 409 N.E.2d 185 (Mass. 1980)).

70. Recently, the New Zealand Law Revision Commission has recommended legislative reversal of decisions in New Zealand that applied a legislative “prejudice” requirement to reporting conditions in claims-made policies. NEW ZEALAND LAW REVISION COMMISSION, *SOME INSURANCE LAW PROBLEMS* (NZLCR 46) 20–23 (1998). Given the insular character of the debate, perhaps it should not surprise that



But, of course, for those willing to venture beyond such potted legal history, there is more that bears on the way claims-made formats operate and on the way insurance law is practiced at the end of the twentieth century. Do we wonder why so many claims-made insureds fail to satisfy claims-made reporting triggers? Under the strict common law rule, it doesn't matter, and consequently the reported opinions offer only occasional information on that subject, but there is enough to suggest the range of snares that claims-made formats can set. Sometimes the insured is careless,<sup>72</sup> or mistakenly expects the claim to be within the policy deductible,<sup>73</sup> loses a calculated gamble that he can resolve a claim without involving the insurer,<sup>74</sup> or reports the claim to some but not all of the relevant insurers.<sup>75</sup> Sometimes the claim arrives at the end of one policy year and the report, though quickly made, is untimely because it falls in the next policy year.<sup>76</sup> Sometimes the claim is made but the insured does not learn about it until much later,<sup>77</sup> or does not recognize it for what it is later held to be.<sup>78</sup> Sometimes the one seeking to invoke

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the Commission appeared to rely heavily on *Burns v. International Ins. Co.*, 929 F.2d 1422 (9th Cir. 1991) (discussed *supra* note 65) and *Chamberlain*, *supra* note 9.

71. See, e.g., *WINDT*, *supra* note 21, at § 1.07 n.78 (collecting authorities). For passionate defense of the heresy, see *Anderson*, *supra* note 9; *Pierce*, *supra* note 9.

72. See, e.g., *Troy & Stalder Co. v. Continental Cas. Co.*, 290 N.W.2d 809 (Neb. 1980) (written report of claims mailed to wrong address).

73. See, e.g., *Zuckerman v. National Union Fire Ins. Co.*, 495 A.2d 395 (N.J. 1985).

74. See, e.g., *Home Ins. Co. of Illinois v. Adco Oil Co.*, 987 F. Supp. 1057 (N.D. Ill. 1997) (malpractice insured thought claim was frivolous and was concerned that notice to insurer would prompt a premium hike).

75. See, e.g., *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 551 N.E.2d 28 (Mass. 1990) (timely report to primary insurer but not to excess insurer).

76. See, e.g., *United States v. Strip*, 868 F.2d 181 (6th Cir. 1989) (applying Ohio law) (policy year ended August 2; complaint served on insured on July 26 while out of town); *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512 (Fla. 1983) (claim made last day of policy period).

77. See, e.g., *Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916 (Ariz. Ct. App. 1994) (suit filed October 15, 1987; coverage ended May 1, 1988; service on defendant not until July 12, 1988); *Slater v. Lawyer's Mut. Ins. Co.*, 278 Cal. Rptr. 479 (Cal. Ct. App. 1991) (suit within policy period but service on defendant insured delayed more than four months); *Village Escrow Co. v. National Union Fire Ins. Co.*, 248 Cal. Rptr. 687 (Cal. Ct. App. 1988) (suit filed within policy period but service on defendant insured delayed more than eleven months).

78. Is a claim made when the lawyer's client demands that the lawyer redo allegedly deficient work, or when the client gets mad enough to file suit? Compare

coverage is not the insured who failed to make a report;<sup>79</sup> sometimes the report was made, but later was determined to be inadequate.<sup>80</sup> Although our reactions to the stories insureds have to tell may depend on such differences, the strict common law of conditions remains stubbornly indifferent to such variations. If reporting a claim to an insurer within a particular policy year was an express condition of the policy, the decisions tell us, then the insured bears the risk of failing to satisfy that condition.

Do we wonder what effect failure to make a conforming and timely report to the insurer had on the insurer? Again, the strict common law of conditions professes indifference, but the cases and commentary nonetheless hasten to explain that any report that arrives late will deny the insurer pricing advantages that the shift from occurrence to claims-made formats was supposed to provide:

The purpose of the notice requirement in "claims made" policies is to ensure "fairness in rate setting," whereas its purpose in an "occurrence" policy is "to permit an insurer to make an investigation of the facts . . . relating to liability." A late notice would clearly always inhibit the insurer's task of setting its future premiums and reserves with full knowledge of the outstanding claims it is obligated to meet, while it would not necessarily have the same effect with regard to the investigation of the facts pertaining to the insured event. Hence, a showing of prejudice is justly required in the latter while not in the former.<sup>81</sup>

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Phoenix Ins. Co. v. Sukut Constr. Co., Inc., 186 Cal. Rptr. 513 (Cal. Ct. App. 1982) (client request that lawyer correct admitted error without charge later characterized as "claim") *with* Hoyt v. St. Paul Fire & Marine Ins. Co., 607 F.2d 864 (9<sup>th</sup> Cir. 1979) (client letter to lawyer questioning work on will held not a claim). When a regulator demands that a financial institution get its house in order, when it seizes the institution, or when it brings suit against the officers and directors for negligent supervision? *See, e.g.,* Mt. Hawley Ins. Co. v. F.S.L.I.C., 695 F. Supp. 469 (C.D. Cal. 1987).

79. *See, e.g.,* Pacific Employers Ins. Co. v. Superior Court, 270 Cal. Rptr. 779 (Cal. Ct. App. 1990) (late report given by administrator of estate of deceased insured).

80. *See, e.g.,* St. Paul Fire & Marine Ins. Co. v. Tinney, 920 F.2d 861 (11<sup>th</sup> Cir. 1991) (timely report to insurer did not detail names and addresses of witnesses and date, time, and place of incident).

81. National Union Fire Ins. Co. v. Talcott, 931 F.2d 166 (1<sup>st</sup> Cir. 1991) (applying Massachusetts law and quoting from Chas. T. Main v. Fireman's Fund Ins.

Of course, it does not require great expertise with the niceties of loss reserving, loss development, trending, and other elements of the pricing process to recognize that even with perfect reporting of all claims by the end of the policy period, pricing and underwriting decisions will still be made with far less than the “full knowledge” of past experience the courts seem to imagine, that projection of that experience into the future still remains the most daunting part of the pricing process, and that most of the pricing and underwriting advantages of claims-made formats would remain even if the tardiness of an occasional report were excused.<sup>82</sup> Still, within the reigning orthodoxy, all this is quite fundamentally beside the point. The strict law of conditions makes clear that there is no need to ask whether an insurer was prejudiced by failure to provide a report necessary to trigger coverage. So why, we might wonder, do courts go to such lengths to adorn opinions with paeans celebrating the pricing advantages of claims-made triggers?

There is more about which we might wonder. Why, those who come to the question with some appreciation for the variety of claims-made formats

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Co., 551 N.E.2d 28 (Mass. 1990)). Kroll, *supra* note 19, at 928, provided one of the creedal formulations:

An underwriter who is secure in the fact that claims will not arise under the subject policy . . . after its termination or expiration can underwrite a risk and compute premiums with greater certainty. The insurer can establish his reserves without having to consider the possibilities of inflation beyond the policy period, upward spiraling jury awards, or later changes in the definition and application of negligence.

Though Kroll’s first sentence clearly is true—more information can only help—the second clearly is not; even if the insurer has received a report of all claims that may trigger a policy, the ultimate cost of those claims to the insurer still will be in doubt. *See generally* authorities cited *supra* note 22.

82. The rhetoric that equates the excuse of a reporting condition with a return to occurrence triggers is badly off the mark. Excusing a reporting condition in a claims-made-and-reported policy makes the provision operate much the same as do the large number of “claims-made” formats which do not insist that the report be made within the policy period, and those forms still provide the insurer with significant pricing advantages over occurrence formats. They free the insurer from the “incurred but not made” (IBNM) portion of the IBNR; a reporting trigger tries to free the insurer from the remainder of the IBNR, the “made but not reported” (MBNR) claims. *See* discussion of multi-event triggers *infra* Part III(a).

actually being employed in the market might ask, do those differences seem to matter so little in the claims-made litigation immunizing reporting conditions from the notice-prejudice rule? True, in a few pivotal early battles the fact that the insuring clause was explicitly “claims-made-and-reported” helped with the argument that the reporting condition should be regarded as coverage-defining.<sup>83</sup> But courts and commentators were far more likely to rely on Appleman, the Krolls, and other glossators of the claims-made canon for broad assertions that “[t]he essence . . . of a claims-made policy is notice to the carrier within the policy period”<sup>84</sup> and “claims-made or discovery policies are essentially reporting policies,”<sup>85</sup> and to treat those characterizations as determinative without regard for the niceties of the kind of claims-made format actually at issue. Would the same stubborn indifference to detail hold if the report were timely but failed to include the name or address of a witness required by the reporting condition?<sup>86</sup> If instead of invoking the “notice-prejudice rule,” the insured predicated his excuse argument on a claim of impracticability, or waiver, or prior breach by the

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83. Most claims-made-and-reported policies carefully locate both triggers in the insuring clause; occurrence policies often leave notice provisions to languish pages later with other loss adjustment conditions. For an argument that location of a reporting condition in the insuring clause should insulate it from excuse arguments, see Barry G. Kaiman & Laura C. Nachison, *Courts in the Business of Insurance: Claims Made and Reported Policies*, DEFENSE COUNSEL. J. 43 (1990); for the contrary argument that function, not form, should govern, see *Slater v. Lawyers' Mut. Ins. Co.*, 278 Cal. Rptr. 479, 487-88 (Cal. Ct. App. 1991) (Johnson, dissenting).

84. *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512, 514. See, e.g., *Thoracic Cardiovascular Associates, Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 920 (Ariz. Ct. App. 1994); *Serrmi Prods. v. Ins. Co.*, 411 S.E.2d 305, 306 (Ga. App. 1991); *Continental Cas. Co. v. Maxwell*, 799 S.W.2d 882, 887 (Mo. 1990).

85. *Gulf Ins. Co.*, 433 So. 2d at 515. See, e.g., *United Nat'l Ins. Co. v. Jacobs*, 754 F. Supp. 865, 868 (M.D. Fla. 1990); *First Alabama Bank v. First State Ins. Co.*, 1990 U.S. App. LEXIS 6744 (N.D. Ala. 1988); *City of Harrisburg v. International Surplus Lines Ins. Co.*, 596 F. Supp. 954, 961 (D. Pa. 1984); *Sletton v. St. Paul Fire & Marine Ins. Co.*, 780 P.2d 428, 430 (Ariz. 1989); *KPFF, Inc. v. California Union Ins. Co.*, 66 Cal. Rptr. 2d 36, 42 (Cal. Ct. App. 1997).

86. See, e.g., *St. Paul Fire & Marine Ins. Co. v. Tinney*, 920 F.2d 861 (11<sup>th</sup> Cir. 1991) (error to grant summary judgment to insurer simply because timely report to insurer did not detail names and addresses of witnesses and date, time, and place of incident).

insurer?<sup>87</sup> Are we to understand that every condition in a claims-made policy is immune from excuse arguments? If not, why not?<sup>88</sup>

And why, those who come to this same history with some knowledge of the development of the notice-prejudice rule might ask, has an argument that a particular nonoccurrence of a condition should be excused been so easily and so regularly conflated with arguments that the policy provision establishing that condition is contrary to public policy or unconscionable or did not make it into the contract because contrary to objective reasonable expectations of insureds? Whether a reflection of the conceptual and rhetorical poverty of insurance law, or a tactical choice by defense lawyers who know better, the result is an odd mix in which legal formalism, dominated by the assumption that policy provisions speak plainly to dictate precise results, combines with a bargain-basement legal realism that sees in every coverage dispute another skirmish in a titanic struggle between freedom of contract and social control. The insurance law on display in claims-made litigation is an insurance law that trades in results and disdains such doctrinal distinctions: application of the notice-prejudice rule to reporting conditions is characterized as a refusal to enforce claims-made formats; decisions declaring reporting conditions immune from the notice-prejudice rule are characterized as vindication of claims-made formats.

And why, those who venture into the thickets of claims-made litigation from outside the insular traditions of insurance may wonder, has the dispute over whether reporting conditions in claims-made policies should be immune from the notice-prejudice rule drawn so little on the sources of guidance available elsewhere in insurance law and the more generalized law of contracts? Whether the notice-prejudice rule should apply, both sides agree, turns on whether the reporting condition is a essentially a "coverage" clause

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87. See, e.g., *Thoracic Cardiovascular Associates, Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 923 (Ariz. Ct. App. 1994) (excuse of failure to report claim during policy period on grounds of impracticability unavailable even though insured did not receive service until many months after suit filed and policy period ended; according to the court, a claims-made-and-reported "insured assumes the risk that claims will not be covered unless they are both discovered and reported during the policy period"); *St. Paul Fire & Marine Ins. Co. v. Estate of Hunt*, 811 P.2d 432, 434-35 (Colo. Ct. App. 1991) (excuse for impracticability due to mental impairment not available because "the condition requiring the insured to provide notice of a claim during the policy period was a material part of the agreed exchange").

88. For one exception to the general obliviousness to these issues, see Richard L. Suter, *Insurer Prejudice: Analysis of an Expanding Doctrine in Insurance Coverage Law*, 46 ME. L. REV. 221 (1994).

and thus immune, or essentially something else—a “procedural,” “loss adjustment,” “administrative,” “merely technical” condition—and thus not immune. The distinction between “core” and “noncore” contractual provisions is an important one both inside and outside insurance law,<sup>89</sup> and insurer resistance to the development of the “notice–prejudice rule” for occurrence policies included assertions that notice provisions there too were at the “essence of the contract.”<sup>90</sup> But there is no hint of those connections in the claims–made literature. An insurance law that characterizes every insurer defeat as a refusal to enforce the policy is not likely to be looking for doctrinal guidance in the long history of insurance litigation concerning which policy provisions should be classed as “coverage” provisions immune from warranty statutes, incontestable clauses, and excuse on the basis of impracticability and waiver, and even less likely to break out of its insularity to consult the *Restatement (Second) of Contracts* about what should be involved in determining when a contract condition is so central to the bargain that noncompliance should not be excused.

And, so, we must finally wonder, what if insurance lawyers were not so easily convinced by their job description that they are adrift in conceptual backwaters in which traditional contracts rules cannot be expected to function in the normal ways? What if those involved in claims–made trigger litigation were to have recourse to the *Restatement* and to other windows into the general law of contracts in search of bases upon which to distinguish noncompliance with insurance policy conditions that sometimes may be excused from noncompliance with insurance policy conditions for which excuse will not be available? What would they learn about the various ways in which insurance policy conditions operate to lessen the insurer’s obligation? And what might that mean for future claims–made litigation?

## II. A LONGER PRIMER ON INSURANCE POLICY CONDITIONS AND WHEN THEIR NONOCCURRENCE MAY BE EXCUSED

We can now return to the questions with which we began: In what sense is the coverage provided by claims–made formats “less” than the coverage provided by “occurrence” formats? Is the coverage provided by various forms of claims–made policies less in the same sense that an insured under

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89. See *infra* notes 240–45.

90. See, e.g., Edward A. Shure, *Contract Provisions for Notice and Proof After Discovery of Loss Are Conditions Precedent to the Insured’s Right of Recovery*, 1967 ABA INS. NEG. & COMP. LAW PROC. 95.

a family auto policy has less coverage than if she had purchased collision coverage to go with the other coverages she did buy? In the sense that her homeowner's policy provides less coverage than it otherwise would because it excludes liabilities arising out of business pursuits and excepts property damage caused by rodents? Should we regard these risk-allocation provisions differently than we regard provisions that purport to immunize the insurer from liability for property damage occurring while the insured property is vacant or unoccupied, for theft losses not evidenced by visible external marks of forced entry, and when notice of an otherwise-covered event is not given within a reasonable time? And what should we make of the recurrent reassurance that the coverage provided by a claims-made policy "may be less, but so, therefore, is the cost?"

Of course, within the reinforcing orthodoxies of neo-classical contract and neo-classical economics,<sup>91</sup> such questions are quite meaningless. In a world where value is equated with willingness to pay, where every preference can be satisfied at a price, and where both insurer and insured can be imagined to have foreseen, priced, and allocated all relevant risks for every possible future state of the world,<sup>92</sup> there simply is no reason to try to distinguish among the variety of provisions that populate insurance policies.

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91. "The classical contract ... is so to speak the legal corollary of the zero-transactions-cost conception of the world." Erik Furubotn & Rudolf Richter, *The New Institutional Economics: An Assessment*, 1992 J. INST'L & THEORETICAL ECON. 1, 20.

92. Rational choice models typically assume that the players "know, or can know, all the feasible alternative actions open to them, that they know, or can easily discover, all relevant prices, and that they know their wants or desires." Thomas S. Ulen, *Cognitive Imperfections and the Economic Analysis of Law*, 12 HAMLINE L. REV. 385, 385-86 (1989). When the decisions involve the future, as contracting decisions must, models of rational choice under uncertainty assume:

that individual decisionmakers can compute (subjective) probability estimates of uncertain future events; that they perceive accurately the dollar cost or outcome of the uncertain outcomes; that they know their own attitudes toward risk; that they combine this information about probabilities, monetary values of outcomes, and attitudes toward risk to calculate the expected utilities of alternative courses of action and choose that action that maximizes their expected utility.

If each has been validated by the actual assent of expected-utility-maximizing parties, then each should be strictly enforced.

But in a world in which the soothing assumptions of expected utility models do not hold,<sup>93</sup> where bounded rationality<sup>94</sup> guarantees that not all

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93. For an accessible introduction to the limits of rational choice models as guides to human decision making, and to contracts and contract law, see Melvin Aron Eisenberg, *The Limits of Cognition and the Limits of Contract*, 47 STAN. L. REV. 211 (1995). The literature of "behavioral economics" is expanding rapidly as both economics and law confront the "now incontestable point" that "economic rationality is systematically violated, and that decision-making errors are both widespread and predictable." David Laibson & Richard Zeckhauser, *Amos Tversky and the Ascent of Behavioral Economics*, 16 J. RISK & UNCERTAINTY 7, 9 (1998). See generally RICHARD H. THALER, QUASI RATIONAL ECONOMICS (1991); Christine Jolls, Cass R. Sunstein, & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471 (1998); Mark Kelman, *Behavioral Economics as Part of a Rhetorical Duet: A Response to Jolls, Sunstein, and Thaler*, 50 STAN. L. REV. 1577 (1998); Matthew Rabin, *Psychology and Economics*, 36 J. EC. LIT. 11 (1998).

The lessons are applicable to decision making by both parties to the insurance transaction. See, e.g., Robin M. Hogarth & Howard Kunreuther, *Risk, Ambiguity, and Insurance*, 2 J. RISK & UNCERTAINTY 5 (1989) (traditional expected utility models of insurance markets inadequate because imprecision of estimates of probability of loss affects decisions of both buyers and sellers of insurance); Eric J. Johnson et al., *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK & UNCERTAINTY 35 (1993) (loss aversion framing and status quo framing found in actual insurance markets as well as experimental settings); Richard Kihlstrom & Alvin Roth, *Risk Aversion and the Negotiation of Insurance Contracts*, in FOUNDATIONS OF INSURANCE ECONOMICS 264, 268 (George Dionne & Scott Harrington, eds. 1991) (when insurer uncertain of ability to diversify, assumption that insurer will be risk neutral no longer holds; "behavior of negotiated insurance contracts for more general insurance problems thus remains an open question"); Gary H. McClelland et al., *Insurance for Low-Probability Hazards: A Bimodal Response to Unlikely Events*, 7 J. RISK & UNCERTAINTY 95 (1993) (bimodality found in laboratory reactions to low probability, high consequence risks); Paul J.J. Schoemaker & Howard C. Kunreuther, *An Experimental Study of Insurance Decisions*, 46 J. RISK & INS. 603, 616 (1979) (cost much more acceptable if framed as insurance premium rather than simple loss). See also HOWARD KUNREUTHER ET AL., DISASTER INSURANCE PROTECTION: PUBLIC POLICY LESSONS (1978) (decisions by consumers of insurance inconsistent with expected utility models); Robert Eisner & Robert Strotz, *Flight Insurance and the Theory of Choice*, 69 J. POL. ECON. 355 (1961) (same).

94. By "bounded rationality," I mean not only that obtaining and using information can be costly, and not only that there may be absolute limits on abilities to acquire and process information, but also that there may be systematic cognitive



uncertainties will be converted effortlessly into probabilities, and where the potential for opportunism<sup>95</sup> must be included among the hazards the future may hold, we may be less inclined to concede that the presence of a visible external marks provision in the theft-from-automobile coverage provided by a homeowners policy means that the insured has manifested a preference for that condition—or that, along the margin, some more-sophisticated insured has manifested it for her<sup>96</sup>—in the same way she has manifested a preference for limiting price and coverage by choosing not to buy collision coverage. If bounded rationality prevents the parties from lingering over a complete menu

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and motivational barriers to rational choice. The first receives recognition in economic models that incorporate search costs and informational asymmetries, the second in economic models of decision making under uncertainty, but the third is potentially more deeply subversive. See Kenneth E. Scott, *Bounded Rationality and Social Norms*, 150(1) J. INST'L & THEORETICAL ECON. 315 (1994). The term is generally credited to Herbert Simon. See, e.g., HERBERT A. SIMON, *MODELS OF BOUNDED RATIONALITY* (1982); Herbert A. Simon, *Rationality in Psychology and Economics*, in RATIONAL CHOICE: THE CONTRAST BETWEEN ECONOMICS AND PSYCHOLOGY 25 (Robin M. Hogarth & Melvin W. Reder eds. 1987); Herbert A. Simon, *A Behavioral Model of Rational Choice*, 69 Q.J. ECON. 99 (1955). For a useful modern summation, see John Conlisk, *Why Bounded Rationality?*, 34 J. ECON. LIT. 669 (1996).

95. By “the potential for opportunism,” I mean the risk that “human agents will not reliably self-enforce promises but will defect from the letter and spirit of an agreement when it suits their purposes.” OLIVER E. WILLIAMSON, *THE ECONOMIC INSTITUTIONS OF CAPITALISM* 388 (1985). For other efforts to define opportunism, see, e.g., *id.* at 65 (“self-interest-seeking with guile”); George M. Cohen, *The Negligence-Opportunism Tradeoff in Contract Law*, 20 HOFSTRA L. REV. 941, 957 (1992) (“any contractual conduct by one party contrary to the other party’s reasonable expectations based on the parties’ agreement, contractual norms, or conventional morality.”); Charles J. Goetz & Robert E. Scott, *Principles of Relational Contracts*, 67 VA. L. REV. 1089, 1139 n. 118 (1981) (“strategic behavior designed to exploit a contractually created monopoly position”); Timothy J. Muris, *Opportunistic Behavior and the Law of Contracts*, 65 MINN. L. REV. 521 (1981) (conduct that is “contrary to the other party’s understanding of the contract, but not necessarily contrary to the agreement’s terms”).

96. For a crisp statement of the argument, see Alan Schwartz & Louis Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630 (1979); for a recent examination of the limitations of that argument, see R. Ted Cruz & Jeffrey J. Hinck, *Not My Brother’s Keeper: The Inability of an Informed Minority to Correct for Imperfect Information*, 47 HASTINGS L.J. 635 (1996).

of possible policy provisions—each with its associated price tag—as they make fully-informed, fully-rational choices about how to construct their fully-specified, fully-presentiated insurance contract, and if the threat of opportunistic behavior makes deferring decisions about how to allocate responsibility for the unknown an unattractive option, what then?<sup>97</sup>

*A. Enforcing Reasonable Expectations or Policing Against Opportunism?*

How we respond to that question may depend on which of the “twin behavioral assumptions”<sup>98</sup> of bounded rationality and opportunism we choose

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97. That question has fueled a vigorous debate. For a recent version of the claim that rational choice models should incorporate new insights about cognitive and motivational behaviors, see Cass R. Sunstein, *Behavioral Analysis of Law*, 64 U. CHI. L. REV. 1175 (1997). For the view from the other side of the methodological divide, see Robert E. Scott, *Error and Rationality in Individual Decisionmaking: An Essay on the Relationship between Cognitive Illusions and the Management of Choices*, 59 S. CAL. L. REV. 329 (1986); Alan Schwartz, *Proposals for Product Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 380–82 (1988). For a sense of the passions that these issues can stir, see Richard Posner, *The New Institutional Economics Meets Law and Economics*, 149(1) J. INST'L & THEORETICAL ECON. 73 (1993); O.E. Williamson, *Transaction Cost Economics Meets Posnerian Law and Economics*, 149(1) J. INST'L & THEORETICAL ECON. 99 (1993); Richard Posner, *Reply*, 149(1) J. INST'L & THEORETICAL ECON. 119 (1993).

98. The phrase is taken from OLIVER E. WILLIAMSON, *REVISITING LEGAL REALISM: THE LAW, ECONOMICS, AND ORGANIZATION PERSPECTIVE* 16 (Working Paper No. 95–12, Center for the Study of Law and Society, Berkeley 1996). As Williamson delights in pointing out, the traditional assumptions of classical economics and classical contracts—that contracts are fully specified and leave no room for opportunistic behavior—render both economics and law uninteresting. In this “contractual utopia,” relaxing but one assumption at a time does not change things: with unbounded rationality and opportunism, comprehensive ex ante contracting might be expected to take the sting out of opportunism; with bounded rationality and no opportunism, “general clauses” could be used to defer potential problems for peaceful resolution if and when they arise. Thus, says Williamson, the only interesting contracts questions are prompted by the coincidence of bounded rationality and opportunism, “which I maintain accords with reality and is where all of the difficult contracting issues reside.” WILLIAMSON, *supra* note 95, at 67. Dieter Schmidtchen, *Time, Uncertainty, and Subjectivism: Giving More Body to Law and Economics*, 13 INT'L REV. L. & EC. 61, 75 (1993), summarizes the neo-institutional criticism of an exclusively ex ante perspective:

to emphasize. On the one hand, we might try to assess the effects of bounded rationality on the quality of the insured's assent to the inclusion of various provisions in standard insurance policy forms, and respond by trying to determine an appropriate insurance contract *ex ante*. On the other hand, we might focus on the vulnerability that results from sequential performance of aleatory insurance contracts chock-full of express conditions and try to derive ways to police contractual performance *ex post*. The first approach springs naturally from deeply-imbedded intuitions that contract law "is designed primarily to facilitate market exchange by providing *ex ante* safeguards against contract or market failure";<sup>99</sup> the second is animated by alternative visions of contract law offered by neo-institutionalists who seek to identify conditions under which opportunism is likely to flower and who emphasize the role of contract institutions and contract law as *ex post* governance mechanisms for controlling opportunism.<sup>100</sup> For lawyers contemplating an insurance coverage question, the first hand points toward the "Doctrine of

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The result of unbounded rationality and given probability distributions for all states of the world will be the perfect contingent contract. If we further assume that court ordering is efficacious, nothing unexpected will happen. All relevant issues of a contract are settled at the *ex ante* bargaining stage. . . . The *ex post* (execution) stage of a contract does not bring up any interesting issues for further analysis. This is the world of the traditional neo-classical theory . . . . Orthodox law and economics, in the Chicago style, for example, drops the assumption of perfect contingent contracts and efficacious cost adjudication. But the maximizing man stays on stage, while the analysis of the *ex post* (execution) aspects of contracts is withdrawn within the background.

99. JULES L. COLEMAN, RISKS & WRONGS 73 (1992).

100. As Professor Cohen notes, the second approach "has traveled under several different names—relational contracting, transaction cost theory, new institutional economics . . . . [T]he distinguishing feature common to all variants of this approach . . . is the focus on the need to deter opportunistic, as opposed to negligent, contracting behavior." Cohen, *supra* note 95, at 953. For an excellent survey of some of this work, see Howard A. Shelanski & Peter G. Klein, *Empirical Research in Transaction Cost Economics: A Review and Assessment*, 11 J. L. EC. & ORG. 335 (1995). For recent efforts to set out the agenda of the new institutional economics, see DOUGLASS C. NORTH, INSTITUTIONS, INSTITUTIONAL CHANGE AND ECONOMIC PERFORMANCE 17–18 (1990); OLIVER E. WILLIAMSON, THE MECHANISMS OF GOVERNANCE (1996); Furubotn & Richter, *supra* note 91.

Reasonable Expectations,”<sup>101</sup> construction contra proferentem,<sup>102</sup> and similar doctrinal tools concerned with determining the content and meaning of the contract;<sup>103</sup> the second hand beckons the lawyer in a different direction, toward “bad faith”<sup>104</sup> and “excuse of failure of condition”<sup>105</sup> and a host of similar devices for policing opportunistic performance and enforcement of

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101. The “Doctrine of Reasonable Expectations” properly is attributed to Professor (now Judge) Robert E. Keeton, who announced discovery of the “principle” underlying some judicial decisions “at variance with policy provisions” in 1969 and then guided its evolution into a “doctrine.” See Robert Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967, 1281 (1970); Robert E. Keeton, *Reasonable Expectations in the Second Decade*, 12 FORUM 275 (1976). See also JERRY, *supra* note 48, § 25D; ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINE AND COMMERCIAL PRACTICES* § 6.3(a)(3), at 632 (Practitioners ed. 1988); Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981); Stephen J. Ware, *A Critique of the Reasonable Expectations Doctrine*, 56 U. CHI. L. REV. 1461 (1989); William Mark Lashner, Note, *A Common Law Alternative to the Doctrine of Reasonable Expectations in the Construction of Insurance Contracts*, 57 N.Y.U. L. REV. 1175 (1982). For efforts to capture the modern state of the “doctrine,” see BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES* § 1.03[b][2] (3d ed. 1995); Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823 (1990).

102. For useful recent indications of the sorts of things that go on under this rubric, and efforts to wrestle with their normative implications, see Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171 (1995).

103. See, e.g., JEFFREY W. STEMPEL, *INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS* § 5.2 (1995); James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992); Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach*, 57 OHIO ST. L.J. 543 (1996).

104. See generally STEPHEN S. ASHLEY, *BAD FAITH ACTIONS: LIABILITY AND DAMAGES* (2d ed. 1997); WILLIAM M. SHERNOFF, *INSURANCE BAD FAITH LITIGATION* (1984); KEETON & WIDISS, *supra* note 101, at §§ 6.2, 7.8, 7.9; Symposium, *The Law of Bad Faith in Contract and Insurance*, 72 TEX. L. REV. 1203 (1994).

105. See generally RESTATEMENT (SECOND) OF CONTRACTS § 225 cmt. b (1981) (identifying seven categories of excuse of failure of condition).

contract obligations.<sup>106</sup> Although contract law and contract institutions involve efforts of both sorts,<sup>107</sup> in insurance—as throughout contracts—the first hand is much better developed than the second.<sup>108</sup>

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106. See *infra* notes 196–207 and accompanying text.

107. See generally Cohen, *supra* note 95 (distinguishing “least cost avoider” and “opportunism” traditions in law and economics literature); Charles J. Goetz & Robert E. Scott, *The Mitigation Principle: Toward a General Theory of Contractual Obligation*, 69 VA. L. REV. 967, 968 n.5 (1983) (contrasting “two distinct and largely unrelated analytic traditions,” which they label the “bargain model” and “transaction cost” traditions); Jason Scott Johnston, *Law, Economics, and Post-Realist Explanation*, 24 LAW & SOC’Y REV. 1217 (1990) (contrasting “model of precautions” and “transaction cost economics”). For Stanley Fish, those tensions give contract law its strength: “It is *because* it is a world made up of materials that pull in diverse directions that contract law can succeed in its endless project of making itself into a formal whole.” Stanley Fish, *The Law Wishes to Have a Formal Existence*, in *THE FATE OF LAW* 159, 184 (Austin Sarat & Thomas R. Kearns eds., 1991).

Long before high-stakes coverage litigation sparked renewed interest in insurance law, Professor Slawson combined both perspectives in a single influential article. W. David Slawson, *Mass Contracts: Lawful Fraud in California*, 48 S. CAL. L. REV. 1 (1974). For a recent return visit to these themes, see W. DAVID SLAWSON, *BINDING PROMISES* 151–74 (1996) (posing choice directly for insurance). For a view from the outside, see Per-Olof Bjuggren et al., *Should A Regulatory Body Control Insurance Policies Ex Ante or Is Ex Post Control More Effective?*, 19 GENEVA PAPERS ON RISK & INS. 37 (1994).

108. The dominance of the first hand is easily explained. Neo-classical economics naturally is drawn by a powerful methodological tropism toward the ex ante. Academics who move away from classical contingent claims modeling to acknowledge the role of asymmetries of information gravitate toward agency theory, mechanism design, and similar efforts to construct efficient ex ante solutions to the problems posed by information costs; in such modeling, the threat of opportunistic behavior is collapsed into moral hazard, and moral hazard becomes just another aspect of asymmetric information. Neo-classical contracts displays the same methodological preoccupation with “anticipating problems, specifying contingencies, aligning incentives, and, in general, prespecifying obligations fully.” Thomas Palay, *Relational Contracting, Transaction Cost Economics and the Governance of HMOs*, 59 TEMPLE L.Q. 927, 930 (1986). See also Wallace K. Lightsey, *A Critique of the Promise Model of Contract*, 26 WM. & MARY L. REV. 45, 49 (1984) (criticizing “three primary inadequacies of the promise model: discreteness, discontinuity, and presentation”); Peter Linzer, *Uncontracts: Context, Contorts and the Relational Approach*, 1988 ANN. SURVEY AM. LAW 139 (exploring extent to which consent and presentation remain the primary building blocks of contracts).

### 1. Vindicating Reasonable Expectations?

Law students, flushed with first recognition of how far the realities of standard insurance policy form marketing sometimes depart from idealized “strong assumptions about the capacities of rational commercial actors to calculate the probability of even remote events and, when desirable, to strike ex ante bargains that reflect their expected value,”<sup>109</sup> often are quick to conclude that not all provisions in standard insurance policy forms were created equal and that we should make distinctions on the basis of perceived differences in the quality of the insured’s assent. Thus, for example, whether or not to buy collision coverage was a choice that almost certainly was brought home to the insured at the time she applied for auto insurance and again at each renewal. By contrast, the business exclusion from liability coverages is a standardized part of homeowners policies, but whether the insured realizes it or not, its effects often can be avoided by purchasing an inexpensive rider. And, of course, a prospective insured is not likely to know much about rodent damage exclusions, vacancy-or-unoccupancy warranties, visible-external-marks evidentiary conditions, or notice provisions, or to worry about them if she does know about them, and in any event, if she wants insurance there’s probably nothing she can do to prevent them from becoming a part of her contract with the insurer. Shouldn’t those differences count for something, law students habitually ask.

Not really, they quickly learn. True, standard form insurance contracting is in tension with conventional pieties of orthodox autonomy- and consent-based contracts models.<sup>110</sup> True, most of the provisions that repeat-player insurers, through the Insurance Services Office and other industry support organizations, think to include in standard insurance policy forms cannot fairly be said to have been validated by actual assent of the insureds. And, true, efforts within the academy to wrestle with the implications of relaxing assumptions about informational and cognitive resources of contracting parties have produced a rich theoretical literature concerning the inevitability of incomplete contracts, how to identify the resulting gaps, and how best to go about filling those gaps with default rules.<sup>111</sup> In insurance, those efforts have been mirrored by a parallel academic and practice literature working

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109. Clayton P. Gillette, *Commercial Relationships and the Selection of Default Rules for Remote Risks*, 19 J. LEG. STUD. 535, 539 (1990).

110. For an especially useful description of this tension, see MICHAEL J. TREBILCOCK, *THE LIMITS OF FREEDOM OF CONTRACT* 78-146 (1993).

111. See generally *Symposium on Default Rules and Contractual Consent*, 3 S. CAL. INTERDISCIPLINARY L.J. 1 (1993); authorities cited *infra* note 116.

riffs on the theme that sometimes "objectively reasonable expectations" of insureds will be vindicated "even though a painstaking study of the policy provisions would have negated those expectations."<sup>112</sup>

But these developments do not mean that insurance law is now in the business of ignoring standard insurance policy forms in favor of building a contract by combining the dickered terms with judicially-supplied gap fillers designed to mimic the expectations of actual or hypothetical insureds. The reality, of course, is that real insureds simply do not have expectations of any kind about most of the subjects treated by the provisions that lurk unread in their policies, and no one who thinks about it for more than a moment is likely to imagine that it should be any other way.<sup>113</sup> But then what? It is difficult to muster much enthusiasm for telling insureds that coverage-enhancing provisions of their policies may not be available because they and other reasonable insureds did not know they were there, and even the most sanguine concerning judicial competence to construct appropriate gap-filling

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112. Robert Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970). See also authorities cited *supra* note 101.

113. As Michael Trebilcock notes: "Almost implicit in the transaction cost justification for standard form contracts is the assumption that parties will often not read them or, if they do, will not wish to spend significant amounts of time attempting to renegotiate the terms." TREBILCOCK, *supra* note 110, at 119. See also Melvin Aron Eisenberg, *Text Anxiety*, 59 S. CAL. L. REV. 305 (1986) (reasonable for consumers to refuse to read form contracts); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173, 1226 (1983) ("The ideal adherent who would read, understand, and compare several forms is unheard of in the legal literature and, I warrant, in life as well."). Empirical work seems to validate these impressions:

When asked about their insurance decisions, subjects in both laboratory studies and survey studies indicated a disinclination to worry about low probability hazards. Such a strategy is understandable in view of the fact that limitations of people's time, energy, and attentional capacities create a "finite reservoir of concern." Unless we ignored many low-probability threats we would become so burdened that any sort of productive life would become impossible.

Howard Kunreuther & Paul Slovic, *Economics, Psychology, and Protective Behavior*, 68 AM. ECON. REV. 64, 67 (May 1978).

default rules<sup>114</sup> are unlikely to find much in the thousands of law review pages to help with a project of judicial construction of off-the-rack gap fillers to supplement the parties' agreement in fact. "Whatever is, is efficient"<sup>115</sup> is one way out of the dilemma, but those who refuse to subscribe to such simple verities are unlikely to find in any of the contending theories of default rules<sup>116</sup> anything useful to say about whether damage to the front of an insured auto caused by striking a deer should be covered under the "collision" or "other than collision" coverage of a personal auto policy.

In practice, then, even the most aggressive of the insurance law analogs to the "hypothetical contract" literature do not try to build the undickered

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114. For less-than-sanguine evaluations of that competence, see TREBILCOCK, *supra* note 110, at 101; Richard Craswell, *Remedies When Contracts Lack Consent: Autonomy and Institutional Competence*, 33 OSGOODE H. L.J. 209 (1995); Gillian K. Hadfield, *Judicial Competence and the Interpretation of Incomplete Contracts*, 23 J. LEG. STUD. 159 (1994).

115. The phrase is attributed to Armen Alchian by John Lott, *In Celebration of Armen Alchian's 80<sup>th</sup> Birthday: Living and Breathing Economics*, 34 ECON. INQ. 412, 413 (1996).

116. Prescriptions include gap-filling default rules designed variously to "mimic the market," e.g., Robert E. Scott, *A Relational Theory of Default Rules for Commercial Contracts*, 19 J. LEGAL STUD. 597 (1990); David Charny, *Hypothetical Bargains: The Normative Structure of Contract Interpretation*, 89 MICH. L. REV. 1815 (1991); to reflect "communitarian values," e.g., Steven J. Burton, *Default Principles, Legitimacy, and the Authority of a Contract*, 3 S. CAL. INTERDISC. L.J. 115, 116-17 (1993); Jay M. Feinman, *Critical Approaches to Contract Law*, 30 UCLA L. REV. 829, 858 (1983); to recognize "norms implicit in the parties' relationship" to "avoid contractual breakdown," e.g., Ian R. Macneil, *Contracts: Adjustment of Long-Term Economic Relations Under Classical, Neo-classical, and Relational Contract Law*, 72 NW. U. L. REV. 854 (1978); and to create incentives to induce potential contracting parties to disclose asymmetrically-distributed information. E.g., Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87 (1989).

For skepticism about the possibility of any overarching approach, and insistence on the importance of contextual issues, see Dennis Patterson, *The Pseudo-Debate Over Default Rules in Contract Law*, 3 S. CAL. INTERDISC. L.J. 235 (1993) (characterizing literature of default rules as pseudo debate posing old questions in language of other disciplines); Todd D. Rakoff, *Social Structure, Legal Structure, and Default Rules: A Comment*, 3 S. CAL. INTERDISC. L.J. 19 (1993) (emphasizing need for contextualization); W. David Slawson, *The Futile Search for Principles for Default Rules*, 3 S. CAL. INTERDISC. L.J. 29 (1993) ("Default rule analysts have contributed nothing new to the subject except the new word they have coined for it.").



portions of insurance contracts from scratch. Instead, they assume, more or less explicitly, that the policy must be the starting point for determining the contours of the insurance contract,<sup>117</sup> and that the “reasonable expectations” to be vindicated must be Llewellynesque generalized expectations that policy provisions will be neither unfairly surprising nor surprisingly unfair.<sup>118</sup> Now

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117. See, e.g., RESTATEMENT (SECOND) OF CONTRACTS § 211 (1) (1981):

Except as stated in Subsection (3), where a party to an agreement signs or otherwise manifests assent to a writing and has reason to believe that like writings are regularly used to embody terms of agreements of the same type, he adopts the writing as an integrated agreement with respect to the terms included in the agreement.

118. In Karl Llewellyn’s familiar formulation:

What has in fact been assented to, specifically, are the few dickered terms, and the broad type of the transaction, and but one thing more. That one thing more is a blanket assent (not a specific assent) to any not unreasonable or indecent terms the seller may have on his form, which do not alter or eviscerate the reasonable meaning of the dickered terms.

KARL N. LLEWELLYN, *THE COMMON LAW TRADITION: DECIDING APPEALS* 370 (1960). See also Karl N. Llewellyn, *The Standardization of Commercial Contracts and Continental Law*, 52 HARV. L. REV. 700 (1939) (book review). The policing function prescribed by Llewellyn finds somewhat circumspect expression in RESTATEMENT (SECOND) OF CONTRACTS § 211(3) (1981): “Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not a part of the agreement.” The critical explanation is provided in *Comment f*:

*f. Terms excluded.* Subsection (3) applies to standardized agreements the general principles [governing interpretation of contracts]. Although customers typically adhere to standardized agreements and are bound by them without even appearing to know the standard terms in detail, they are not bound to unknown terms which are beyond the range of reasonable expectation. . . . [A] party who adheres to the other party’s standard terms does not assent to a term if the other party has reason to believe that the adhering party would not have accepted the agreement if he had known that the agreement contained the particular term. Such a belief or assumption may be shown by the prior negotiations or

that most jurisdictions have abandoned jejune flirtations with enforcing only provisions about which the insured had actual subjective knowledge,<sup>119</sup> the outside possibility that a court might excise a provision of a standard insurance policy form on the grounds that it was unexpected is unlikely to put most standard form provisions in much jeopardy.<sup>120</sup> In the absence of any real expectations on the part of insureds about most of the subjects treated by standard insurance policy forms, the search for the unexpected almost inevitably will be degraded into a search for the extraordinary, and standardized forms are hardly the place to go prospecting for anything other than the ordinary.

Thus, even in jurisdictions where some version of the Doctrine of Reasonable Expectations is in full flower, there are good reasons not to embrace law student enthusiasms for a project of distinguishing among most standard insurance policy form provisions on the basis of the quality of the insured's assent. The Doctrine of Reasonable Expectations can be put to many uses, but refusing to enforce a policy provision because the insured did not know it was there or did not understand its purport should not be among them.<sup>121</sup> We know that the rodent-damage exception in a homeowners policy

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inferred from the circumstances. Reason to believe may be inferred from the fact that the term is bizarre or oppressive, from the fact that it eviscerates the non-standard terms explicitly agreed to, or from the fact that it eliminates the dominant purpose of the transaction.

For a skeptical review of the limited use (and misuse) of § 211(3) in insurance decisions, see James J. White, *Form Contracts under Revised Article 2*, 75 WASH. U. L.Q. 315 (1997).

119. The highwater mark for this approach may have been *Hionis v. Northern Mutual Insurance Co.*, 230 Pa. Super. 511, 327 A.2d 363 (1974). The Pennsylvania court backed away from the implications of this approach in *Standard Venetian Blind Co. v. American Empire Insurance Co.*, 503 Pa. 300, 469 A.2d 563 (1983).

120. See generally Abraham, *supra* note 101 (cataloging variety of functions to which "Doctrine of Reasonable Expectations" can be put); Henderson, *supra* note 101 (similar project).

121. No one has improved on Professor Leff's characteristically pointed comment about such projects: "[D]eal control is ordinarily a stupid option; it is silly to seek to shape and control the contours of a process that does not take place." Arthur Allen Leff, *Contract as Thing*, 19 AM. U. L. REV. 131, 148 (1970). The problem, Leff argued, is that "so long as one is bemused by the word 'contract,' even

will be treated as an effective part of the integrated agreement of the parties even though we also know that the insured may not have been aware of the exclusion, usually will have no effective understanding of how it is affected by concurrent causation analyses, and as a practical matter could not have contracted to allocate the risk of squirrel damage to the insurer. So too will virtually every other provision to be found in insurance policy forms. And yet, experienced insurance lawyers will acknowledge, some of the provisions we are considering are more likely to receive rough treatment from judges than are others. Distinctions do get made. How should we make them?

## 2. Policing Against Opportunism?

The answer will not become truly accessible until we move beyond reflexive bargain-model ways of thinking about insurance contracts and begin to confront the implications of the neo-institutional claim that—in Williamson's trenchant phrase—“*ex post* support *institutions* of contract *matter*.”<sup>122</sup> Neo-institutional economics incorporates into its models not only “bounded rationality” but also recognition that “some individuals are opportunistic some of the time and that differential trustworthiness is rarely transparent *ex ante*,”<sup>123</sup> and thus takes as part of its task to identify and to explore contract institutions that find their explanations in efforts to control opportunism by contracting parties.<sup>124</sup> For the neo-institutional economist working in the intersection of law, economics, and organization theory, the principal concern is to identify the conditions under which opportunism is most likely to occur and to match transaction types with the most appropriate mode of governance. For those who come to such questions from the legal side of the disciplinary divide, the agenda is the same: to determine when a combination of bounded rationality and transaction specific investments will create the potential for opportunism and to determine which institutional

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when it is intelligently modified by the cognomen ‘adhesion,’ it is likely that one will sometimes seek to impress his controls on a process which does not exist.” *Id.* at 149.

122. WILLIAMSON, *supra* note 95, at 29 (emphasis in original).

123. *Id.* at 64 (emphasis in original).

124. “Taken together, the overall import of bounded rationality and opportunism for transaction cost economics is this: organize transactions so as to economize on bounded rationality while simultaneously safeguarding the transactions in question against the hazards of opportunism.” OLIVER E. WILLIAMSON, *THE MECHANICS OF GOVERNANCE* 48 (1996). For an examination of private enforcement activities outside “the shadow of the law,” see Edward L. Rubin, *The Nonjudicial Life of Contract: Beyond the Shadow of the Law*, 90 NW. U. L. REV. 107 (1995).

devices<sup>125</sup> offer the best protections against opportunism in contract negotiation,<sup>126</sup> performance,<sup>127</sup> and enforcement.<sup>128</sup>

In insurance, of course, it is not hard to find both industry practices and legal techniques that are prompted by concerns about effects of opportunism. Because asymmetric information renders insurers vulnerable to fraud and misrepresentation, adverse selection, and moral hazard,<sup>129</sup> insurers employ a battery of pre-issuance underwriting procedures designed to allow them to be selective about those with whom they will contract, buttress those with

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125. The case against "single institutionalism" is put most effectively in NEIL A. KOMESAR: *IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS & PUBLIC POLICY* (1994). For a quick introduction to the basic argument, see Neil A. Komesar, *Exploring the Darkness: Law, Economics, and Institutional Choice*, 1997 WIS. L. REV. 465; David A. Luigs, *Imperfect Alternatives: Choosing Institutions in Law, Economics, and Public Policy*, 93 MICH. L. REV. 1559 (1995) (book review). Although comparative institutionalism in the legal academy often poses the choices as between markets or legislative or judicial control, private ordering through contracts and organizational form also should be counted among the contenders. See, e.g., Palay, *supra* note 108, at 931–32:

In contrast to the traditional economics approach which always finds the necessary binding mechanisms [to hold the agreement together] in markets or legal orderings, the relational contracting and transaction cost approach argues that the relational glue sometimes is supplied by private orderings, that is, through the efforts and expenditures of the parties themselves . . . .

126. See generally G. Richard Shell, *Opportunism and Trust in the Negotiation of Commercial Contracts: Toward a New Cause of Action*, 44 VAND. L. REV. 221 (1991); Juliet P. Kostritsky, *Bargaining with Uncertainty, Moral Hazard, and Sunk Costs: A Default Rule for Precontractual Negotiations*, 44 HASTINGS L.J. 621 (1993).

127. See generally Steven J. Burton, *Breach of Contract and the Common Law Duty to Perform in Good Faith*, 94 HARV. L. REV. 369 (1980); Robert S. Summers, *The General Duty of Good Faith—Its Recognition and Conceptualization*, 67 CORNELL L. REV. 810 (1982).

128. See generally STEVEN J. BURTON & ERIC G. ANDERSEN, *CONTRACTUAL GOOD FAITH: FORMATION, PERFORMANCE, BREACH, ENFORCEMENT* chs. 5–7 (1995).

129. See generally KENNETH J. ARROW, *ESSAYS IN THE THEORY OF RISK BEARING* 142–43 (1971); CAROL HEIMER, *REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS* (1985); Michael Rothschild & Joseph E. Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 629 (1976).

contractual provisions designed to control the insurer's exposure to other potential sources of claims on the insurance fund, and reinforce those efforts with post-loss claims adjustment techniques designed to ferret out fraud and limit loss adjustment costs. Insurance law provides the underpinnings for such insurer efforts with the principle of *uberrimae fidei* and other doctrinal devices for protecting insurers against the dangers of dealing with insureds with power to behave opportunistically.<sup>130</sup>

Both insurance economics and insurance law historically have tended to emphasize the potential that insurers may be victimized by opportunism on the part of insureds.<sup>131</sup> However, in recent decades discussions have broadened to include consideration of how best to deter opportunistic behaviors on the part of insurers. Can traditional contract damages measures and concern for reputational effects really be expected to deter opportunistic breaches by insurers?<sup>132</sup> Or is their force significantly undercut by "legal

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130. See generally Hugh Gravelle, *Insurance Law and Adverse Selection*, 11 INT'L REV. L. & ECON. 23 (1991); THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 344 (Peter Newman, ed. 1998).

131. Richard Epstein captures the dominant perspective this way:

The English developed a law of marine insurance, and its content was shaped by the 19th century judicial presumption of distrust. The party to an insurance contract about which the Courts were most sceptical [sic] was not the rich and powerful insurance company, but rather the insured party. It is not difficult to see why. The insured was in possession of the property, and had the lion's share of the information about the nature of the risks that were being run.

Richard Epstein, *Do Judges Need to Know Any Economics?*, 1996 NEW ZEALAND L.J. 235, 236. Cf. Harris Schlesinger, *Uncommon Knowledge: Bilateral Asymmetry of Information in Insurance Markets*, RISK MGM'T & INS. REV., Vol. 1, No. 2, p. 1 (noting that classic treatments of imperfect information in insurance markets all focus on insureds' private information about their own loss probabilities, and decrying lack of work on how insurers' private information affects markets for insurance).

132. "In many transactional settings, promises are kept for reasons wholly unrelated to the existence of a legally enforceable contract." Lisa Bernstein, *Social Norms and Default Rules Analysis*, 3 S. CAL. INTERDISC. L.J. 59, 67 (1993). See also David Charny, *Nonlegal Sanctions in Commercial Relationships*, 104 HARV. L. REV. 375 (1990); Oliver E. Williamson, *Credible Commitments: Using Hostages to Support Exchange*, 73 AM. ECON. REV. 519 (1993). Muris, *supra* note 95, at 526-528, summarizes the literature on "non-contract solutions to the opportunism problem" as

efficiencies of scale” enjoyed by mass-contracting insurers<sup>133</sup> and by the difficulties consumers experience when they try to determine the “claims

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1) reputation; 2) price adjustments to recognize effects of opportunism or to create incentives to not shirk; 3) vertical integration; 4) precision in contract language to make opportunistic behaviors more clearly breaches of contract. Of course, as he notes, *id.* at 527, “[e]ach of these methods . . . will fail to deter opportunism in some situations.” Insurance often is one of those situations. Although insurers are repeat players who must be concerned about consumer perceptions, individuals only infrequently have claims, and when insurers do resist claims, it is often difficult to determine whether or not the resistance was justified.

133. When the other party is a “mass contractor,” the usual damage rules often operate to provide even less deterrence to unwarranted breaches:

Since a mass contractor *is* a mass contractor, he will have had sufficient legal business both in and out of court to have at least one lawyer, and frequently a battery of lawyers, already familiar with his business, with the fields of law to which it pertains, and with his standard forms. Familiarity with the standard forms is particularly important. An attorney for an insurance company, for example, will know the clauses of the policy virtually by heart and will have available detailed legal memoranda already composed, providing all the pertinent law on the interpretation and probable enforcement of each clause. These legal efficiencies of scale not only significantly reduce the mass contractor’s average cost; they lower the marginal cost of each case to nearly zero. . . . Thus, the mass contractor’s attitude toward each particular case is likely to be, “Of course, we’ll fight it. We’re already tooled up and ready to go, so fighting it will cost us only X dollars—perhaps zero dollars—more than if we don’t.

Slawson, *supra* note 107, at 29-30. *See also* STEMPEL, *supra* note 103, at § 19.3; at 466-67 (“[I]nsurers always get to ‘play the float’ in any dispute.”); Mark Pennington, *Punitive Damages for Breach of Contract: A Core Sample From the Last Ten Years*, 42 ARK. L. REV. 31, 54 (1989) (“Insurance is far from the market ideals of complete information and no transaction costs. Opportunistic breaches are especially likely, and traditional damage rules do not sufficiently deter them.”).

With regard to claims for small amounts of money, the insurance company has some incentive to refuse payment because little likelihood exists that the claimant will pursue the claim. As for large claims, the insurance company may find it profitable to delay payment as long as possible to keep for itself the time value of the

service quality” of competing insurers?<sup>134</sup> Unfair claims practices statutes, prejudgment interest, statutory provisions for attorney’s fees for insureds who successfully pursue coverage litigation against insurers, mutualization, and—especially—the emergence of theories for imposing extra-contractual liability on insurers who in bad faith drag their heels in paying claims or performing their defense or other obligations all can be understood as reactions to the threat of insurer opportunism.<sup>135</sup>

What does all this have to do with how we should regard different sorts of policy provisions purporting to allocate risks between insurer and insured? Unfortunately, for most involved in insurance litigation, the answer remains less than obvious. Say “bad faith” to an insurance lawyer, and you suggest the possibility of extra-contractual liability,<sup>136</sup> usually sounding in tort, and provoke worries about how best to keep the concept from metastasizing

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amount due. Finally, prolonged delays in payment may make the insured more willing to settle for less than the amount due, particularly if the insured is financially desperate.

*Id.* at 53–4. The problem is not limited to claims by the small or the unsophisticated; in the words of the chairman of Dow Corning Corporation, “it has become standard operating procedure for some insurance companies to procrastinate and dispute rather than honor policies with companies that become embroiled in litigation.” Richard Hazleton, *The Tort Monster That Ate Dow Corning*, WALL ST. J., May 17, 1995, at A21.

134. In some economic modeling, a lower quality insurance product is equated with a higher risk of default—through insolvency, or bad claims service. *See, e.g.*, Marla Stafford & Brenda Wells, *Service Quality in the Insurance Industry: Consumer Perceptions Versus Regulatory Perceptions*, 13 J. INS. REG. 462 (1995); Marla Stafford & Brenda Wells, *The Effect of Demographic Variables on Perceived Claims Service Quality*, 19 J. INS. ISSUES 163 (1996). For an important theoretical and empirical challenge to the “assumption that the market treats all alike,” see Tom Baker & Karen McElrath, *Whose Safety Net? Home Insurance and Inequality*, 21 L. & SOC. INQ. 229 (1996) (documenting importance of adjuster discretion in claim settlement processes and outcomes).

135. *See generally* Gary Schuman, *The Covenant of Good Faith and Fair Dealing: Responsibilities of First-Party Insurers*, 47 FED. INS. & CORP. COUNS. 107 (1997) (explaining that competition does not protect insureds in claims context because insured no longer can take business of covering that risk to another insurer); William T. Barker et al., *Is An Insurer a Fiduciary To Its Insureds?*, 25 TORT & INS. L.J. 1, 8 (1989) (same).

136. *See generally* Ashley, *supra* note 104; Shernoff, *supra* note 104; The Law of Bad Faith in Contract and Insurance, *supra* note 104.

beyond its proper role as an incentive for insurers to promptly perform contractual obligations that clearly are owing.<sup>137</sup> Suggest that the implied obligation of good faith also imposes limits on when an insurer may invoke a failure of condition as a basis for refusing to perform or that hard-nosed insistence on the letter of the policy should be branded “opportunism,” and at best you provoke head-shaking and politely-suppressed condemnation of the unworldliness of fuzzy-headed academics.<sup>138</sup> But, as Professor Eric Andersen most forcefully has argued, both the *Uniform Commercial Code* and the *Restatement* make clear that the good faith obligation implicit in contracts of all kinds operates as a restraint not just on opportunistic efforts to avoid clear-cut performance obligations, but also as a restraint on bad faith in the exercise of discretion granted by enforcement terms. Professor Andersen’s gloss on the statutory and *Restatement* language, featured in a law review article<sup>139</sup> and more recently in his treatise on bad faith,<sup>140</sup> may not be

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137. See, e.g., Alan O. Sykes, “Bad Faith” Breach of Contract by First-Party Insurers, 25 J. LEGAL STUD. 405 (1996); Alan O. Sykes, *Judicial Limitations on the Discretion of Liability Insurers to Settle or Litigate: An Economic Critique*, 72 TEX. L. REV. 1345 (1994).

138. In the conventional understanding, there can be no bad faith tort liability in the absence of coverage. See, e.g., Schuman, *supra* note 135, at 115–118 (reviewing authorities).

139. Eric G. Andersen, *Good Faith in the Enforcement of Contracts*, 73 IOWA L. REV. 299 (1988). In Andersen’s view,

an enforcement term may be invoked only if, under the circumstances existing at the time enforcement is sought, the term would advance the purposes for which it was included in the agreement without imposing needless costs on the nonenforcing party. If that test is not satisfied, the benefits of the term should not be available to the party seeking them, even though inclusion of the term was unobjectionable when the contract was formed.

*Id.* at 301. Andersen emphasizes the difference between this “good faith in enforcement” obligation and standards of conduct required in order to avoid liability for tortious bad faith:

Making effect rather than motive the touchstone of good faith in enforcement does not make the good faith doctrine a miserly one. To the contrary, it makes the doctrine more generous. The costs imposed when enforcement is inconsistent with the agreement’s purposes are no more necessary or less expensive because they are



part of the stock in trade of most lawyers, but in fact if not in name<sup>141</sup> both the general law of contracts and the law of insurance are full of examples of doctrinal devices for policing exercise of discretion to employ enforcement mechanisms apparently authorized by the contract.<sup>142</sup> In the general law of

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sought innocently rather than with malice. Thus, good faith in enforcement not only embraces the notions of “decency, fairness or reasonableness” by responding to the harm caused by malicious invocation of an enforcement term, it also covers those situations in which such a term would accomplish something other than what it was intended to do, even though the enforcing party invoked it in the honest belief that it was appropriate to do so.

*Id.* at 324.

140. See BURTON & ANDERSEN, *supra* note 128.

141. See *id.* at 271 (good faith in enforcement is “an emerging doctrine. Evidence of its influence is widespread, yet it is overtly applied in relatively few cases.”). Andersen, *supra* note 139, at 301, says:

The doctrine accounts for many cases in which courts have, or should have, declined to enforce an express contractual condition and illustrates that a number of decisions in which courts have cited public policy reasons for refusing to enforce a contract can be justified more satisfactorily by a good faith doctrine that respects, rather than trumps, freedom of contract.

142. Other useful explorations of this theme include Thomas A. Diamond & Howard Foss, *Proposed Standards for Evaluating When the Covenant of Good Faith and Fair Dealing Has Been Violated: A Framework for Resolving the Mystery*, 47 HASTINGS L.J. 585, 609–12 (1996) (“failure to utilize a less harsh alternative” as bad faith); Eisenberg, *supra* note 93; Mark P. Gergen, *A Defense of Judicial Reconstruction of Contracts*, 71 IND. L.J. 45, 46 (1974) (when “terms malfunction because of the unexpected,” interpretive techniques must include “judicial reconstruction” of the contract to prevent opportunism and to vindicate the “principle of loss alignment [which] relieves a party from a significant and unexpected loss under a contract when such relief would leave the other party in a position no worse than she would have been in had the contract not been made”); Muris, *supra* note 95; Dennis M. Patterson, *A Fable from the Seventh Circuit: Frank Easterbrook on Good Faith*, 76 IOWA L. REV. 503 (1991) (good faith polices manner in which contract rights are exercised); Alan Schwartz, *Relational Contracts in the Courts: An Analysis of Incomplete Agreements and Judicial Strategies*, 21 J. LEGAL STUD. 271, 313 (1992) (“Process values are offended . . . [if] the other party relies on minor contract technicalities to breach in bad faith or extort a more favorable performance.”).

contracts, these efforts range from the mundanely familiar (constructive conditions<sup>143</sup> and the mitigation principle<sup>144</sup>) through the familiar but controversial (the rules against enforcing penalties<sup>145</sup> and regulating the use of limited remedies<sup>146</sup>) to more exotic and controversial applications of the bad faith principle (lender liability<sup>147</sup> and employer liability for strategic

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143. See generally Edwin W. Patterson, *Constructive Conditions in Contracts*, 42 COLUM. L. REV. 903, 926–28 (1942) (role of constructive conditions in avoiding forfeitures and unjust enrichment); Rakoff, *supra* note 113 (sensitivity of gap-filling constructive conditions to differences in context at time of performance).

144. See generally RESTATEMENT (SECOND) OF CONTRACTS § 350 (1981); U.C.C. § 2–708(1) (1977); Goetz & Scott, *supra* note 107.

145. See generally RESTATEMENT (SECOND) OF CONTRACTS § 356 (1) (1981); U.C.C. § 2–718(1) (1977). Andersen summarizes this way:

[W]hen a contract is enforced through the invocation of a liquidated damages clause, the law requires the same accommodation of the parties' interests that is made under the common-law damages remedy. The enforcing party's expectation interest will be protected, but only in a way and to an extent that eliminates unnecessary costs to the breaching party.

Andersen, *supra* note 139, at 310. Under the traditional formulation of the anti-penalty rule, the measure of any disproportion compares the agreed sum with the damages anticipated at the time of contracting. 5A ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS § 1059 (1964). That understanding has been relaxed in the modern UCC and *Restatement* provisions allowing the injured party to save a liquidated damages provision by showing that it was proportional to actual damages. See Melvin A. Eisenberg, *Comment, Liquidated Damages: A Comparison of the Common Law and the Uniform Commercial Code*, 45 FORDHAM L. REV. 1349, 1353–58 (1978). For a sense of the controversy penalty rules inspire, compare Eisenberg, *supra* note 93, and Gergen, *supra* note 142, with Charles J. Goetz & Robert E. Scott, *Liquidated Damages, Penalties and the Just Compensation Principle: Some Notes on an Enforcement Model and a Theory of Efficient Breach*, 77 COLUM. L. REV. 554 (1977), and Alan Schwartz, *The Myth That Promisees Prefer Supracompensatory Remedies: An Analysis of Contracting for Damage Measures*, 100 YALE L.J. 369 (1990).

146. See generally U.C.C. § 2–719 (1977); Jon Eddy, *On the "Essential" Purposes of Limited Remedies: The Metaphysics of UCC Section 2–719(2)*, 65 CAL. L. REV. 28 (1977).

147. See generally Daniel R. Fischel, *The Economics of Lender Liability*, 99 YALE L.J. 131, 139 (1989); Gillette, *supra* note 109; William H. Lawrence & Robert

violation of the implicit norms of internal labor markets<sup>148</sup>). In insurance, “the competing goals of contract enforcement: securing to the injured party the benefits of its bargain and avoiding the imposition of unnecessary costs on the breaching party”<sup>149</sup> have been forced to play out differently, but many otherwise inexplicable features of the insurance terrain reflect a common preoccupation with policing against opportunism by insurers in the use of failure of condition defenses apparently authorized by contract.

Thus, I will argue, when viewed through this neo-institutional lens, insurance contracts pose special problems for insureds not only because they often are embodied in standard policy forms full of provisions dealing with low-salience, low-probability contingencies—that can be said of many, perhaps most, contracts encountered in a modern mass economy<sup>150</sup>—but because three features of insurance contracts tend to make the insured especially vulnerable to opportunistic behavior on the part of the insurer. Put simply, because the obligations of parties to an insurance contract will be performed sequentially, if at all, the insured is vulnerable to opportunistic decisions by insurers that sometimes may produce disproportionate forfeitures. Because insurance contracts are full of express conditions, there is little room for creative use of constructive conditions to ameliorate that vulnerability. And because insurance contracts are aleatory, restitution is not available as a device for ameliorating the insured’s vulnerability. The point is central enough—and, in the context of modern insurance law, unfamiliar enough—to warrant making it in some detail.

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D. Wilson, *Good Faith in Calling Demand Notes and in Refusing to Extend Additional Financing*, 63 IND. L.J. 825 (1988).

148. See generally PAUL C. WEILER, GOVERNING THE WORKPLACE: THE FUTURE OF LABOR AND EMPLOYMENT LAW 63–67 (1990); Stewart J. Schwab, *Life-Cycle Justice: Accommodating Just Cause and Employment at Will*, 92 MICH. L. REV. 8 (1993).

149. Andersen, *supra* note 139, at 301.

150. For an early influential introduction, see Matthew O. Tobriner & Joseph R. Grodin, *The Individual and the Public Service Enterprise in the New Industrial State*, 55 CAL. L. REV. 1247 (1967).

*B. The Special Vulnerability of the Insured to Insurer Opportunism*

1. Ameliorating Techniques Available for Most Non-Insurance Contracts

Consider the following conditional promises to pay money, each in its own way a familiar part of the contracts canon: various promisors undertake to pay, respectively, *IF* (1) a promisee delivers a specific horse; or (2) a promisee constructs a mansion according to specifications; or (3) a promisee works for 12 months; or (4) an insured suffers a covered loss to covered property.

**Scenario 1. Sale of Goods: Vulnerability Avoided by Concurrent Performances.** A dusty crossroads sale: seller promises to deliver a particular horse; buyer promises to pay the specified price. Seller then fails to perform. Must buyer nonetheless pay?

Of course not, at least not since *Kingston v. Preston*.<sup>151</sup> Such a result would “outrage common sense,”<sup>152</sup> for we understand that the “parties contemplate not merely an exchange of their mutual promises, but also an exchange of the two performances that are being promised.”<sup>153</sup> Indeed, if we imagine our hypothetical to be peopled by the rugged individualists of the great American horse-trading tradition, we do not really anticipate that they will be asking a court for guidance about how to flesh out their incompletely-specified one-time spot market exchange. Instead, we expect the seller to hold tightly to the reins until satisfied that she is receiving the payment she was promised, and we expect the buyer to part with his money only when the reins are firmly in hand. But should the parties fail to make this relationship between their performances clear, the law will supply gap-filling constructive concurrent conditions of exchange to assure that neither party is rendered too vulnerable to nonperformance by the other. True, if the buyer breaches, the seller may lose the value of her expectancy, but she still has her horse and still can go back into the market in search of an alternative buyer; if the seller breaches, the buyer may lose his expectancy, but he still has his money to spend at the local sale barn. By structuring perfect tender of the performances as concurrent conditions of exchange — either expressly, or with the help of judicially-supplied gap fillers—forfeitures can be avoided

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151. 2 Dougl. 689, 99 Eng. Rep. 437 (K.B. 1773).

152. *Goodison v. Nunn*, 4 T.R. 761, 764, 100 Eng. Rep. 1288, 1289 (K.B. 1792) (Lord Kenyon).

153. 3A CORBIN, *supra* note 145, § 728, at 399–400.

even without judicial intervention and neither side will be vulnerable to loss of more than the benefit of the bargain.

Thus, the great American horse trading tradition can work well enough when we are trading horses in spot market transactions structured to guarantee concurrent performances. But, as noted by observers ranging from Thomas Hobbes<sup>154</sup> and Arthur Allen Leff<sup>155</sup> to Danny Manning<sup>156</sup> and John Grisham,<sup>157</sup> with sequential performances comes vulnerability to opportunistic behavior. If sequential performances cannot be avoided, what then?

**Scenario 2. Construction Contract: Vulnerability Due to Sequential Performances Ameliorated by the Doctrine of Substantial Performance.** A construction contract: Jacob & Youngs promises to build a mansion for Kent according to detailed specifications, including a requirement that the

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154. "He that performeth first, has no assurance the other will perform after; because the bonds of words are too weak to bridle men's ambition, avarice, anger, and other passions, without the fear of some coercive Power." THOMAS HOBBS, *LEVIATHAN* 89–90 (Oxford ed. 1955) (first published in 1651).

155. "Under the American law of contracts, after the other party has fully performed his obligation, it is absolutely irrational for you fully to perform yours." Arthur Allen Leff, *Injury, Ignorance, and Spite — The Dynamics of Coercive Collection*, 80 *YALE L.J.* 1 (1970). In insurance, the most trenchant statements of the point have come from W. David Slawson:

In reality, an insurer, or any other mass contractor whose obligation is to pay money, normally is not liable for any *damages* for breach of contract. All that he is liable for is to *perform* the contract. If criminal law or tort law worked the same way, the only penalty imposed on a driver who hit a pedestrian on a crosswalk would be to require the driver to back up and drive over the crosswalk again, this time without hitting the pedestrian.

Slawson, *supra* note 107, at 7.

156. "An insurance policy is just a lawsuit. You think they just hand over the money?" Quoted in Harvey Araton, *On Pro Basketball: Choosing the Soft Life Over the Good Life*, *N.Y. TIMES*, Dec 9, 1994, at B11.

157. In *The Rainmaker*, John Grisham imagines an insurer that initially denies all claims on the assumption that most claimants will never find their way to a lawyer. JOHN GRISHAM, *THE RAINMAKER* 313–16, 361–62 (1995). For a critical review from a legal perspective, see Alan I. Widiss, "Bad Faith" in *Fact and Fiction: Ruminations on John Grisham's Tale About Insurance Coverages, Punitive Damages, and the Great Benefit Life Insurance Company*, 26 *U. MEM. L. REV.* 1377 (1996).

plumbing be built of Reading Pipe; Kent promises to pay. The contract limits the occasions for opportunism by providing for a series of progress payments conditioned upon successful completion of stages of construction, but this simple self-help device cannot solve the "last period problem."<sup>158</sup> Kent moves into the completed house without much incentive to make the last progress payment, and six months after taking possession, his architect emerges from the basement with the good news: some of the pipe installed by Jacob & Youngs was Cohos Pipe rather than Reading Pipe. "Aha," we imagine lawyer Kent thinking to himself, "under the rule of *Kingston v. Preston*, I need not make the final payment because use of Reading Pipe was a condition precedent to my duty to pay."

"Wrong," Judge Cardozo informed Kent and succeeding generations of lawyers.<sup>159</sup> Not every breach of a performance obligation will excuse the

158. For a helpful introduction to "last period" problems, see Muris, *supra* note 95, at 528 ("non-contract law solutions to the opportunism problem" less likely to be effective when "parties appear unlikely to contract with each other in the future").

159. *Jacob & Youngs v. Kent*, 129 N.E. 889 (N.Y. 1921). Although contracts students often cut their substantial performance eye teeth on *Jacob & Youngs v. Kent*, in fact the roots of the doctrine were planted only four years after *Kingston v. Preston* in *Boone v. Eyre*, 126 Eng. Rep. 160(a) (K.B. 1777). "[W]here a breach may be paid for in damages," Lord Mansfield opined, "there the [buyer] has a remedy on his covenant, and shall not plead it as a condition precedent." *Id.* Cardozo covered the same ground:

Some promises are so plainly independent that they can never by fair construction be conditions of one another. Others are so plainly dependent that they must always be conditions. Others, though dependent and thus conditions when there is departure in point of substance, will be viewed as independent and collateral when the departure is insignificant. Considerations partly of justice and partly of presumable intention are to tell us whether this or that promise shall be placed in one class or in another. . . .

. . . .

We must weigh the purpose to be served, the desire to be gratified, the excuse for deviation from the letter, the cruelty of enforced adherence. Then only can we tell whether literal fulfillment is to be implied by law as a condition. This is not to say that the parties are not free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery. That question is not here. This is merely to say that the law will be slow to impute the purpose, in the silence of the parties, where the

other party's obligation to perform. Because the parties had not unequivocally made compliance with the Reading pipe specification an express condition precedent to Kent's obligation to pay, there was room for Cardozo to fill the gap with a constructive condition requiring only "substantial performance." Of course, Cardozo was able to assure us:

The courts never say that one who make a contract fills the measure of his duty by less than full performance. They do say, however, that an omission, both trivial and innocent, will sometimes be atoned for by allowance of the resulting damage, and will not always be the breach of a condition to be followed by a forfeiture.<sup>160</sup>

Though the parties remain "free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery . . . the law will be slow to impute the purpose, in the silence of the parties, where the significance of the default is grievously out of proportion to the oppression of the forfeiture."<sup>161</sup> Thus, Cardozo was able to conclude, the constructive condition precedent to Kent's duty to pay had been satisfied, and Kent's remedy for failure to use Reading Pipe was limited to a claim for damages.<sup>162</sup>

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significance of the default is grievously out of proportion to the oppression of the forfeiture.

Jacob & Youngs v. Kent, 129 N.E. 889, 890–91 (N.Y. 1921) (citations omitted). *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 241 (1981) (factor analysis for determining when performance is substantial). *See also* RICHARD DANZIG, THE CAPABILITY PROBLEM IN CONTRACT LAW 108–28 (1978) (details of *Jacob & Youngs* litigation); Patterson, *supra* note 143, at 926–28 (role of constructive conditions in avoiding forfeitures and unjust enrichment).

160. Jacob & Youngs v. Kent, 129 N.E. at 890.

161. *Id.* at 891.

162. Goetz and Scott employ a more modern vocabulary to describe the doctrine of substantial performance:

The rule of substantial performance—or material breach—assures the breacher of his accrued contractual gains whenever the tender is consistent with the overall scheme of the contract, although deficient in some particulars. The doctrine expands the duty to mitigate in specialized environments by requiring the mitigator to

**Scenario 3. Employment Contract: Vulnerability Due to Sequential Performances Ameliorated by Restitution.** A simple employment contract: Britton promises to work for Turner for one year; Turner promises to pay Britton \$120 upon completion of the work. Britton works for nine and a half months, but then breaches his obligation to complete the contract. May Britton nonetheless recover from Turner?

Indeed, Judge Parker told us in 1834,<sup>163</sup> he may. True, “the law will not imply and make a contract different from that which the parties have entered into,”<sup>164</sup> completion of the labor was a condition precedent to Turner’s contractual duty to pay, and “[i]t is clear, then, that he is not entitled to recover upon the contract itself.”<sup>165</sup> But, concluded the *Britton* court, off the contract, in restitution, things could be different: “[I]f . . . a party actually receives labor . . . and thereby derives an advantage, over and above the damage which has resulted from the breach of the contract by the other party, . . . the law thereupon raises a promise to pay to the extent of such excess.”<sup>166</sup> By beginning performance, the court emphasized, Britton had placed himself in “a much worse situation than he who wholly disregards his contract”;<sup>167</sup> nine and one-half months into the transaction Turner had

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accept a deficient performance, together with objectively measured damages.

. . . .

The substantial performance doctrine reduces opportunistic claims by softening the breacher–nonbreacher distinction, thereby removing opportunities to exploit inadvertent breaches. Such a rule is sensible in cases such as construction contracts where the circumstances suggest that renegotiation costs will be substantial.

Once construction is underway, the alternatives for both parties become inferior to the existing relationship . . . .

Goetz & Scott, *supra* note 107, at 1009–10.

163. *Britton v. Turner*, 6 N.H. 481 (1834).

164. *Id.* at 491.

165. *Id.* at 486.

166. *Id.* at 492.

167. *Id.* at 487.

A party who contracts to perform certain specified labor, and who breaks his contract in the first instance, without any attempt to perform it, can only be made liable to pay the damages which the other party has sustained by reason of such non performance,



already received “nearly five-sixths of the value of a whole year’s labor.”<sup>168</sup> Any prejudice to Turner caused by Britton’s early departure could simply be accounted for in the calculation of the amount of Turner’s unjust enrichment.<sup>169</sup>

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which in many instances may be trifling—whereas a party who in good faith has entered upon the performance of his contract, and nearly completed it, and then abandoned the further performance—although the other party has had the full benefit of all that has been done, and has purhaps [sic] sustained no actual damage—is in fact subjected to a loss of all which has been performed, in the nature of damages for the non fulfilment of the remainder . . . .

*Id.* at 486–87.

168. *Id.* at 487. As the Vermont court explained a few years later, to deny any recovery under such circumstances “operates as a forfeiture and in the nature of a penalty” and “[i]t is not the object of the law to punish the party for a violation of his contract, but to make the other party good for all damages he may sustain by such violation.” *Gilman v. Hall*, 11 Vt. 510 (1839) (following *Britton v. Turner*).

169. Of course, not all courts agreed. The traditional contractarian view denying restitutionary recovery emphasized two themes. First, allowing restitution would be an attack on fundamental contractual values. *Stark v. Parker*, 19 Mass. (2 Pick.) 267 (1824), sounded the refrain: “It will not admit of the monstrous absurdity, that a man may voluntarily and without cause violate his agreement, and make the very breach of that agreement the foundation of an action which he could not maintain under it.” Second, allowing restitutionary recoveries would impose on employers the burden of proving the amount of the damages caused by the breach. *See generally* Edwin Patterson, *Restitution for Benefits Conferred by Party in Default Under Contract*, 1952 REPORT OF N.Y. LAW REVISION COMM’N 93 (N.Y. Leg. Doc. No. 65 (1952)).

The debate has been usefully examined from a variety of perspectives. *See, e.g.*, Wythe Holt, *Recovery by the Worker Who Quits: A Comparison of the Mainstream, Legal Realist, and Critical Legal Studies Approaches to a Problem of Nineteenth Century Contract Law*, 1986 WIS. L. REV. 677 (emphasizing class-based distinctions between treatment of workers in default and other contracting parties in default); Herbert Laube, *The Defaulting Employee—Britton v. Turner Reviewed*, 83 U. PA. L. REV. 825 (1935) (concluding, *id.* at 852: “After a hundred years of controversy, *Britton v. Turner* stands approved by considerations of morality, equality and social solidarity. Only the classic doctrine of contracts condemns it.”). Of course, even where restitution was not permitted, other techniques might produce much the same results. Thus, courts could take the sting from the absence of a restitutionary remedy by treating the contract as divisible, rather than entire, and legislatures could enact periodic payment statutes to assure that latter-day Brittons would not suffer forfeitures and latter-day Turners would not retain undeserved windfalls. As

This rule, by binding the employer to pay the value of the service he actually receives, and the laborer to answer in damages where he does not complete the entire contract, will leave no temptation to the former to drive the laborer from his service, near the close of his term, by ill treatment, in order to escape from payment . . . .<sup>170</sup>

**Scenario 4. Insurance Contract: Vulnerability Unameliorated?** An early insurance contract: DeHahn promises to indemnify Hartley up to policy limits for diminutions in the value of his interest in the ship *Juno* and its contents on a voyage from Africa to the West Indies, subject to the condition, among others, that the ship “sailed from Liverpool . . . with 50 hands or upwards.” During the insured voyage, the ship is taken “by certain enemies of our lord the now King” and the insured’s property “is wholly lost to him.” DeHahn pays the limits of his contract, then discovers that the *Juno* had left Liverpool for Africa with only 46 hands, and sues to recover the payments mistakenly made to Hartley. The insured points out that 6 hours out of Liverpool the ship stopped at Anglesea to pick up 6 more hands, and thus had a full complement of seamen long before it arrived in Africa and the risk for the first time attached; the jury expressly finds that during the six-hour voyage from Liverpool to Anglesea, the ship “was equally safe as if she had had 50 hands on board her for that part of the said voyage.” On such facts, was the insured entitled to payment from the insurer?

He was not, Lord Mansfield tells us, for “a warranty in a policy of insurance is a condition or a contingency” that “must be strictly complied with” without regard for why it was included in the contract, why it was not satisfied, or the effects of that failure on the insurer.<sup>171</sup> Thus, Hartley was entitled to nothing, even though the failure of condition in no way prejudiced

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Professor Levmore notes in a recent synoptic article, denials of restitution to the breaching party, though still sometimes characterized as the traditional view, are rare today. Saul Levmore, *Explaining Restitution*, 71 VA. L. REV. 65, 105 n.91 (1985). See also 2 E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 8.14 (2d ed. 1998).

170. *Britton*, 6 N.H. at 494.

171. *DeHahn v. Hartley*, 99 Eng. Rep. 1130, 1131 (K.B. 1786), *aff’d*, 100 Eng. Rep. 101 (Ex. 1787).

the insurer.<sup>172</sup> In other settings, substantial performance or restitution would be available to ameliorate the potential for forfeiture created by a minor defect in the first of two sequential performances. Why not here?

## 2. Why Insurance Is Different

### a. Aleatory Contracts and the Fundamental Transformation

The answer, as we have seen, does not depend on niceties of eighteenth-century British marine insurance law; the black letter rule requiring strict compliance with express conditions is by its terms equally applicable to the boilerplate conditions in a modern homeowners policy or a professional's claims-made liability policy.<sup>173</sup> Rather, the answer lies in the way insurance policies of all kinds combine an aleatory promise with express conditions. Because insurance contracts are full of express conditions, there is little room

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172. Each of the judges took a stab at articulating the seriousness of the perfect compliance principle. Thus, in Lord Mansfield's view, "It is perfectly immaterial for what purpose a warranty is introduced; but, being inserted, the contract does not exist unless it be literally complied with." *Id.* at 346, 99 Eng. Rep. at 1131. Ashhurst added this emphasis: "The very meaning of a warranty is to preclude all questions whether it has been substantially complied with; it must be literally so." *Id.* And Buller concluded his opinion this way: "[T]he whole forms one entire contract, and must be complied with throughout." *Id.*

173. In this country, the citation of choice often has been *Wood v. Hartford Fire Insurance Co.*, 13 Conn. 533 (1840).

If a house be insured against fire, and the language of the policy is, "warranted, during the policy, to be covered with thatch," the insurer will be discharged, if, during the insurance, the house should be covered with wood or metal, although his risk is diminished; for a warranty excludes all argument in regard to its reasonableness, or the probable intent of the parties. . . . Parties may contract as they please. When a condition precedent is adopted, the court cannot enquire as to its wisdom or folly, but must exact its strict observance.

*Id.* at 544. The opinion is a double-edged sword, for having framed the strict common law rule in its most virulent form, the court then promptly demonstrated how to avoid its application through the simple expedient of finding that the condition at issue has been satisfied. *See also* EDWIN W. PATTERSON, ESSENTIALS OF INSURANCE LAW § 61, at 239 (1935) ("[T]he rule came down to this, practically: that the insurer's motives for inserting the warranty would not be inquired into.").

for creative use of constructive conditions to ameliorate the insured's vulnerability. Because the insurer's promise is aleatory, restitution is not available as a device for ameliorating that vulnerability. Of course, neither feature of insurance contracts alone would be enough to create this vulnerability. The stringent effects of strict conditions can, in appropriate circumstances, be ameliorated through the use of restitution; *Britton v. Turner* showed us how, and section 374 of the *Restatement (Second) of Contracts* confirms the continued vitality of that approach.<sup>174</sup> Where necessary, an aleatory contract can be fleshed out by constructive conditions crafted to avoid forfeitures; much of Professor Corbin's treatment of aleatory contracts is devoted to how to do precisely that.<sup>175</sup> But standard insurance policy forms combine aleatory promises with express conditions, and thus render unavailable doctrinal techniques for avoiding forfeiture that routinely would be available in other settings.<sup>176</sup>

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174. See RESTATEMENT (SECOND) OF CONTRACTS § 374 (1981).

175. "A promise in an aleatory contract is constructively conditional on absence of action by the promisee that substantially increases the risk that the promisor assumed." CORBIN, *supra* note 145, § 730, at 416. Corbin offers this example of application of the principle: "The insurer against fire is discharged from duty to pay the loss if the insured himself sets fire to the property." *Id.*

176. Thus, it is no accident that so many of the illustrations found in the treatment of express conditions by the *Restatement (Second) of Contracts* are drawn from insurance cases. In other settings, the apparent sting of the strict black-letter law of express conditions has effectively been drawn by the combination of self-help measures and doctrinal devices reviewed in the text. Indeed, outside of insurance, so pervasive are the escape mechanisms that Professor Childres has argued that the *Restatement* should acknowledge that the black letter rule had been rendered moribund and abandon the rule altogether. See Robert Childres & Bruce Dennis Sales, *Restatement (Second) and the Law of Conditions in Contracts*, 44 MISS. L. REV. 591 (1973). See also Robert Childres, *Conditions in the Law of Contracts*, 45 N.Y.U. L. REV. 33, 34 (1970) ("[T]he traditional rule is a myth, not entirely abandoned verbally, but supplanted sub silentio."). Professors Kessler and Gilmore put it this way:

In most respectable academic literature the idea that express conditions [must be literally performed] is introduced only to be dismissed as false or misleading. To many, if not most, practicing lawyers, however, the idea seems to commend itself as an article of faith. Counsel for insurance companies . . . have been particularly ardent believers in the sanctity of express conditions.

Well, might be the response, why not? After all, "aleatory" is a term derived from the Latin for "dice"; an "aleator" is a gambler.<sup>177</sup> People do wander into casinos and pull the arm and lose their quarters, without prompting us to wring our hands about forfeitures. Why should failure of a condition in an insurance policy be regarded any differently?

Such reactions reflect a flawed understanding of what makes an "aleatory contract" different. Although the *Restatement (Second) of Contracts* says that "[a] party may make an aleatory promise, under which his duty to perform is conditional on the occurrence of a fortuitous event,"<sup>178</sup> the presence of conditions to hedge in the obligations undertaken by itself is not enough to distinguish aleatory promises from the rest of the world of contracts. Rather, what makes an aleatory contract different from the sales, construction, and labor contracts is that it is not primarily an exchange of performances.<sup>179</sup> As Professor Corbin's treatise summarizes:

When two parties make a bilateral contract, they are making an exchange of promises. Each party accepts the promise of the other party as the agreed equivalent of his own. . . . In most such cases the parties contemplate not merely an exchange of mutual promises, but also an exchange of the two performances that are being exchanged. . . .

It is upon the facts stated in the foregoing paragraph that the rules of law respecting implied and constructive conditions, the rules of mutual dependency of exchanged promises, are based. It is not regarded as a square deal for one of the promisors to be required to render the performance promised by him when he has not received and is not going to receive the performance that was promised to him in return. Having reasonably anticipated an agreed performance in exchange for his own, it is not in accordance with prevailing notions of justice to give something for nothing.<sup>180</sup>

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FRIEDRICH KESSLER & GRANT GILMORE, *CONTRACTS CASES AND MATERIALS* 846 (2d ed. 1970) (citation omitted).

177. See PETER L. BERNSTEIN, *AGAINST THE GODS: THE REMARKABLE STORY OF RISK* 47 (1996).

178. *RESTATEMENT (SECOND) OF CONTRACTS* § 76, cmt. c (1981).

179. See *RESTATEMENT (SECOND) OF CONTRACTS* §§ 232, 239 (1981).

180. CORBIN, *supra* note 145, at 194. See also *id.* § 728, at 399-400:

By contrast, in an aleatory contract,

The performance that is promised may never be rendered, and yet the failure to render it may not be a breach of the promise. Both parties to such a promise . . . are incurring a hazard or taking a chance; and the hazard is so far conspicuously incurred that neither party can justly complain if the chance goes against him. . . . When such aleatory promises are exchanged, it is not necessarily contrary to prevailing notion of justice that one of the two parties should get something for nothing. This is because he himself took a similar chance and might have been compelled to give something for nothing.<sup>181</sup>

Thus, in the sales, construction, and labor contracts, the parties sought not just an exchange of promises, but an exchange of performances. In the sales agreement, the seller preferred the money to the horse and the buyer preferred the horse to the money; we do not understand either party to be assuming the risk of ending up with neither horse nor money. In *Jacob & Youngs v. Kent*

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In the great majority of bilateral contracts, the legal duty of each promisor is either expressly or constructively conditional upon substantial performance by the other contractor . . . . The fact that these promises are conditional in their legal operation does not make them aleatory, however. The performance of the condition in these cases may be uncertain; and a promisor may, therefore, never come under a duty of rendering the promised performance. In these cases, however, the condition precedent to a promisor's duty is concerned with the very return performance for which he has promised to give his own performance in exchange. . . . A contract is aleatory only when the parties contemplate that one of them may have to perform even though the other does not have to, even though the other party does not perform at all. The legal result of this is that in case of an aleatory contract one of the parties may come under a legal duty of rendering immediate performance even though the other party does not and never will come under such a duty.

181. *Id.* § 728, at 401.

and *Britton v. Turner* a similar understanding of the relationship between the promised performances was crucial to the decisions to use substantial performance or restitution to prevent the threatened forfeitures. By contrast, in the insurance contract, we may assume that both Hartley and the DeHahn devoutly hoped that no performance by the insurer would be necessary; there the parties may have regarded the premium as the agreed equivalent for the expected value of the insurer's conditional promise to perform, but that is not the same as saying they regarded the premium as the agreed equivalent for the insurer's payment of a covered claim. In 1998, in Lincoln, Nebraska, \$210 buys an umbrella insurer's promise to pay up to \$700,000 to settle liability claims exceeding my primary coverages, and I am content to believe that—properly discounted to reflect probabilities and expense loadings—the value of the insurer's promise is at least a rough actuarial equivalent for my premium. But that does not make the performances equivalent.

Much of the law of implied and constructive conditions is designed for non-aleatory contracts and has as its object vindication of the intuition that parties to most contracts will seek to avoid situations which put one party at risk of having given something for nothing. If the seller still has his horse, he can go back into the market; if the buyer still has his money, he can seek out other horse traders. But it is not always possible to structure a relationship to completely avoid rendering one party vulnerable to the opportunism by the other. The traditional understanding of the conditions under which opportunism is likely to thrive emphasizes both bounded rationality that prevents perfect ex ante contractual control of opportunism and “asset specificity”—“sunk investments that are undertaken in support of particular transactions, the opportunity cost of which investments is much lower in best alternative uses or by alternative users should the original transaction be prematurely terminated.”<sup>182</sup> The pipe buried in Kent's

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182. WILLIAMSON, *supra* note 95, at 55. See also Furubotn & Richter, *supra* note 91, at 21 (characterizing “*transaction-specific expenditures*” as those that “are irreversible in the sense that the principal cannot be regained through the market (i.e., by sale) if the original business relations are discontinued”). For an excellent survey of the economic literature, see Shelanski & Klein, *supra* note 100, at 340 (emphasizing the spectrum of governance structures that can be used to deal with the bilateral monopoly potential). For application to contract modification and mitigation problems, see, e.g., Goetz & Scott, *supra* note 107, at 969 (chief variable for application of mitigation principle is whether there is a market for substitute performance); Jason Scott Johnson, *Default Rules/Mandatory Principles: A Game Theoretic Analysis of Good Faith and the Contract Modification Problem*, 3 S. CAL.

basement is one concrete example of a “sunk investment”; so too is Britton’s nine months of labor. Neither could be readily recaptured and put to other uses. The result is, in Williamson’s evocative formulation, a “fundamental transformation”<sup>183</sup> that moves the parties from a “thick or competitive market *ex ante* to a thin market or bilateral monopoly *ex post*.”<sup>184</sup> Because insurance contracts are aleatory, the insured is rendered vulnerable by a form of “asset specificity” that makes other examples pale by comparison.<sup>185</sup> Hartley’s

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INTERDISC. L.J. 335, 343 (1993) (“[M]arket for substitute performance and effectiveness of the legal remedy for breach combine to determine a party’s vulnerability to modification holdup games.”).

183. WILLIAMSON, *supra* note 95, at 61–63.

184. Cohen, *supra* note 95, at 955.

. . . [W]hat was a large numbers bidding condition at the outset is effectively *transformed* into one of bilateral supply thereafter. The reason why significant reliance investments in durable, transaction specific assets introduces contractual asymmetry between the winning bidder on the one hand and nonwinners on the other is because economic values would be sacrificed if the ongoing supply relation were to be terminated.

Faceless contracting is thereby supplanted by contracting in which the pairwise identity of the parties matters. Not only is the supplier unable to realize equivalent value were the specialized assets to be redeployed to other uses, but the buyer must induce potential suppliers to make the same specialized investments were he to turn to an outsider. The incentives of the parties to work things out rather than terminate are thus apparent. This has massive ramifications for the organization of economic activity.

Oliver E. Williamson, *The Economics of Governance: Framework and Implications*, 140 J. INST’L & THEORETICAL ECON. 195, 208 (1984) (emphasis in original).

185. The Supreme Court of Delaware recently made the point explicitly:

Insurance is different. . . . Unlike other contracts, the insured has no ability to “cover” if the insurer refuses without justification to pay a claim. Insurance contracts are like many other contracts in that one party (the insured) renders performance first (by paying premiums) and then awaits the counter-performance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counter-performance. In a typical



“investment” in his insurance contract includes not just the few pounds of premium, but the opportunity costs of forgoing other ways of dealing with his exposure, including at the extreme deciding to get out of the shipping game completely.<sup>186</sup>

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contract, the non-breaching party can replace the performance of the breaching party by paying the then-prevailing market price for the counter-performance. With insurance this is simply not possible. This feature of insurance contracts distinguishes them from other contracts.

E.I. DuPont de Nemours & Co. v. Pressman, 679 A.2d 436, 447 (Del. 1996). *See also* Rawlings v. Apodaca, 726 P.2d 565, 570 (Ariz. 1986) (in “both first- and third-party situations the contract and the nature of the relationship give the insurer an almost adjudicatory responsibility”). Unfortunately, old habits die hard. Most insurance lawyers, when confronted with an insurance opinion or commentary tying the obligation of good faith to the “unique relationship,” or disparities in bargaining power, are more likely to understand those assertions as an invocation of ex ante disparities in bargaining power than as concern about the bilateral monopoly that can result from transaction-specific investments. *See, e.g.,* Epstein, *supra* note 131, at 239: “Courts imagine that standardization carries with it an element of coercive force that no contract should contain. So they take upon themselves the unwise task of neutralizing that power.”

186. Thus, conventional variations on the theme that “an applicant for insurance stakes his premium payment on the chance that there will be a loss,” *e.g.,* State Farm Mut. Ins. Co. v. Calhoun, 112 So. 2d 366, 372 (Miss. 1959), are fundamentally misleading, for costs of relying on a promise to provide insurance protection include more than a premium. The point is not just that, in an important sense, all costs are opportunity costs, *see generally* ARMEN A. ALCHIAN, ECONOMIC FORCES AT WORK 301 (1977), but that the opportunities forsaken by reliance on a promise to provide insurance can prove much different than the opportunities forsaken by reliance on a promise that is part of a nonaleatory exchange. If the paint doesn’t arrive on time, there will be other days and other paint dealers. But once the boat has sunk or the *c’est tui que vie* has expired, it is too late to seek alternative sources of insurance coverage. The law reacts to the special character of reliance on aleatory contracts in many ways. For one example, promises to procure insurance provide one of the classic occasions for application of promissory estoppel. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 90, cmt. e (1981); 2 FARNSWORTH, *supra* note 169, § 2.119, at 169. The same concerns have prompted the development of special rules to police negligent handling of life insurance applications. *See, e.g.,* Duffie v. Bankers’ Life Ass’n, 139 N.W. 1087 (Iowa 1913); Robinson v. United States Benevolent Soc’y, 94 N.W. 211 (Mich. 1903). *See generally* M.O. Regensteiner, Annotation, *Rights and Remedies Arising Out of Delay in Passing Upon Application*

Why does equity find a way to protect the breaching Britton against a forfeiture of his labors but leave Hartley to contemplate an empty pier with neither his premium nor the policy proceeds? The answer, of course, is that restitution at root is a way of forcing the defendant to disgorge what otherwise would be unjust enrichment.<sup>187</sup> Turner's restitutionary liability is limited to the value of the benefit he received from Britton's labors. Because insurance is aleatory, the rough equivalence between loss and benefit necessary for restitution to be an effective protection against forfeiture simply will not be present. Hartley will not be protected from forfeiture by getting his premium back.<sup>188</sup> The ship is gone and so is the opportunity to avoid or to transfer the risk of its loss.

If restitution cannot help Hartley, then what about substantial performance? After all, leaving Liverpool four men short no more prejudiced DeHahn than the substitution of Cohos for Reading pipe redounded to Kent's detriment. Why not conclude that too was only an immaterial breach, and allow the court to construct a condition of substantial performance that was satisfied because the changes in no way enlarged the insurer's obligation?

The answer, of course, is that the substantial performance route charted by Cardozo does not run through insurance law.

In *Jacob & Youngs v. Kent*, Cardozo interpreted the Reading Pipe specification as a promise by the construction company to employ Reading Pipe, but did not interpret that provision as making provision of Reading Pipe

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for Insurance, 32 A.L.R.2d 487 (1953) (cataloging decisions based on both contractual and tort theories).

187. See generally 1 GEORGE E. PALMER, THE LAW OF RESTITUTION § 1 (1978); Levmore, *supra* note 169.

188. Of course, we could conclude that the measure of DeHahn's unjust enrichment is not the premium paid by Hartley, but rather the claim payment it would have had to make to Hartley but for the happy and immaterial coincidence that Hartley's crew was four men short; in this view, DeHahn hoped that he had gotten lucky in the same way that Turner and Kent hoped that they had gotten lucky. This gambit finds occasional support. See, e.g., *Jones v. Bituminous Cas. Co.*, 321 S.W.2d 798, 802 (Ky. 1991) (notice-prejudice rule based on recognition that "in the absence of prejudice a strict forfeiture clause simply provides the insurance company with a windfall"). But invocation of the restitutionary rationale seems a rhetorical flourish that is junior to the conclusion that the purpose of the notice provision is to protect the insurer against prejudice in claims adjustment activities. See generally Levmore, *supra* note 169, at 107 (courts that deny restitution for partial performers may be interpreting contract as designed to create super incentives to performance, so that pro rata restitution would not be appropriate).

an express condition precedent to Kent's obligation to pay. The dissent did not agree with that critical move,<sup>189</sup> and most of the admiration for Cardozo's opinion ultimately rests on the skill with which he was able to allow the consequences of treating the provision as a strict condition to inform his sense of what the parties must have intended.<sup>190</sup> But in insurance law, as usually understood, there is no such room to wiggle.<sup>191</sup> According to the *Restatement*, the "preference for an interpretation that merely imposes a duty on the obligee to do the act and does not make the doing of the act a condition of the obligor's duty" just "does not apply when the contract is of a type under which only the obligor generally undertakes duties":<sup>192</sup>

It therefore does not apply to the typical insurance contract under which only the insurer generally undertakes duties, and a term requiring an act to be done by the insured is not subject to this standard of preference. In view of the general understanding that only the insurer undertakes duties, the term will be interpreted as making the event a condition of the insurer's duty rather than as imposing a duty on the insured.<sup>193</sup>

In insurance, then, if a provision makes it into the contract, no matter what its label, it almost always will be understood to have created an express

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189. See *Jacob & Youngs v. Kent*, 129 N.E. 889, 892 (N.Y. 1921) (McLaughlin, J., dissenting).

190. See, e.g., Arthur L. Corbin, *Mr. Justice Cardozo and the Law of Contracts*, 48 YALE L.J. 426 (1938) ("Probably no other case can be found in which the question of dependency of promises and of implied conditions of an owner's duty to pay is discussed with as much enlightened intelligence and charm of expression as we find in Cardozo's opinion."); Lawrence A. Cunningham, *Cardozo and Posner: A Study in Contracts*, 36 WM. & MARY L. REV. 1379, 1381 (1995) (contributions of Cardozo in *Jacob & Youngs* "were achieved using a thickly textured doctrinalism involving conscious mediation amongst the competing values at stake in the law of contracts."); Patterson, *supra* note 23, at 282 (celebrating Cardozo's opinion as a "clash . . . between two classic argumentative forms . . . the textual and the prudential.").

191. "No satisfactory counterparts to the penalty and mitigation doctrines exist when contract enforcement is accomplished by express conditions that do not operate directly through a liquidated payment obligation." Andersen, *supra* note 139, at 311. Andersen's answer, of course, is rigorous use of "good faith in enforcement." *Id.*

192. RESTATEMENT (SECOND) OF CONTRACTS § 227 cmt. d (1981).

193. *Id.*

condition to the insurer's duties, and there simply will be no room for a gap-filling constructive condition of substantial performance. And if that express condition has not been completely satisfied, the black letter common law rule tells us, the insurer has no duty to perform.

For most failure of condition defenses, the results produced by the strict common law rule seem perfectly appropriate. Clearly we do not want to require a life insurer to start paying off for near death experiences or a hole-in-one insurer to start fending off claims based on truly remarkable double eagles. We know that the insured who opted for collision but not comprehensive coverage should not get any help from her auto insurer in repairing chips in her windshield even if they were caused by rocks thrown up in a near-collision. And we are confident that an insurer that promises to pay \$1,000,000 if it snows four or more inches in Central Park on January 8 between 10 a.m. and 10 p.m. should not have to respond to the contention that three and three-tenths inches is close enough.<sup>194</sup>

Why do we know instinctively that to excuse less than full compliance with those conditions would be to do what Cardozo and Parker refused to do: to remake the contract of the parties? The answer may seem obvious: with an aleatory contract, Corbin tells us, the possibility that one party will give up something for nothing is a chance that "is so far conspicuously incurred that . . . [he cannot] justly complain if the chance goes against him."<sup>195</sup> That characterization fits conventional egoistic gambles—no one is likely to have much sympathy for the "Pick Six" lottery player who picks only five—and it fits some insurance policy provisions as well. Had Hartley's ship been lost after the term of the insurance had expired, we would be unlikely to waste time wondering if the insurer nonetheless should pay.

However, that explanation does not take us as far as we need to go for, as we have seen, most of the provisions that lurk in standard insurance policy forms hardly can claim that kind of validation. Must we nonetheless insist

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194. See Gavin Souter, *Snow Promotion a Near Miss; Less than an Inch More Snow Would Have Translated into a \$1 Million Claim*, BUS. INS., Jan. 15, 1996, at 46 (insurer's obligation on \$1 million policy covering insured's exposure on lease payments forgiveness promotion conditioned on 4 inches of snow in Central Park on January 8 between 10 a.m. and 10 p.m.). For a more commercially-significant version of snow insurance, see Michael Prince, *Interest in Snow Insurance Is Accumulating*, BUS. INS., Jan 6, 1997, at 31 (airport authority pays \$35,000 premium for insurer's promise to pay \$25,000 for each inch of snow above 40 inches that falls on Dulles, up to \$1 million).

195. CORBIN, *supra* note 145, at 401.

that modern Hartleys are chargeable with having assumed the risk of failure to comply with each and every policy provision? Or should we be prepared to distinguish some risks of getting nothing that are part of the aleatory contract's gamble from some that are not? Why should it be impermissible opportunism for Kent to send his architect to the basement with a flashlight to look for immaterial departures from contract specifications but unremarkable business-as-usual for an insurer to instruct its claims department to deny a claim because of an immaterial, non-prejudicial failure of a boilerplate insurance policy condition?

b. Traditional Ameliorating Techniques for Insurance Contracts

The better response is that opportunism is opportunism, whether it appears authorized by the structure of a construction contract or by insurance policy boilerplate, and that insurance law, despite its formal fidelity to the strict common law rule, only sometimes has been blind to the potential for disproportionate forfeitures worked by the combination of aleatory promises with insurance policy forms full of express contractual conditions. True, insurance law continues to defend the proposition that — absent legislatively mandated benefits, of course—the insurer is free to decide what risks it is willing to assume, for courts will not make a contract for the parties. However, that underwriting discretion does not necessarily include discretion to use methods of avoiding unwanted risks that visit a disproportionate forfeiture on the insured. With “substantial performance” and “restitution” unavailable in insurance, the instinct to prevent inappropriate forfeitures has had to manifest itself in other ways. But quietly, sporadically, often atheoretically, insurance law manages to find ways to put limits on the ability of insurers to invoke failure of condition defenses when permitting the defense would create a disproportionate forfeiture.

Sometimes the limits are statutory. Many jurisdictions have turn-of-the-century statutes restricting insurer efforts to convert application representations into conditions in order to avoid the materiality constraints of misrepresentation law,<sup>196</sup> and standard policy statutes sometimes have converted broadly-framed conditions into more-narrowly-framed exceptions

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196. See, e.g., MASS. GEN. LAWS ANN. ch. 175, § 186 (West 1987). Such statutes apply only to representations and affirmative warranties applicable to circumstances at the inception of the contract; they thus do not apply to “continuing” warranties and conditions that seek to control post-inception changes in the risk.

that do not pose the same potential for disproportionate forfeitures.<sup>197</sup> Legislation in a few states denies the insurer a defense based on failure to satisfy a post-loss notice condition unless that failure prejudiced the insurer,<sup>198</sup> and an occasional statute denies the insurer a defense based on post-inception, pre-loss failures of some conditions unless the failure "increased the risk of loss"<sup>199</sup> or "contributed to the loss."<sup>200</sup> In Australia, a 1984 statute implementing the recommendations of a Crown Commission attempts to mirror *Jacob & Youngs v. Kent* by giving the insurer an offset in the amount of any injury to the insurer caused by certain failures of condition.<sup>201</sup> Such statutory alterations of the strict common law rule are few, and determining what policy provisions are governed by them is a continuing source of difficulty.<sup>202</sup> Consequently, when the sensibilities on

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197. See generally Thomas L. Wenck, *The Historical Development of Standard Policies*, 35 J. RISK & INS. 537, 544-45 (1968). This effect was especially pronounced in life insurance. See generally Robert Works, *Coverage Clauses and Incontestable Statutes: The Regulation of Post-Claim Underwriting*, 1979 U. ILL. L.F. 809, 856-57.

198. See, e.g., WISC. STAT. ANN. § 631.81 (West 1995).

199. In New York, for example, a "warranty statute" drafted by Professor Patterson in the 1940's provides: "No breach of warranty shall avoid an insurance contract or defeat recovery thereunder unless such breach materially increased the risk of loss, damage or injury within the the coverage of the contract." N.Y. INS. LAW § 150(2) (McKinney 1985). For Patterson's explanation, see PATTERSON, *supra* note 173, § 74.

200. In Nebraska, a statute in effect since the Progressive Era makes certain post-inception, pre-loss failures of condition defenses available only if the failure of condition "was in existence at the time of loss and contributed to the loss." NEB. REV. STAT. § 44-358 (REISSUE 1993). See generally Robert Works, *Insurance Policy Conditions and the Nebraska Contribute to the Loss Statute: A Primer and a Partial Critique*, 61 NEB. L. REV. 209 (1982). New Zealand has a similar statute. Insurance Law Reform Act of 1977, § 11 (N.Z.), adopted on the recommendation of the Contracts and Law Reform Committee. See N.Z. LAW REFORM COMMITTEE, ASPECTS OF INSURANCE LAW ¶¶ 28-30 (1975). For Patterson's criticisms of "contribute-to-the-loss standards," see PATTERSON, *supra* note 173, § 73.

201. See Insurance CONTRACTS ACT, 1984, § 54 (Austl.). The approach is rationalized in AUSTRALIAN LAW REFORM COMM'N, REPORT ON INSURANCE CONTRACTS, NO. 20 (1982). Apparently both New Hampshire and Washington long ago flirted with similar statutory requirements that the insured's recovery sometimes be reduced in lieu of forfeiture. See generally PATTERSON, *supra* note 173, § 75.

202. In 1935, Patterson put it this way:

display in *Jacob & Youngs v. Kent* and *Britton v. Turner* manage to find expression in insurance law, it usually is because a court has found a way to skirt the strict common law rule without denying it.

Judicial techniques for avoiding the strict common law rule come in several familiar forms. An insurer may be estopped to rely on a failure of condition defense if the court is able to conclude that a representation chargeable to the insurer has produced reasonable detrimental reliance by the insured.<sup>203</sup> Noncompliance with a condition may be excused because compliance was "impracticable,"<sup>204</sup> because the insurer had already materially breached its obligations under the contract,<sup>205</sup> or because the insurer can be said to have "waived" compliance.<sup>206</sup> All these techniques are notoriously fact-dependent, all are said to be ineffective against a "coverage clause," and the decisions they generate do not travel well. The result is a "mushy body of case law"<sup>207</sup> in which courts sometimes appear to adhere to

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If one merely lists the states in which a statutory modification of the common-law doctrine is now in force, the list would embrace a majority of the states of the Union, and one might rashly conclude that the common law rules had been entirely swept away. A closer scrutiny of the statutes reveals that this conclusion is far from being correct. Many of the statutes have avowedly only a limited application, and judicial interpretation has further limited their scope.

PATTERSON, *supra* note 173, at 309. Patterson's conclusion remains apt, as does his characterization of the difficulties posed by such statutes: "Many of the statutes just referred to were drawn by amateurs, and it is often well-nigh impossible to determine their meaning." *Id.* at 311.

203. See Clarence Morris, *Waiver & Estoppel in Insurance Litigation*, 105 U. PA. L. REV. 925 (1957).

204. See RESTATEMENT (SECOND) OF CONTRACTS § 271 (1981). See also Annotation, *Beneficiary's Ignorance of Existence of Life or Accident Policy as Excusing Failure to Give Notice, Make Proofs of Loss, or Bring Action within Time Limited by Policy or Statute*, 28 A.L.R.3d 292 (1969); C.T. Drechsler, *Property Insurance: Insured's Ignorance of Loss or Casualty, Cause of Damage, Coverage or Existence of Policy, or Identity of Insurer, as Affecting or Excusing Compliance with Requirements as to Time for Giving Notice, Making Proof of Loss, or Bringing Action Against Insurer*, 24 A.L.R.3d 1007 (1969).

205. See RESTATEMENT (SECOND) OF CONTRACTS § 255 (1981).

206. See RESTATEMENT (SECOND) OF CONTRACTS § 84 (1981).

207. The characterization is drawn from PATTERSON, *supra* note 173, § 94, at 278.

the black letter of the equitable doctrines they apply, and sometimes seem to allow the potential for forfeiture an unannounced place in the calculus of decision.

But the technique that most clearly mimics *Jacob & Youngs v. Kent* in evading the strict common law rule employs purposive interpretation to permit the conclusion that—first appearances sometimes to the contrary—no failure of condition occurred. We have seen how Cardozo allowed his appreciation of the consequences of a failure of condition to inform his interpretation of the purpose of the Reading Pipe provision. For Cardozo, “intention not otherwise revealed may be presumed to hold in contemplation the reasonable and the probable,”<sup>208</sup> and he thought it neither reasonable nor probable that the parties to that construction agreement would use a strict contractual condition in order to bet progress payments on whether Kent could discover an immaterial, not-readily-cured, departure from the specifications.

[T]his is not to say that the parties are not free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery. . . . This is merely to say that the law will be slow to impute the purpose, in the silence of the parties, where the significance of the default is grievously out of proportion to the oppression of the forfeiture.<sup>209</sup>

Once Kent had conceded the insignificance of the substitution of Cohoes pipe for Reading Pipe, Cardozo had no difficulty discerning the disproportion between the harm done to Kent by the breach and the harm that would be done to the construction company if the provision were treated as an express condition. Interpreting the Reading Pipe provision as a promise, and constructing a condition of “substantial performance,” permitted Cardozo to prevent “the oppression of the forfeiture.”

Of course, a court confronting an immaterial failure to satisfy a provision in an insurance policy usually will not be free to follow Cardozo to the conclusion that the policy provision should be interpreted as a promise rather

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208. *Jacob & Youngs v. Kent*, 129 N.E. at 891. Professor Dennis Patterson calls this “perhaps the most important sentence in the entire opinion.” Patterson, *supra* note 116, at 284, n.183.

209. *Jacob & Youngs v. Kent*, 129 N.E. at 891.



than a condition.<sup>210</sup> But it can follow Cardozo in rejecting the positivist conceit that the meaning of a provision can be determined without considering its effects, and it can allow its appreciation of the consequences of a failure of condition to inform its understanding of *whether* the provision was satisfied. Thus, no special creativity was required for courts to decide that the insurer's purpose for including an "increase in hazard" warranty in the standard fire policy could be satisfied without forfeiting coverage every time mom started the morning oatmeal or dad fired up his pipe,<sup>211</sup> and from such mine-run efforts to ascribe appropriate purposes to insurance policy conditions it is but a short move to the conclusion that less-than-literal compliance may still satisfy a wide variety of policy provisions.<sup>212</sup> In this

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210. Of course, in the heat of advocacy, the distinction sometimes is ignored. Occasionally an opinion will treat a policy provision as a promise rather than as an express condition. *See, e.g.,* Howard v. Federal Crop Ins. Corp., 540 F.2d 695, 697 (4th Cir. 1975) (loss adjustment condition construed as "promise" rather than "condition" because it involved "something to be done" rather than "something not to be done"); Anderson et al., *infra* note 232, at 857 (urging use of "doctrine of 'substantial performance'" to assure that "[a] policyholder's breach of a policy condition should result, at most, in recoupment or damages to the insurance company."). Of course, that approach is impossible to square with the *Restatement*. *See* RESTATEMENT (SECOND) OF CONTRACTS § 261 Illus. 2 & 3 (1981).

211. *See generally* JERRY, *supra* note 48, at 295-96; PATTERSON, *supra* note 173, at 325-27; F.V. Lapine, Annotation, *Change in Purposes for Which Premises Are Occupied or Used as Increase of Hazard Voiding Coverage*, 19 A.L.R.3d 1336 (1968); M.T. Brunner, Annotation, *Casual or Temporary Repairs, and the Like, as Constituting Increase of Hazard So As to Avoid Fire or Other Property Insurance*, 28 A.L.R.2d 757 (1953).

212. Failure to satisfy the "iron safe clause" provided grist for both judicial and academic mills. *See, e.g.,* E. Le Fevre, Annot., *Insurance: Waiver of, or Estoppel to Assert, Iron Safe Clause*, 33 A.L.R.2d 615 (1954). As Williston somewhat grudgingly acknowledged, with iron safe conditions "the meaning of the words is perfectly plain. What influences the court is the fact that it is so unfair and harsh to make the condition applicable in view of the situation which has arisen." 5 SAMUEL WILLISTON & WALTER H.E. JAEGER, A TREATISE ON THE LAW OF CONTRACTS § 806, at 859 (3d ed. 1961).

Nothing is commoner than for a promisor who wishes to protect himself by a condition to impose one which will certainly have that effect even though in some cases the condition may work undeserved hardship. On the natural construction of the policy in question it would seem that the insurer did not care to take the risk

fashion, “vacancy and unoccupancy” clauses can be read to speak only at the inception of the contract.<sup>213</sup> A provision excluding from coverage death “while . . . serving as a member of the crew of any aircraft” can be construed to apply only during portions of the flight when the individual actually is helping to fly the plane.<sup>214</sup> A warranty limiting the values a jeweler is to display in show windows can be said to be relevant only to smash-and-grab thefts from the window, and thus to be no bar to recovery for armed robbery losses.<sup>215</sup> With history like that to draw upon, we should not be surprised to find that modern courts, faced with a choice between interpreting a notice provision to say “I will pay, but not if your notice is late *regardless of whether its untimeliness in any way prejudices my claims adjustment efforts*” and “I will pay, but not if your notice is late *and its untimeliness prejudices my claims adjustment efforts*,” often follow the counsel crystalized in the *Restatement (Second) of Contracts*<sup>216</sup> and choose the interpretation that avoids a forfeiture.<sup>217</sup> Over time some such interpretive moves can become so familiar that they acquire their own short-hand labels: “affirmative

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of discussing reasons alleged for the nonproduction of the books, preferring instead to throw on the insured the duty of producing them at his peril. This construction works such hardship, however, that the court declines to give the words their natural meaning.

*Id.* at 861–62.

213. See, e.g., *Stout v. City Fire Ins. Co.*, 12 Iowa 371 (1861). See generally PATTERSON, *supra* note 173, at 310–14; Allan E. Korpela, Annotation, *What Constitutes “Vacant” or “Unoccupied” Dwelling within Exclusionary Provision of Fire Insurance Policy*, 47 A.L.R.3d 398 (1973); Joseph E. Edwards, Annot., *What Constitutes “Vacancy” or “Unoccupancy” within Fire Insurance Policy on Building Other Than Dwelling*, 36 A.L.R.3d 505 (1971).

214. See, e.g., *Alliance Life Ins. Co. v. Ulysses Volunteer Fireman’s Relief Ass’n*, 529 P.2d 171 (Kan. 1974); *Vander Laan v. Educators Mutual Ins. Co.*, 97 N.W.2d 6 (Mich. 1959).

215. See, e.g., *Diesinger v. American & Foreign Ins. Co.*, 138 F.2d 91 (3d Cir. 1943). See generally Tracy A. Bateman, Annotation, *Construction and Effect of “Jeweler’s Block” Policies or Provisions Contained Therein*, 22 A.L.R.5th 579 (1994).

216. RESTATEMENT (SECOND) OF CONTRACTS § 227 (1981).

217. See, e.g., *Iowa Ins. Co. v. Meckna*, 144 N.W.2d 73 (Neb. 1966) (notice provision satisfied because insurer’s purpose in requiring notice not impeded by insured’s failure to give notice).

warranty,”<sup>218</sup> “temporary breach,”<sup>219</sup> “divisibility”<sup>220</sup> — and, most notably in recent years—the “notice-prejudice rule.”<sup>221</sup>

But most do not. As Llewellyn wryly noted, and as generations of lawyers picking through appellate opinions from half-a-hundred jurisdictions can confirm, “the effect of such work on ‘Words and Phrases’ and the like can be pretty awful.”<sup>222</sup> Reliance on equitable preclusions and purposive interpretation to ameliorate the harshness of the strict common law rule means lawyers for insureds, who come to the task only infrequently and often one policy provision at a time, are likely to find that each example of equitable and interpretive techniques being used to overcome a failure of condition defense seems to come with its own built-in counter example; efforts by commentators to generalize judicial techniques often get no further than a listing of the doctrinal tools or taxonomic efforts to classify provisions that seem especially vulnerable to judicial efforts to ameliorate the effects of the strict common law rule. We miss a lot when we view these cases individually. Without the perspective necessary to appreciate that sometimes they may be manifestations of the larger contractual program for controlling disproportionate forfeitures, we may celebrate judicial technique without understanding when and why it should be applied, and leave its manifestations vulnerable to the claim that they are ad hoc, perhaps

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218. See, e.g., PATTERSON, *supra* note 173, at 310–14; JERRY, *supra* note 48, at 515–16.

219. See generally PATTERSON, *supra* note 173, at 317–23.

220. See generally *id.* at 342–46; Jerald H. Sklar, *The Divisibility of Warranties in Insurance Policies*, 18 VAND. L. REV. 719 (1965).

221. See generally authorities cited *supra* note 49.

222. LLEWELLYN, *supra* note 118, at 365. The result, Llewellyn complained, is that “the sound impulse for fairness — better, against outrage — fails to cumulate into any effective or standard techniques, except in a very few areas such as life and fire insurance.” *Id.* Llewellyn’s rosy characterization of the situation in life and fire insurance may well have been apt at the time, for constructing taxonomies of insurance policy provisions and the judicial reactions they provoked once was at the core of academic work in insurance law. Thus, for example, Williston’s contracts treatise devoted twenty-four sections to “Excuses for Non-Performance of Conditions in Insurance Policies.” WILLISTON & JAEGER, *supra* note 212, at §§ 745–68. Today, however, Llewellyn’s complaint seems especially applicable to insurance contracts. For an examination of the difference in the rhetorical and legal tools on display in insurance coverage litigation a century ago, see Robert Works, *Back to the Future of Post-Loss Insurance Conditions in Nebraska*, 70 NEB. L. REV. 229 (1991).

unprincipled, expressions of anti-insurer animus or the search for a deep pocket.

But these phenomena need not and should not be seen that way. Despite their diversity and the sporadic nature of their appearances, they are reactions to a common problem, and they should be seen as specific applications of the generic principle that nonoccurrence of some conditions should be excused under the “principle of special scrutiny”<sup>223</sup> articulated in Section 229 of the *Restatement (Second) of Contracts*: “To the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the nonoccurrence of that condition unless its occurrence was a material part of the agreed exchange.”<sup>224</sup>

Unfortunately, in recent years these connections only occasionally have been made explicit. When Connecticut first confronted whether to align itself with jurisdictions that had proclaimed a prejudice requirement for failure of notice condition defenses, the opinion was crafted by Justice Peters, fresh from the Yale Law School faculty and ready to locate both the “notice-prejudice rule” and section 229 within the same intellectual tradition as *Jacob & Youngs v. Kent*. In *Aetna Casualty & Surety Co v. Murphy*,<sup>225</sup> Justice Peters began with a quick survey of the legal landscape:

We are confronted, in this case, by a conflict between two competing principles in the law of contracts. On the one hand, the law of contracts supports the principle that contracts should be enforced as written, and that contracting parties are bound by the contractual provisions to which they have given their assent. Among the provision for which the parties may bargain are clauses that impose conditions upon contractual liability. “If the occurrence of a condition is required by the agreement of the parties, rather than as a matter of law, a rule of strict compliance traditionally applies.” . . . On the other hand, the rigor of this traditional principle of strict compliance has increasingly been tempered by the recognition that the occurrence of a condition may, in appropriate circumstances, be excused in

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223. The phrase is drawn from Eisenberg, *supra* note 93, at 236.

224. RESTATEMENT (SECOND) OF CONTRACTS § 229 (1981). *See generally* Eisenberg, *supra* note 93, at 236–240; BURTON & ANDERSEN, *supra* note 128, at §5.5.4; II FARNSWORTH, *supra* note 169, at § 8.7.

225. 538 A.2d 219 (Conn. 1988).

order to avoid a 'disproportionate forfeiture.' See, e.g., 2 Restatement (Second) Contracts (1981), § 229.<sup>226</sup>

Justice Peters acknowledged that section 229 and *Jacob & Youngs v. Kent* and the notice-prejudice rule in insurance shared a common intellectual lineage,<sup>227</sup> and then applied the standards of section 229 to determine whether nonoccurrence of the notice condition in the occurrence-triggered comprehensive general liability policy should be excused:

In the setting of this case, three considerations are central. First, the contractual provisions presently at issue are contained in an insurance policy that is a "contract of adhesion," the parties to this form contract having had no occasion to bargain about the consequences of delayed notice. Second, enforcement of these notice provisions will operate as a forfeiture because the insured will lose his insurance coverage without regard to his dutiful payment of insurance premiums. Third, the insurer's legitimate purpose of guaranteeing itself a fair opportunity to investigate accidents and claims can be protected without the forfeiture that results from presuming, irrebuttably, that late notice invariably prejudices the insurer.<sup>228</sup>

Thus, failure to satisfy the notice condition should be excused. "Literal enforcement of notice provisions when there is no prejudice is no more appropriate than literal enforcement of liquidated damages clauses when there are no damages."<sup>229</sup>

Justice Peters' assimilation of strict conditions and penalty clauses was neither original or strained. The first *Restatement* confirmed the long-standing recognition that express conditions can present the same opportunities and concerns as do more familiar forms of penalty provision:

A contract may be framed so that what is in form a condition will, if given effect, involve the consequences of a collateral agreement for a penalty in case of breach. Enforcement of

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226. *Id.* at 221.

227. *Id.* at 221-22.

228. *Id.* at 222.

229. *Id.* at 223.

such a collateral agreement is confessedly opposed to public policy and provisions creating a condition that would produce the same result should be no more operative because put in the form of a condition.<sup>230</sup>

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230. RESTATEMENT OF CONTRACTS § 302, cmt. a (1932). *See also* WILLISTON & JAEGER, *supra* note 212, at § 739 (“A condition may be as penal in its effects as a promise to pay a penalty. . . . The substance of the two bargains is the same; it is only the form that differs, and relief against the effect of penalties should depend as little as possible upon form.”); William Loyd, *Penalties and Forfeitures*, 29 HARV. L. REV. 117, 135 (1915):

To habitually remake agreements on the strength of circumstances that have subsequently transpired would add an element of uncertainty to bargaining dangerous to freedom of contract and the extension of credit. To refuse to take account of the disproportion between the stipulated consequences of breach and the actual risk of loss would turn such transactions into a speculation. The function of jurisprudence, in the furtherance of progress, is to reduce to a minimum the purely fortuitous elements in the law of obligations . . . until through economic invention, perhaps insurance, perhaps the development of ideas still unknown to us, the problem itself becomes obsolete.

*Id.* at 135. *See also* BURTON & ANDERSEN, *supra* note 128, at § 5.2.3 (characterizing liquidated damages provisions and express conditions as alternative ways of protecting “performance interests,” and, as such, subject to this “central” principle: “[C]osts to the party in breach unnecessary to the protection of the other’s performance interests should be eliminated.”). Eisenberg, *supra* note 93, at 238, puts it this way:

The principle that governs the review of express conditions is very similar to the principle that governs the review of liquidated damages provisions. Both principles concern sanctions. Both principles allow the courts to override bargained-for provisions even in the absence of unconscionability. Both principles turn on a second look. And just as the special principle concerning liquidated damages is traditionally supported by a rhetoric that centers on the idea of penalty, the principle governing the excuse of express conditions is traditionally supported by a rhetoric that centers on the idea of forfeiture.

And the first *Restatement*'s precursor to section 229 provided: "A condition may be excused without other reason if its requirement (a) will involve extreme forfeiture or penalty, and (b) its existence or occurrence forms no essential part of the exchange for the promisor's performance"<sup>231</sup>

Unfortunately, though the rules governing when a liquidated damage provision should not be enforced because it will operate as a penalty are familiar to most modern lawyers, the cognate provisions for policing against forfeitures caused by the application of strict conditions seem to go mostly unnoticed outside the academy. The possibility that a failure to satisfy a notice condition might be excused under section 229, let alone that section 229 might have a wider range of application to some other failure of condition defenses, would appear to be news to most insurance practitioners, even though they labor in the most fruitful of forfeiture vineyards.<sup>232</sup> And

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More importantly, the principle that governs the excuse of express conditions, like the principle that governs the review of liquidated damages provisions, is best explained not by the traditional rhetoric, but by the limits of cognition.

*Id.* at 238.

231. RESTATEMENT OF CONTRACTS § 302 (1932).

232. See, e.g., Eugene R. Anderson et al., *Draconian Forfeitures of Insurance: Commonplace, Indefensible, and Unnecessary*, 65 FORDHAM L. REV. 825 (1996) (despite title and subject, fails to mention § 229) [hereinafter Anderson, *Draconian Forfeitures*]; Eugene R. Anderson & James J. Fournier, *The Reasonable Expectations Doctrine: Understanding the Law and the Lore Behind Upholding the Reasonable Expectations of Insurance Policyholders*, RISK MGMT. & INS. REV., Vol. 1, No. 2, p. 72, 84–88 (1997) (arguing that the "Doctrine of Reasonable Expectations" in part is an effort to police against opportunistic breach); Suter, *supra* note 88, at 235 (suggesting that "notice–prejudice rule" is application of § 229, but acknowledging that connections are "not generally recognized in the case law"). Of course, there are exceptions. In *Brakeman v. Potomac Ins. Co.*, 344 A.2d 555 (Pa. Super. Ct. 1975), perhaps the most influential early "notice–prejudice rule" decision, Judge Cercone's concurring opinion made the connections to § 229's predecessor. ("The two criteria, which must be weighed together, are the extremity of the forfeiture to the obligee (insured) and the materiality of the nonoccurrence of the condition to the obligor (insurer)."). See *id.* at 560. See also *American Ins. Co. v. C.S. McCrossan, Inc.*, 829 F.2d 702, 705 (8th Cir. 1986) (dicta that § 229 would excuse noncompliance with authorization condition in retrospective rating terms of policy); *Cessna Aircraft Co. v. Hartford Acc. & Indem. Co.*, 900 F. Supp. 1489 (D. Kan. 1995) (tying "notice–prejudice rule" to § 229); *American Fire & Cas. Co. v. Collura*, 163 So.2d 784 (Fla. Dist. Ct. App. 1964) (predecessor to § 229 applicable to failure to satisfy notice

that is unfortunate, for as Justice Peters was at pains to point out, the same concern to prevent disproportionate forfeitures that produced such contracts landmarks as *Jacobs & Youngs v. Kent* and *Britton v. Turner* is operative in insurance litigation, even though neither the doctrine of substantial performance nor restitutionary efforts to force disgorgement of unjust enrichment fit the insurance situation.

*C. Excusing Failures of Condition under Restatement (Second) of Contracts § 229?*

What if we were to take section 229 seriously as a source of guidance about how to treat insurance policy conditions? Would section 229 help us to understand the instinct to treat a notice condition differently than a rodent exclusion? Would it provide us with better tools for isolating just how a claims-made format may be inferior to an occurrence format? And what would it have to say about the application of a “notice-prejudice rule” to failures to satisfy a reporting clause in a claims-made policy?

Section 229 forces us to ask and answer three questions: 1) Was satisfaction of the condition a “material part of the agreed exchange?” 2) What will be “the extent of the forfeiture” suffered by the insured if the condition is not excused? and 3) Will that forfeiture be disproportionate to the “protection that will be lost [by the insurer] if the non-occurrence of the condition is excused to the extent required to prevent forfeiture?”

1. Was Satisfaction of the Condition a “Material Part of the Agreed Exchange?”

In many contractual settings, whether occurrence of the condition was “a material part of the agreed exchange” may be among the most difficult parts of the section 229 inquiry. But in insurance, this first question need not detain us for long. Because insurance contracts are aleatory, the exchange

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condition in auto policy); *Roberts Oil Co. v. Transamerica Ins. Co.*, 833 P.2d 222 (N.M. 1992) (same); *Duerler v. Community Mut. Ins.*, No. 90AP-1337, 1991 WL 60660 at \*4 (Ohio Ct. App. Apr. 18, 1991) (excuse of failure to satisfy cost management provision in medical expense coverage governed by § 229, but not available because provision was “material part of the agreed exchange”); *Ashburn v. Safeco Ins. Co.*, 713 P.2d 742, 745 (Wash. Ct. App. 1986) (failure to satisfy one year suit clause not subject to excuse under § 229 because not a “condition precedent”); *Mistler v. Horace Mann Ins. Co.*, 2 Mass. L. Rptr. 619 (Mass. Dist. Ct. 1994) (failure to satisfy cooperation clause said to pose question whether “loss of coverage is ‘disproportionate’ to ‘loss’ caused the insurer” by the failure of condition).



that takes place is an exchange of the insured's premiums for the insurer's contingent promise to pay.<sup>233</sup> Compliance with any condition other than payment of premiums usually will not be, in the sense in which the *Restatement* uses the term, a material part of the agreed exchange.<sup>234</sup> All the policy conditions may be material in the sense that they provide protection to the insurer against potential costs, and some failures of condition will certainly be material in the sense that the facts depart in significant ways from the assumptions under which the insurance was written. But that does not make every insurance condition—indeed any insurance condition *qua* condition—a material part of the agreed exchange.<sup>235</sup>

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233. See *Cessna Aircraft Co. v. Hartford Acc. & Indem. Co.*, 900 F. Supp. 1489, 1517 (D. Kan. 1995); *Roberts Oil Co. v. Transamerica Ins. Co.*, 833 P.2d 222, 230–31 (N.M. 1992). But see *Duerler v. Community Mut. Ins.*, No. 90AP–1337, 1991 WL 60660, at \*3 (Ohio Ct. App. Apr. 18, 1991) (policy condition that medical treatment be obtained from approved provider said to be “material part of the agreed exchange”).

234. “Where the promises of either or both parties to a bilateral contract are wholly or substantially aleatory, the promises are not for an agreed exchange of performances unless the promise of each party is conditional on the same fortuitous event.” RESTATEMENT OF CONTRACTS § 292 (1932).

235. The analysis in the text is quite different from that proposed by Professors Burton and Andersen. In their view, “§ 229’s requirement that the condition not be a material part of the agreed exchange” becomes “the materiality requirement of § 229,” and that requirement “turns on the importance of the term to the parties at the time the contract was made.” BURTON & ANDERSEN, *supra* note 128, at 194–95. There are two objections to that reading. First, it ignores the *Restatement’s* distinction between conditions that cannot be excused because “a material part of the agreed exchange” and conditions that cannot be excused because “uncertainty of the occurrence of the condition was an element of the risk assumed . . . .” RESTATEMENT (SECOND) OF CONTRACTS § 84 (1981) (waiver); RESTATEMENT (SECOND) OF CONTRACTS § 271 (impracticability). In non–aleatory contracts, the two categories of immune conditions may involve substantial overlap, but with insurance contracts most immune conditions will be so because “uncertainty of the occurrence was an element of the risk assumed” by the insured. “Waiver . . . of the fire required by an insurance policy is not within this Section” not because having a fire was part of the agreed exchange, but because the risk of loss from a peril other than fire was “an element of the risk assumed” by the insured. See RESTATEMENT (SECOND) OF CONTRACTS § 84, cmt. c (1981).

The second objection is even more important. In the Burton and Andersen approach, whether a particular policy provision is immune from excuse arguments under § 229 turns on a traditional *ex ante* inquiry into the importance of the policy

Consequently, in insurance we are free to go directly to the weighing of the consequences of excusing or not excusing the condition prescribed by section 229:

In determining whether the forfeiture is disproportionate, a court must weigh the extent of the forfeiture by the obligee against the importance to the obligor of the risk from which he sought to be protected and the degree to which that protection will be lost if the non-occurrence of the condition is excused to the extent required to prevent forfeiture.<sup>236</sup>

## 2. What Will Be “The Extent of Forfeiture” Suffered by the Insured if the Condition Is Not Excused?

According to the *Restatement*:

“forfeiture” is used to refer to the denial of compensation that results when the obligee loses his right to the agreed

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condition to the insurer considering the entire array of different uses to which that condition might be put. But § 229 assumes that each policy condition is material in the sense that it will sometimes operate to protect the insurer from real costs the insurer wants to avoid. § 229 instead asks how the condition is being employed in the particular case. *See id.* at § 229 cmt. a. (“[T]his Section is concerned with forfeiture that would actually result if the condition was not excused.”). Eisenberg refers to this as the “second look approach”:

If, in the scenario of imperfect fulfillment that actually occurred, a requirement of perfect fulfillment would result in a substantial loss to one party that is significantly out of proportion to the interest of the other in perfect fulfillment, and if the requirement of perfect fulfillment under that scenario appears to be one to which the parties would not have agreed if they had specifically adverted to the actual scenario, courts should not require perfect fulfillment unless it is established that the parties had a specific and well-thought-through intention that perfect fulfillment be required in a scenario like the one that actually occurred.

Eisenberg, *supra* note 93, at 240.

236. RESTATEMENT (SECOND) OF CONTRACTS § 229 cmt. b (1981).

exchange after he has relied substantially, as by preparation or performance on the expectation of that exchange. The extent of the forfeiture in any particular case will depend on the extent of that denial of compensation.<sup>237</sup>

What does that mean for an insurance case? It means that the “extent of the forfeiture” to be placed in the section 229 balance is the amount of recovery from the insurer that will not be available because of the failure of condition. If insured property is damaged, and the insurer refuses to pay because of a failure of condition, the insured suffers a forfeiture regardless of whether the claim is denied because the insurance had lapsed, the cause of loss was an excepted cause, a warranty was breached, or the notice was late. The second prong of the section 229 inquiry is not concerned with the reasons for the denial. It keeps our attention focused squarely on the impact of the failure of condition on the insured. And from that perspective, a “no” is still a “no,” no matter how it is justified. The “extent of the forfeiture” is the extent of the compensation denied.

At first blush, the conclusion that a forfeiture results whenever a failure of condition prevents recovery may seem less than obvious. After all, the *Restatement* does say that the insured suffers a forfeiture when he “loses his right to the agreed exchange after he has relied substantially,”<sup>238</sup> and that language might appear to invite insurers and insureds to offer their competing understandings of the essential core of the agreed exchange. Insurers can dust off the standard-issue argument that an insurer has no present active duty to pay on a loss unless all conditions have been satisfied, and that a failure of condition therefore can not cause an insured to lose a “right” she never had. Insureds, attempting to adapt the same language and logic to their own ends, might be tempted to concede that the insurer’s refusal to perform because the loss occurred outside the policy period or because it was caused by an excluded peril involves no forfeiture, because those conditions are “coverage-defining,” but to argue that a “technical only” nonprejudicial failure to satisfy a post-loss notice condition produces a forfeiture.

The question thus exposed is whether we should rationalize our intuition that section 229 does not authorize us to excuse failure to satisfy a rodent exception by saying that the insured did not suffer a forfeiture *of the agreed exchange*, or by saying that, though the failure of condition created a forfeiture, we are unprepared to excuse that failure because the forfeiture was

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237. *Id.* (cross reference to § 227 cmt. b omitted).

238. *Id.* (emphasis added).

not disproportionate to the protections thereby provided the insurer. The first formulation would say that the insured did not lose what he bargained for: *indemnification-for-loss-to-property-caused-by-fire-unless-fire-was-caused-by-rodents*. The second would say that the insured lost not only his house but also his claim to be indemnified by the insurer, and thus suffered a forfeiture, but that we are not prepared to excuse that failure because the forfeiture was not disproportionate because applying the condition strictly shields the insurer from the risk "from which he sought to be protected" by including the rodent exception.

The two-step approach is preferable, for several reasons. First, it is more consistent with the language of the *Restatement*, which elsewhere insists that most insurance policy conditions are not part of the agreed exchange<sup>239</sup> and which clearly contemplates an inquiry both into whether the insured suffered a forfeiture and, if so, into whether its effect on the insured was disproportionate to harms to the insurer that could have been avoided by compliance with the provision. Second, the alternative, to ask in each case whether the failure of condition caused the insured to lose "the agreed exchange," would condemn lawyers and judges to endless essentialist debates of the sort that in this country enervate efforts to apply the "Doctrine of Reasonable Expectations" and that in Britain and some former Commonwealth countries have condemned their counterparts to a gerbil-cage pursuit of the "core" or "essence" of a contractual undertaking hedged in by conditions.<sup>240</sup> Anyone who has reviewed the claims-made litigation of the past decade, contemplated whether a failure to satisfy an exception clause should be treated as a "fundamental breach,"<sup>241</sup> or has puzzled over the

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239. See *supra* note 235.

240. See, e.g., Dafydd Jenkins, *The Essence of the Contract*, 27 CAMBRIDGE L.J. 251 (1969). Much of the debate has swirled around the work of Professor Coote. See BRIAN COOTE, *EXCEPTION CLAUSES* (1964); Nyuk Chin, *The Problem of Exception Clauses: A Theory of Performance Related Risks*, 15 U. WEST. AUST. L. REV. 347 (1983).

241. In *Karsales Ltd. v. Wallis*, 1 W.L.R. 936 (C.A. 1956), Lord Denning gave the doctrine of fundamental breach its modern incarnation: "exempting clauses . . . no matter how widely they are expressed, only avail the party when he is carrying out his contract in its essential respects." *Id.* at 940. The decision set off a world-wide hunt for a way to identify the "core" duties of contracts. As Professor Meyer explained:

"fundamental obligation" would better express the doctrine's notion of an irreducible core duty, a duty which arises from the

implicit immunity of “coverage clauses” from warranty statutes,<sup>242</sup> incontestable clauses,<sup>243</sup> and equitable doctrines of waiver and estoppel<sup>244</sup> will recognize the difficulties of a search for the “essence” of a contractual obligation.<sup>245</sup> Consider, for example, the essentialist metaphysics required

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relationship created by the contract rather than from the specific terms. As an irreducible duty, it limits party autonomy to provisions outside the core and invalidates attempts to exempt or exculpate within the core.

Alfred W. Meyer, *Contracts of Adhesion and the Doctrine of Fundamental Breach*, 50 VA. L. REV. 1178, 1188–89 (1964). As the difficulties of that project became clear, the doctrine fell on hard times. In *Suisse Atlantique Societe d'Arment Maritime S.A. v. N. V. Rotterdamsche Kolen Centrale*, [1967] 1 A.C. 361, the House of Lords rejected the principle and declared that courts had no general power to invalidate exemption clauses; it did, however, declare that the rule of construction that prima facie parties do not intend exemption clauses to protect against fundamental breaches retained its vitality. In *Photo Production Ltd. v. Securicor Transp. Ltd.* [1980] A.C. 827(H.L.), the House of Lords confirmed that fundamental breach as a rule of law was dead, and indicated that the adoption of the *Unfair Contract Terms Act of 1977* relieved much of the pressure for judicial tools to police exemption clauses. Similar histories were written in former Commonwealth nations. Nevertheless, the habits of thought that gave rise to the project survive. See, e.g., P.S. ATIYAH, AN INTRODUCTION TO THE LAW OF CONTRACT 117 (2d ed. 1971) (“Every contract contains some fundamental obligation which is the primary object of the whole contract.”). For a sustained criticism of the project, see COOTE, *supra* note 240.

242. See, e.g., JERRY, *supra* note 48, § 101 at 523–26 (describing difficulties in distinguishing regulated “warranties” from “coverage provisions”); Works, *supra* note 200, at 232–50 (offering functional approach to classification of policy provisions subject to warranty statute).

243. See, e.g., Works, *supra* note 197; William F. Young, “Incontestable” — *As to What?*, 1964 U. ILL. L.F. 323.

244. The difficulties of trying to distinguish between defensive and offensive use of waiver and estoppel in an insurance setting are summarized in Works, *supra* note 197, at 820–23. See also PATTERSON, *supra* note 173, § 94; W.C. Crais III, Annotation, *Comment Note: Doctrine of Estoppel or Waiver as Available to Bring Within Coverage of Insurance Policy Risks Not Covered by Its Terms or Expressly Excluded Therefrom*, 1 A.L.R.3d 1139 (1965).

245. Professors Burton and Andersen provide a good demonstration of the difficulties. In their view, “confusion about when and why express conditions should be enforced” can be “eased by recognizing that many conditions serve to enforce the agreement, not to define the required performance.” BURTON & ANDERSEN, *supra* note 128, at 8. “If the condition is an enforcement term, good faith allows it to be

for any dispute about whether a notice condition in an ordinary homeowners' policy should be treated as part of the agreed exchange. If we define whether there is a forfeiture by whether the insured will get "the agreed exchange," that means that for notice provisions we must be willing to say that the agreed exchange should be interpreted to be "~~indemnification for loss to property caused by fire unless fire was caused by rodents but not if notice is not given within 10 days and the insured can prove that the insurer was prejudiced~~" rather than "~~indemnification for loss to property caused by fire unless fire was caused by rodents but not if notice is not given within 10 days.~~" Such a conceptualist effort to imagine answers to all questions ex ante is consistent with habits of contractual thought that imagine that all questions of application were presentiated, explicitly or implicitly, at the time of contracting. But that is not the focus of *Jacob & Youngs v. Kent*, nor of the subterranean insurance traditions we have been exhuming, and it not the focus of section 229. Those traditions are self-consciously and aggressively ex post.<sup>246</sup>

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invoked only when doing so advances the purpose for which it was included in the agreement, without unnecessary cost to the party against whom enforcement is sought." *Id.* However, when "the purpose of the express condition is to qualify or describe performance, or to limit the circumstances under which it is due, rather than to provide incentives for its completion or compensation for its breach," *id.* at 305, the condition should be treated as a performance term which cannot be excused.

Whatever the merits of this approach for non-aleatory contracts, in the insurance context the distinction between performance and enforcement terms does not advance us beyond the more familiar distinction between "coverage" and "noncoverage" provisions. Just as every insurance policy condition plausibly can be said to help establish what "coverage" the policy provides, so every insurance policy condition plausibly can be said to "qualify or describe [the insurer's] performance, or to limit the circumstances under which it is due." To make the distinctions necessary in the insurance context, we need a more robust version of what an insurer is trying to accomplish, and that requires a fuller appreciation of what sorts of risks the insurance contract is seeking to allocate. *See generally infra* section II.C.3.

246. RESTATEMENT (SECOND) OF CONTRACTS § 229 cmt. a (1981) provides in pertinent part:

Although both this section and § 208, on unconscionable contract or term, limit freedom of contract, they are designed to reach different types of situations. While § 208 speaks of unconscionability "at the time the contract is made," this Section is concerned with forfeiture that would actually result if the condition were not excused. It is intended to deal with a term that does not

But there is a third reason as well. By treating every failure of condition as creating a forfeiture, and then asking if the forfeiture was disproportionate, we force ourselves to look where we should—at the impact of the failure of condition on the insurer. Much of modern insurance law reacts to the realities of insurance policy boilerplate by treating the insurer's purpose in employing the provision as less important than the insured's real or hypothetical purposes in purchasing the coverage. Under the Doctrine of Reasonable Expectations, the objective reasonable expectations of insureds—but not insurers—are determinative of coverage; under construction *contra proferentem*, if any meaning contrary to that intended by the insurer can be wrung from policy language, it can be declared ambiguous and given the meaning the insurer does not want. But under section 229, the insurer's purpose in employing the condition returns to center stage. If every failure of condition defense creates a forfeiture, then the proper question is whether the extent of that forfeiture is disproportionate to the harms to the insurer that could have been avoided by compliance with the condition. Sometimes compliance with a condition buys freedom for the insurer from costs that are commensurate with the costs imposed on the insured by failure of a that condition, and sometimes it does not. Sometimes the forfeiture is proportionate, and sometimes it is not.

But when is a forfeiture “disproportionate?” Unless we can answer that question, we have accomplished nothing.<sup>247</sup>

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appear to be unconscionable at the time the contract is made but that would, because of ensuing events, cause forfeiture.

*See also* Eisenberg, *supra* note 93 (emphasizing “second look” function of § 229).

247. A preliminary draft of what became § 229 would have set a different standard. Rather than excusing failures of condition “to the extent that non-occurrence of a condition would cause disproportionate forfeiture,” RESTATEMENT (SECOND) OF CONTRACTS § 255 (Tentative draft # 7, 1972), would have excused conditions “[t]o the extent that non-occurrence of a condition would cause extreme forfeiture.” As Professor Murray noted at the time, “the difficulties in determining whether the non-occurrence of the condition is ‘relatively unimportant’ to the obligor and whether the forfeiture is ‘extreme’ should not be underestimated.” JOHN E. MURRAY, MURRAY ON CONTRACTS § 168, at 331 (2d ed. 1974). *See also infra* notes 274–288 and accompanying text.

### 3. When Is a Forfeiture Disproportionate?

We begin our search for a way to distinguish disproportionate from other forfeitures by returning yet again to the deceptively simple question: What do we mean when we say that the coverage provided by an insurance policy is “less?” Ignoring for the moment whether we mean less than would be provided by another policy, or less than the insured wanted, less than is warranted by the price, or less than something else,<sup>248</sup> we usually mean that the insurer is assuming less risk, and the insured is retaining more risk, than would be the case under some other alternative.<sup>249</sup> That is consistent with the conventional understanding that an insurance contract is one choice among the classic alternatives for dealing with risk. In the usual telling, a person facing a risk of, for example, fire loss can choose to retain that risk, can take steps to eliminate or to reduce that risk, or can transfer that risk.<sup>250</sup> Insurance contracts involve a transfer of risks from insured to insurer: the insured takes on a certain present cost in order to avoid an uncertain future cost; the insurer takes on an uncertain future liability in order to obtain a present premium.

We often find it convenient to think and talk as though it really were that simple. Absent the fire insurance contract, we say, the risk of a fire loss would have been borne by the insured; with the insurance contract to transfer that risk, the burden of the loss will be borne by the insurer. Because the collision coverage was subject to a \$250 deductible, we say, the collision insurer will pay \$350 of the \$600 repair bill; had there been no deductible, the risk of the entire \$600 loss would have been transferred to the insurer. In

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248. For thoughtful treatments of the difficulties if we try to move beyond the assumption that value is measured by the price willingly paid by informed buyers and willingly taken by informed sellers, see ELIZABETH ANDERSON, *VALUE IN ETHICS AND ECONOMICS* (1993); HENRY WOO, *COGNITION, VALUE & PRICE: A GENERAL THEORY OF VALUE* (1992).

249. Of course, the characterization is not limited to insurance contracts; we are all accustomed to thinking of contracts of all kinds as ways of allocating risks between the contracting parties. *See, e.g.*, OLIVER W. HOLMES, *THE COMMON LAW* 239 (1881) (characterizing contracts as a “wager” on uncertain future events); RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 92–93 (3d ed. 1986) (contracts as device for allocating future uncertainties). *But see* Morris R. Cohen, *The Basis of Contract*, 46 HARV. L. REV. 553 (1933) (emphasizing role of contract law in distributing unallocated risks).

250. One near-canonical statement of the choices, drawing on early theoreticians of risk in this country and Europe, is ALAN WILLETT, *THE ECONOMIC THEORY OF RISK AND INSURANCE* 71–89 (1951).



such casual modeling, we assume that the expected value of the risk will remain the same whether it is borne by the insured or by the insurer or is carved up between them.<sup>251</sup> If pressed, we may point to different risk preferences, or the insurer's superior ability to diversify, to explain why an insured sometimes will be willing to pay a premium in order to be relieved of a risk and an insurer sometimes will be willing to assume a risk that the insured is willing to pay to avoid.<sup>252</sup>

But, of course, it really is not that simple. Insurance involves the combination as well as the transfer of risks, and with increased numbers comes a reduction in uncertainty; as a result, "[t]he risk that an insurance company carries is far less than the sum of the risks of the insured[s]."<sup>253</sup> Moreover, when we separate control of an activity from responsibility for the costs of that activity,<sup>254</sup> we create moral hazard.<sup>255</sup> The fire insurance

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251. This way of thinking is bred in the bones. Thus, Professor Chirelstein:

In general, the function of a contractual condition is to place the risk of the non-occurrence of the critical event on one party rather than the other. One speaks of "risk" in this connection because the failure of a condition would often entail a loss, or at least a disadvantage, to one of the parties, with some corresponding advantage or immunity to the other.

MARVIN A. CHIRELSTEIN, *CONCEPTS AND CASE ANALYSIS IN THE LAW OF CONTRACTS* 99 (3d ed. 1998).

252. See, e.g., CHARLES J. GOETZ, *CASES AND MATERIALS ON LAW & ECONOMICS* (1984). "Risk *transferral* thus reduces risk costs when an otherwise unchanged risk is reallocated to a person who, merely for psychological reasons, attaches a lower certainty equivalent to the risk." *Id.* at 123. Of course, the willingness of a commercial insurer to assume a risk that the insurer will pay to avoid has less to do with differences in psychological attitudes toward risk than with the insurer's superior ability to diversify by pooling the risk with other independent risks. Pooling permits the insurer to reduce the variance around the mean, and that reduction in uncertainty makes the expected value of the aggregated risks less than the sum of the individual risks being pooled.

253. WILLETT, *supra* note 250, at 73.

254. See NEIL DOHERTY, *INSURANCE PRICING AND LOSS PREVENTION* 6 (1976).

255. The classic economic treatments of moral hazard include Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Bengt Holmstrom, *Moral Hazard and Observability*, 10 BELL J. ECON. 74 (1979); Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968); Steven Shavell, *Risk Sharing and Incentives in the Principal and*

contract may cause the risk of loss by fire to “mutate”:<sup>256</sup> the insured, by virtue of the fire insurance contract, may have less—or more<sup>257</sup>—incentive

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*Agent Relationship*, 10 BELL J. ECON. 55 (1979); Joseph E. Stiglitz, *Risk, Incentives, and Insurance: The Pure Theory of Moral Hazard*, 8 GENEVA PAPERS ON RISK & INS. 4 (1983). For important recent contributions, see HEIMER, *supra* note 129; Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996); Ralph A. Winter, *Moral Hazard and Insurance Contracts*, in CONTRIBUTIONS TO INSURANCE ECONOMICS 61 (Georges Dionne ed., 1992).

256. See DOHERTY, *supra* note 254, at 1. As Doherty notes, “moral hazard” is used in at least two senses:

In one sense, moral hazard refers to abuses of insurance protection which relate to deficiency of character on the part of the insured, for example, faking a claim or exaggerating its amount or even deliberate destruction of property in order to claim the insurance money. . . . A broader interpretation, sometimes called morale hazard, refers to factors such as carelessness and indifference which may not suggest moral deficiency but still refer to personality traits which react with the security of insurance protection.

*Id.* at 2. But that “narrow and emotive” focus distracts from the more important sense in which insurance contracts create moral hazard:

Whilst the contract of insurance transfers incentives for loss prevention to the insurer, it is rarely accompanied by a corresponding right to interfere with the insured’s life, activity or property. There is a separation of incentive and control. Nevertheless, the insurer is not without bargaining power since he may vary the terms and conditions on which he goes on cover. There may be a system of premium reductions and /or extensions of cover if the insured does specific things to reduce the risk. Alternatively, there may be premium penalties, exclusions of cover or threatened withdrawal of cover altogether in the face of adverse features of the risk. A third possibility is that insurance premiums may be directly related to claims experience such that bad risks will, on average, pay more for their insurance than good risks. It is therefore clear that the pricing of insurance and the conditions of cover may create a system of secondary incentives for loss prevention. . . .

*Id.* at 3.

to install sprinklers, to avoid smoking in bed, or to preserve damaged property after a fire.<sup>258</sup> Insurance, thus, not only transfers risks and reduces risks; it also may change risks by affecting the likelihood that a loss will occur and by affecting the likely magnitude of any loss that does occur. Though we are correct in thinking that an insurance contract transfers a quantum of risk from insured to insurer, if we are careful we will acknowledge that the effects of diversification and of moral hazard may make the expected value of the risk borne by the insurer different than would be the expected value of the risk if it were retained by the insured.

And it gets more complicated in less familiar ways. Insurance contracts are not self-executing. Even a simple insured fire loss must be adjusted to determine the fact and amount of the insurer's obligation. Often there will be uncertainties about the contract, the law, the facts, and how the law and contract will be applied to the facts.<sup>259</sup> Answering such questions involves loss adjustment costs and uncertainty costs for both insurer and insured. Economists, when they do not assume such costs away, speak generically of "transaction costs," or more specifically of "decision costs," "probable error costs," "implementation costs," "enforcement costs," or the risk that the contract will prove "unverifiable"; in the language of insurance law associated with Edwin Patterson, these are costs attributable to "juridical

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257. See Isaac Ehrlich & Gary Becker, *Market Insurance, Self Insurance, and Self-Protection*, 80 J. POL. ECON. 623 (1972), who argue that if insurance is structured to provide price or other incentives for increased prevention activities, increases in insurance protection may actually lead to increases in prevention activities — a phenomenon that has been dubbed "moral imperative." See Chunchi Wu & Peter Colwell, *Moral Hazard and Moral Imperative* 55 J. RISK & INS. 101 (1988).

258. Insurance texts emphasize that moral hazard has both an ex ante and an ex post character. The first deals with the insured's altered incentives to avoid loss; the second deals with the insured's altered incentives to mitigate losses after they have occurred. Deductibles are widely regarded as the insurer's chief practical technique for controlling moral hazard; however, a deductible perversely may enhance moral hazard by creating incentives to inflate claims to get above the deductible. See Richard J. Butler & John D. Worrall, *Claims Reporting and Risk Bearing Moral Hazard in Workers' Compensation*, 57 J. RISK & INS. 191 (1991).

259. "Law must be applied, and it is applied by a system of courts and administrative agencies in which the human element is all too apparent." Spencer Kimball, *Nature of the Liability Hazard*, PROPERTY & LIABILITY INSURANCE HANDBOOK 447, 457 (J. Long & D. Gregg eds., 1965).

hazards.”<sup>260</sup> Though introductory insurance texts—perhaps because they tend to focus on potential causes of “loss” rather than potential causes of “costs”—do not give “juridical hazard” the same prominence as “physical hazard” and “moral hazard” as potential sources of burdens insurers assume by underwriting an insurance contract, the real-world importance of “juridical hazard” clearly is reflected in a variety of insurance practices and institutions, not the least of which is the accounting practice that expresses the insurer’s burden as the sum of “loss costs” and “loss adjustment expenses.”

How does this venture into bargain-basement scholasticism help us to understand the role of conditions in insurance contracts and insurance law? At the least, it offers a vocabulary that will permit us to be more precise about just what costs will be borne by whom when an insurer and an insured include various kinds of provisions in an insurance contract, and it provides a warning that the casual conventions that treat policy provisions as allocating discrete and immutable risks to either the insured or the insurer must be approached with some caution. Risk, after all, is in this setting a probability statement about the likely incidence and magnitude of *costs*; potential and actual *costs*—whether they are occasioned by physical, moral, or juridical hazards—should be the focus of our attention.

Of course, we know that an insurer need not take on responsibility for all of these potential costs. It can use marketing strategies and underwriting rules and price to make sure that some risks are not added to its portfolio, and it can use insurance policy provisions to identify conditions that must be satisfied if the insurer is to become obligated to perform. And therein lies the

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260. PATTERSON, *supra* note 173, §§ 66–69 at 272–98. As Patterson explained:

If the elements of coverage were unambiguously defined and if the insured fully understood and honestly abided by them, or even if all the facts were indisputably ascertained and the terms of the contract infallibly applied by court and jury, insurers could get along with fewer conditions. These “ifs” are violent assumptions.

*Id.* at 200. Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 631 (1943), employed the term more as it is used among members of the lay insurance community: “The insurance business probably deserves credit also for having first realized the full importance of the so-called ‘juridical risk,’ the danger that a court or jury will be swayed by ‘irrational factors’ to decide against a powerful defendant.”

second set of complications: as we have seen, express conditions can be very blunt instruments for limiting the risks to which the insurer is subject.

A few simple examples will help to explain why some express conditions carry the potential for disproportionate forfeitures and some do not. Consider first the way an auto insurance policy allocates the costs of an ordinary insured fender-bender: the policy provides that, if damage to the insured automobile is caused by collision, the insurer will pay repair costs in excess of a \$250 deductible. If the cost to repair the automobile to its pre-collision value is \$600, we expect \$350 of those costs to be borne by the insurer and \$250 of those costs to be borne by the insured, and we feel comfortable saying that the insured retained the risk of the first \$250 in collision damage and transferred the risk of damage above that deductible to the insurer. Of course, when we think and talk that way we are ignoring other costs of the collision that go unmentioned in the policy language. The insured must miss a couple of hours of work to secure appraisals of the damage; he may have transportation costs while the car is being repaired; he certainly will regard the whole process as an unfortunate aggravation. And the insurer's costs attributable to the accident are not limited to \$350; at the least there will be loss adjustment costs that can be allocated to this collision claim. But though a fully-specified, fully-nuanced risk-allocating contract would spell out who will bear the burden of each of these costs, the insurance policy's bare-bones conditional promise to pay repair costs in excess of \$250 accomplishes the same results by maintaining an eloquent silence about these additional costs. If there is no mention of lost wages or rental car costs or loss adjustment costs, those costs will remain where they fall.

But what if we complicate things a little more by asking how we should understand the risk allocation worked by the deductible applicable to the collision coverage? We felt comfortable saying that the risk of collision damage of less than \$250 was not among the risks transferred to the insurer; therefore that risk was retained by the insured. But is the quantum of risk avoided by the insurer by virtue of the deductible really equivalent to the quantum of risk retained by the insured as a result of the deductible? Not exactly, for risk is a compound of physical, moral, and juridical hazards, and the net expected value of a risk may differ depending upon which party is being asked to bear it. Making the collision coverage subject to a deductible, insurers hope, will give the insured additional incentives to forgo the extra trip to the store in freezing rain, and make it more likely that minor bumps will go unreported and unfixed and unadjusted and unpaid. Here the language of risk allocation fits less well, for adding the deductible to the auto policy

does not simply allocate a discrete, fixed, and finite risk to the insured; it actually makes the total quantum of risk to be divided up between the parties less than if would be if there were no deductible. And this sort of inevitable mismatch between the quantum of risk avoided by the insurer and the quantum of risk retained by the insured as a result of policy conditions is not limited to deductibles and other policy provisions explicitly aimed at controlling moral and juridical hazards. Even a provision apparently intended to eliminate a physical hazard from the insurer's calculus of concerns—for example, the homeowners policy provision excepting from coverage “loss. . . caused by rodents”—will affect moral and juridical hazard as well, so that the net expected value of the risks allocated by that provision also may differ depending upon which party is being asked to bear them.

Still, such academic quibbles should not prevent us from taking advantage of the simplifying verbal shorthand of “risk allocation.” Insurance policy provisions like deductibles and rodent exceptions do function as devices for allocating risks between insurer and insured. Liability limits, deductibles, coinsurance provisions, and terms defining the duration of the contract, covered and excluded kinds of loss, and covered and excluded causes of loss all usefully can be regarded as techniques by which the insurer, in the language of the *Restatement*, “makes an event a condition of his duty in order to shift to the obligee the risk of its nonoccurrence.”<sup>261</sup> Such “coverage provisions” share an intrinsic complementarity that allows us to equate what the coverage is with the insurer's burden and what the coverage is not with the insured's burden. If the condition has been satisfied, then the insurer must bear some costs that otherwise would have fallen on the insured; nonoccurrence of a condition means that the insured will bear some costs that otherwise would have been shifted to the insurer. In that sense, policy conditions allocate risks between insurer and insured, and usually we need not pause to point out that the risks avoided by virtue of the provision may not have exactly the same expected value as the risks thereby retained.

But for some kinds of insurance policy conditions, most visibly notice and other loss-adjustment conditions, continuing warranties, and evidentiary conditions, the potential mismatch is fundamentally different. For example, when a personal automobile insurer makes prompt notice of loss a condition of its duty to perform, we understand that the insurer is trying to avoid costs associated with late notice—costs that we would classify as the product of

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261. RESTATEMENT (SECOND) OF CONTRACTS, § X (*Topic 5. Conditions and Similar Events. Introductory Note*) (1981).

juridical hazard.<sup>262</sup> But is it helpful to say that the insurer is using the notice condition to allocate to the insured the risk of having to bear those costs? We can imagine a policy provision that unambiguously would do exactly that, by providing that the insured rather than the insurer shall bear any costs caused by untimely notice; under such a nuanced risk-allocation provision, if the insurer were forced by the delay in the notice to conduct a more expensive investigation, the extra costs of that investigation would be paid by the insured. But insurers typically do not include such narrowly-tailored provisions to shift the costs of noncompliance with the notice provision from insurer to insured.<sup>263</sup> Instead, they employ an express condition that operates

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262. The classic ascription of purpose to notice conditions was provided in *Brakeman v. Potomac Ins. Co.*, 371 A.2d 193, 197 (Pa. 1977):

[A] reasonable notice clause is designed to protect the insurance company from being placed in a substantially less favorable position than it would have been in had timely notice been provided, e.g., being forced to pay a claim against which it has not had an opportunity to defend effectively. In short, the function of a notice requirement is to protect the insurance company's interests from being prejudiced.

See generally WINDT, *supra* note 21, § 1.04.

263.

In the absence of transaction costs, an ideal insurance arrangement would address these contingencies, specifying the exact proof required to "establish" essential facts, the circumstances under which the insurer must respond to doubt about the facts by incurring additional costs of investigation, and the disposition of the claim pending the outcome of additional investigation or litigation. It would be attentive to the relative burden of establishing the facts, placing the costs of establishing them on the party that can bear them most cheaply . . .

Given the range of contractual provisions in play and the way in which the optimal bargain may depend on particular facts and circumstances, however, we might anticipate that the transaction costs of addressing these matters expressly will often exceed the benefits *ex ante* and that insurance contracts will then fail to provide much guidance as to the appropriate treatment of factual uncertainties. Indeed, express attention to the treatment of factual uncertainties in insurance agreements appears to be fairly rare.

quite differently: when notice is late, the condition shields the insurer from juridical hazards associated with late notice, but it does so by excusing the insurer from any obligation to perform and by denying all recovery to the insured. This potential mismatch between the costs that the insurer avoids when the condition is satisfied and the costs that the insured bears when the condition is not satisfied is different in kind from the rather incidental mismatches due to moral hazard and juridical hazard we encountered with the deductible and the rodent exception. The condition purports to authorize the insurer to deny all obligations to the insured whether or not the failure of condition prejudiced the insurer.<sup>264</sup>

The same phenomenon can be seen at work in “continuing warranties” employed by insurers to control their exposure to moral and physical hazards.<sup>265</sup> Consider, for example, the once-common provision in property

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Alan O. Sykes, “*Bad Faith*” *Breach of Contract by First-Party Insurers*, 25 J. LEGAL STUD. 405, 424–25 (1996) (noting one exception: travel insurance with elaborate provisions governing presumption of death). Compared to the complete contingent claims contract with which Professor Sykes is comparing standard insurance policy forms, that is doubtless true. But insurance policies do display efforts to deal with factual uncertainties, most notably by employing express conditions that turn on easily-established facts rather than real object of the insurer’s concern.

264. Of course, an insurer need not assert a defense every time the policy language provides a colorable argument that a claim is not covered. What in Scandinavian insurance circles is called *kulanse*, see, e.g., Knut S. Selmer, *Gratuitous Deviation from the Terms of Form Contracts: Scandinavian Insurance Companies’ Administration of Deferred Acceptance-of-Risk Clauses*, 33 U. CHI. L. REV. 502, 503 (1966), and in this country sometimes is called a payment *ex gratia*, is simply recognition of the discretion that broadly-framed policy language can confer. Apparently that recognition is sometimes formalized in claims adjustment manuals: “If there is six months to a year delay, use your discretion relative to acceptance if there is no prejudice.” AETNA TECHNICAL CLAIM MANUAL B-5-1 (Oct. 1977), quoted in Anderson, *Draconian Forfeitures*, *supra* note 232, at 862–69. In legal terms, the result often is characterized as a “waiver.” See generally RESTATEMENT (SECOND) OF CONTRACTS § 84 (1981). See also Baker & McElrath, *supra* note 134 (exploring exercise of discretion in adjustment of claims).

265. See generally PATTERSON, *supra* note 173, §§ 53–55 at 199–204 (detailing a “conception of warranty that includes the *purposes* for which warranties are used, the *legal consequences* which flow from noncompliance, and the *evils* or *injustices* that ameliorative statutes are intended to remedy”); Edwin Patterson, *Warranties in Insurance Law*, 34 COLUM. L. REV. 595 (1934); Edwin Patterson, *The Apportionment of Business Risks Through Legal Devices*, 24 COLUM. L. REV. 335 (1924). William



insurance policies declaring the policy void "if the property . . . shall be encumbered by mortgage."<sup>266</sup> The primary purpose of such provisions was unremarkable: to alleviate insurer concerns that less-than-full ownership of insured property might entail greater moral hazard than if the insured's interest were full. But the method of the moral hazard warranties created the same potential for a fundamental mismatch between the costs the insurer avoids when the condition is satisfied and the costs the insured bears when the condition is not satisfied as do notice provisions and other loss adjustment conditions explicitly aimed at controlling the insurer's exposure to juridical hazards. In theory, an insurer who recognized that informational asymmetries and quantification difficulties will make it impossible to price the moral hazard posed by a mortgage on the property could choose to limit its exposure to the most egregious manifestations of moral hazard by crafting a narrowly tailored exception from coverage for losses "caused by reduced incentives to care resulting from a change in the insured's ownership interest." Such a provision would respond directly to the insurer's concerns about having its costs increased by moral hazard, but—as the recent history of "expected or intended" litigation demonstrates—that formulation obviously would present the insurer with a considerable juridical hazard. A provision declaring the policy void "if the property . . . shall be encumbered by mortgage" involves much less juridical hazard than would one that required the insurer to show that partial ownership contributed to the loss, for the simple reason that a trip to the register of deeds for proof of a failure of condition usually will be much easier than would be a courtroom safari through the insured's psyche or soul. But this effort to avoid the juridical hazards associated with more nuanced risk allocation provisions comes at a price: a potential mismatch between the costs avoided by the insurer when the provision is satisfied and the costs borne by the insured when it is not.

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R. Vance, *The History of the Development of Warranty in Insurance Law*, 20 YALE L.J. 523 (1911), is much less helpful, for it focuses chiefly on the struggle over whether insurers would be allowed to convert pre-issuance underwriting representations into warranties in order to avoid the materiality and other limitations of the law governing rescission on the grounds of misrepresentation. See note 196 *supra* and accompanying text. The warranties we are considering are those which would be satisfied, or not, by what occurs during the term of the policy.

266. See generally PATTERSON, *supra* note 173, § 68 at 280–90; George W. Goble, *The Moral Hazard Clauses of the Standard Fire Insurance Policy*, 37 COLUM. L. REV. 410 (1937).

So too with physical hazard warranties. It is not difficult for us to imagine the concerns about physical hazards that prompted insurers to include “vacancy or unoccupancy” clauses in their property insurance policies. And it is not difficult to understand why they did not choose to frame those clauses to except from coverage losses “caused by” vacancy and unoccupancy. Such a provision would require that the insurer demonstrate a causal nexus between the fact that the owners were on sabbatical in New Zealand and destruction of their house by a covered peril. In some proportion of fires that occur while the owners are away, the insurer will not be able to convince the trier of fact of the causal nexus; even when it succeeds, the effort may prove costly. By crafting the policy as a warranty that will be violated if the loss occurs “while” the house is vacant or unoccupied, the insurer can avoid even having to try. Choosing a “while” formulation rather than a “caused by” formulation thus produces a reduction in the expected value of the insurer’s loss costs and loss adjustment costs under the policy, but it also creates a potential that the insured will suffer a forfeiture that is disproportionate to the costs the insurer thereby avoids.

Evidentiary conditions like the familiar “visible external marks of forced entry” requirement of some theft coverages<sup>267</sup> pose the same potential for a

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267. “External marks” conditions are the most familiar example of evidentiary conditions, chiefly because they posed the problem for two judicial decisions that are much studied in American law schools. See *Ferguson v. Phoenix Assur. Co.*, 370 P.2d 379, 387 (Kan. 1962) (“[W]here a rule of evidence is imposed by provision of an insurance policy, as here, the assertion of such rule by the insurance carrier, beyond the reasonable requirements necessary to prevent fraudulent claims against it in proof of the substantive conditions imposed by the policy, contravenes the public policy of this state.”); *C & J Fertilizer, Inc. v. Allied Mut. Ins. Co.*, 227 N.W.2d 169 (Iowa 1975) (placing result on grounds of “reasonable expectations,” “implied warranty,” and “unconscionability”). Together the two opinions provide a mini catalog of the sort of ex ante regulatory perspectives that still dominate the thinking in insurance. BURTON & ANDERSEN, *supra* note 128, prefer their “good faith in enforcement” analysis.

Another fecund source of evidentiary condition litigation are conditions found in policies that promise benefits if the insured dies, or is disabled, or suffers a dismemberment, as a result of an accident. In order to avoid the juridical hazard associated with such causal inquiries, insurers sometimes condition liability on proof that the death, disability, or dismemberment occurred within a specified period of time. See generally Eric M. Holmes, *Interpreting an Insurance Policy in Georgia: The Problem of the Evidentiary Condition*, 12 GA. L. REV. 783 (1978); William Young, *Insurance Policy Defenses: In Search of Restatements*, 34 ARK. L. REV. 507,

mismatch between costs avoided by the insurer when the condition is satisfied and costs borne by the insured when it is not. We can acknowledge the legitimacy of the insurer's wish to limit its exposure to some juridical uncertainties about whether a theft, as opposed to an inside job, really occurred, but at the same time recognize that failure to narrowly tailor the evidentiary condition to serve that purpose could permit denial of a claim even when there is no doubt that a theft occurred. But with evidentiary conditions there is at least a taxonomic difference. Compliance with the notice condition and moral and physical hazard warranties usually will be within the control of the insured. Those provisions could be characterized as designed to create incentives for the insured to provide timely notice, leave the property unmortgaged, and keep furniture and people in the insured dwelling, and the insurer's failure to more narrowly tailor those conditions to fit those purposes could be explained in at least two ways: as an effort to avoid the juridical hazards that would result from the use of more nuanced provisions, or as an effort to create even more powerful incentives to comply. Just as contracts scholars speculate that basketball fanatics who worry that default rule damage measures may not give the bus driver with whom they have contracted sufficient incentives to get them to the tournament on time, and may thus bargain for a contract provision requiring super-compensatory damages in the event of breach in order to create additional incentives for timely performance,<sup>268</sup> so we might imagine that insurers employ broadly framed strict conditions in order to create a threat of a complete forfeiture as an added inducement to the insured to make sure that the conditions are satisfied. But with evidentiary conditions, that alternative explanation for the broadly-framed condition is not available. The point of the evidentiary condition requiring visible external marks is not to change the insured's conduct. The point is to avoid a juridical hazard.

Still, our concerns about the potential mismatch between risk avoided and risk retained occasioned by such provisions do not depend on whether we think a particular policy condition was drafted to play a "risk allocation" or "incentive creating" role. Whether we understand the overbreadth to be the product of sloppy drafting, a conscious program to minimize juridical hazard,

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521-23 (1981); Laurent B. Frantz, Annotation, *Validity and Construction of Provision in Accident Insurance Policy Limiting Coverage for Death or Loss of Member to Death or Loss Occurring Within Specified Period After Accident*, 39 A.L.R.3D 1311 (1971).

268. The hypothetical *Case of the Anxious Alumnus* was introduced in Goetz & Scott, *supra* note 145, at 578-79.

an effort to create supercompensatory incentives, or a cynical effort to create random defenses of the sort so often encountered in comic strips, in application it may operate as a kind of penalty provision, and—as Justice Peters recognized—in those circumstances noncompliance should be excused to the extent necessary to prevent disproportionate forfeiture.

We can now attempt a modest and provisional summation of the way section 229 should be applied to failures of insurance policy conditions. An insured who does not recover on a fire policy because a rodent exception was not satisfied suffers a forfeiture, but the forfeiture is not disproportionate because the provision operates to protect the insurer from the very costs that are thereby assigned to the insured. However, an insured who does not recover on a fire policy because a notice condition was not satisfied suffers a forfeiture that may or may not be disproportionate depending upon how the failure to satisfy the notice condition affected the insurer. In both cases, “the coverage is less” in the sense that the insured is bearing more risk than would have been the case if the condition were not present, “and so, therefore, is the cost.” But less is a “syntactically mobile modifier”<sup>269</sup> and section 229 asks us to consider whether the coverage afforded the insured is less in quite a different sense: less than it need be in order to achieve the insurer’s purpose in employing the condition. The rodent exception cannot make the coverage “less” in this second sense, for it subjects the insured to the risk of forfeiture of all claims for rodent damage in order to protect the insurer from the risk of having to pay for rodent damage. However, the notice condition may make the coverage less in this second sense, for it subjects the insured to the risk of forfeiture in order to protect the insurer from some of the costs associated with claims adjustments—costs that in particular cases may range from zero to well in excess of the value of the insured’s claim.

Of course, this sort of imbalance does not make an auto policy with a notice provision substantively unfair, any more than the rodent exception made the homeowners policy substantively unfair. Viewed *ex ante*, which is the only proper perspective when the question is whether a provision is to be treated as an enforceable part of the contract, it makes sense to say of all these conditions: “the coverage is less, but so, therefore, is the cost.” But section 229 tells us to take a “second look” *ex post* at provisions that undeniably are a part of the contract in order to determine whether on particular facts a failure to satisfy the condition should be excused, and sometimes from that vantage loss adjustment conditions, warranties, and evidentiary conditions

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269. George P. Fletcher, *The Right and the Reasonable*, 98 HARV. L. REV. 949, 953 (1985).

will be seen to work a fundamental mismatch between the costs that would have been avoided by the insurer if the condition had been satisfied and the costs the insurer says should be borne by the insured because the condition was not satisfied.

Does that mean that an insurer is acting in “bad faith” if denies what is clearly an otherwise covered theft claim because a “visible external marks” condition has not been satisfied? Professors Burton and Andersen say “yes.”<sup>270</sup> Does that mean that any insurer who invokes a failure of condition defense when to do so is not necessary to protect the insurer against the costs that prompted inclusion of the provision is behaving “opportunistically?” That is the label employed by Professor Muris and a number of other commentators.<sup>271</sup> Of course, so long as “bad faith” and “opportunism” are deployed within texts where their meanings and consequences can be carefully controlled, there is no reason to quarrel with these characterizations. But in application, where the critical differences between Professor Andersen’s “contractual bad faith in enforcement” and the bad faith that gives rise to extra-contractual damages may prove illusive,<sup>272</sup> the rhetoric that asks whether a particular failure of condition should be excused in order to avoid a disproportionate forfeiture can claim important advantages. In conventional

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270. BURTON & ANDERSEN, *supra* note 128, at 194. They acknowledge that “[t]he effect of such holdings [under section 229] is often identical to that of an application of the good faith in enforcement analysis.” Nevertheless, they conclude: “The good faith analysis provides a more focused approach to achieving the end sought by § 229.” *Id.* Elsewhere, Burton and Andersen provide this capsule summary:

. . . . [I]f the facts of the particular case make it plain that the safe burglary was not an inside job, then the court is justified in declining to give effect to the condition. Doing so would fail to advance the purpose for which the condition was included in the agreement in the first place. Claiming the benefit of it for other reasons would be bad faith.

Steven J. Burton & Eric G. Andersen, *The World of a Contract*, 75 IOWA L. REV. 861, 874 (1990) (citation omitted).

271. *See generally* authorities cited *supra* note 95.

272. For an exploration of the way in which “fear of imposing exemplary damages for breach of implied duties . . . led the Texas Supreme Court to gut the doctrine of good faith in contract,” see Mark Gergen, *A Cautionary Tale About Contractual Good Faith in Texas*, 72 TEX. L. REV. 1235, 1237 (1994).

usage, “bad faith” and “opportunism” carry connotations of blameworthiness and breach of duty that we may be reluctant to ascribe to an adjuster or lawyer who believes in the strict common law rule and uses it to justify denying a claim on the basis of a technical failure of condition. Section 229 trains attention where it should be: on the effect of the failure of condition on the insurer.

Even those who see in section 229 an analog to more familiar mechanisms for ex post policing of limited remedies and penalty provisions may resist this effort to lay a section 229 template over insurance cases. Thus, their argument might go, in neither the rodent damage case nor the late notice case is the forfeiture “disproportionate” because the financial consequences to the insurer when there is compliance with the condition are commensurate with the financial consequences to the insured when there is not compliance. If a house covered by fire insurance suffers \$100,000 in damages, that \$100,000 loss will be borne by the insurer if the damage was caused by fire and all other conditions were satisfied; however, the \$100,000 loss will be borne by the insured if the damage was caused by rodents, or if the notice was not timely, or if any other policy condition was not satisfied. Thus, the argument might go, there is nothing disproportionate about a result that denies compensation to an insured because of a failure of condition—any failure of condition.

This argument misunderstands the question the *Restatement* poses for us. Under section 229 we are not to compare the financial consequences to the insurer of compliance with all conditions (insurer pays) with the financial consequences to the insured of noncompliance with even one condition (insurer does not pay). Rather, we are to compare the costs avoided by the insurer when there is compliance with the condition with the costs avoided by the insurer (and thus borne by the insured) when noncompliance with the condition gives the insurer a defense.<sup>273</sup> When we put a failure to satisfy a

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273. Although a focus on the relative impact of compliance and noncompliance on the insurer might seem to shift attention away from the forfeiture suffered by the insured when there is a successful failure of condition defense, we must remember that there is no question about the extent of the insured’s forfeiture: it equals the amount of the insurer’s nonpayment. The question is whether that forfeiture is “disproportionate.” To what? To the costs caused by noncompliance with the condition. Framing the question in this way keeps attention on the relevant issue: does enforcing the term “advance the purposes for which it is included in the agreement without imposing needless costs on the [insured].” BURTON & ANDERSEN, *supra* note 128, at 194. See also Gergen, *supra* note 142, at 70 (“Disproportionate

rodent condition on the section 229 scales, we find that the cost avoided by the insurer and thus borne by the insured by virtue of a successful failure of condition defense (\$100,000 in damages caused by rodents) is at least roughly commensurate with the cost that would have been avoided by the insurer had the condition been satisfied (\$100,000 in damages caused by rodents). The same will be true of most insurance policy conditions dealing with traditional "coverage" questions: what property, whose interests, what events, caused by what perils, with what limits, during which period? Such provisions do operate to allocate roughly proportionate risks to one party and away from the other, and thus failure to satisfy such provisions will never be excused under section 229. But when we put a failure to satisfy a notice condition on the section 229 scales, we find that the cost borne by the insured as a result of the failure of condition (\$100,000 in damages) may or may not be commensurate with the costs to the insurer caused by failure to comply with the condition. In order to determine whether the failure of condition works a disproportionate forfeiture we will have to put a value on the costs to the insurer that would have been avoided by compliance with the condition but were not avoided because of noncompliance.

Sometimes that will be easy. At one end of the spectrum is the case most closely analogous to *Jacobs & Youngs v. Kent*: the notice condition was not satisfied, but both parties agree that the insurer was in no way prejudiced. At the other end of the spectrum is another easy case: the condition was not satisfied, and as a result the insurer lost its right to recover the full amount of its obligation from a third party. In the first, the failure of condition defense would produce a disproportionate forfeiture, and the failure of condition should be excused; in the second, the forfeiture suffered by the insured is matched by the harm to the insurer that could have been avoided by compliance, and thus the failure of condition should not be excused.

But what about cases that fall somewhere in between? What if the late notice caused an adjuster to spend an extra half-day in his car retracing a route already taken, or meant that one of six witnesses no longer is available? In *Jacob & Youngs v. Kent*, the decision that the construction company was entitled to the final progress payment depended in part on the conclusion that Kent did not need the protections of withholding payment because he could be protected by his ability to recover damages resulting from breach of the promise to provide Reading Pipe. Of course, in insurance, failure to satisfy

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forfeiture occurs when enforcement of a condition would leave the obligee with a reliance loss while significantly overcompensating the obligor for his loss from nonfulfillment of the condition.”).

a condition almost never will be a breach of promise and thus damages are not an option. Can section 229 accomplish the same thing by authorizing excuse of the nonoccurrence of the condition only to the extent necessary to avoid disproportionate forfeiture?<sup>274</sup> Or do the costs of applying that more discriminating standard warrant recourse to relatively crude proxies like the “prejudice” and “materiality” standards?<sup>275</sup> And who bears the burden of proof on these questions?<sup>276</sup>

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274. RESTATEMENT (SECOND) OF CONTRACTS § 229 (1981).

275. Some insight may be provided by theoretical work on the optimal degree of tailoring of contractual rules and standards, which in turn draws on the burgeoning debate about rules versus standards and the optimal complexity of each. See, e.g., Ian Ayres, *Preliminary Thoughts on Optimal Tailoring of Contractual Rules*, 3 S. CAL. INTERDISC. L. J. 1 (1993). See also Colin S. Diver, *The Optimal Precision of Administrative Rules*, 93 YALE L.J. 65 (1983); Isaac Ehrlich & Richard A. Posner, *An Economic Analysis of Legal Rulemaking*, 3 J. LEGAL STUD. 257 (1974); Louis Kaplow, *A Model for the Optimal Complexity of Legal Rules*, 11 J.L. ECON. & ORG. 150 (1995); Louis Kaplow, *Rules Versus Standards: An Economic Analysis*, 42 DUKE L.J. 557, 624–29 (1992); Eric A. Posner, *Standards, Rules, and Social Norms*, 21 HARV. J.L. & PUB. POL’Y 101 (1997). But our very real concerns that the benefits of more nuanced approaches to determining the effects of failures of insurance conditions will be overwhelmed by the costs of administration should be seen in light of the many other ways in which the law of contracts seeks to reconcile “the competing goals of contract enforcement: securing to the injured party the benefits of its bargain and avoiding the imposition of unnecessary costs on the breaching party.” Andersen, *supra* note 139, at 301. For an accessible introduction to the subtle difficulties of determining the costs and benefits of judicial approaches to policing opportunism, see Cohen, *supra* note 95, at 987–90; Muris, *supra* note 95, at 529–31.

276. The “notice–prejudice rule” at an early stage divided into two lines of authority, one placing the burden of showing that the insurer was not prejudiced on the insured, and the other placing the burden of showing that the insurer was prejudiced on the insurer. See generally WINDT, *supra* note 21, § 1.04 (collecting authorities). For surveys of the allocation of burdens of proof in notice–prejudice rule jurisdictions, see BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES* § 4.02[b][5] (8th ed. 1995); Anderson, *Draconian Forfeitures*, *supra* note 232, at 862–69. WINDT, *supra* note 21, § 1.04, at 15, reports that the rule placing the burden on the insurer “is followed in most states, and it is continuing to gain wider acceptance.” Of course, in other settings, the mitigation doctrine normally assigns to the breaching party the burden of establishing that part of the loss actually incurred could have been avoided by the victim of the breach. See, e.g., III FARNSWORTH, *supra* note 169, § 12.12, at 228. As often has been noted, shifting burdens may serve as transitional devices from one substantive rule to



The moment we begin to ask such questions, we invite several obvious potential objections to using section 229 to police against disproportionate forfeitures. If, as I have argued, policy provisions should be interpreted purposively, and if a plausible understanding of loss adjustment conditions and continuing warranties and evidentiary conditions includes recognition that their apparent overbreadth may reflect insurer efforts to avoid juridical hazard that would attend more nuanced provisions, won't holding out the possibility that a failure of condition might be excused subject the insurer to exactly the kind of juridical hazards the insurer sought to avoid? Or, put another way, isn't the insurer prejudiced whenever it is required to attempt to prove whether or how much it was prejudiced by a failure of condition, or even to defend against claims that it was not prejudiced? The answer, of course, is "yes." Once we move beyond classroom hypotheticals where the critical facts concerning the impact of the failure of condition on the insurer can be supplied by assumption, any approach that denies the insurer the benefits of the strict common law rule can be said to prejudice the insurer because a more nuanced treatment of the effects of noncompliance will, on average, be more costly to apply. When we make the factual and legal predicates for decision more complicated, we create additional juridical hazards for the parties.

Shouldn't the insurer be as free to choose which juridical hazards it is willing to assume as it is to choose which physical hazards or moral hazards it is willing to assume, and shouldn't it be as free to manifest those choices in insurance policy boilerplate? The answer, of course, is "yes." The underwriting discretion traditionally enjoyed by insurers should apply also to juridical hazards. Section 229 does not police the insurer's ends, only its means. Section 229 still permits the insurance contract to assign the costs of juridical hazards to insureds, so long as the means employed are narrowly tailored to accomplish that result.<sup>277</sup> Thus, section 229 in no way affects the

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another. See generally Tamar Frankel, *Presumptions and Burdens of Proof as Tools for Legal Stability and Change*, 17 HARV. J.L. & PUB. POL'Y 759 (1994).

277. In the same way that the law encourages contracting parties to create bonds and other hostage mechanisms as incentives for performance, but balks when the hostages are human and when the self-help collection techniques include the application of ball bats to kneecaps, so in insurance it balks when the policy provisions sweep so broadly that they produce disproportionate forfeitures. For a sophisticated and entertaining introduction to these themes, see Charles J. Goetz, *Contractual Remedies and the Normative Acceptability of State-Imposed Coercion*,

ability of an insurer to assign juridical costs to the pool of insureds by incorporating such costs in its premium calculations, and section 229 would not inhibit efforts by an insurer to provide that the payout to an individual insured will be offset by an amount equal to the juridical costs caused by the individual insured's delay in giving notice, including the costs of determining the application of section 229 to the individual insured's claim.<sup>278</sup> But when a condition operates to assign costs to an individual insured that are significantly greater than the costs that compliance with the condition would allow the insurer to avoid, that is a penalty, works a disproportionate forfeiture, and section 229 tells us the failure of condition should be excused to the extent necessary to avoid that disproportionate forfeiture.<sup>279</sup>

Won't excusing some failures of condition mean an increase in the loss and expense costs for the insurer's risk portfolio, and aren't those costs likely to be reflected in insurance prices? Of course. But the assertion that an unnuanced, broadly-framed, cheaply-applied provision may be in the interests of both insurer and insureds as a group ought not to carry the same

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4 CATO J. 975 (1985). See also F. Eric Fryar, Note, *Common-Law Due Process Rights in the Law of Contracts*, 66 TEX. L. REV. 1021 (1988).

278. For a familiar example of contract provisions explicitly allocating some of the costs of juridical hazard, see III FARNSWORTH, *supra* note 169, § 12.18, at 310 (attorney's fees provisions). Of course, efforts to allocate juridical costs to the individual insured creating them in practice likely will be limited to direct costs; uncertainty costs and reputational costs likely will be so difficult to value that they will be borne by the party bearing the burden of proof. But that is not unique to excuse of express conditions; it is a usual consequence of mitigation rules.

279. But wait, a skeptic who has followed the argument this far might object. Why measure the amount of the forfeiture in the individual failure of condition scenario against the effect on the insurer of the individual failure of condition? Is not the more relevant question whether the costs of forfeitures worked by all failures of conditions in this class of cases are disproportionate to the juridical costs imposed on insurers and the pool by all failures of condition in this class of cases? The response is simple. Both questions are relevant. A pool can be priced in an appropriate way, on average, but still create disproportionate forfeitures if strict conditions operate to penalize insureds who fail to satisfy conditions beyond what is necessary to compensate the pool for the costs of noncompliance. We do not say that penalties are permissible because they reduce the ex ante costs for everyone, and we police limited remedies in sales of goods to assure not only that there is real agreement, and that the agreement is conscionable, but also that the conscionable and bargained for remedy does not "fail of its essential purpose." U.C.C. § 2-719 (1981). So too with failures of express conditions under § 229.

rhetorical weight now that we have been reminded of *Jacob & Youngs* and *Britton* and section 229 and their analogs throughout contracts and insurance law. We are unlikely to think Kent should escape his obligation to make the last progress payment on his mansion because he is economically literate enough to speculate that the purchase price of the house must have included an implicit risk premium to compensate Jacob & Youngs for the expected value of the risk that accidental use of functionally equivalent but nonconforming pipe would cause a forfeiture of the last payment. And we will not think it an answer to Britton's restitution claim to be told that his wages must have been enhanced to compensate him for the expected value of the risk that he might enrich his employer by walking away from both work and wages. Why not? Because, though we must concede that the parties *are free to* strike bargains that included egoistic gambles on whether Cohoes pipe would show up in Kent's basement or Britton would leave after nine months, we simply do not think that they *did* choose to roll the dice in that way. As Cardozo put it, several different ways:

This is not to say that the parties are not free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery. . . . This is merely to say that the law will be slow to impute the purpose, in the silence of the parties, where the significance of the default is grievously out of proportion to the oppression of the forfeiture.<sup>280</sup>

So too with boilerplate conditions in standard insurance policy forms. If fully-informed insureds blessed with unbounded rationality really were choosing from a menu of policy conditions that includes both the narrowly tailored and those with a potential for disproportionate forfeitures, each with its associated price tag, we would have no compunctions about telling the insured whose gamble on a cheaper policy with a strict notice condition turns out to be a loser to toss his claim form in the trash along with his losing lottery tickets. But in a world that poses few such clear-cut choices to insureds *ex ante* and where bounded rationality constrains the insured's

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280. *Jacob & Youngs v. Kent*, 129 N.E. at 891. Earlier in the opinion, Cardozo sounded the same refrain: "Intention not otherwise revealed may be presumed to hold in contemplation the reasonable and probable. If something else is in view, it must not be left to implication. There will be no assumption of a purpose to visit venial faults with oppressive retribution." *Id.*

ability to evaluate the options that are available, the important choice often will be the ex post choice of what purpose(s) we should impute to the language that did make it into the standard insurance policy.

For most insurance policy conditions, the argument from costs informs this interpretive enterprise in familiar ways. When the issue is whether a loss was caused by a rodent or medical expense resulted from “experimental treatment,” the interpretive heuristic that asks “what coverage and implied cost these consumers would want ex ante, when faced with the choice and the bill”<sup>281</sup> functions chiefly as a reminder that we should regard the insurer as trustee for the greater number of insureds who comprise the risk pool, and thus should insist that conditions that allocate roughly commensurate costs to the insured and away from the insurer (and the pool of insureds) should be rigorously enforced undiluted by ex post sympathies for individual claimants. As Patricia Danzon, focusing on medical expense coverage disputes, makes the familiar point:

Courts must recognize that insurance creates an intrinsic conflict between the insured patient’s preferences ex ante, when he or she selects a health plan and pays the premium, and those preferences ex post, when illness strikes and care appears to be virtually free, because of insurance coverage. An alternative view of this ex ante versus ex post tension is the conflict between the individual interest of the patient who wants care and the interest of insured consumers as a group, all of whom face some probability of falling ill and who collectively bear the cost of care through higher premium payments. . . . [E]fficient standards of care should reflect the ex ante preferences or, equivalently, the average preferences of insureds as a group.<sup>282</sup>

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281. Patricia Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 494 (1997).

282. *Id.* at 493. Of course, opposition to ex post second looks at the risk allocations worked by contract provisions is a natural concomitant of contract models that assume complete presentation, for on that assumption the individual insured is trying to shift responsibility for costs not covered by the insurance to the larger group of insureds. See generally Louis E. Wolcher, *The Accommodation of Regret in Contract Remedies*, 73 IOWA L. REV. 797, 800–03 (1988). If the insured has not accurately discounted the possibility that his initial decision to purchase might be in error, this objection loses much of its force. See *id.* (identifying ways in which legal

And that seems exactly right. The purpose of such conditions, though not the precise boundaries of their application, rarely will be in dispute. Section 229 should offer no help to homeowners with squirrel damage or medical expense insureds seeking insurance funding for experimental treatments because we recognize that the purpose and effect of denying those claims is to shield the insurer and the pool from roughly the same costs unsuccessful claimants thereby will be forced to bear.

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rules governing contract remedies accommodate ex post regret); Eisenberg, *supra* note 93 (tying “second look” to cognitive limitations that prevent full presentation); Gergen, *supra* note 142, at 46 (denying tension between concerns for freedom of contract and ex post doctrines of impracticability, mistake, penalties, forfeiture, and good faith, which operate in a “twilight zone of contract where terms malfunction because of the unexpected”).

However, when assumptions of complete presentation are relaxed so that there is genuine uncertainty about the contours of the agreement of the parties, the concern about the ex post perspective is not that it may produce decisions that trump earlier choices, but that the first serious look at the question will come after a low-probability contingency has occurred and a particular victim has been identified. For example, when the question is what frontier medical treatments are or should be covered by medical expense insurance—a question that may be posed by vague policy language about medical necessity—“disputes are most appropriately viewed as an insurance–purchasing decision by a pool of subscribers, not a medical treatment decision made by an individual patient.” MARK HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 70 (1997). *See generally id.* at 68–73; Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1464–65 (1994). PETER W. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES 192 (1988), makes the point this way:

[S]table insurance requires unemotional assessment of risk and disbursement of payments, with the temperament of an actuary and a bookkeeper, treating people as statistics. The driving force in liability law today is sympathy and emotion in the individual case. Legal rules rooted in a spirit of compulsion, and applied emotionally case by case, are profoundly inimical to insurance.

*Id.* But see Don Welch, *Ruling with the Heart: Emotion-Based Public Policy*, 6 S. CAL. INTERDIS. L.J. 55 (1997) (decrying the general aversion to affective, emotion-based arguments): “Heeding one’s emotions can, in general, be a good guide to remaining in harmony with the fundamental commitments that result from one’s considered judgment.” *Id.* at 85.

But when the argument from costs is applied to a loss adjustment condition, a warranty, or an evidentiary condition, it may appear to frame a choice between two quite different ways of understanding the purpose(s) of the provision. Thus, to contend that we should not excuse failure of a notice condition even when the failure did not prejudice the insurer's efforts to adjust the individual claim because to do so will increase the cost of insurance is to challenge the assumption that the purpose of a notice provision is to protect the insurer from increased juridical costs caused by late notice. The implicit assertion is that insurers also employ unnuanced notice conditions in order to be able to deny payments to insureds whose notice is late even if the insurer's claims-adjusting efforts and other juridical costs were not affected by the delay, and that insureds should be taken to have consented to this allocation of risks in order to secure less costly coverage. In this interpretation, insurers (and insureds) expect a number of successful defenses based upon failures of condition—some prejudicial and some not prejudicial—and to deny them the savings that result from those defenses will drive up claims costs and prices, to the detriment of all but the unfortunate few caught in the snare set by the conjunction of express policy conditions with the strict common law rule.

Faced with a choice between interpreting a notice condition as designed to protect the insurer from adverse effects on its claims adjustment efforts, or as designed also to create a reverse lottery in which savings on juridical costs and occasional disproportionate forfeitures fund small premium reductions for the many, both Cardozo and the *Restatement* counsel choosing the interpretation that reduces the risk of disproportionate forfeitures.<sup>283</sup> And that too seems exactly right. Acknowledging that a forfeiture may redound to the benefit of the other, more fortunate, members of the pool does not make that forfeiture any more or less disproportionate; if compliance with a notice condition saves the insurer (or the pool) \$500, and noncompliance costs the insured \$100,000, the disproportion of the forfeiture is the same whether the windfall is pocketed by the insurer's shareholders or its policyholders.

The reality is that the argument from costs, if framed in the usual way as a speculation about the choices prospective insureds might make if presented

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283. See RESTATEMENT (SECOND) OF CONTRACTS § 227 (1972). See also ROBERT E. SCOTT & DOUGLAS L. LESLIE, CONTRACT LAW AND THEORY 606 (2d ed. 1993) ("Since viewed from the lens of a typical transaction, the express condition appears unusual, it is treated with suspicion. A metaphor such as how 'the law abhors a forfeiture' is simply a reflection of the presumption that ordinary people do not expressly condition their obligations.").

with a complete menu of appropriately priced policy conditions, cannot tell us which interpretation should prevail.<sup>284</sup> Perhaps a representative insured, if squarely presented with the choice, might opt to save a few dollars in premium costs by authorizing the insurer to deny payment if notice is late without regard to the effects of that tardiness on the insurer. But, then again, perhaps she would not. True, we all know individuals who leave their insured homes to drive to the convenience store in their insured automobiles in order to buy a lottery ticket, but the apparent incongruity of this juxtaposition of risk-avoiding and risk-seeking behaviors is less than it may appear.<sup>285</sup> When insureds arrive at the convenience store, they bet a few dollars, not the house or the car.

Not everything has a price, after all, and security perhaps least of all. My complaint that there are few good restaurants in Lincoln scarcely is met by the rejoinder that at least they're cheap, and my discovery that the dark things in my scone are not raisins is unlikely to be more pleasant because I am told that rat droppings are free and that lax sanitation keeps the price of bakery products low. So too with insurance policies. Do we really think that a

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284. For particularly accessible introductions to why, see Gillette, *supra* note 109, at 542 (explaining why "the area of remote risks . . . is not a fruitful area for application of majoritarian default rules"); Jeffrey L. Harrison, *Trends and Traces: A Preliminary Evaluation of Economic Analysis in Contract Law*, 1988 ANN. SURV. AM. L. 73, 100-04 (demonstrating "practical indeterminacy" of efforts to derive efficient default rules); Jeffrey L. Harrison, *The Chicago School and the Development of a Comprehensive Legal Theory: A Comment on Professor Crespi*, 22 LAW & SOC. INQUIRY 185, 187 (1997) (rehearsing reasons conventional economic thinking cannot illuminate preferences regarding "qualitative differences among contracts").

285. Edward J. McCaffery, *Why People Play Lotteries and Why it Matters*, 1994 WIS. L. REV. 71 (discussing efforts to square participation in lotteries with usual assumptions concerning consumer choice under uncertainty): "A general teaching of [the literature of cognitive biases] is that, due to the reflection effect, individuals are risk averse as to gains but risk preferring as to loss. This finding . . . would have individuals failing both to take fair gambles and to insure against likely losses." *Id.* at 78. In fact, of course, individuals routinely do both. McCaffery's resolution "has people rationally playing lotteries to get what lotteries rather efficiently, easily and uniquely offer: a shot at instant wealth." *Id.* at 93. In short, "people may have a 'compartmentalized' view of their life and finances, with different utility functions for different spheres of activity. In particular, individuals might consider their periodic lottery play as a certain type of savings, while pursuing more risk averse activities in other areas." *Id.* at 122. For an historical treatment of the tension between gambling and insurance, see Baker, *supra* note 255, at 257-59.

policy provision declaring that one in every one thousand meritorious fire insurance claims will be randomly denied, with savings in premium costs for everyone, would be embraced by the hypothetical fully-informed rationally-maximizing insureds of the simpler economic models? Or, for that matter, that the hypothetical fully-informed rationally-maximizing insurer would choose to reduce premiums enough to induce those insureds to retain a forfeiture risk more cheaply diversified by the insurer?<sup>286</sup> And if we are not confident that the answer is “yes,” then why should we impute to real-world insureds an intent to use a strict notice condition unconcerned with how the tardiness affected the insurer?

Section 229 and its subterranean analogs throughout contracts and insurance law are confirmation that we need not, and should not, no matter what the strict common law rule may purport to say about it. By making the interpretive inquiry focus on the purpose(s) of the insurer in employing the condition, and counting those purposes as served to the extent the insurer escapes costs that would have been avoided had the condition been satisfied,<sup>287</sup> they free us from fruitless speculations about what faceless

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286. Eisenberg, *supra* note 93, at 240, makes the obvious point:

It might be argued that even if one party, A, would be reluctant to agree to a condition if he fully understood that he would face draconian sanctions for insignificant variations from perfect fulfillment, the other party, B, would insist on those sanctions. That is possible, but unlikely. If both parties fully understand the operation of the condition, then the price B pays for A's performance will be higher than it otherwise would be, to reflect A's additional risks. Given perfect knowledge by both parties, B would probably prefer to pay less, without the power to impose draconian sanctions for imperfect fulfillment of the condition, than to pay more with that power.

287. In the words of the *Restatement*, the task is to identify the “risk from which [the insurer] sought to be protected and the degree to which that protection will be lost if the non-occurrence of the condition is excused to the extent required to prevent forfeiture.” RESTATEMENT (SECOND) OF CONTRACTS § 229 cmt. b (1981). But room for disagreement about the exact nature of that risk does not mean that the parties left a gap to be filled by speculation about what arrangements fully rational bargainers would prefer. See Burton & Andersen, *supra* note 270, at 865 (urging contextual interpretive efforts rather than immediate recourse to supplemental gap fillers). If we remember that the task is to ascribe purposes to policy language chosen by the



insureds might choose or expect, and remind us that we need not accept as axiomatic the assumption that each additional condition in an insurance policy makes the coverage, and thus the price, less by assigning to the insured only those costs thereby deflected away from the insurer (and the pool). Most do, but some do not. When our understanding of the purpose(s) of a condition tells us that an insurer is using noncompliance with a condition to impose on the insured costs that are disproportionate to the costs that the insurer would have avoided had there been compliance, nonoccurrence of the condition should be excused to the extent necessary to prevent disproportionate forfeiture.

### III. APPLICATION OF THE MODEL TO CLAIMS-MADE LIABILITY FORMATS

Enough! It is time to return at least briefly to deepest claims-made land, there to test our new tools against two of the thorniest problems in the claims-made thicket: the “forfeiture risk” created by “claims-made-and-reported” and “potential-claims-discovered-and-reported” triggers, and the “classification risk” created by triggers that fall so late in the tort liability sequence that the insurer knows of the potential claim before any policy has been triggered. As we have seen, when lawyers first ventured into these precincts, they came ill-equipped to locate the notice-prejudice rule within contract law’s larger agenda of policing against opportunism or to debate whether it should be applied to failures of reporting conditions in claims-made policies. On a return trip, might a lawyer with section 229 in his kitbag be able to see distinctions where before none appeared? Would appreciation that most insurance policy conditions are narrowly tailored to allocate commensurate risks between insurer and insured but that others pose the potential for disproportionate forfeitures prove adequate to the task of identifying which failures of condition might on appropriate facts be excused? Or does the simple classificatory method sketched above falter when asked to do duty beyond tame hypotheticals involving excepted causes,

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insurer, we will find it easier to take the insurer at its word and to use the costs avoided by satisfaction of the condition as the baseline against which to measure the cost of noncompliance to the insurer. The insurer has said that it is content to pay if the notice is on time, the house doesn’t remain too long vacant, or the theft is evidenced by visible external marks. By focusing on why the insurer is content to pay under those circumstances, we have a baseline against which to measure the effects of what actually did happen.

loss adjustment conditions, continuing warranties, and evidentiary conditions?

Section 229 invites us to ask questions the neo-classical tradition keeps carefully submerged. Why did the insurer make the provision creating the condition a part of the insurance contract? What insurer purposes(s) does it serve? What costs does compliance with the condition permit the insurer to avoid? Or—the same question—how, exactly, does occurrence of the condition make the policy cheaper?

The conventional explanation for why claims-made policies are less expensive than occurrence policies is that claims-made formats reduce insurers' costs by shielding insurers from some of the uncertainties and expenses associated with intramural disputes about which insurers are to be tagged with responsibility for coverage obligations under difficult-to-apply "occurrence" triggers, and by reducing the need for loadings to compensate insurers for subjecting themselves to the uncertainties associated with longer-tailed occurrence policies. Of course, those explanations, though accurate, are not complete. A fuller answer also would acknowledge that new claims-made policies should be significantly cheaper than occurrence policies because retro dates and "other insurance" clauses mean that claims-made policies take a number of years to mature; in medical malpractice insurance, for example,

Claims-made policies are lower in cost in the first few years of coverage because the insurer's risk exposure is lower. Claims resulting from medical services rendered during the first year of coverage will likely not be asserted against the physician during that year. The cost of the premium increases, thereafter, on a yearly basis, as the insured's cumulative exposure to claims increases. The yearly increases in premiums are referred to as "steps" and represent the insurer's increasing liability exposure as the physician's period of exposure also increases. . . . The increases in cost level off when the physician reaches a "mature" level, after approximately 5 years of claims-made coverage. After the mature level has been reached, the costs of claims-made and occurrence premiums are generally comparable.<sup>288</sup>

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288. Johnson, *supra* note 27, at 1571. See also KEETON & WIDISS, *supra* note 9, § 5.10(d)(1) & (3), at 594–96, 598–01 (emphasizing that lower costs of claims–

And, to be truly complete, an explanation for why claims-made policies generally are cheaper also should recognize the contributions of multiple-event triggers and triggers that operate late in the tort liability sequence: in theory, an insurer who anticipates that multiple-event triggers will permit successful failure of condition defenses in some instances even though the denial of compensation to the insured exceeds the costs of noncompliance to the insurer can reflect the expected windfalls worked by those forfeitures in its premium calculations, and an insurer who expects to be able to use renewal underwriting to avoid some idiosyncratic risks after they have become known can be paid a reduced premium to reflect that assignment of classification risk to the insured.

*A. Ameliorating the Forfeiture Risk in Claims-Made Policy Formats?*

But, of course, section 229 does not ask why claims-made policies in the aggregate are cheaper than occurrence policies, or why a particular claims-made format is cheaper than would be an occurrence policy with otherwise identical coverage provisions, or even how a particular condition in a claims-made policy makes that policy cheaper than it otherwise could be. Section 229 is concerned with when a particular instance of noncompliance with a particular condition might be excused, and thus asks us to explore the extent to which that particular instance of noncompliance added to the insurer's costs. A simple analogy may help with this critical distinction. Just as in misrepresentation litigation we may acknowledge that the insurer's question to the applicant clearly is a material part of the insurer's underwriting efforts but nonetheless conclude that the applicant's misrepresentation was not materially false, so in excuse litigation under section 229 we may concede that each policy condition contributes to controlling insurer costs but nonetheless be interested in the extent to which a particular failure of condition did or did not impose upon the insurer costs the condition was intended to avoid.

Sometimes application of the section 229 template to failure of a condition in a claims-made policy will appear easy. If an insured against whom a claim was made on January 2, 1997 tries to argue that the insurer whose pure claims-made policy lapsed at midnight the preceding December

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made coverage in first years are due in large part to the immaturity of the experience).

"Much of the impetus for development of 'claims made' coverage was an interest in deferring a 'crisis' over costs of malpractice coverage. Predictably, 'claims made' coverage temporarily deferred, but did not resolve, the 'crisis' over costs." *Id.* at 598.

31 nonetheless should be obligated to provide coverage for the claim because a January 2 claim is no more costly than a December 30 claim,

#### **Case 1: Failure to Satisfy Single Event Trigger**

**1996 – INSURER A**

**CONDITION: Claim Made in 96**

**FACTS: Claim Made in 97**

we will have no difficulty concluding that the failure of condition should not be excused under section 229. Why? Because we understand the policy provision to be a definition of the insured event that shields the insurer from the same costs that it thereby imposes on the insured: it protects the insurer from responsibility for costs of claims made before and after the policy period by leaving a commensurate responsibility—costs of claims made before and after the policy period—with the insured. Such a condition cannot work a disproportionate forfeiture. So too with any single event—negligence, exposure, injury, manifestation, discovery of something by someone, claim by someone against someone, report of something by someone to someone—a policy might establish as a trigger for coverage. There is nothing for section 229 to do with single-event triggers for the same reason there is nothing for section 229 to do with a rodent exception: in each case, we ascribe to the provision the purpose of protecting the insurer from the very costs that the provision allocates to the insured.

What if an insured under a policy with a “reported potential claim” trigger makes a timely report to the insurer of an injury to a third party caused by the insured’s negligence, but fails to satisfy the policy condition requiring that the report include the “name and address of any witness?” Is that the kind of nonoccurrence of a condition that might be excused under section 229? Indeed it is. But why? We would not be prepared to excuse failure to report a potential claim during the policy period no matter how minimal the delay. Why should we contemplate excusing failure to make the report in the prescribed fashion? The answer must be that we understand the report of a potential claim to be a single-event trigger of coverage that necessarily

#### **Case 2: Failure to Satisfy Loss Adjustment Condition**

**1996 – INSURER A**

**CONDITIONS:**

**Report in 96 of Potential Claim  
Witnesses fully identified**

**FACTS:**

**Report in 96 of Potential Claim  
Witnesses not fully identified**

allocates to the insured costs commensurate with the protections it provides the insurer, but we understand the purpose of the requirement that witnesses be identified to be to cabin the juridical hazards associated with adjusting the claim. Because the insurer's legitimate interest in controlling that juridical hazard is expressed in a policy condition that puts the insured's entire coverage at risk, and because the costs that failure of condition may impose on the insurer can range from zero to well in excess of the value of the insured's claim, we recognize that failure of the condition could in some scenarios work a disproportionate forfeiture. Thus, the section 229 inquiry should proceed as it does with any loss adjustment condition.

But why, we might wonder, do we understand the single-event trigger in Case 2 to be "report of potential claim" rather than "report-of-potential-claim-including-names-and-addresses-of-witnesses?" Why cannot the complementarity of burden avoided and burden retained that we assume for single-event triggers insulate the failure to comply with the fuller description of what the report should include? The answer is implicit in section 229's functional focus on the additional protections each additional condition provides the insurer, but the English language is slippery, and the term "condition" is one of most difficult to keep in hand. When we ask what additional protections "the condition" affords the insurer, our focus should not be on the policy provision but rather on the circumstance or action that the policy provision insists must occur if the insurer is to have a duty to perform. Section 229 does not contemplate excuse of nonoccurrence of a policy provision; it contemplates excuse of nonoccurrence of a state of affairs identified by a policy provision as a condition. To accept the argument that the state of affairs that did not happen in Case 2 was "report-of-potential-claim-including-names-and-addresses-of-witnesses" would be to exalt form over function. We are not likely to allow a homeowner's insurer to convert notice requirements currently subject to the notice-prejudice rule into immune triggers of coverage by defining the triggering event in that occurrence policy as "physical injury to person or property . . . of which notice to the insurer is given in timely fashion." And we should not think that a claims-made insurer can through creative drafting make identification of the witnesses an indivisible part of a "report of circumstances" trigger of coverage.

Of course, this threshold question of how to identify the "condition" nonoccurrence of which might or might not be excused is not free from difficulty. Even if we conclude that a single event—for example, a "claim" made by the victim against the insured, or a "report of potential claim" by the

insured to the insurer—is the relevant trigger, we must still determine whether the essential constituent elements of that event in fact occurred. When does a billing dispute with a client ripen into a “claim” against the insured? Will identification of a potential claim in a renewal application satisfy the “report of potential claim” condition in the current policy? Will a blanket notification to the insurer that some of the financial institution’s employees made improper loans be enough to satisfy that condition? If we conclude that a communication from insured to insurer can be a “report of potential claim” even though it does not identify every witness with particularity, but that it cannot be a “report of potential claim” unless it is in a form that differentiates it from the paper generated by normal renewal underwriting and unless it identifies a particular incident with some particularity, we are ascribing a purpose to the “report of potential claim” provision and declaring that the purpose has been satisfied in the first instance but not in the second and third. Of course, both the identification of purpose, and the determination of whether that purpose was satisfied in the particular case, may be hotly contested. But once we determine that identification of a particular incident is a necessary constituent element of a “report of potential claim,” we entail the conclusion that failure to identify a particular incident is a failure of condition that is not subject to excuse.

Multiple-event triggers add another level of complexity to the process of ascribing purposes to policy provisions. What if an insured with a “claims-made-and-reported” policy for 1996 is the subject of a claim during the 1996 policy year, but does not report

the claim to the insurer until 1997? Should we regard the tardy report as the kind of nonoccurrence of condition that might be excused under section 229? Or should we treat it as part of an indivisible “claims-made-and-reported” definition of the insured event both parts of which must be satisfied in 1996 if the insurer is to be liable? Or might there be other alternatives?

Here, for the first time, we confront directly the special problems posed by multiple-event triggers of coverage. By itself, a claims-made trigger involves no overbreadth and poses no potential for disproportionate forfeitures. By itself, a reporting trigger involves no overbreadth and poses no potential for disproportionate forfeitures. But linked together in a

### Case 3: Claims-Made-and Reported Trigger

1996 – INSURER A	
CONDITIONS:	Claim in 96 Report in 96
FACTS:	Claim in 96 Report in 97

multiple-event “claims-made-and-reported” trigger, they may pose the potential for the sort of disproportionate forfeiture that we normally associate with warranties, loss adjustment conditions, and evidentiary conditions. Why is that?

The explanation is implicit in section 229’s focus on identifying the *additional* protections each new condition affords the insurer. With single-event triggers, we necessarily start from a baseline of zero. Because we cannot imagine an insurance policy without a trigger of coverage to tell us whether or not a particular policy is applicable to a particular insurance story, we have no difficulty ascribing to any single-event trigger the insurer may choose to employ the function of protecting the insurer from the very costs that the provision thereby assigns to the insured.<sup>289</sup> But with a multiple-event “claims-made-and-reported” trigger like that in Case 3, an insured might argue, we do not start with a baseline of zero. By making it a condition of the coverage that the insured be the subject of a claim during the policy year, the policy insulates the insurer from responsibility for costs of claims not made within the policy period, and does so by assigning those costs to the insured. What *additional* protections, section 229 tells us to ask, does the insurer get by insisting that the report also be made within the policy period?

As we have seen, insurers and the courts are ready with an answer—the insurer cannot be truly free from the “incurred but not reported” (IBNR) exposure that is said to have prompted the move to claims-made formats unless its coverage obligations are limited to claims that have been reported to the insurer by the end of the policy period. Changing from an occurrence trigger to a single-event, claims-made trigger frees the insurer from some but not all of the IBNR problem: requiring that the claim first be made during the policy period shields the insurer from the portion of the IBNR exposure

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289. So long as the trigger is conceptualized as a single event, it can—at least in the philosophical systems in which most of us work—be an event which occurs in one and only one policy period. Cf. Fischer, *supra* note 11, at 676 (“[A] claim is either made or it is not.”). If the “report of potential claim” was not made in 1996 because there was not sufficient detail for us to treat it as a “report of potential claim,” then it can still be made in the future when there is sufficient detail. But if the trigger is conceptualized as involving two different events—for example, a claim first made against the insured and a report of that claim by the insured to the insurer—then the first logically can fall in one and only one period and the second in one and only one period. By the terms of such dual-event triggers, if both events fall in the same policy period, that policy is triggered; if they fall in different policy periods, neither policy is triggered.

attributable to claims incurred but not made (IBNM) by the end of the policy year, but it leaves the insurer to bear the remainder of the IBNR exposure—claims made but not reported (MBNR) by the end of the policy year. Thus, the purpose for requiring report of the claim within the policy year is to free the insurer from the MBNR as well, and the reporting condition trigger accomplishes that by assigning the MBNR to the insured. And so, the argument would go, refusing to excuse a failure to satisfy the reporting condition cannot involve a disproportionate forfeiture.

But that is an explanation for why the insurer would choose to make a reporting condition the trigger of coverage, not an explanation for why an insurer would choose to employ a multiple-event trigger requiring both that the claim first be made against the insured during the policy period and that the claim be reported to the insurer during the policy period. If the insurer can be shielded from the entire IBNR exposure by a single-event reporting condition trigger that would allocate that IBNR exposure to the insured, isn't use of a multiple-event "claims-made-and-reported" trigger the same sort of failure to tailor means narrowly that we encountered with loss adjustment conditions, continuing warranties, and evidentiary conditions?

Indeed it is. Multiple-event triggers remind us of Kent and his flashlight, and one obvious possible response to the overbreadth of the "claims-made-and-reported" triggers would be to treat the claim as the trigger and to put the reporting condition on the section 229 scales. So long as challenges to late-report claims denials were framed as efforts to apply the "notice-prejudice rule" to reporting requirements in claims-made-and-reported formats, it was easy enough for courts to conclude that late reports must necessarily prejudice the insurer's pricing efforts. Section 229's requirement that the prejudice be proportionate to the amount of the insured's forfeiture would force us to confront the realities of claims-made pricing to determine how, exactly, a late report interferes with the insurers loss adjustment and pricing efforts, and under that standard insurers would be much less likely to prevail.

Still, recognizing that multiple-event triggers pose problems similar to those presented by loss adjustment conditions, warranties, and evidentiary conditions does not necessarily mean that section 229 should put courts in the business of weighing the extent of the harm to an insurer caused by late reports. There is another alternative. Rather than interpreting "claims-made-and-reported" formats as establishing the "claim" as the baseline trigger and then asking what additional protections the reporting condition trigger provides, might we instead interpret the "report" as the baseline trigger and



ask what additional protections the insurer gains by also insisting that the “claim” be made in the same policy period?

Consider Case 4. The facts are the same as those in Case 3, with one addition: the insured bought identical “claims-made-and-reported” coverage from the same insurer in both 1996 and 1997. For a lawyer with only the

**Case 4: “Claims-Made-and-Reported” Triggers; Same Insurer**

1996 – INSURER A		1997 – INSURER A	
CONDITIONS:	Claim in 96 Report in 96	CONDITIONS:	Claim in 97 Report in 97
FACTS:		Claim in 96; Report in 97	

“notice-prejudice rule” to bring to bear on behalf of the insured, nothing has changed. Success still depends on convincing the court that the claim triggered the 1996 policy and that the late report did not prejudice the insurer. But section 229 opens up another alternative. Why, it invites us to wonder, should we automatically assume that a “claims-made-and-reported” insured who satisfies the “claim” condition of the 1996 policy and the “report” condition of the 1997 policy will be seeking to excuse the reporting condition of the first policy in order to trigger its coverages? Might not an insured take seriously the rhetoric that declares that “the essence of claims-made policies is a report to the insurer” and seek to invoke coverage under the second policy on the grounds that the failure to have a claim in that policy year should be excused? Why not conclude that in a claims-made-and-reported format the report is the trigger and that the failure to have a claim during the policy period is the condition non-occurrence of which might be excused?

This way of interpreting “claims-made-and-reported” formats—by ascribing to the reporting condition the function of identifying the essential trigger of coverage—is not as strange as it first might appear. Insurer insistence that the report is “essential” has always seemed elusive. Understood as an assertion that insurers cannot run a claims-made insurance program without making report of a claim during the policy period a condition of coverage, it is clearly nonsense; many claims-made policies do not require that the report be made during the policy year. Understood as an assertion that a late report necessarily prejudices the insurer because it interferes with the insurer’s pricing efforts, it is clearly suspect both because it is difficult to credit the contention that a single late report can much affect

the insurer's pricing<sup>290</sup> and because it provides no way to distinguish the prejudice a late report causes a claims-made-and-reported insurer from the prejudice late reports cause other insurers—both “occurrence” and “claims-made”—that do not insist that the report be made during the policy period. But understood as an assertion that we should interpret a claims-made-and-reported policy as making the report the trigger of coverage, it makes sense. We can concede the insurers' premise that the move to claims-made formats was prompted by a desire to reduce the insurers' IBNR exposure, and grant also that the exposure cannot totally be eliminated if a policy can be triggered before the claim has been reported, but still point out that multiple-event triggers are an unnecessarily unnuanced way to accomplish that goal. Faced with a choice of interpreting a claims-made-and-reported policy as making the claim, or the report, or both, the trigger, we should follow Cardozo and section 229 and choose the interpretation that minimizes the chances for forfeitures without denying the insurer the essential protections we believe the language was intended to provide. And that, it might appear, could mean treating the report as the condition which must happen within the policy period if a “claims-made-and-reported” policy is to be triggered, thus putting courts in the business of weighing the harm to the insurer caused by the fact that the claim was early!<sup>291</sup>

The possibility that the “report” could be regarded as the baseline trigger of coverage would appear to fit dual-event “potential-claim-discovered-and-reported” formats at least as well. The promiscuity with which courts

#### **Case 5: “Potential-Claim-Discovered-and-Reported” Trigger**

1996 – INSURER A	1997 – INSURER A
<b>CONDITIONS:</b> Discovery in 96 Report in 96	<b>CONDITIONS:</b> Discovery in 97 Report in 97
<b>FACTS:</b> Discovery in 96; Report in 97	

290. *See generally* notes 22, 81–82, and accompanying text.

291. If the insured is in its first year with the claims-made-and-reported insured, it might seem obvious that the failure of the claim to occur during the policy year should not be subject to excuse. Any other result would open the insurer to adverse selection. But, of course, the inquiry into the impact on the insurer of a failure of the “claim” condition would require examination of the other underwriting and risk control mechanisms being employed by the insurer, and if those mechanisms include a retro date, the objection could lose much of its force. *See generally infra* cases 7–10.

and commentators use “discovery” and “claims-made” and “reporting” as labels for all manner of claims-made formats might lead the incautious to flirt with the idea of treating “discovery” of circumstances that might ripen into a future claim as the trigger for coverage and subjecting failure to report that discovery to the section 229 calculus, but that interpretation would deny the insurer almost all of the advantage of the move to “claims-made” triggers. Here, at least, the industry rhetoric complaining that application of the notice-prejudice rule to reporting conditions in claims-made formats would convert claims-made coverage into occurrence coverage is closer to the mark. Excusing the failure to make a report in a potential-claim-discovered policy would have the effect of making the trigger—discovery of a potential claim—something very much like the trigger in an occurrence policy applicable to professional negligence. Might we instead treat the report as the essential trigger and contemplate on some circumstances excusing the fact that the discovery of the claim did not occur in the policy year?<sup>292</sup>

Of course, these speculations do not mean that we would be compelled to indulge the suggestion that a report is essential to the functioning of every claims-made format. Many claims-made policies contemplate that some claims that ultimately will be associated with a particular policy period will not be reported during the policy period. Some require only that notice of a claim be given “as soon as practicable,” others that the notice be given within 60 days of the claim, still others that the notice be given as soon as practicable but in no event more than 60 days after the end of the policy period. For such formats, there seems to be no reason not to take the insurer at its word. The policy does not try to achieve complete elimination of the

**Case 6: Failure to Satisfy Non-Trigger Notice Provision**

1996 – INSURER A	1997 – INSURER B
<b>CONDITIONS:</b> Claim in 96 Notice “as soon as practicable”	<b>CONDITIONS:</b> Claim in 97 Notice “as soon as practicable”
<b>FACTS:</b> Claim in 96; Notice Tardy and in 97	

292. Policies with alternative “claims-made-and-reported” and “potential-claims-discovered-and-reported” triggers appear to pose no new challenges. Either the claim or the report of claim should be treated as the single-event trigger for the first prong, and either the discovery of potential claim or the report of potential claim the single-event trigger for the second prong. Of course, the window for insurer opportunism is smaller when a claims-made-and-reported trigger is joined by an alternative “potential-claim-discovered-and-reported” trigger.

IBNR exposure from the insurer's portfolio. The policy says that a claim first made within the policy year is the single-event trigger. In such policies, the provision requiring a "report" or "notice" of the claim to the insurer should be understood to function just as it does in occurrence formats: it provides the insurer with protections for both its claims-adjustment and its pricing efforts. And under both occurrence and claims-made policies in which the claim in the trigger of coverage, section 229 authorizes an inquiry into whether in the particular case the loss of those protections due to the tardiness of the notice is enough to keep the forfeiture from being disproportionate.

Thus, when the policy is a pure "claims-made" policy, we should regard the claim as the trigger that is necessarily immune from excuse arguments. When confronted with a dual "claims-made-and-reported" policy, we should treat either the claim or the report, but not both, as the immune trigger; when faced with a dual "potential-claim-discovered-and-reported" policy, we should treat either the discovery, or the report, but not both as the immune trigger. But how should we regard "retro date" provisions? What if a "pure"

#### **Case 7: Pure Claims-Made Trigger with Retro Date**

<b>1996 – INSURER A</b>	
<b>CONDITIONS:</b>	Negligence after 1/1/96 Claim in 96
<b>FACTS:</b>	Negligence in 95 Claim in 96

claims-made policy promising that the insurer will respond to a claim made against the insured during calendar year 1996 also makes it a condition of the insurer's obligation that the negligence precipitating the claim have taken place after January 1, 1996? Do our concerns about multiple-event triggers mean that section 229 should be available to an insured wanting to argue that it is not significantly more difficult to adjust a 1996 claim based on 1995 negligence than to adjust a 1996 claim precipitated by 1996 negligence? She should not, for the retro date shields the insurer from costs—of claims precipitated by pre-1996 negligence—that are commensurate to the costs—of claims precipitated by pre-1996 negligence—thereby assigned to the insured, just as the claims-made condition in the same policy allocates commensurate costs away from the insurer to the insured. The combination of a retro date with another trigger does not involve the overbreadth encountered in claims-made-and-reported and potential-claim-discovered-and-reported policies because we ascribe different and independent timing purposes to the retro

date and to the single-event trigger. With claims-made-and-reported and potential-claim-discovered-and-reported formats, one of the multiple-event triggers appeared to be redundant. But a retro date cannot guarantee the insurer freedom from claims first made after 1996, and the claims-made condition cannot guarantee the insurer freedom from negligence occurring before 1996, and thus in Case 7 we are not presented with that sort of timing redundancy.

The distinction is easier to see if we assume that the same insurer renews the policy for calendar 1997, with the retro date remaining January 1, 1996.

**Case 8: Pure Claims-Made Trigger with Retro Date Fixed at Inception of Relationship**

1996 – INSURER A	1997 – INSURER A
CONDITIONS: Neg after 1/1/96 Claim in 96	CONDITIONS: Neg after 1/1/96 Claim in 97
FACTS: Neg in 96; Claim in 97	

The retro date condition continues to allocate consequences of pre-1996 negligence away from the insurer and to the insured, and the claims-made condition allocates the costs of pre-1997 and post-1997 claims away from the insurer and to the insured. Consequently, each should be classified as immune from section 229 scrutiny.

What is more, this conclusion does not change if we assume that the insured moves to a new insurer in calendar 1997 and that the new insurer employs a January 1, 1997, retro date. The purpose of the retro date provision in Insurer B's policy is to shield the insurer from liability for claims

**Case 9: Pure Claims-Made Trigger with Retro Date; Different Insurers**

1996 – INSURER A	1997 – INSURER B
CONDITIONS: Neg after 1/1/96 Claim in 96	CONDITIONS: Neg after 1/1/97 Claim in 97
FACTS: Negligence in 96; Claim in 97	

arising out of negligence prior to the inception of its relationship with the insured, and that is precisely the risk that thereby is assigned to the insured. True, the insured now faces a potential gap in coverage because claims after January 1, 1997, precipitated by negligence before 1997 will not be covered by any policy, but that is not a problem to which section 229 can respond.

The forfeiture which the insured will suffer is not disproportionate to the protections the provisions provide the insurer.

But what if we imagine that the insured does not change insurers, but at renewal the insurer nonetheless “advances the retro date” in the 1997 policy to January 1, 1997? In form, the provision operates as did retro dates in the preceding three hypotheticals. But in context we may be tempted to regard the insurer’s reasons for employing this retro date condition quite differently. In Case 7, Insurer A established the retro date at the inception of the relationship; in Case 8, Insurer A kept the retro date at the inception of the relationship even in its renewal policy; in Case 9, Insurer B established a new retro date at the inception of its relationship with the insured. In each of those cases the insurer plausibly could contend that the purpose of the retro date provision was to protect the insurer against adverse selection; in those cases we have no difficulty understanding the use of the retro date provision to be an unexceptional exercise of the insurer’s underwriting discretion to choose with whom and on what terms it will do business.

**Case 10: Pure Claims-made Trigger with Retro Date Advanced; Same Insurer**

1996 – INSURER A	1997 – INSURER A
<b>CONDITIONS:</b> Neg after 1/1/96 Claim in 96	<b>CONDITIONS:</b> Neg after 1/1/97 Claim in 97
<b>FACTS:</b> Negligence in 96; Claim in 97	

With Case 10, however, that explanation will not do. In 1996, the insurer was willing to assume the risk of claims made and reported in 1996 based on negligence in 1996; in 1997, it is willing to assume the risk of claims made and reported in 1997, but not if they are based on negligence during 1996. Why not? Would it affect our understanding of the situation to be told that the insurer advanced the retro date for the individual insured because it had learned of negligence by the insured in 1996 that had not yet triggered any policy? And if so, in which direction does that bit of context cut? Is there a difference between employing a retro date in order to avoid adverse selection at the beginning of what may become a multi-year relationship and employing a retro date in order to avoid known risks at the beginning of a renewal policy? Would it be more or less troubling to learn that the insurer was not reacting to known circumstances but merely advancing the retro date for all renewal insureds in order to keep its claims-made exposures

immature? Clearly, there is something about an insurer advancing the retro date that nags, and it should not surprise us to learn that the practice is one against which regulators inveigh.<sup>293</sup> But that does not mean the retro date provision is overly-broad. The insured's problem is not one for which section 229 provides an answer.<sup>294</sup>

What do these ten cases tell us about section 229 and the sensibilities it seeks to express? Three things in particular seem worth emphasizing. First,

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293. *See, e.g.*, ARK. CODE § 23-79-306 (g) (1987):

(1) A retroactive date may only be advanced with the written consent of the first named insured and upon one (1) or more of the following conditions:

- (A) If there is a change in insurer other than another insurer within the same insurer holding company or group;
- (B) If there is a substantial change in the insured's operations which would have been a material factor in the insurer's acceptance or declination of the risk; or
- (C) At the request of the first-named insured.

(2) Prior to the advancement of the retroactive date under subdivisions (1)(A), (B), or (C) of this subsection, the insured must receive a disclosure form for his signature which acknowledges that he has been advised of his right to purchase an extended reporting period endorsement.

In New York, the minimum standards for claims-made policies include the following: "A retroactive date may not be changed during the term of the claims-made relationship and any new extended reporting period." Regulation No. 121, N.Y. COMP. CODES R. & REGS. tit. 11, § 73.3 (b) (1993). Such formal regulatory restrictions remain relatively rare.

294. This treatment of retro dates might suggest that we should revisit the suggestion that the "claim" condition in a "claim-made-and-reported" or a "discovery" condition in a "potential-claim-discovered-and-reported" policy might be subject to excuse arguments under § 227. On facts like those in Case 7, Insurer B plausibly might contend that the requirement that the claim first be made after the inception of the policy year should be ascribed a function it lacks in a renewal policy: it operates as a *de facto* retro date protecting the insurer from claims made prior to the inception of the relationship and allocating responsibility for those claims to the insured. Thus, the argument might go, it deserves to be treated as immune from excuse arguments for the same reason that retro dates fixed at the outset of the relationship deserve to be treated as immune.

the process of ascribing purposes is not easy. Exploding the positivist conceit that we can determine the meaning of a policy provision without regard to its consequences helps make the project more tractable; so too does shifting the focus away from vestigial will-theory fictions that pretend to be searching for a joint intent and away from the overcompensations of insurance law's fatal fascination with the "objective reasonable expectations" of the insured. But even cast as a problem of ascribing purposes to the insurer, the project will not be easy. Context matters. Even if we are asking the correct question, ascribing appropriate purposes will require many return trips to different parts of the claims-made thicket.

The second thing these cases tell us is that classifying policy provisions as vulnerable to section 229 oversight or as immune from such review is only the first step. Even if we have correctly isolated the purpose(s) that should be ascribed to the particular policy condition, we still must determine to what extent those purpose(s) have been satisfied. In this first survey of claims-made conditions we have not attempted to confront those questions directly, but we have seen enough of the complexity that waits once we move beyond hothouse hypotheticals to warn us that section 229's authorization to courts to engage in a fine-tuning of the burden avoided and burdened assumed may well be beyond what we reasonably can ask lawyers and courts to do. If the issue is not whether the insurer was prejudiced, but how much it was prejudiced, the inquiry will be much more difficult and the allocation of burdens of proof and persuasion will be much more important. Australia currently is trying to apply a statutory rheostat that requires courts to calibrate with precision the harm done to an insurer by a failure of condition,<sup>295</sup> and the early experience there suggests that other alternatives to the strict common law rule that do not require such fine-tuning should be explored.<sup>296</sup> But details of how the standard should be framed can be worked out through experience if we keep our eye on the point of the exercise: ameliorating forfeitures that are not necessary to protect the insurer from the costs it sought to avoid.

The third and most significant reason that section 229 may seem to come up short as a way of dealing with the problems posed by claims-made formats is that section 229 is an attempt to deal with only one specific manifestation—overbreadth—of the larger problem of how to determine the

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295. See authority cited *supra* note 201.

296. I explore the Australian experience in Bob Works, *Excuse of Failure of Insurance Conditions Turned Upside Down: The View from Down Under* (forthcoming).



mix of contractual and regulatory institutions best suited to police the potential for insurer opportunism created by the combination of bounded rationality and transaction-specific investments. Section 229 insists that discretion created by unnuanced insurance policy conditions should be exercised only to guarantee to the insurer the protections the provision was inserted to provide, and should not be employed to create windfalls for the insurer even if those windfalls ultimately redound to the benefit of policyholders. But that “forfeiture risk”—though it has dominated this essay—is only one part of the larger problem of how to police the potential for opportunism that goes with bounded rationality and sunk investments. As these last examples make clear, pushing coverage triggers later into the tort liability insurance sequence makes it more likely that an insurer will be able to employ its underwriting discretion—through cancellation of an existing contract, refusal to renew at the end of the term, or renewal with advanced retro dates, laser exclusions, or dramatic price effects—after the insurer knows a particular insured is likely to be subject to a claim but before any policy has been triggered. The problem posed by late triggers is not a problem of overbreadth; the uncertainties that claims-made insurers avoid by pushing the trigger for coverage later into the tort liability claim sequence are commensurate with the uncertainties thereby assigned to insureds. But late triggers nonetheless are a concern because they can be used to subject individual insureds, perhaps unnecessarily, to classification risk.

*B. Ameliorating the Classification Risk in Claims-Made Policy Formats?*

What do we mean by “classification risk?” When insurance is written for a specific term, the choice of whether to trade a premium for a transfer of risk can be revisited by both parties at the end of each policy period. If things have changed since the last underwriting review, then the price/coverage relationship also is likely to change. What sort of things may have changed? Some involve the expected value of the loss: what might change is the probability of loss, or the potential amount of loss, or the insurer’s faith in its ability to make appropriate predictions about those risk factors. But other factors that may influence the insurer’s willingness to assume the risk transfer have nothing to do with changes in the perceived riskiness of prospective insureds; rather the insurer may be more or less willing to write a renewal contract due to different capacity constraints, changes in its agency force, different projected overhead costs, better or worse investment returns, or alterations in its business philosophies. By keeping the term of the insurance contract short, the insurer limits its exposure to the risk of changes; by

lengthening the term, or—the same thing—by providing some guarantee of renewability, the insurer increases its share of the risk of changes. Risk of change not assumed by the insurer stays with insureds.

The market offers several different models of how parties to insurance contracts can assign the risk that circumstances will change during the term.<sup>297</sup> At one end of the spectrum are the fixed term policies that predominate in most of the property-casualty industry. The insurer assumes the risk of changes in the desirability of the exchange during that term, but limits its exposure to that risk by keeping the term short. At the other end of the spectrum is the “perpetual policy”; in exchange for a single pre-paid premium, the insurer undertakes to insure the property for so long as the insured desires.<sup>298</sup> Between these two extremes fall a variety of “guaranteed

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297. For a sophisticated effort to model the possibilities, see Mark V. Pauly, Howard Kunreuther & Richard Hirth, *Guaranteed Renewability in Insurance*, 10 J. RISK & UNCERTAINTY 143 (1995). See also Kevin D. Cotter & Gail A. Jensen, *Choice of Purchasing Arrangements in Insurance Markets*, 2 J. RISK & UNCERTAINTY 405 (1989):

‘Most health insurance, as well as a substantial portion of life and disability insurance, is purchased on a risk-pooling basis. [statistics] . . . Virtually all group contracts pool risks, in which all members of the group have identical premiums and benefits regardless of their loss experience or risk factors. Individually purchased life insurance is usually either whole-life, renewable term, or extended-period term, all of which guarantee coverage over an extended period with no change in premium other than for age. . . . This contrasts with the purchase of automobile, personal property, and personal liability insurance. Contracts in these lines are typically short-term (one year or less), renewal is rarely guaranteed, and premiums are based on loss experience.

Other studies of multi-period contracting in the presence of classification risk include Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. EC. REV. 941 (1963); Thomas R. Palfrey & Chester S. Spatt, *Repeated Insurance Contracts and Learning*, 16 RAND J. EC. 356 (1985); Mark Pauly, *The Welfare Economics of Community Rating*, 37 J. RISK & INS. 407 (1970).

298. The Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, the nation’s oldest property insurance company (1752), still offers homeowners perpetual policies, paid off with single deposit, with full premium refunded when policy is canceled. Terrence Samuel & Duane Winner, *Historic*

renewable” contracts that provide a pre-commitment from the insurer, but with no enforceable obligation for the insured to renew.<sup>299</sup>

Simple enough. The complication lies in this question: when we say that a policy provision limiting coverage to a particular term protects the insurer from some of the risk of changes, do we mean that it assigns that risk to the pool of insureds, or to the individual insured? Some hazards are correlated for all members of the insured pool; others are not. Some contributors to adverse changes in an insured’s risk profile will affect all members of the insured pool: inflation, new technologies, new environmental exposures, epidemics. Some will be idiosyncratic to an individual insured: although there has been no change in the likelihood that members of the insured pool will develop multiple sclerosis, and no increase in the costs of treating multiple sclerosis, this insured did develop multiple sclerosis. Every insured for a term assumes the risk that correlated risk factors may change before the end of the term, making the pool of risks less desirable in future terms. The “classification risk” is the additional risk that idiosyncratic, uncorrelated risk

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*Insurance Company Makes Another Historic Move*, PHIL. INQ., Aug. 12, 1996, at C2, col. 3.

299. See Cotter & Jensen, *supra* note 297 (explaining why long-term pooling contracts are possible in health, life, and disability insurance but difficult to sustain in property and liability insurance):

One possible reason for these differences in purchasing arrangements is that the classification risk of future uncertain changes in one’s risk type provides an incentive for long-term risk pooling contracts. . . . Such contracts are feasible, however, only when the loss probabilities increase with age. When loss probabilities decrease with age, it is generally not possible to write a long-term pooling contract that discourages older individuals with a favorable loss history from leaving the contract in lieu of coverage on more favorable terms. Consequently, sequential short-term pooling contracts arise as a second-best arrangement when neither group nor individual long-term pooling contracts are feasible. Property and liability insurance do not involve loss probabilities related to age, but a lack of classification risk in these lines of insurance decreases the incentive for long-term arrangements.

*Id.* at 406. As we shall see, when liability policies do involve classification risk the same imperatives apply.

factors may change for an individual insured before the end of the term, thus adversely affecting the individual insured's desirability for the next term when compared to the rest of the pool.

How do claims-made formats allocate the classification risk? In the academic models that grace the finance literature, the answer is clear: the risk of idiosyncratic changes in an insured's desirability continues to be diversified across the pool of insureds.<sup>300</sup> Of course, this answer is driven by the assumptions of the model. Working from the initial premise that the insurer's role in traditional commercial insurance arrangements stems from its comparative advantage in dealing with uncorrelated risks, the finance literature explains claims-made formats as an effort to decompose risk into two categories—correlated risk, which cannot be diversified in an insurance pool and which therefore should not be transferred to the insurer, and uncorrelated idiosyncratic risk, for which the magic of the law of large numbers still operates. Needless to say, such models do not confront the possibility that reporting requirements, renewal applications, laser exclusions, or mobile retro date provisions may be used to force the individual insured to bear the costs of idiosyncratic risks that have ripened into known preexisting circumstances before any policy has been triggered. By assuming that all claims are paid when made, that all claims-made policies automatically are renewed, and that retrospective rating makes the pool of insureds bear its own costs, such models take the insurer out of the risk assumption business almost entirely, and collapse almost completely any distinction between a reciprocal mutual pooling arrangement administered by an insurer and claims-made policy formats marketed by a commercial insurer.<sup>301</sup> In such a world, the

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300. See, e.g., Doherty, *supra* note 8; Luc Grillet, *Corporate Insurance and Corporate Stakeholders: Limits of Insurability and Public Policy*, 11 J. INS. REG. 291 (1993); Anne E. Kleffner & Neil A. Doherty, *Costly Risk Bearing and the Supply of Catastrophic Insurance*, 63 J. RISK & INS. 657 (1996).

301. As Grillet summarizes:

The movement from constant to random premium contracts can be illustrated with Doherty's framework. In essence, the insurance market employs constant premium contracts if risks are easily diversifiable, or in other words, if the risk-pooling properties of the Law of Large Numbers hold. If a segment of the insurance market is plagued by substantial event and/or information correlation, risk-spreading for these undiversifiable risks will be achieved through random premium or risk-sharing contracts. . . . The insurer will offer random premium contracts, which in the extreme case means

costs of both correlated and uncorrelated risks are borne by the insured pool. In such a world, it makes sense to say that “the claims-made form represents a preferred form of contracting under conditions of non independence between insurable risks.”<sup>302</sup>

Of course, within the orthodox intellectual traditions of insurance law, a different answer is equally clear: the classification risk is borne by the individual insured. In insurance, as elsewhere, freedom of contract finds its “first and most important application . . . in the right to choose one’s trading partners,”<sup>303</sup> and unless the insurer has promised to renew regardless of changes in the desirability of the insured, it matters not whether that underwriting discretion is manifested as an initial refusal to deal, as a refusal to renew, or as a renewal that carves known potential claims out of the renewal coverage. Because an insurer can choose to reject the application of a new prospective insured, it can choose to limit the coverage it does write on a new applicant by a laser exclusion of idiosyncratic circumstances known to the insurer or by a retro date that excludes later claims based on circumstances known to the insured at the inception of the contract. As Judge Posner correctly notes:

Like the exclusion of a known preexisting condition from a health insurance policy, the exclusion from a claims-only policy of claims based on conduct that occurred before the

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that he base[d] the premium [charge] to the policyholder on the information available *after* the loss has been realized. This enables him to remove the event and information correlation from his portfolio. . . . The policyholder still achieves partial risk-shifting. Why? The policyholder shares his loss with the losses of the other pool members. He can insure his idiosyncratic risk, because his retroactively calculated premium is not based on his individual loss but on his individual share in the realized collective loss of the insurance pool.

Grillet, *supra* note 300, at 310. Professor Doherty makes the same point: “The intention is not to nullify the effects of insurance against the policyholder’s idiosyncratic risk, but to remove insurer risk. Thus the retroactive correction to the individual’s premium is not based on his or her individual loss but on the collective loss in the pool.” Doherty, *supra* note 8, at 232.

302. *Id.* at 243.

303. RICHARD EPSTEIN, ANTIDISCRIMINATION IN HEALTH CARE: COMMUNITY RATINGS AND PREEXISTING CONDITIONS 1 (1996).

policy was issued and that was known to have claim potential is uncontroversially proper.<sup>304</sup>

But is it also “uncontroversially proper” for an insurer that was providing claims-made coverage when the conduct took place and became known—to the insured, to the insurer, or to both<sup>305</sup>—to employ its renewal underwriting discretion to make certain that it will assume no responsibility for known circumstances under future policies? Within a spot-market paradigm that understands insurance contracts as short-term relations that must be formed, and then performed, after which they cease to exist, there is no reason to distinguish between Case 7, where the retro date protects the insurer from adverse selection at the inception of its relationship with the insured, and Case 10, where the advanced retro date seeks to protect the insurer from potential claims based on conduct that occurred and became known while the same insurer was on the risk. So long as each insurance contract is seen as a simple transfer of risk for a term, the question will be whether the insurer agreed to assume any of the classification risk to which the insured otherwise would be subject. Posed that way, the answer usually will appear to be “no.”

Thus, in the still-dominant insurance law way of thinking, a ten-year history of renewals with the same insurer is just a history of ten different contracts, and preexisting conditions that became known before the first contract takes effect should be treated no differently than conditions that became known between the sixth and seventh renewal. However, a neo-institutional perspective sensitive to the vulnerabilities that go with relation-

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304. *Truck Ins. Exchange v. Ashland Oil, Inc.*, 951 F.2d 787, 791 (7th Cir. 1992) (citations omitted). Indeed, Judge Posner added, sounding a note we have heard before, there is “nothing exploitive about such limited coverage if the insurance premium were correspondingly small.” *Id.* at 790.

305. Insurers may underwrite against “preexisting conditions” directly on the basis of information known to insurer, or indirectly by expressly excluding claims based on information known to the insured at the time the policy was issued or by relying on the implicit “fortuity defense.” See generally Stephen A. Cozen & Richard C. Bennett, *Fortuity: The Unnamed Exclusion*, 20 FORUM 222 (1985) (summarizing recent developments including growing use of subjective standard focusing on knowledge of insured); Richard L. Fruehauf, *Note, The Cost of Knowledge: Making Sense of “Nonfortuity” Defenses in Environmental Liability Insurance Coverage Disputes*, 84 VA. L. REV. 107 (1998) (contending that “nonfortuity” arguments add little to existing policy and misrepresentation and concealment defenses, but that actual knowledge of legal liability variant of “nonfortuity” arguments may function as per se concealment defense).

specific investments might see a distinction between Case 7 and Case 10. Claims-made contracts conceived, not as a simple transfer of risk from an insured to an insurer, but as a reciprocal undertaking by members of an insured pool with the commercial insurer functioning as their agent for administering the pool, might carry quite a different set of implications about whether the costs of idiosyncratic risk that becomes known after the inception of the relationship is to be shared among members of the pool or whether instead it is to be visited upon the individual insured in order to reduce costs to the pool.

Of course, the reality necessarily is more complex than either the reciprocal pooling arrangements of the financial models or the spot market exchanges between strangers with no common history and no common future that so dominate conventional insurance law thinking. Claims-made policies can not effect a complete mutualization of correlated and uncorrelated risks without the very strong assumptions of the financial models; the commercial claims-made insurer has a stake in the claims costs of the pool of insureds, and those claims costs can be affected by preventing known potential sources of claims from being admitted or readmitted to pool. Moreover, Judge Posner's analogy to medical expense insurance is double-edged, and not just because federal COBRA<sup>306</sup> and HIPAA<sup>307</sup> legislation and their state complements now trump the common law assumption that refusal to insure known medical expense risks "is uncontroversially proper" even for individuals who have managed to gain initial access to an insured pool.<sup>308</sup> Some claims-made insureds will find unrestricted renewal coverage at the pool price even after their idiosyncratic sources of potential claims have become known, just as in group medical expense insurance before COBRA and HIPAA, because the classification risk has been mutualized by their membership in a community-rated pool. But others will not, and the later trigger of claims-made formats means that a greater number of insureds

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306. 29 U.S.C. §§ 1161–1168 (Supp. 1995).

307. The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936 (1996).

308. For insureds who have once gained admission to medical expense insurance through an employee group plan, COBRA guarantees continuing coverage from that group plan for a period after the loss of eligibility; HIPAA allows qualifying members of a group health plan to apply credit earned by participation in their old group plan against waiting periods and preexisting condition limitations if they move to a new group or individual plan. *See generally* JOSEPH A. SNOE, AMERICAN HEALTH CARE DELIVERY SYSTEMS 80–123 (1998).

under liability policies will be exposed to the application of renewal underwriting discretion after their idiosyncratic risk potential has become known, just as the later trigger of medical expense insurance imposes a greater exposure to the classification risk on medical expense insureds not sheltered by a community-rated pool or ameliorating federal legislation.

A few examples may help to highlight how the classification risk imposed by claims-made formats can differ from the classification risk borne by insureds covered by policies with more traditional triggers. When my daughter turns sixteen and begins driving, we expect that the increase in risk will be reflected in an increase in the price charged for the family's auto coverage. We have no reason to be offended by such efforts at risk classification; in a competitive insurance market, classification of exposures on the basis of perceived contributions to the expected losses of the pool is necessary for rate equity and to prevent the insured pool from unraveling. But expected loss is a prediction about the average loss of the pool of risks being combined. Actual losses of individual members of the pool still are largely a function of chance. When my daughter backs the family car into the neighbors' recreational vehicle, we may worry that her negligence may be a precursor to further price hikes or even a refusal by the insurer to provide further coverage, but we do not worry about whether the damage to the recreational vehicle will be covered. The occurrence trigger of the auto policy guarantees that the policy will have been triggered before anyone has any opportunity to know that she has distinguished herself from the majority of insureds who will not be making a claim. The classification risk to which we are subject includes the risk that my daughter may signal to the insurer that she is a poorer risk than the ordinary sixteen-year-old driver, and that the new information may be used by the insurer in its renewal underwriting, but it does not include the risk that damage she causes while insured will not be covered. Or, to put the matter yet another way, at the end of a policy period we expect that insurer concerns about any "known risks" may be reflected in price or underwriting effects, but we expect any "known losses" already will have triggered a policy.

In the abstract, and with simple examples, the assumption that the classification risk borne by an individual insured includes "known risk"—the chance that during the policy term the insured will discover idiosyncratic risk factors that so far have not triggered any policy and that legitimately may affect an insurer's willingness to accept a future risk transfer—but not "known losses"—events that simultaneously trigger any policy then in effect and make the loss no longer insurable because no longer "fortuitous"—can



seem obvious and uncontroversial. A fire loss in 1996 triggers a 1996 property insurance policy insuring against the perils of fire; when renewal time arrives, the 1996 fire is relevant to the 1997 renewal decision only to the extent that it supports inferences about potential losses that could trigger the 1997 policy. And messier facts need not destroy that fundamental complementarity. Thus, no one would doubt that a fire started by New Year's Eve revelers that destroys part of the insured house before the midnight expiration of the 1996 policy, and the rest after the ball has dropped, will be treated as a fire that occurred in the 1996 policy period. Under the "loss-in-progress" rubric, efforts by the 1996 fire insurer to argue that its liability is limited to damage that occurred before midnight simply should fail; efforts to tag the 1997 fire insurer with responsibility for damage that occurred after midnight should be equally unavailing.<sup>309</sup> Indeed, we expect the same complementarity to prevail when occurrence triggers in liability policies must be applied to progressive personal injuries or property damage. As two recent authors capture the conventional understanding:

The fortuity principle and trigger analysis are distinctly different but complementary. When applied in the context of a continuous or cumulative personal injury or property damage case, these interrelated concepts provide that coverage would be triggered under the policy in effect when damage or injury first occurs (or becomes manifest). Liability for the CGL carrier on the risk at that time is contractually fixed, whether or not all resulting injury or damage has occurred during that policy period. Damage or injury caused by the same occurrence but materializing after

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309. See *Snapp v. State Farm Fire & Cas. Co.*, 24 Cal. Rptr. 44 (Cal. Ct. App. 1962) (if contingent event insured against occurred during policy period, insurer is liable for full loss even if extent of damage cannot be ascertained at end of policy period). Other contexts beget other rubrics. Thus, in accident and disability insurance settings, the "process of nature" rule is used to justify the conclusion that complications and intensification of injury that result from an accident should be treated as occurring on the watch of the insurer at the time of the accident even if they are experienced in later policy periods. See, e.g., *National Life & Acc. Ins. Co. v. Edwards*, 174 Cal. Rptr. 31 (Cal. App. 1981). See generally Fischer, *supra* note 11, at 627, 664–65, 677–86. Cf. James F. Hogg, *The Tale of a Tail*, 24 WM. MITCHELL L. REV. 515 (1998) (challenging argument that responsibility of occurrence insurer for progressive injury losses should be reduced if losses continue during years in which insured had untriggered claims-made coverage).

termination of the triggered policy is not insured under subsequent policies due to the loss-in-progress rule.<sup>310</sup>

Such examples, though useful, can obscure a fundamental point: the comforting complementarity on display in these familiar stories is dependent upon the policy triggers being employed. In these cases, the very event that triggers one policy is the event that renders the damage no longer fortuitous and thus not insurable under a subsequent policy. And, in these cases, the trigger usually is satisfied before the insurer gains knowledge of the idiosyncratic circumstances that distinguish this insured from other insureds and that might prompt a negative underwriting decision. But as another look at our exploded liability insurance claim sequence should remind us, a policy trigger set late in the tort liability insurance claims sequence sometimes will not be satisfied until after the loss has become certain or after the insurer has learned of an idiosyncratic risk factor that seems certain to produce a loss.

#### **Potential Stages in the Evolution of Liability Insurance Claims**

**allegedly tortious act or omission by insured**  
**exposure of potential victims**  
**injury in fact**  
**manifestation of victim's injury**  
**insured should have discovered circumstances that may give rise to a claim**  
**insured discovers circumstances that may give rise to a claim**  
**insured discovers specific acts or omissions that may give rise to a claim**  
**insured reports to insurer circumstances that may give rise to a claim**  
**insured reports to insurer specific acts that may give rise to a claim**  
**insured reports to insurer circumstances that may give rise to a claim**  
**claim for compensation by victim against insured**  
**insured reports claim to insurer**  
**victim files suit against insured**  
**investigation by insurer**  
**defense and reserving decisions by insurer**  
**negotiations between insured and victim**  
**judgment or settlement**  
**payment to victim**

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310. Harold M. Provizer & Noel F. Beck, *Making Sense of the Fortuity Doctrine*, FOR THE DEFENSE, February 1996, at 20, 25. See also Richard L. Antognini, *When Will My Troubles End? The Loss in Progress Defense in Progressive Loss Insurance Cases*, 25 LOY. L.A. L. Rev. 419 (1992).

What if an explosion during the term of a pure claims-made policy has leveled adjoining buildings and sent numerous victims to hospitals and morgues, but by the end of the policy period no claims have yet been filed? Can the claims-made insurer simply walk away at the end of the term? Or consider the situation of a lawyer continuously insured under pure claims-made policies issued by the same insurer from 1986 through 1996 who realizes in September, 1996, that he negligently missed a July 1, 1996, statute of limitations filing deadline. Had the lawyer been insured under old-fashioned professional liability formats once in vogue, the lawyer's negligence during the 1996 policy year would have triggered the 1996 policy and would be relevant to the 1997 renewal decision only to the extent that it supports inferences about the lawyer's riskiness in the future. But with a pure claims-made trigger, not only is the 1996 policy not triggered, but now the insured knows of the potential claim, and if the insured truthfully answers the questions on his renewal application, soon the insurer will know as well. In these cases the comforting complementarity usually worked by occurrence triggers is absent. Not only have the explosion and missed filing deadline failed to trigger any policies, but we may wonder whether renewal underwriting by insurers and the fortuity requirement will permit any subsequent policy to be triggered.

Well, might be the response, so what?<sup>311</sup> That is the nature of claims-made formats. They are cheaper because less risk is being transferred. Academic models and appellate opinions may emphasize that claims-made formats protect the insurer from the risk of correlated changes in liability rules, inflation, medical technology, and the like by assigning those risks to insureds. But another part of the risk being assigned to the insured is the risk that the renewal insurer will choose to exercise its underwriting discretion to keep known idiosyncratic risk factors—including “known losses” that have not triggered earlier policies—from becoming a burden to the insurer and ultimately to the pool of insureds. Policy triggers that operate at the same time or before losses become known do not create opportunities for insurers to underwrite in order to avoid a “known loss”; there the classification risk includes only the possibility that known risk factors will influence the

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311. See, e.g., Jaap Spier, *Long Tail (Liability) Risks and Claims Made Policies*, 23 GENEVA PAPERS ON RISK & INS. 152 (1998) (claims-made formats designed to shift risks to insureds). However, even in the course of a spirited defense of claims-made formats, Professor Spier acknowledges room for possible concern “in the case of ‘classical damage’, occurring just before the elapsing of the contract, if the damage would not be covered under any policy.” *Id.* at 166.

willingness of the renewal insurer to assume responsibility for future losses, but it does not include the possibility that the insurer will choose to duck responsibility for losses that have already become inevitable. With policy triggers that operate later in the sequence, the insurer's discretion is not so obviously limited, and in the conventional understanding there is no reason to think that the claims-made insurer is obligated to react any differently to knowledge of explosion-caused death and destruction or a missed statute of limitations deadline than it does to knowledge that a factory lacks a sprinkler system or that a lawyer has new clients in the savings and loan industry or no longer maintains a formal docket control system. Once a policy term ends with the policy still untriggered, both idiosyncratic "known risks" and idiosyncratic "known losses" that might trigger a subsequent policy will be factors to be considered when a renewal insurer makes underwriting and pricing decisions for subsequent terms. In the orthodox understanding, that is part of the classification risk to which the claims-made insured is subject, just as it is part of the classification risk to which some medical expense insureds still are exposed.<sup>312</sup>

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312. As we have seen, in the positive analysis of institutional economics, one of the chief determinants of long-term contractual commitments is the presence of relation-specific investments; long-term commitments may be necessary to induce a party to make the relation-specific investment that creates the vulnerability to hold-ups at the end of short-term contract. *See generally* WILLIAMSON, *supra* note 95, at 71-84. Applied to insurance, that means that we should expect fully-informed, fully-rational insureds to react to the vulnerabilities to classification risk that go with late-operating triggers by demanding that insurers make long-term commitments or allow the trigger to be pulled earlier in the tort liability sequence. And sometimes insureds do react in that way. The practice literature addressed to insurance-buying professionals routinely suggests that the only real protection against classification risk is to establish long-term relations with an insurer. *See, e.g.,* Thomas A. Konopka, *The Advantage of Claims-Made Forms for Insurance Buyers*, RISK MANAGEMENT REPORTS, July/Aug., 1991, at 11, 16 (chief protection against classification risk is "selecting a carrier with a demonstrable commitment to meeting the insured's long-term-liability protection needs"). Consequently, there is significant resistance to claims-made formats and, when occurrence policies are not available, insistence that nominally "claims-made" formats include extended reporting periods, "circumstances discovered and reported" triggers, and guarantees that retro dates not be advanced. But such protections are far from universal, they provide only limited protections against opportunism at renewal, and they constitute a fundamental retreat from the implications of pure "claims-made" and "claims-made-and-reported" triggers.

But is it really so obvious that the classification risk to which insureds are exposed by late triggers must include not only "known risks" but also "known losses?" Imagine the polar example of a late trigger, a "claims-paid" policy trigger providing that the insurer's obligation to pay will not be triggered until a claim against the insured actually had been paid—and the insurer, as under most mainstream liability insurance policies, asserts a right to control the defense. How would we react to a policy trigger that cannot be satisfied unless the insurer permits it to be satisfied? The choice will seem familiar to those whose memories of first-year contracts include Cardozo and Lady Duff-Gordon:<sup>313</sup> either we say the insurer's control of the timing of the

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However, the institutional implications of the claims-made insured's vulnerability to classification risk may be even more fundamental. As Brent Clark has noted: "as loss situations become known, claims-made insurance has a tendency to 'evaporate' as it becomes increasingly difficult to transfer the risk of a known loss to an insurer. Thus, the purchase of claims-made insurance may create the illusion of risk transfer that could involve firms in extremely damaging situations later on." Brent M. Clark, *The Broad Implications of Claims-Made Insurance*, RISK MANAGEMENT REPORTS, Vol. XIII, No. 4, at 9, 23 (1986). Recognition of this reality means that, for some corporate buyers, what is nominally liability insurance becomes a mechanism by which the individual insured employs claims-made coverage with paid-loss retrospective rating to smooth the impact of at least some of the losses that it ultimately will bear itself. "Thus, the broad implication of claims-made insurance may be a decreasing reliance on commercial insurance to finance risk." *Id.* at 31.

Doubtless concern about these vulnerabilities has been one important contributor to the proliferation in recent decades of a variety of captives, reciprocals, risk retention groups, and other forms of mutual organization distinguished from commercial liability insurance enterprises by the fact that "[r]isk is pooled amongst those who are commonly exposed rather than transferred to external risk bearers." Neil A. Doherty & Georges Dionne, *Insurance with Undiversifiable Risk: Contract Structure and Organizational Form of Insurance Firms*, 6 J. RISK & UNCERTAINTY 187, 188 (1993) (mutual organizational forms and claims-made policies modeled as giving policyholders stake in the residual value of the insurer; thus are alternative responses to correlated uncertainties about liability insurance payouts). *See also* John M. Marshall, *Insurance Theory: Reserves versus Mutuality*, 12 ECON. INQ. 476 (1974) (reserve principle appropriate where law of large numbers can provide acceptable predictability; mutualization where it cannot). The same point has been applied to the recent history of liability insurance by Doherty, *supra* note 300, at 239–240; Grillet, *supra* note 300, at 308–311.

313. *Wood v. Lucy, Lady Duff-Gordon*, 118 N.E. 214, 214 (N.Y. 1917):

triggering event makes the putative risk transfer illusory, or we say the risk transfer is not illusory because the insurer's discretion is "instinct with an obligation" to make its decisions in good faith<sup>314</sup>—and then we worry about what the flexible standard of good faith might be made to mean in this setting.

In fact, we are unlikely to encounter such a brazen effort to preserve underwriting discretion until after both the fact and the magnitude of a loss have been determined. But we will encounter many instances in which the liability insurer gains knowledge of irremediable idiosyncratic circumstances before a policy has been triggered, and not only when the format is some variation of "claims-made." Occurrence triggers too can operate after a known loss.<sup>315</sup> Thus, for example, recognition of the vulnerability that goes with late triggers was an important factor in judicial rejection of "manifestation" as the sole trigger of coverage for claims involving asbestosis and other "progressive loss" claims. As the opinion in *Keene Corp. v. Insurance Company of North America*<sup>316</sup> explained:

To demonstrate why the policies require that both exposure and manifestation trigger coverage, we begin by positing a rule in which manifestation is the *sole* trigger of coverage. If that interpretation were adopted, . . . [the insured] Keene would not be covered for diseases manifesting themselves

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The law has outgrown its primitive stage of formalism when the precise word was the sovereign talisman, and every slip was fatal . . . A promise may be lacking, and yet the whole writing may be 'instinct with an obligation,' imperfectly expressed. . . We are not to suppose that one party was to be placed at the mercy of the other.

314. See Robert A. Hillman, "*Instinct with an Obligation*" and the "*Normative Ambiguity of Rhetorical Power*," 56 OHIO ST. L.J. 775 (1995).

315. See generally Geert Schoorens & Caroline Van Schoubroeck, *Insuring the Uninsurable? The Appeal of the Circumstances Clause*, 23 GENEVA PAPERS ON RISK & INS. 169 (1998) (urging use of circumstances-reported triggers to avoid classification risk posed by both occurrence and claims-made formats); Gerhard Wagner, *Comments on the Appeal of the Circumstances Clause and the Uninsurability of Long Tail Risks*, 23 GENEVA PAPERS ON RISK & INS. 178 (1998) (questioning costs of such an approach).

316. 667 F.2d 1034 (D.C. Cir. 1981). See also *Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc.*, 633 F.2d 1212, 1230 (6th Cir. 1980) (Merritt, J., dissenting).

after 1976. By that time it was widely known that prolonged inhalation of asbestos has a high probability of causing disease. From about then on, insurance companies ceased issuing policies that adequately cover asbestos-related disease. Yet we can still expect thousands of cases of those diseases to manifest themselves throughout the rest of the century. If we were to hold that only the manifestation of disease can trigger coverage, the insurance companies would have to bear only a fraction of Keene's total liability for asbestos-related diseases.<sup>317</sup>

In *Keene* and other "triple trigger" and "continuous trigger" decisions, the courts are able to avoid leaving insureds to bear the costs of known exposures that have not yet triggered a policy by saying that what would be a preexisting condition for a renewal policy with a manifestation trigger—the known exposure—also is enough to trigger the earlier policy. Of course, other interpretive moves sometimes may accomplish the same result. For example, in *Chemstar, Inc. v. Liberty Mutual Insurance Co.*,<sup>318</sup> faced with twenty-eight different product liability claims for damage to twenty-eight different properties over a four-year period based on plaster pitting that manifested itself in different policy periods, the court rejected the continuous trigger interpretation but still was able to "protect the insured's access to insurance" by holding that coverage was triggered for all claims when the problem first manifested itself in the first claimant's house.<sup>319</sup> In such decisions, the

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317. *Keene Corp.*, 667 F.2d at 1045–46.

318. 797 F. Supp. 1541 (C.D. Cal. 1992), *aff'd*, 41 F.3d 429 (9<sup>th</sup> Cir. 1994).

319. *Id.* at 1552. As the court explained:

[U]nlike the continuous injury trigger, the manifestation trigger avoids a conflict with the loss-in-progress rule. The loss-in-progress rule is based on the principle that insurance is designed to protect against contingent or unknown risks of harm, rather than harm that is certain or expected. Accordingly, the loss-in-progress rule precludes coverage for losses that were known before the policy period, even if the damage progresses during the policy period.

The loss-in-progress rule and the manifestation trigger complement one another and protect the insured's access to insurance: To use the current case as an example, even after

vulnerability to renewal underwriting that would result from a trigger that might not be satisfied until after an injurious process has become known is a powerful argument for interpreting the occurrence trigger as satisfied by events that fall early in the sequence.<sup>320</sup> Indeed, in *Montrose Chemical Corp.*

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plaster-pitting manifested in the first home, subsequent insurers would be willing to issue policies to Chemstar because they could rely on the loss-in-progress rule to preclude coverage for progressive plaster-pitting. By contrast, the continuous injury trigger risks exposing the insured to gaps in coverage: Once plaster-pitting manifests in the first home, a potential insurer that is aware of the heightened risk of further plaster-pitting in other homes would be unwilling to issue policies to Chemstar because the insurer would be held liable for plaster-pitting that occurs during its policy period.

*Id.* at 550–51 (citations omitted).

320. *See, e.g., Keene Corp. v. Ins. Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981).

This conclusion is consistent with the law involving insurance coverage of losses that begin during a period of coverage but continue to develop after a policy's expiration. For example, *Snapp v. State Farm Fire & Casualty Co.*, 206 Cal. App. 2d 827, 24 Cal. Rptr. 44 (1962), . . . stated that "[t]o permit the insurer to terminate its liability while the fortuitous peril which materialized during the term of the policy was still active would not be in accord either with applicable precedents or with the common understanding of the nature and purpose of insurance."

These cases illustrate the principle that when it becomes known that an occurrence has set in motion a process that has a significant probability of resulting in a covered loss, the insurer on the risk at that time is liable for the full loss. It does not matter whether the insurer learns of a progressing loss through direct observation, as in *Snapp*, or through statistical inference, as in asbestos-injury cases. It is the use of that knowledge to shift a covered risk back to the insured that is not permitted.

*Id.* at 1046–47.



*v. Admiral Ins. Co.*,<sup>321</sup> in rejecting an interpretation of an occurrence policy that would have created just that vulnerability, the court seemed to make the preexisting condition problem the synecdoche for the distinction between occurrence and claims-made policies: "To read an occurrence policy to afford coverage only when the injury or damage becomes manifest during the policy period . . . unfairly transforms the more expensive occurrence policy into a cheaper claims made policy."<sup>322</sup>

With claims-made formats, such interpretive moves usually will not be available. Explosions and missed statutes of limitations are not "claims made" against the insured, and there is no point in trying to argue that they should be enough to trigger a "claims-made" or "claims-made-and-reported" policy in effect when they happened. But acknowledging that claims-made triggers subject insureds to discretionary renewal underwriting decisions, and that sometimes that discretion will be exercised after losses become both inevitable and known, need not mean that the exercise of that discretion must be unconstrained. Perhaps there is a middle ground between insurance law's traditional assumption that the insured bears the full burden of classification risk no matter how many policy renewals he's been through and the finance literature's assumption that the idiosyncratic portion of classification risk is fully mutualized in the pool. Might we take our lead

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321. 5 Cal. Rptr. 2d 358 (Cal. Ct. App. 1992). See also *Harford County v. Harford Mut. Ins. Co.*, 610 A.2d 286, 294 (Md. 1992) (quoting *Montrose* with approval).

322. *Montrose Chemical Corp. v. Admiral Ins. Co.*, 5 Cal. Rptr. 2d 358, 368 (Cal. Ct. App. 1992). The opinion of the Court of Appeals later was displaced by the opinion of the Supreme Court, but not without this confirmation of the characterization: "We agree with the conclusion of the Court of Appeal below that to apply a manifestation trigger of coverage to Admiral's occurrence-based CGL policies would be to effectively rewrite Admiral's contracts of insurance with Montrose, transforming the broader and more expensive occurrence-based CGL policy into a claims made policy." *Montrose Chemical Corp. v. Admiral Ins. Co.*, 913 P.2d 878 (Cal. 1995).

Note that the vulnerability to renewal underwriting after a loss has become inevitable can arise even with earlier occurrence triggers. For example, on the *Chemstar* facts it would be possible for the insured and the insurer to learn of potential for plaster-pitting even before some ultimate users were exposed; of course, in theory alternative measures—an aggressive recall campaign, for example—might still prevent the risk from coming to fruition with respect to those future end users. See also Fischer, *supra* note 13, at 675–76 (noting that breast implants pose similar potential).

from the assumptions of the finance literature and its less formal echoes in some appellate opinions and conclude that the purpose of even pure claims-made formats is to insulate the insurer from uncertainties about correlated risks, but to continue to allow idiosyncratic risks to be combined and diversified through the pool, and that therefore it is bad faith for an insurer to exercise its underwriting discretion to force the occasional individual insureds whose idiosyncratic circumstances become known before renewal to bear the full costs of their own misadventures? There are interesting potential parallels in the law and literature of employment law, where the obligation of good faith and fair dealing may on appropriate facts provide some protections against opportunistic efforts by employers to terminate employees at will,<sup>323</sup> and in the law of lender liability, where good faith may sometimes set limits on a lender's discretion to decide whether to renew a financing arrangement with a debtor.<sup>324</sup> In each of these arenas, judicial use of the good faith standard is more likely after sunk investments have rendered the other party vulnerable to opportunistic exercise of discretion granted or permitted by the contract. In the employment setting, the fundamental transformation comes

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323. See, e.g., Schwab, *supra* note 148 ("courts have been boldest" in protecting nominally at will employees where protection is most needed, i.e., at the beginning and end of employees' careers, where employees' investments in firm-specific skills trap workers in their present jobs and render them vulnerable to employer opportunism). See also WEILER, *supra* note 148, at 63-67; Kenneth G. Dau-Schmidt, *Employment Security: A Comparative Institutional Debate*, 74 TEX. L. REV. 1645 (1996). *Contra* Edward B. Rock & Michael L. Wachter, *The Enforceability of Norms and the Employment Relationship*, 144 U. PA. L. REV. 1913 (1996) (sunk investments and potential for opportunism prompt "internal labor markets" to develop informal practices and norms that provide just cause protections in fact even where legal rule is employment at will).

324. See, e.g., Gillette, *supra* note 109 (advocating thick contextual inquiries to determine whether a lender who refuses to renew is acting in good faith, while acknowledging difficulties of trying to determine whether a particular relationship is straight loan with both lender and borrower engaged in egoistic gambles about what the future may hold, or whether the lender has tied up the borrower's collateral so as to create a monopoly with respect to future extensions of credit). In lender liability litigation, the sunk investments may take the form of grants of security to a lending institution that effectively prevent the borrower from seeking secured loans elsewhere. See Gillette, *supra* note 109, at 565-74. See also Daniel R. Fischel, *The Economics of Lender Liability*, 99 YALE L.J. 131, 139 (1989) (lack of access to new lenders likely when lender has acquired costly information about borrower, and where the market cost of credit has risen).

in the form of relationship specific investments that cannot be transferred to other employers; in the lender liability setting, the fundamental transformation occurs when security arrangements effectively prevent the borrower from gaining access to other credit markets. Might we conclude that in claims-made insurance, the fundamental transformation occurs and thus the obligation to exercise renewal underwriting discretion in good faith arises when an idiosyncratic loss becomes inevitable during the term of a claims-made policy?

Still, analogies to the ways in which flexible standards of good faith can be used to police discretion in employment contracts and lending arrangements, though easily asserted, may prove too facile. Exercise of renewal underwriting discretion is not opportunism unless it offends the letter or spirit of the agreement, and the news that claims-made formats are sold subject to a tacit understanding that the insurer will not visit the costs of an irremediable idiosyncratic risk on an individual member of the pool when it could be diversified through the pool likely will come as a surprise to anyone accustomed to viewing insurance transactions as involving but two parties, the insurer and the insured, and insurance contracts as transfers of discrete risks for a term. But might we look to the models of claims-made contracting in the finance literature, not as part of an orthodox *ex ante* perspective asking if assumptions of those models somehow have become incorporated into the expectations of the parties to claims-made contracts, but instead as Schwab uses the assumptions of the life-cycle model of employment contracts<sup>325</sup> and Gillette employs alternative understandings of lending relationships,<sup>326</sup> as a guide to where the occasions for opportunism are most pronounced and where the expenditure of judicial resources in an effort to prevent bad faith is most likely to prove productive?

Of course, finding a doctrinal handle is not the only problem. Difficulties of application will prove daunting. We can opine with confidence that an insured should not be able to row through flood waters threatening his house in order to buy flood insurance for the first time,<sup>327</sup> and that an insurer that

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325. See Schwab, *supra* note 148, at 38–51 (arguing that courts intervene despite at-will presumption in portions of life-cycle when dangers of employer opportunism are high).

326. See Gillette, *supra* note 109, at 552–74 (discussing spectrum of commercial relationships).

327. “A homeowner could not insure his house against flood damage when the rising waters were already in his front yard.” *Bartholomew v. Appalachian Ins. Co.*, 655 F.2d 27, 29 (1st Cir. 1981). See *Summers v. Harris*, 573 F.2d 869 (5th Cir.

has written flood insurance should not be permitted to cancel or nonrenew when the flood waters begin lapping at the door.<sup>328</sup> But beyond such obvious examples, our efforts to find something in the relationship to tell us whether the insurer or the insured should bear a particular portion of the classification risk will be very difficult. Insurance opinions are full of unsatisfactory efforts to explain the line of demarcation between “known loss” and “known risk” when the issue is whether the risk has become so certain that it is no longer a fortuity. Can we expect any better when the issue is whether the loss has become so certain that it should be bad faith not to renew?

Perhaps not, but our understanding of both issues would be advanced by explicit recognition of the vulnerabilities worked by the “fundamental transformation.” Underwriting discretion that is unexceptionable when employed in a competitive setting, before the fundamental transformation has occurred, may be inappropriate when employed after the insured has been locked in by an irremediable change in circumstances. Thus, if I negligently leave a boulder perched on the precipice at the edge of my property, and the insurer learns of that idiosyncratic potential for causing damage to my neighbor in the valley below, I will have no reason to object if the insurer reacts by raising my rates, incorporating a laser exclusion of damage caused by rolling rocks, or refusing to insure me at all—either initially or at renewal. The rock is still but a potential cause of loss; I can still take other measures to eliminate or ameliorate the risk. But once the boulder begins to roll and damage to neighboring persons and property becomes inevitable, I am locked in and it should be too late for the insurer to price or to underwrite against that loss even if as yet no perambulators have been crushed and no lives ruined.<sup>329</sup>

That simple intuition can, on appropriate facts, survive the trip to the claims-made setting. If the factory already has exploded, it should be too late for even a claims-made liability insurer to walk away. In *Heen & Flint Associates v. Travelers Indemnity Co.*,<sup>330</sup> the court vindicated that instinct by

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1978) (“loss in progress” rule prevents coverage for damage by flood water that entered house during policy period; flood was continuation of flooding process “in progress” at policy inception).

328. Fire, not flood, was featured in the most-familiar aphorism: “Of what avail would it be, to take a policy against fire, to permit its cancellation when the fire is approaching.” *Home Insurance Co. v. Heck*, 65 Ill. 111, 114 (1872).

329. See generally Schoorens & Van Schoubroeck, *supra* note 315 (urging use of potential claims reported triggers to help ameliorate vulnerabilities of lock-in).

330. 400 N.Y.S.2d 994 (N.Y. S. Ct. 1977).

declaring the claims-made trigger unconscionable because it appeared to permit the insurer to refuse to renew for future years in order to avoid future claims certain to ensue.<sup>331</sup> In *Helfand v. National Union Fire Insurance Co.*,<sup>332</sup> faced with an attempt by National Union to cancel the third year of a claims-made policy when it learned that “that there were significant law suits pending against the directors and officers and more were expected to be filed,”<sup>333</sup> the court chose to attack the exercise of the discretion granted by the absolute cancellation clause rather than the substance of the clause itself. The traditional understanding that cancellation provisions in an insurance policy are not contrary to public policy and need not be exercised for cause did not mean that the insurer was free to cancel after knowledge of imminent legal action make it impossible for insureds to seek alternative coverage elsewhere in the market.

Liability carriers do not have an unfettered right to cancel coverage, notwithstanding mutual cancellation clauses to that effect. Cancellation provisions in an insurance contract are subject to the implied covenant of good faith and fair dealing just like any other clause.

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331. *Id.* at 998–99:

It is my determination that a provision in a “claims made” policy that permits an insurer, where it has notice of a potential claim, to refuse to renew that policy, is unconscionable. Such a provision allows an insurer to avoid the risk of serious potential claims arising from accidents committed within the policy period, and leaves the insured without coverage after the expiration of the policy, since no other insurer will be willing to accept the known risk and thus buy its way into a potential lawsuit.

I, therefore, limit the provision of the Travelers’ policy that requires a claim to be made against the insured during the policy period, to instances where continued coverage is available from the same or from some other insurer . . . .

332. 13 Cal. Rptr. 2d 295 (Cal. Ct. App. 1992), *cert. denied*, 510 U.S. 824 (1993).

333. *Id.* at 315–16.

An arbitrary cancellation is a breach of the covenant of good faith and fair dealing. "Where a contract confers on one party a discretionary power affecting the rights of the other, a duty is imposed to exercise that discretion in good faith and in accordance with fair dealing." To exercise that power arbitrarily and to the detriment of the other party is inconsistent with that party's justified expectations.<sup>334</sup>

Of course, within the inherited traditions of the private insurance enterprise, cancellation is one thing, nonrenewal quite another.<sup>335</sup> Should the obligation to exercise underwriting discretion in good faith apply there as well? "Yes," the Colorado Supreme Court recently held. In *Yasuzawa v. PHICO Insurance Co.*,<sup>336</sup> the insurer's argument "that it does not have a duty of good faith toward its insureds in the nonrenewal or negotiation context"<sup>337</sup> was flatly rejected.

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334. *Id.* at 315–17. The *Helfand* court invoked the old saw from *Home Ins. v. Heck*, 65 Ill. 111, 114 (1872) (quoted *supra* note 328). 13 Cal. Rptr 2d at 317. See also *Murphy v. Seed–Roberts Agency, Inc.*, 261 N.W.2d 198 (Mich. Ct. App. 1977) (bad faith to exercise cancellation clause in medical malpractice policy in order to offer reinstatement at much higher premium); *L'Orange v. Medical Protective Co.*, 394 F.2d 57 (6th Cir. 1968) (violation of public policy to cancel malpractice policy in effort to affect conduct of insured in pending malpractice suit). The scant authority and commentary is collected in Johnathan M. Purver, Annot., *Liability Insurer's Unconditional Right to Cancel Policy as Affected by Considerations of Public Policy*, 40 A.L.R.3d 1439 (1971). Of course, efforts to analogize to the understandings in other kinds of insurance can cut both ways; in medical expense insurance, for example, there is no similar practice of treating cancellation as impermissible once medical expenses become inevitable.

335. See, e.g., STATE OF NEW YORK INS. DEP'T, *THE PUBLIC INTEREST NOW IN PROPERTY AND LIABILITY INSURANCE REGULATION* 49 (1969) (elaborating reasons for traditional pattern of regulatory restrictions on cancellations but not nonrenewals); Robert Works, *Whatever's FAIR—Adequacy, Equity, and the Underwriting Prerogative in Property Insurance Markets*, 56 NEB. L. REV. 445, 487–90 (1977) (same). For an indication of just how firmly entrenched the prerogative not to renew has been, see Martin J. McMahon, Annot., *Insured's Right of Action for Arbitrary Nonrenewal of Policy, Where Insurer Has Option Not to Renew*, 37 A.L.R.4th 862 (1985).

336. 875 P.2d 1354 (Colo. 1993) (citations omitted), *rev'g* *Ballow v. PHICO Ins. Co.*, 841 P.2d 344 (Colo. Ct. App. 1992).

337. *Id.* at 1362.

As a general principle, we agree that an insurer may choose to nonrenew an insured for any reason. However, an insurer is required to act in good faith when carrying out its decision not to renew either a single insured or entire blocks of business. In this setting, we believe that good faith should be measured according to the legal standard used in the first-party context: unreasonable conduct and either knowledge or reckless disregard of the unreasonableness of the conduct.<sup>338</sup>

As the court's elaborate recitation of the facts made clear, the insurer's bad faith in PHICO lay in assuaging insureds' fears about the classification risk problem that is intrinsic to claims-made formats, then leaving them in the lurch with accumulated practice histories and no access to tail or replacement nose coverage. The concurring opinion thought the majority opinion should have taken even greater pains to tie the renewal obligation of good faith to the peculiar lock-in worked by claims-made formats: "[Claims-made coverage] makes the policyholder a virtual economic captive of the insurer. The unique nature of claims-made insurance gives rise to heightened duties during renewal negotiations because claims-made insurance contemplates a continuing relationship between the parties."<sup>339</sup>

That, ultimately, is the question. Should we continue to assume that each liability insurance arrangement can be modeled as a discrete purchase of a risk transfer for a term, and thus continue to sweep claims-made formats within the general rule that treats the distinction between cancellation and

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338. *Id.* at 1363 (citations omitted).

PHICO enticed the doctors to purchase claims-made coverage through promises of longevity and assurances that the terms and method of calculating the premium for a tail policy would be fixed. It then undermined these promises by unilaterally changing the terms of the tail policy to discourage renewal by the doctors, and without disclosing its plan to nonrenew them. Instead, PHICO continued to reassure doctors that it had no intention of leaving the state in the several months prior to its withdrawal from the Colorado market. Rather than dealing with the doctors in good faith once it decided not to renew them, PHICO concealed its intention and actively misled the doctors to their detriment.

*Id.*

339. *Id.* at 1372-73.

nonrenewal as inviolate?<sup>340</sup> Or should our appreciation of the fundamental transformation suggest a more complex and interdependent relationship?

### CONCLUSION

Within the neo-classical habits of thought still dominant in insurance law, “the coverage is less, but so, therefore, is the cost” is a conversation-stopper, reassurance that—even with bounded rationality and mass marketed standard insurance policy forms—the disciplines of competitive insurance markets still provide the best answers to most questions concerning the quantity, quality, and price of insurance products. As redeployed in this essay, however, it is but the beginning of a further conversation, a reminder of the vulnerability to opportunism worked by the fundamental transformation, and thus an invitation to ask how—exactly, as applied in the individual case—the policy provision makes the coverage less.

The still-unfamiliar ways in which claims-made insurance policy formats allocate “forfeiture risk” and “classification risk” are a useful place to begin these discussions. Recognition that competitive markets at the inception of insurance relationships cannot guarantee freedom from opportunism *ex post* will do much to remedy the inadequate descriptions of claims-made formats that first prompted this extended meditation, and will help to identify the practices that should attract special attention, but it does not entail any particular institutional response. Deciding what combination of contract terms, market developments, and legislative and judicial initiatives can best cabin exercise of the discretion claims-made formats confer will require many more forays into the claims-made thicket.

Of course, the habit of asking how, exactly, a policy condition makes the coverage less should prove helpful well beyond the problems posed by multiple-event and late-operating triggers in liability policies. The difficulties with claims-made formats, though real and relatively intransigent, in time will wane. Increased understanding of the claims-made forfeiture risk and classification risk will yield more circumstances-discovered-and-reported triggers, more long-term contracts, more mutualization, more careful compliance with conditions, and, where they do not, better bases for

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340. *See, e.g.,* *Gahres v. PHICO Ins. Co.*, 672 F. Supp. 249 (E.D. Va.1987); *Travelers Ins. Co. v. Leshner*, 231 Cal. Rptr. 791 (Cal. Ct. App. 1986)); *Coira v. Florida Medical Ass’n*, 429 So. 2d 23 (Fla. App. 1983); *Egnatz v. Medical Protective Co.*, 581 N.E.2d 438 (Ind. App. 1991); *Armstrong v. Safeco Ins. Co.*, 765 P.2d 276 (Wash. 1988).



assessing assertions that legislative or judicial amelioration is appropriate. But the broader issues will remain. A century ago proof-of-loss conditions in fire policies required a signature of the local magistrate, and lawyers and judges of the day wondered how to frame their resistance to the disproportionate forfeitures that would have resulted from blind enforcement of those conditions.<sup>341</sup> Today we wonder how we should respond to a reporting condition in medical malpractice policies that purports to require the names and addresses of all potential witnesses, and whether the notice-prejudice rule should apply to other post-loss failure of conditions<sup>342</sup> and beyond liability insurance.<sup>343</sup> A century ago, insurance law was wrestling with what to do with good health clauses and affirmative warranties that purported to shift classification risk to insureds;<sup>344</sup> today we worry about late-operating liability and medical expense insurance triggers; tomorrow classification risk concerns will surface in other settings.

The methodological uncertainty that has prevented insurance law from adequately acknowledging the challenges of claims-made policy formats is the same methodological uncertainty that for most of the twentieth century has left insurance law unsure of where to find its conceptual bearings. "What do they know of the law of insurance, who only the law of contracts know?"<sup>345</sup> was a good question when Professor Woodruff first posed it, and it is a good question now, but both the question and the responsory judicial mantra reassuring that "a contract of insurance is no different from any other contract" fudge a fundamental question. Is the contract law that insurance law is—or is not—like the abstract conceptualism of classical contract, with its foundational belief in individualism and freedom of contract and its methodological preference for treating legal categories acontextually and language as objective? Or is it the contract law of standard forms and contracts of adhesion, where recognition of the lack of actual assent to many of the provisions found in standard forms can produce a judicial finger on the

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341. See, e.g., *German-American Ins. Co. v. Etherton*, 41 N.W. 406 (Neb. 1889); Works, *supra* note 222, at 241–43.

342. See, e.g., Anderson et al., *supra* note 232, at 842–45.

343. See, e.g., Michael E. Brown, *Property and Prejudice: Must Insurers Show Prejudice When Denying Coverage Based on Conditions in the Property Policy?*, TIPS COMMITTEE NEWS, INSURANCE COVERAGE LITIGATION COMMITTEE, Summer, 1997, at 1.

344. See generally Vance, *supra* note 265.

345. EDWIN H. WOODRUFF, *SELECTION OF CASES ON THE LAW OF INSURANCE* 5 (2d ed. 1924).

interpretive scales or the substitution of gap-filling default rules said to vindicate the hypothetical “objective reasonable expectations” of insureds? Or is it the contract law of modern neo-institutional thought, with its attention both to bounded rationality and to the potential for opportunism and its concern to identify both private and public devices for policing against opportunism?

The answer matters, for recognizing the aridity of the acontextual, formalistic approaches still ascendant in much of insurance law is only the first challenge; the second, and more difficult, question for modern insurance law remains what part of the insurance context makes insurance different, and what reactions those differences should suggest. “Situation sense” works only if we are confident we know what it is about the situation that should interest us. Efforts to capture contextual concerns about insurance contracting in the “Doctrine of Reasonable Expectations” are radically incomplete because they focus on *ex ante*—formation—difficulties and ignore *ex post*—performance and enforcement—difficulties. Often the relevant contextual detail in insurance disputes is not that the insured did not understand what was in the policy, or lacked any practical alternative to what was in the policy, but that the policy creates occasions for opportunism which are being exploited in the particular case. Insurance law needs to acknowledge that not all questions can be answered by reference to the actual or assumed intent of the parties, and to recognize explicitly that for some cases an *ex post* perspective will be an appropriate complement to more familiar ways of looking at insurance questions. By raising “Excusing Nonoccurrence of a Condition to Avoid Disproportionate Forfeiture” to the same level of explicit principle as “Vindicating Objective Reasonable Expectations,” we will come closer to having the tools we need to wrestle effectively with insurance law’s enduring puzzles.