

DISAPPEARING INK: THE EMERGING DUTY TO REMOVE INVALID POLICY PROVISIONS

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I. INTRODUCTION

It happens all the time. With astonishing regularity, courts hold that contract provisions are “void,” “invalid,” or “unenforceable.”¹ What the courts do *not* go on to say is whether, or under what circumstances, the party who drafted the contract must remove that provision from existing contracts, or must refrain from including it in future contracts.

Any reader of this article can almost certainly think of several instances where courts have held contract provisions to be void, invalid, or unenforceable. In the author’s home state of Ohio,² over the last 100 years, the state’s highest court has held more than 30 different kinds of contract provisions to be unenforceable.³ Many of these decisions

1. Courts appear to use these terms interchangeably. As shown within, courts use each of these terms to mean that the provision is contrary to law or public policy and may not be enforced. *See infra* notes 3-30.

2. The author has practiced law in the State of Ohio for nearly 25 years. Consequently, many of the cases, statutes, and regulations cited in this article will refer to Ohio law. In discussing general principles of law, it is obviously impractical to cite examples from each of the 50 states, and Ohio insurance law is fairly typical of that found elsewhere. Most of the cited Ohio statutes and regulations are either verbatim or slightly modified variations of NAIC model legislation. Further, there is no question that courts in other states regularly invalidate policy provisions while providing no guidance as to whether the invalidated provision must be removed from the policy. To cite just one very common example, at least ten states have held that state law mandatory minimum coverage requirements negate intentional act exclusions in auto insurance policies. *See, e.g.,* *Speros v. Fricke*, 98 P.3d 28, 36-37, n.6 (Utah 2004).

3. *See infra* note 4. This paper addresses the situation where a contract or policy provision has been invalidated by the highest court of a state. Needless to say, there are even more occasions where a provision has been declared to be invalid and unenforceable by a trial court or an intermediate court of appeals, but where the state’s highest court has not passed on the question of its validity. Occasionally, this happens even where a state statute explicitly permits the exclusion. One example of this occurred in *Burnett v. Motorist Mut. Ins. Co.*, 875 N.E.2d 642 (Ohio Ct. App. 2007), *rev’d*, 890 N.E.2d 307 (Ohio 2008). In that case, the court of appeals held that a state statute that expressly permitted “household exclusions” in uninsured/underinsured motorist policies violated Equal Protection. *Id.* at 646. The court therefore invalidated both the exclusion and the statute that permitted it. *Id.* The Ohio Supreme Court later reversed, holding that the application of the statute to that case did not violate Equal Protection. *Burnett v. Motorists Mut. Ins. Co.*, 890 N.E.2d 307, 308 (Ohio 2008). Because the decision of an intermediate court of appeals has no binding effect outside of its own limited geographic jurisdiction, the author believes that insurers should not be required to remove a policy provision based on the decision of an inferior court. The proposed model legislation found at Appendix A expressly recognizes that no duty to remove a provision would arise unless and until the provision has been invalidated by a state’s highest court.

invalidated very ordinary provisions found in contracts of every stripe.⁴ Thus, many sorts of provisions in many kinds of contracts have been held to be void, invalid, and/or unenforceable. But insurance contracts seem to draw special (perhaps unwelcome) attention from the courts. The Ohio Supreme Court has invalidated several provisions found in insurance policies.⁵

4. Examples of invalidated provisions include one requiring arbitration of child custody and parental visitation disputes, *Kelm v. Kelm*, 749 N.E.2d 299, 304 (Ohio 2001); provisions in collective bargaining agreements inconsistent with statutory requirements, *Streetsboro Educ. Assoc. v. Streetsboro City Sch. Dist.*, 626 N.E.2d 110, 115 (Ohio 1994); a political “check off” provision in a collective bargaining agreement, *City of Cincinnati v. Ohio Council 8*, 576 N.E.2d 745, 752 (Ohio 1991); a condominium management provision that exceeded the length of time permitted by statute, *McKnight v. Bd. of Dir., Anchor Pointe Boat-A-Minium Assoc., Inc.*, 512 N.E.2d 316, 322 (Ohio 1987); “penalty” provisions (as distinguished from reasonable liquidated damages provisions), *Samson Sales, Inc. v. Honeywell, Inc.*, 465 N.E.2d 392, 393-94 (Ohio 1984); a licensing agreement provision requiring the licensee to operate a full-service gasoline station that was in conflict with a statute, *State ex rel. Cities Service Oil Co. v. Orteca*, 409 N.E.2d 1018, 1021 (Ohio 1980); unreasonable restrictions in a covenant not to compete, *Extine v. Williamson Midwest, Inc.*, 200 N.E.2d 297, 300 (Ohio 1964); usurious contracts in violation of a statute, *Angevine v. Midwest Fin. Corp.*, 187 N.E.2d 24, 26 (Ohio 1962); a provision in a mortgage purporting to authorize a breaking and entering by the mortgagee, *Hileman v. Harter Bank & Trust Co.*, 186 N.E.2d 853, 855 (Ohio 1962); an oral agreement to make a will, *Sherman v. Johnson*, 112 N.E.2d 326, 330 (Ohio 1953); an attorney fee provision in a workers’ compensation case calling for a fee greater than that specified by the statute, *Adkins v. Staker*, 198 N.E. 575, 577 (Ohio 1935); an oral agreement to extend a real estate listing, *Franke v. Blair Realty Co.*, 164 N.E. 353, 356 (Ohio 1928); exculpatory language in contracts between a telegraph company and its customers, *Telegraph Co. v. Griswold*, 37 Ohio St. 301, 313 (1881); and a contract provision requiring one party to pay the other party’s attorney fees in any breach of contract action, *State v. Taylor*, 10 Ohio 378 (1841).

5. These include a provision in an uninsured/underinsured motorist policy requiring that the insured suffer bodily injury in order to recover uninsured motorist benefits, *Moore v. State Auto Mut. Ins. Co.*, 723 N.E.2d 97, 102 (Ohio 2000); a provision in an uninsured/underinsured motorist policy restricting available benefits to a single per person limit for holders of all bodily injury and consortium claims arising out of a single bodily injury, *Schaefer v. Allstate Ins. Co.*, 668 N.E.2d 913, 917 (Ohio 1996); a provision in an uninsured/underinsured motorist policy requiring physical contact as a prerequisite to recovery, *Girgis v. State Farm Mut. Auto Ins. Co.*, 662 N.E.2d 280, 283 (Ohio 1996); a provision in an uninsured/underinsured motorist policy stating that coverage does not apply to the use of any motor vehicle by an insured to carry persons or property for a fee, *Stanton v. Nationwide Mut. Ins. Co.*, 623 N.E.2d 1197, 1200 (Ohio 1993); a liability insurance provision that purports to consolidate wrongful death damages suffered by individuals, *Savoie v. Grange Mut. Ins. Co.*, 620 N.E.2d 809, 813 (Ohio 1993); a policy provision stating that an arbitration award not exceeding the financial responsibility limits is binding, but that it is not nonbinding if the award exceeds such limits, *Schaefer v. Allstate Ins. Co.*, 590 N.E.2d 1242, 1249 (Ohio 1992); the “household exclusion” in an uninsured/underinsured motorist policy, *State Farm Auto. Ins. Co. v. Alexander*, 583 N.E.2d 309, 311-12 (Ohio 1992); an uninsured motorist policy provision restricting coverage to bodily injury or death sustained by a member of the named insured’s household, *Sexton v. State Farm Mut. Auto. Ins. Co.*, 433 N.E.2d 555, 560 (Ohio 1982); a provision in an uninsured/underinsured motorist policy excluding coverage for injuries sustained while riding a snowmobile, *Metro. Prop. & Liab. Ins. Co. v. Kott*, 403 N.E.2d 985, 986 (Ohio 1980); a provision in an uninsured/underinsured motorist policy reducing benefits by the amount of any workers’ compensation payments received by the claimant, *Bartlett v. Nationwide Mut. Ins.*

This list includes only these decisions of the state's court of last resort. It does not even begin to touch upon the provisions invalidated by decisions of inferior trial courts and intermediate courts of appeal which, for one reason or another, never reached the Supreme Court.⁶ And those intermediate appellate courts, it should be noted, have not limited themselves to invalidating provisions that are contrary to state statutes. In at least one case, a court of appeals held that an "other owned auto" exclusion in an uninsured motorist endorsement was invalid and unenforceable, even though the provision was *expressly permitted* by statute.⁷ In another case, an Ohio court of appeals invalidated a policy exclusion of uninsured motorist coverage where the insured had executed a fully compliant rejection in 1994, but had not signed another rejection for the 1996 policy year.⁸ The court so ruled even though the version of the controlling statute specifically provided that "unless the named insured requests such coverage in writing, such coverages need not be provided in a supplemental renewal policy where the named insured has rejected the coverages in connection with the policy previously issued to him by the same insurer."⁹

As shown above, the problem of invalid provisions is not limited to contracts of insurance. And insofar as the problem applies to insurance contracts, it is not limited to invalid *exclusions*. Some *grants* of insurance coverage are also invalid and unenforceable. Some states now permit insurance coverage to be available for punitive damages, despite the adverse effects such insurance might have on the two purposes of punitive damages, which are to punish the wrongdoer and to deter others. In other states, the legislature has expressly forbidden insurers to provide coverage for punitive damage awards.¹⁰ But policies containing

Co., 294 N.E.2d 665, 667 (Ohio 1973); and an "other insurance" clause purporting to relieve the insurer from liability where the insured had other similar insurance, *Curran v. State Auto. Mut. Ins. Co.*, 266 N.E.2d 566, 569 (Ohio 1971).

6. This problem is also addressed in the proposed legislation included as Appendix A to this article. Consistent with current practice, the author believes that insurers should be required to refrain from enforcing contractual provisions within the geographic boundaries of the jurisdiction of an intermediate appellate court that has invalidated the decision, but should not be required to remove that provision from its policies because it may well be valid and enforceable elsewhere in the state.

7. *Burnett v. Motorist Mut. Ins. Cos.*, 875 N.E.2d 642, 646 (Ohio Ct. App. 2007), *rev'd*, 890 N.E.2d 307 (Ohio 2008). The court of appeals reached this conclusion by finding that the statute that authorized the exclusion violated the Equal Protection Clauses of the United States and Ohio Constitutions. The Ohio Supreme Court later reversed.

8. *Fleishour v. Grange Mut. Cas. Co.*, 1999 Ohio App. LEXIS 1540 at *4.

9. The applicable version of R.C. 3937.18 was that enacted by S.B. 20, which went into effect on October 20, 1994.

10. *E.g.*, OHIO REV. CODE ANN. § 3937.182 (West 2009).

grants of coverage are often sold in states where insurance coverage for punitive damages is deemed to be contrary to public policy.¹¹

Most states also prohibit insurance coverage for intentional torts. It has been stated that “[i]n the case of a ‘direct intent’ tort, the presence of insurance would encourage those who deliberately harm another.”¹² However, states may and often do permit employers to purchase coverage for workplace intentional torts, where the employee may avoid the bar of statutory immunity for the employer if it can be shown that the employer knew that a serious risk of physical injury was present and that injury was “substantially certain” to occur.¹³ Thus, coverage for “substantially certain” workplace intentional torts may be permitted, but coverage for “direct intent” torts such as battery is not.¹⁴ The issue is further complicated by the fact that some contract provisions are not always *unconditionally* void or unenforceable. That is, a provision may be valid and enforceable in some cases, but invalid and unenforceable in others. Instances where the courts have arrived at this conclusion are numerous.¹⁵

A second confounding factor is that, once a state’s highest court has invalidated a policy provision, that very provision may later be revalidated either by statutory amendment or later judicial decisions. An extreme example of this happened in Ohio between 1978 and 1994. During that 16 year period, the Ohio Supreme Court first invalidated,

11. *State Farm v. Blevins*, 551 N.E.2d 955, 958-59 (Ohio 1990); *Ruffin v. Sawchyn*, 599 N.E.2d 852, 855-56 (Ohio Ct. App. 1991); *Casey v. Calhoun*, 531 N.E.2d 1348, 1350 (Ohio Ct. App. 1987).

12. *Harasyn v. Normandy Metals, Inc.*, 551 N.E.2d 962, 965 (Ohio 1990).

13. *See id.* at 965-66.

14. *Id.* at 965.

15. Examples include a policy provision precluding enforcement of a one-year contractual limitations period in suits seeking uninsured/underinsured motorist coverage was held to be invalid unless the insured had a “reasonable time” to commence suit after exhausting the tortfeasor’s liability limits, *Kraly v. Vannewkirk*, 635 N.E.2d 323, 329 (Ohio 1994); anti-stacking language in an uninsured/underinsured motorist policy was held to be enforceable in intra-family situations (the stacking of uninsured/underinsured limits purchased by family members in the same household) but not in inter-family situations (the aggregation of policy limits purchased by two or more people who are not members of the same household), *Savoie v. Grange Mut. Ins. Co.*, 620 N.E.2d 809, 814 (Ohio 1993); contract provisions requiring payment of the other party’s attorney fees have been held to be invalid unless they are (1) between parties of equal bargaining power, (2) contained in an indemnity contract, or (3) contained a declaration of condominium ownership or by-laws, *Crown Food Service Group, Inc. v. Hughes*, No. C-3-98-063, 1999 U.S. Dist. LEXIS 21701, at *22-25 (S.D. Ohio July 12, 1999); a subrogation provision requiring the insured to obtain the consent of the underinsured motorist carrier to any settlement with the tortfeasor was held to be valid unless the insurer failed to respond to a request for consent within a reasonable time, *McDonald v. Republic-Franklin Ins. Co.*, 543 N.E.2d 456, 460 (Ohio 1989); and antenuptial agreements that are not fair and reasonable, *Zimmie v. Zimmie*, 464 N.E.2d 142, 146 (Ohio 1984).

then revalidated, then invalidated, then revalidated, then invalidated the “other owned auto” exclusion. This occurred despite the fact that there had been no intervening changes in the statute. The only difference between these five cases was the identity of the Justices rendering the decision.

The first of the decisions addressing the validity of the other owned auto exclusion was *Grange Mut. Cas. Co. v. Volkmann*.¹⁶ In *Volkmann*, the Ohio Supreme Court concluded that the other owned vehicle exclusion was contrary to the policy behind Ohio Rev. Code Ann. § 3937.18 and was therefore unenforceable.¹⁷

Just two years later, in *Orris v. Claudio*,¹⁸ the Supreme Court reversed itself. The Court held that “where a policy of insurance contains reasonably specific language excluding other motor vehicles owned by the named insured from the uninsured motorist provision of the policy, such exclusion is valid, and not contrary to the public policy contained in R.C. 3937.18.”¹⁹

Two years later, in *Ady v. West Amer. Ins. Co.*,²⁰ the Court reversed itself again, overruled *Orris*, and held that “this statutorily mandated coverage cannot be whittled away by private parties.”²¹ After stating that “any restriction on full coverage should emanate from the General Assembly”²² rather than from the parties to the insurance contract, the Court held that “the exclusion [upheld] in *Orris* is contrary to the purpose of the statute”²³ and therefore invalid.

Ady did not remain the law for long. Four years later, in *Hedrick v. Motorists Mut. Ins. Co.*,²⁴ the Court held that *Ady*—being a plurality opinion—did not render the “other owned auto” exclusion invalid or unenforceable.²⁵ The *Hedrick* majority maintained that only the syllabus (and not the plurality opinion) in *Ady* received four votes from the seven justices, and that syllabus held only that any contractual restriction on the coverage mandated by R.C. 3937.18 must comply with the purpose of the statute.²⁶ The *Hedrick* Court concluded that the “other owned

16. 374 N.E.2d 1258 (Ohio 1978).

17. *Id.* at 1261.

18. 406 N.E.2d 1381 (Ohio 1980).

19. *Id.* at 1383.

20. 433 N.E.2d 547 (Ohio 1982).

21. *Id.* at 549.

22. *Id.*

23. *Id.* at 551.

24. 488 N.E.2d 840 (Ohio 1986).

25. *Id.* at 842.

26. *Id.*

auto” exclusion was consistent with the purpose of the statute, so it overruled *Ady* and revalidated the exclusion.²⁷

Hedrick—which permitted the “other owned auto” exclusion—remained good law for approximately eight years until *Martin v. Midwestern Group Ins. Co.*²⁸ In *Martin*, the Supreme Court overruled *Hedrick*, and again invalidated the “other owned auto” exclusion.²⁹ Shortly thereafter, the Ohio legislature responded by amending the uninsured/underinsured motorist statute to explicitly permit “other owned auto” exclusions.³⁰

Somewhat surprisingly, the issue of whether and when invalid contract provisions—especially insurance policy provisions—must be removed has received scant attention from the courts, commentators, and regulators. In one recent article, the author addressed the question of whether an attorney may, consistent with the ethical duties owed under the Model Rules of Professional Conduct, either draft a contract clause of doubtful validity to try to gain an advantage (while exposing his client to the risk that the clause will not be valid) or propose a contract clause that is unquestionably invalid (whether the lawyer knows it or not).³¹ But that article spoke only to the ethical obligations of attorneys, and did not directly address the question of whether, when, or how a party to a contract that contains an invalid provision must respond to a court decision invalidating that provision.

Nearly two decades ago, Bailey Kuklin wrote an article addressing the knowing inclusion of unenforceable contract and lease terms in ordinary commercial contracts.³² Kuklin reviewed the then-existing statutes and case law, ultimately concluding that “the common law courts have not developed a general remedy” for this problem and that “if a general remedy is called for, it may be up to the legislatures to provide it.”³³ But Kuklin’s article was not directed to the insurance industry in particular, nor did it address the question of what must or

27. *Id.* at 843.

28. 639 N.E.2d 438 (Ohio 1994).

29. *Id.* at 441 (“Because we do not believe *Hedrick* is in accord with the law of our state, which is that uninsured motorist coverage was designed by the General Assembly to protect persons, not vehicles, we now expressly overrule it.”).

30. H.B. 261 was passed by the legislature, signed by the governor, and went into effect on September 3, 1997. It amended R.C. § 3937.18.

31. Christina L. Kunz, *The Ethics of Invalid and “Iffy” Contract Clauses*, 40 LOY. L.A. L. REV. 487 (2006).

32. Bailey Kuklin, *On the Knowing Inclusion of Unenforceable Contract and Lease Terms*, 56 U. CIN. L. REV. 845 (1988).

33. *Id.* at 914-15.

should happen where one party has included a policy provision believing in good faith that it is valid and enforceable, only to have that provision later nullified by the courts. It also did not address the unique nature of the insurance industry and the frequently observed tension between the courts and the legislature, as illustrated above.

This article, then, is intended to address how insurers should be expected to respond to court decisions invalidating policy provisions. Ultimately, the author proposes model legislation for consideration by the National Association of Insurance Commissioners.

II. THE PROBLEM

A. Insurers Sometimes Retain Invalid Policy Provisions

As shown by the cases cited in Section II(C) below, insurers sometimes retain provisions in their policies even after they have been invalidated.³⁴ The reasons why this may be the case are discussed in subsection II(B) below. But by way of overview, there are at least eight legal reasons—plus one practical reason—why this may be the case. First and foremost, there appears to be not even a single reported decision invalidating a policy provision that explicitly requires the insurer to remove it. The decisions almost always say only that the challenged provision is “void,” “invalid,” or “unenforceable.” If an insurer ceases to enforce the invalidated provision, then it has presumptively complied with the explicit directive given by the court that invalidated the provision. And there appears to be no statute, rule, or regulation anywhere in the United States that requires insurers to remove invalid policy provisions (or, alternatively, that permits them to retain them under specified circumstances). It is that very absence that this article and the proposed rule attached hereto as Appendix A is intended to remedy.

Second, if a policy provision is only conditionally invalidated (that is, it is enforceable in some cases but not in others), then an insurer can reasonably expect that it is permitted to keep that provision in its policies. Indeed, there is not a single decision from any jurisdiction in

34. Occasionally insurers file new policy forms that contain provisions that are already invalid under state law. *See, e.g.*, Time Limitations in Accident Benefit Policies, 65 Pa. D. & C.2d 17 (Pa. Att’y Gen. Apr. 26, 1974). But that occurrence is rare, and could perhaps be dealt with simply by more vigorous regulatory review (at least in those jurisdictions where insurers must file policy forms and endorsements). The more troublesome question is whether and when insurers should be required to take action if a provision is invalidated after the policy has been sold to the customer.

the United States purporting to require an insurer to take any action with respect to a policy provision that is merely conditionally unenforceable.

Third, in some cases, the enforceability of a policy provision may merely be doubtful. If a state's highest court indicates, in *dicta*, that certain exclusions or classes of exclusions not directly before the court may be unenforceable, then the provision has not been directly invalidated, but is merely of doubtful continuing validity.

Fourth, courts everywhere agree that every person is presumed to know the law. This rule has been applied in the specific context of knowledge of the effects of changes in insurance law and the corresponding effect on policy provisions. If every person is presumed to know the law, then removal of the invalid provision is arguably unnecessary.

Fifth, courts have also held that, despite the heightened duties that insurers owe to their insureds, that heightened duty imposes no obligation to inform insureds of changes in insurance law. If every person is presumed to know the law, and if insurers' quasi-fiduciary obligations do not require them to inform insureds of changes in insurance law, then a rational argument could be made that current law also imposes no duty to remove policy provisions that were valid when issued, but have been invalidated by a court decision in the interim.

Sixth, it is anecdotally agreed, and empirically established, that insureds generally do not read their policies either before or after a loss. Consequently, the removal of invalid provisions is arguably a vain act.

Seventh, many court decisions hint, and some scholars agree, that an insurer's duty to inform insureds of their rights and the coverage available under the policy arises only after a loss has occurred.

Eighth, there are several decisions that strongly imply that there is no duty to remove invalid provisions. This has occurred, for example, in a case where a provision in a policy which was invalid when the policy was issued later became valid and enforceable by operation of law when the applicable statute was amended to permit such exclusions.

Finally, as a purely practical matter, an insurer may believe (based on news reports or industry sources) that the legislature intends to pass legislation in the immediate future that would revalidate the challenged exclusion. For example, within days after the Ohio Supreme Court changed the law with respect to the validity of the "other owned auto" exclusion for the fifth time in 1994, newspapers throughout the State of

Ohio urged the General Assembly to change the statute to revalidate the exclusion and quoted legislators who promised to do just that.³⁵

B. Reasons Why Insurers May Sometimes Leave Invalid Policy Provisions in Place

There is no question that insurers have, from time to time, permitted invalid policy provisions to remain in their policies. There are many reasons why insurers may believe, perhaps with some justification, that it is appropriate for them to do so.

1. No Statute, Regulation, or Court Decision Requires Removal of Invalid Provisions

Court decisions that invalidate policy provisions generally state that the provision is either “invalid,” “void,” or “unenforceable.”³⁶ Not a single judicial decision has ever explicitly gone on to say that the insurer was under an affirmative duty to remove it from its policies.

This situation is comparable in many respects to Supreme Court decisions that invalidate legislation as being unconstitutional. As long ago as 1803, the United States Supreme Court held in *Marbury v. Madison*³⁷ that “an act of the legislature, repugnant to the Constitution, is void.”³⁸ But when the Supreme Court voids a law as being unconstitutional, Congress is not obliged to repeal it. Rather, the executive and judicial branches simply may no longer enforce it.

There are statutes that apply to transactions outside the insurance arena that *do* prohibit continued inclusion of provisions known to be prohibited. For example, the Uniform Residential Landlord and Tenant

35. The day after the Supreme Court issued its decision in *Martin* invalidating the “other owned auto” exclusion, an article appeared in the Columbus Dispatch explaining the essence of the decision and quoting state senator Roy L. Ray—who was the head of the Insurance Committee—as stating: “I think we ought to abolish the [uninsured/underinsured motorist] law and rewrite it so it’s damned clear and the court cannot possibly misinterpret it.” James Bradshaw, *Insurance Ruling May Raise Prices*, COLUMBUS DISPATCH, Oct. 6, 1994, at 1A. A similar story ran one day later in the Cleveland Plain Dealer. That article, published by the Associated Press, quoted and explained both *Martin*’s majority ruling and its dissent, which took the view that “this case involves whether [the plaintiff, Martin] should get something for nothing.” *Accident Coverage Stretched: Court Allows Collection of Uninsured-Driver Benefits*, CLEVELAND PLAIN DEALER, Oct. 7, 1994, at 8B. And on November 10, 1994—36 days after the *Martin* decision was rendered—the Columbus Dispatch published an editorial urging the General Assembly legislatively to supersede the decision. Editorial, *Auto Rates – Insurance Laws Need Tuneup after Ruling*, COLUMBUS DISPATCH, Nov. 10, 1994, at 14A.

36. See *supra* notes 5, 15.

37. 5 U.S. (1 Cranch) 137 (1803).

38. *Id.* at 177.

Act explicitly forbids landlords from deliberately using rental agreements that contain provisions known to be prohibited.³⁹ But since no comparable legislation exists in the realm of insurance, an insurer could conclude that it is permissible to leave provisions in policies even after they have been invalidated.

A distinction might fairly be drawn between an insurer that knowingly inserted an invalid provision into a policy form at the time it was initially promulgated or was last revised, as opposed to an insurer that has merely allowed a provision to remain in place after it has been declared to be unenforceable. In the first case, the insurer might fairly be faulted for intending to deceive readers of the policy—including its own insureds—by including a provision that it knew from the very outset was unenforceable. In the latter case, by contrast, the insurer included a provision that it presumably believed in good faith was valid and enforceable when the policy form was issued. Further, after invalidation, that insurer may reasonably expect that legislative or judicial action in the immediate future may restore the challenged provision to validity.⁴⁰ That was certainly true in the case of the validity of the “other owned auto” exclusion in UM/UIM policies, a subject upon which the Ohio Supreme Court changed its position with distressing regularity.

The proposed legislation attached as Appendix A would address both situations. The proposed legislation would prohibit insurers from filing with the insurance commissioner, or first putting into use, any policy form or endorsement containing a provision invalid at that time. And to the extent that court decisions invalidate provisions found in existing policies, the proposed legislation establishes specific requirements and timeframes within which removal must be accomplished.

2. Some Provisions Are Only Conditionally Unenforceable

In several of the instances mentioned in subsection I above, the challenged policy provisions were held to be only conditionally

39. Section 1.403(b) of the Uniform Residential Landlord and Tenant Act provides that: “If a landlord deliberately uses a rental agreement containing provisions known by him to be prohibited, the tenant may recover in addition to his actual damages an amount up to [3] months’ periodic rent and reasonable attorney’s fees.” UNIF. LANDLORD AND TENANT ACT § 1.403(b) (as amended August 1974), *available at* <http://www.law.upenn.edu/bll/archives/ulc/fnact99/1970s/urлта72.pdf>.

40. This is particularly true in a jurisdiction such as Ohio, where changes in insurance statutes and decision law are commonplace.

unenforceable. That is, they are enforceable in some situations, but not in others.

One spectacular example of a policy provision that may be conditionally unenforceable (at least in some jurisdictions) is the pollution exclusion. The qualified (or “sudden and accidental”) pollution exclusion was first introduced into ISO policies in 1973, the absolute pollution exclusion was first inserted in 1986, and the “total” pollution exclusion was introduced in approximately 1990.⁴¹ All of these variants excluded, to one degree or another, the “discharge” or “release” of “pollutants.”

Other writers have thoroughly documented the misrepresentations made by insurance industry trade organizations in connection with the adoption of the 1970 qualified pollution exclusion and the 1986 absolute pollution exclusion.⁴² For example, in 1970, one of the Insurance Services Office’s predecessors circulated a document in connection with the submission of the qualified pollution exclusion suggesting that it “clarified but did not reduce the scope of coverage” provided in earlier versions of the CGL policy.⁴³ And when the “absolute” pollution exclusion was introduced, the ISO stated in a 1984 explanatory memorandum that “clean-up costs are specifically excluded as a clarification of current intent,”⁴⁴ thus implying that the exclusion was intended to do little more than preserve the status quo except to exclude coverage for Superfund liabilities.

The conflict between the extraordinarily broad language of the pollution exclusions (particularly the absolute and total pollution exclusions) and the insurer representations as to the intended scope came to a head in 1993, when the Supreme Court of New Jersey rendered its decision in *Morton Int’l, Inc. v. General Acc. Ins. Co. of America*.⁴⁵ In *Morton*, the Court was called upon to construe the qualified pollution exclusion, which precludes coverage for releases unless they were both abrupt and accidental.⁴⁶ The *Morton* Court held that the language of the

41. Patrick J. Wielinski, Liability Insurance Coverage for Mold Exposures (Jan. 17, 2003) at 3-6, <http://www.cbylaw.com/publications/pjw-Lorman%20Mold%20Jan%202003.pdf>.

42. See, e.g., John A. MacDonald, *Decades of Deceit: The Insurance Industry Incursion into the Regulatory and Judicial Systems*, 7 COVERAGE 3 (Nov./Dec. 1997); Jeffrey W. Stempel, *Reason and Pollution: Correctly Construing the “Absolute” Exclusion in Context and in Accord with its Purpose and Party Expectations*, 34 TORT & INS. L.J. 1 (1998).

43. MacDonald, *supra* note 42, at 6-7.

44. *Id.* at 8.

45. 629 A.2d 831 (N.J. 1993).

46. *Id.* at 834.

qualified pollution exclusion unambiguously precluded coverage for releases of pollutants unless they were both abrupt and accidental.⁴⁷

But because of the insurance industry's "presentation and characterization of the standard pollution-exclusion clause to state regulators," the Court expressly "decline[d] to enforce the standard pollution-exclusion clause as written."⁴⁸ Instead, the Court held that the qualified pollution exclusion—even though unambiguous—could only be enforced in cases where "the insured intentionally discharged, disbursed, released, or caused the escape of a known pollutant,"⁴⁹ which had been the scope of coverage under the predecessor CGL policy.

The New Jersey Supreme Court later applied exactly the same reasoning to the 1986 absolute pollution exclusion. In *Nav-Its, Inc. v. Selective Inc. Co. of America*,⁵⁰ the Court quoted with approval the language from its earlier decision in *Morton*, wherein it stated that it would "decline to enforce the pollution-exclusion clause as written."⁵¹ Instead, the Court held that the clause would be enforceable only to the extent that it applied to "those hazards traditionally associated with environmentally related claims."⁵²

The West Virginia Supreme Court has limited the enforceability of the pollution exclusion in precisely the same way. In *Joy Tech. Inc. v. Liberty Mut. Ins. Co.*,⁵³ the Court discussed two days of hearings held by the West Virginia Insurance Commissioner when the absolute pollution exclusion was being considered.⁵⁴ During that hearing, Liberty Mutual included as part of its submission an explanatory memorandum which stated in part that:

The above exclusion [the exclusion which is in issue in the present case] clarifies this situation so as to avoid any question of intent. Coverage is continued for pollution or contamination caused injuries where the pollution or contamination results from an accident⁵⁵

After reviewing this testimony, the West Virginia Supreme Court held that despite the broad language of the pollution exclusion, "the

47. *Id.* at 847 ("If applied as written, . . . the clause sharply and dramatically would restrict the coverage that previously had been provided under CGL policies for property damage caused by accidental pollution . . .").

48. *Id.* at 848.

49. *Id.*

50. 869 A.2d 929 (N.J. 2005).

51. *Id.* at 937.

52. *Id.* at 938.

53. 421 S.E.2d 493 (W. Va. 1992).

54. *Id.* at 498-99.

55. *Id.* at 499 (emphasis added).

policies issued by Liberty Mutual covered pollution damage, even if it resulted over a period of time and was gradual, so long as it was not expected or intended.”⁵⁶

A federal court applying Pennsylvania law recently concluded that regulatory estoppel may be used to expand the qualified pollution exclusion based on the insurer’s representations to state insurance regulators that the “sudden and accidental” language of the qualified pollution exclusion did not involve a substantial decrease in coverage from the prior language.⁵⁷

In three other states, pollution exclusions have been limited, or held unenforceable altogether, by administrative regulation. In Louisiana, the Department of Insurance promulgated an Advisory Letter,⁵⁸ which summarized the conclusions it reached after “an extensive three year review of the use of standard pollution exclusions.”⁵⁹ The Department observed that insurers had sometimes denied coverage because of the standard pollution exclusion “even though there was no underlying pollution incident which would justify the use of the exclusion.”⁶⁰ While the Advisory Letter did not detail the precise representations that had been made as part of the approval process, the Department was clearly concerned that misrepresentations had been made, stating that it would “take such action as is necessary to assure that the integrity of the regulatory process is not undermined,” and that “it is of critical importance that such exclusions are used in a manner which is consistent with their stated purpose.”⁶¹ The Advisory Letter stated that the “parameters for a reasonable denial of coverage . . . under a standard pollution exclusion, are set by (1) the regulatory record which establishes the stated purpose of the exclusion”⁶² Therefore, the Department established four factors that each insurer must consider on a case-by-case basis in deciding whether the policy’s pollution exclusion was enforceable.⁶³

56. *Id.* at 500.

57. *Simon Wrecking Co. v. AIU Ins. Co.*, 530 F. Supp. 2d 706, 714 (E.D. Pa. 2008), *on reconsideration*, 541 F. Supp. 2d 714 (E.D. Pa. 2008) (citing *Sunbeam Corp. v. Liberty Mut. Ins. Co.*, 781 A.2d 1189, 1192-93 (Pa. 2001)).

58. Use of Standard Pollution Exclusions, La Dept. of Ins. Advisory Letter No. 97-1 (June 4, 1997).

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. The Advisory Letter stated in pertinent part that:

Therefore, in handling claims the LDOI strongly advises insurers to consider the following in deciding whether or not a claim triggers a policy’s pollution exclusion. 1)

Pollution exclusions have been rendered unenforceable by administrative action in Vermont and Minnesota. In Vermont, the Department of Insurance and Banking promulgated regulations rendering such clauses invalid, and that declaration of invalidity has been upheld by the courts.⁶⁴ And in Minnesota, the Commissioner of Commerce had declared that pollution exclusions in general liability policies must contain an exception for hostile fire.⁶⁵ Under that ruling, “any individual insurer wishing to use such an endorsement would need the approval of the Department, which would approve ‘reasonable’ filings on an individual basis.”⁶⁶ In one case where the insurer neither sought nor obtained the approval of the pollution exclusion endorsement attached to the insured’s policy, a Minnesota court held that the endorsement was unenforceable.⁶⁷

It is therefore clear that one of the most frequently litigated exclusions in CGL policies today—the “pollution exclusion” in its various forms—is conditionally unenforceable in some jurisdictions.⁶⁸ Insurers are consequently faced with the problem of how to deal with policy provisions that may legitimately be enforced in some cases, but not in others.

Does the claim involve an incident which caused an environmentally significant discharge of pollutants resulting in environmental damage? 2) Do the policyholder’s regular business activities place it in the category of an ‘intentional active industrial polluter’? 3) Does the claim involve an injury alleged to have been caused by a product, including exposure to fumes, which was being used in accordance with its intended purpose? 4) Does the claim involve an injury alleged to have been caused by exposure to asbestos or lead?

If the answer is “NO” to (1) or (2) or “YES” to (3) or (4) of the above the denial of coverage and/or refusal to provide a defense may result in administrative action.

Id.

64. E.B. & A.C. Whiting Co. v. Hartford Fire Ins. Co., 838 F. Supp. 863, 867 (D. Vt. 1993) (*citing*, Gerrish Corp. v. Universal Underwriters Ins. Co., 754 F. Supp. 358, 371 (D. Vt. 1991), *aff’d* 947 F.2d 1023 (2d Cir. 1991)).

65. Hawkins Chem. Inc. v. Westchester Fire Ins. Co., 159 F.3d 348, 350 (8th Cir. 1998).

66. *Id.* at 351.

67. *Id.* at 352 (“In this case, North River wrote a specifically disapproved endorsement into Hawkins’s policy. The endorsement therefore lacks legal force Because North River’s pollution endorsement was void under Minnesota law, the district court lacked the power to enforce it.”).

68. Other jurisdictions arrive at the same result, though they do so by concluding that the exclusion is ambiguous, rather than unenforceable. *See, e.g.*, Andersen v. Highland House Co., 757 N.E.2d 329, 332 (Ohio 2001) (holding that the policy “never clearly exclude[d] claims for deaths or injuries caused by . . . carbon monoxide poisoning”).

3. Enforceability May Be Merely Doubtful

In some instances, the continuing validity of a policy provision may be merely doubtful. For example, in *State Farm v. Alexander*,⁶⁹ the Ohio Supreme Court explicitly invalidated the “household exclusion” in a UM/UIM endorsement.⁷⁰ In doing so, it stated in *dicta* that “policy restrictions that vary from the statute’s requirements are unenforceable.”⁷¹ The version of Ohio’s uninsured/underinsured motorist statute, Ohio Rev. Code Ann. § 3937.18, that was in effect at the time did not explicitly permit exclusions barring coverage when the insured was carrying persons or property for a fee, where there was no physical contact with the uninsured motor vehicle, or the “other owned auto” exclusion found in most policies.⁷² Given the Ohio Supreme Court’s statement in *Alexander*, one could reasonably predict that the Ohio Supreme Court probably would invalidate those exclusions (as it ultimately did).

Still, the *Alexander* Court did not directly address—much less explicitly invalidate—the “other owned auto” exclusion. Should an insurer be required to perform a preemptory removal of all questionable policy exclusions, even though they have never been explicitly invalidated? After all, it was entirely possible that the Ohio Supreme Court might have a change of heart on the subject, just as it had in other instances in the recent past. Insurers were left with little or no guidance as to whether they could or should continue to issue policies containing exclusions which were probably—but not definitively—invalid under Ohio law.

4. Every Person is Presumed to Know the Law

In virtually every jurisdiction, courts apply the maxim that every person is conclusively presumed to know the law.⁷³ This rule applies in cases involving allegations of fraud or misrepresentation. It has been said that “fraud cannot be predicated upon misrepresentations as to matters of law” because “everyone is presumed to know the law, both

69. 583 N.E.2d 309 (Ohio 1992).

70. *Id.* at 312.

71. *Id.* at 311-12.

72. Am. Sub. H.B. 1, 117th Gen. Assem. (Ohio 1988).

73. See generally 29 AM. JUR. 2D *Evidence* § 290 (2008) (“A rule frequently stated is that everyone is presumed to know the law.”).

civil and criminal, and is bound to take notice of it, and therefore cannot, in legal contemplation, be deceived by such misrepresentations.”⁷⁴

This maxim has been applied in the specific context of insurance policies.⁷⁵ For example, in *Bertler v. Employers Ins. of Wausau*,⁷⁶ one employee brought a personal injury action against a fellow employee and the fellow employee’s homeowner’s insurance carrier. The action was brought pursuant to a Wisconsin statute which provided that the making of a workers’ compensation claim against an employer did not affect the right of the injured employee to maintain an action in tort against any other party for injury sustained by the claimant.⁷⁷ The tortfeasor’s insurer filed a motion for summary judgment requesting that the complaint against it be dismissed based on the “business pursuits” exclusion in its policy.⁷⁸ The trial court granted summary judgment to the insurer based on that exclusion.⁷⁹

On appeal, the Supreme Court of Wisconsin first held that, by its terms, the business pursuits exclusion would bar coverage.⁸⁰ But it then had to decide whether that provision was contrary to public policy.⁸¹ In doing so, it made broad statements holding that the actual coverage provided by an insurance policy may be different (and greater) than that apparent from the policy’s written terms, and that both the insurer and the insured are charged with knowledge of the applicable law that expands the stated coverage.⁸²

In a more recent Kentucky case, a real estate institute brought an action against a real estate educator and his competing business for

74. 37 AM. JUR. 2D *Fraud and Deceit* § 98 (2008).

75. 43 AM. JUR. 2D *Insurance* § 207 (2008) (“All persons are presumed to know the law, and the mere lack of knowledge of the contents of a written contract for insurance cannot serve as a legal basis for avoiding its provisions.” (citing *Moore v. Globe American Cas. Co.*, 208 S.W.3d 868 (Ky. 2006))).

76. 271 N.W.2d 603 (Wis. 1978).

77. *Id.*

78. *Id.* at 604-05.

79. *Id.* at 605.

80. *Id.* at 608.

81. *Id.*

82. The court stated:

By operation of law and as a matter of public policy, an insurance agreement may be deemed to afford protection not explicit from or even contrary to its written terms. The parties are chargeable with knowledge of the statutes and with the fact that policies cannot be issued in conflict with them. Missing terms required by a statute will be read into the policy. Terms in conflict with the statutes will be amended to conform to them. This must be the result even though increased liability not reflected in the original premium is the consequence.

Id.

infringement of its service mark.⁸³ The defendant's insurer intervened, seeking a declaratory judgment that it had no duty to defend its insured.⁸⁴ The insurer argued that the intentional acts exclusion in its policy relieved it of its duty to defend and indemnify.⁸⁵

The insured argued that he thought he had an unfettered right to use his own last name as a service mark.⁸⁶ He also maintained there was no evidence of subjective knowledge that his conduct was in violation of the provisions of federal law.⁸⁷ Nevertheless, the trial court ruled in favor of the insurer.⁸⁸

The court of appeals affirmed.⁸⁹ It determined that the insured's knowledge that the use of his last name could cause confusion was evidenced by a letter he had written.⁹⁰ More importantly, the court determined that knowledge that his conduct violated federal law would, for reasons of public policy, be imputed to him because "it is axiomatic that all persons are presumed to know the law."⁹¹

In another case,⁹² a tortfeasor and his insurer secured a release from an injured party as to all claims arising out of an auto accident.⁹³ This release was obtained prior to the payment of no-fault benefits by the injured party's insurer.⁹⁴ The court held that the release did not defeat the no-fault insurer's statutory right of subrogation against the tortfeasor, because the tortfeasor and his insurer would be presumed to know the law which gave the injured party's no-fault insurer a statutory right of subrogation.⁹⁵

These rules also apply to the question of whether an insured is bound to know that a provision of his policy may have been invalidated by statute. For instance, in the case of *In re Estate of Holycross*,⁹⁶ the

83. *Educ. Training Sys., Inc. v. Monroe Guar. Ins. Co.*, 129 S.W.3d 850, 851 (Ky. Ct. App. 2003).

84. *Id.* at 852.

85. *Id.*

86. *Id.* at 853.

87. *Id.*

88. *Id.* at 852.

89. *Id.* at 853.

90. *Id.*

91. *Id.* (citing *Midwest Mut. Ins. Co. v. Wireman*, 54 S.W.3d 177, 181-92 (Ky. Ct. App. 2001)).

92. *Poole Truck Line Inc. v. State Farm Mut. Auto. Ins. Co.*, 294 S.E.2d 570 (Ga. Ct. App. 1982).

93. *Id.* at 570.

94. *Id.*

95. *Id.* at 572 ("Those who use the roads in Georgia . . . are presumed to know the law which gives the injured party's insurance company the statutory right of subrogation . . .").

96. 858 N.E.2d 805 (Ohio 2007).

decedent obtained a life insurance policy through his employer and named his first wife as beneficiary in 1972.⁹⁷ In 1993, the decedent and his wife were divorced.⁹⁸ The divorce decree did not indicate any change in the policy, and his ex-wife remained the named beneficiary.⁹⁹

In 1997, the decedent remarried.¹⁰⁰ He passed away in 2003, and the insurer paid the policy proceeds to his first wife.¹⁰¹ The decedent's second wife claimed that, under a law passed in 1990, she was the proper beneficiary of the proceeds as the decedent's surviving spouse.¹⁰²

In a prior decision, the Ohio Supreme Court had clearly established the rule that a person who owned an insurance policy in existence before the statute went into effect, and who wished to remove his or her ex-spouse as the beneficiary, had to undertake an affirmative act to remove the ex-spouse despite the language of the 1990 statute.¹⁰³ That decision had been rendered in 1990, 13 years before the decedent died.¹⁰⁴ The Ohio Supreme Court held that the decedent was *conclusively presumed* to know the law relating to the effect of a divorce on a beneficiary designation that had resulted from a judicial decision rendered by the Court.¹⁰⁵

If the courts mean what they say, then insurers might fairly believe that a lay reader of an insurance policy is duty bound—indeed, is “conclusively presumed”—to be aware of any intervening court decision that invalidated a policy provision in whole or in part.

5. Insurers Have No Duty to Inform Insureds of Changes in the Law

Courts routinely hold that insurers are under no duty to disclose changes in the law to their insureds. For example, in *Walter v. Allstate*,¹⁰⁶ the plaintiff's husband was killed in a motor vehicle

97. *Id.* at 806.

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.* at 809.

104. *Id.* at 807.

105. *Id.* at 809 (“All persons are ‘conclusively presumed to know the law. . . .’ Thus, we presume that for the last 13 years, persons who owned policies in effect prior to May 31, 1990, and took no action to revoke an ex-spouse as beneficiary upon divorce intended that ex-spouse to remain the beneficiary on the policy.”).

106. No. 96-CA-84, 1997 WL 219229 (Ohio Ct. App. Apr. 10, 1997), *appeal not allowed*, 683 N.E.2d 792 (Ohio 1997).

collision.¹⁰⁷ After settling her wrongful death claim against the tortfeasor, the plaintiff sued her underinsured motorist insurance carrier, alleging that it was a breach of the insurance company's duty of good faith to fail to inform her about a change in the law which effectively reduced the amount of underinsured coverage available under her policy.¹⁰⁸ The court of appeals held that the trial court erred in imposing a duty on the insurer to notify its insured about changes in the law, or of the corresponding effect on the policy.¹⁰⁹

These decisions holding that insurers owe no duty to advise their insureds of changes in the law apply even where the plaintiffs allege that insurers owe a fiduciary duty. For example, in *Stefanov v. Grange Mut. Cas. Co.*,¹¹⁰ the court held that there is no requirement that insurers disclose every change in the law that affects policy coverage.¹¹¹

107. *Id.* at *1.

108. *Id.*

109. *Id.* at *2. The Court held that:

The trial court erred in imposing on an insurer a duty to notify its insured of changes in the law, and the corresponding effect on the policy. We recognize the duty of good faith, which arises out of the special relationship between an insurer and insured. However, this special relationship does not require an insurer to notify the insured of the current legal interpretation of its policy provisions. Insurance law is typically in a state of flux, as cases proceed through the courts. Policy provisions are often subjected to differing interpretations by different courts throughout the state, pending ultimate review by the Supreme Court. In the instant case, the same policy provision has been interpreted differently over a relatively short period of time. The provision had one meaning prior to 1993, a second meaning after the *Savoie* decision, and a return to the original meaning with the amendment of the statute in 1994. The law does not require an insurer to attempt to inform all of its insureds of every change in interpretation of the law.

110. No. 70209, 1997 WL 476829 (Ohio Ct. App. Aug 21, 1997), *appeal not allowed*, 687 N.E.2d 296 (Ohio 1997).

111. *Id.* at *7 (“Lastly, plaintiff-appellee maintains that Grange Mutual, defendant-appellant, breached a fiduciary duty to its insured by failing to disclose a change in the law that effectively limited plaintiff-appellee’s uninsured motorist coverage to \$250,000.00. While it is true that Ohio courts have found the relationship of an insurance company to its insureds to be analogous to that of a fiduciary, this court is unable to find case law in support of plaintiff-appellee’s position that the analogous duty requires the insurance company to advise the insured regarding the status of the law on uninsured motorist coverage. In fact, the only case this court has been able to find on point directly rejects plaintiff-appellee’s contention. Without any such precedent, this court must refrain from placing such an additional fiduciary requirement on an insurance company in the State of Ohio. Particularly when the enactment of Am. Sub. S.B. 20 did not alter the terms of the existing contract as much as provide a different interpretation for the pre-existing terms.”). Other decisions to the same effect include *Cincinnati Equitable Ins. Co. v. Wells*, No. 20286, 2004 WL 1072270, at ¶19 (Ohio Ct. App. May 14, 2004) (“[I]nsurance companies have no duty, ordinary or fiduciary, to keep their insureds aware of changes in the law.”); *Burton v. Allstate Ins. Co.*, No. CA2004-10-247, 2005 WL 2416726, at ¶16 (Ohio App. Oct. 3, 2005) (“An insurer has no duty to inform an insured about changes in insurance laws.”).

The absence of any duty to advise insureds of changes in the law has been held to extend to policy provisions that have become invalid. For example, in *Perryman v. Motorist Mut. Ins. Co.*¹¹² the insured owned and operated an automobile service station.¹¹³ Two months before he sold the property, six underground storage tanks were removed from the property.¹¹⁴ These tanks had been used to store various petroleum products.¹¹⁵ After the removal, an investigation revealed that the tanks had leaked and that contamination had migrated off-site and into the groundwater.¹¹⁶ The insured presented a claim for reimbursement of the costs of investigation and remediation.¹¹⁷ His agent advised him that coverage would be rejected because of the pollution exclusion.¹¹⁸

Two years later—and still within the applicable limitations period for presenting a claim—the Indiana Supreme Court held that the absolute pollution exclusion was ambiguous and therefore unenforceable.¹¹⁹ But the insured did not learn of that decision until after the limitations period for presenting his original claim had expired.¹²⁰ He then brought suit against his insurer, alleging that it had a duty to advise him that the pollution exclusion had become unenforceable.¹²¹

The trial court granted summary judgment to the insurer, finding that the insurer had no duty to disclose the subsequent decision rendering the pollution exclusion unenforceable.¹²² The court of appeals affirmed, holding that the Indiana Supreme Court decision was a matter of public record that was equally available to the insured as it was to the insurer. The court was also unwilling to impose a duty on insurers to revisit previously denied claims every time a Supreme Court decision invalidated a policy provision.¹²³

112. 846 N.E.2d 683 (Ind. Ct. App. 2006).

113. *Id.* at 685.

114. *Id.* at 686.

115. *Id.*

116. *Id.*

117. *Id.*

118. *Id.* at 686.

119. *Id.* at 688.

120. *Id.*

121. *Id.* at 690.

122. *Id.* at 686.

123. The court stated:

Perryman now encourages this court to find that Motorist violated its duty by failing to advise Perryman of our supreme court's decision in *Kiger* which signaled a change in the law. In this regard, Perryman maintains that Motorist had a duty to revisit and investigate Perryman's claim again two years after it was first denied and determine that, based on *Kiger*, coverage existed under the Garage Policy.

If every person truly is conclusively presumed to know the law, and if insurers truly have no duty to inform insureds of changes in insurance law (including no duty to advise insureds that certain policy provisions have become unenforceable), then an insurer might reasonably believe there is no duty to remove an invalid policy provision. This is especially true where, as is next demonstrated, insureds are unlikely to ever read their policies, making the removal of an invalid provision a vain act.

6. Insureds Do Not Read Their Policies Before or After a Loss, So Removing an Invalid Provision is a Vain Act

Many insurers believe—with considerable justification—that insureds do not read their policies, so that revising the policy would largely be an empty gesture. The cases and commentators are in nearly unanimous agreement that insureds simply do not read their policies. If that is the case—or if insureds consistently consult either their agent, insurance adjusters, coverage counsel, or independent adjusters after a loss occurs—then insurers could well believe that it is unnecessary to remove an invalid policy provision, particularly if they believe it may later be judicially or legislatively revalidated.

It has been observed that “[n]obody really believes that insurance policyholders read their policies when they are delivered Insureds are not policy-readers, and they probably do not read leases, warranties, finance charges, or lengthy operating manuals.”¹²⁴ A similar observation was made 135 years ago by a Justice of the New Hampshire Supreme Court, who quite colorfully described the many reasons why insureds do not even attempt to read insurance policies¹²⁵

Forms of applications and policies (like those used in this case), of a most complicated and elaborate structure, were prepared, and filled with covenants, exceptions, stipulations, provisos, rules, regulations

We decline to impose such duty. Our supreme court’s published decision in *Kiger* was a matter of public record, equally available and accessible to Perryman. By now attempting to shift responsibility of his duty to be aware of the law, Perryman would have us not only create a new burden on insurance companies to keep abreast of developments in claims that have been rejected already but which are still viable within the statute of limitations’ term, but also reward plaintiffs who fail to diligently research Indiana law within the statute of limitations term in order to timely bring a claim. This we will not do. Accordingly, we conclude that Perryman’s fraud claim fails.

Id. at 691.

124. James A. Collier, *Readability in Insurance: An Analysis of the Comprehension of New Policies*, 8 J. INS. ISSUES 79, 79 (1985).

125. *Delancey v. Insurance Co.*, 52 N.H. 581, 1873 WL 4180 (N.H. 1873) .

and conditions, rendering the policy void in a great number of contingencies. These provisions were of such bulk and character that they would not be understood by men in general, even if subjected to a careful and laborious study: by men in general, they were sure not to be studied at all. The study of them was rendered particularly unattractive, by a profuse intermixture of discourses on subjects in which a premium payer would have no interest. The compound, if read by him, would, unless he were an extraordinary man, be an inexplicable riddle, a mere flood of darkness and confusion. Some of the most material stipulations were concealed in a mass of rubbish, on the back side of the policy and the following page, where few would expect to find anything more than a dull appendix, and where scarcely any one would think of looking for information so important as that the company claimed a special exemption from the operation of the general law of the land relating to the only business in which the company professed to be engaged. As if it were feared that, notwithstanding these discouraging circumstances, some extremely eccentric person might attempt to examine and understand the meaning of the involved and intricate net in which he was to be entangled, it was printed in such small type, and in lines so long and so crowded, that the perusal of it was made physically difficult, painful, and injurious. Seldom has the art of typography been so successfully diverted from the diffusion of knowledge to the suppression of it.¹²⁶

Similar sentiments were echoed by the Chief Justice of the Indiana Supreme Court in *State Security Life Ins. Co. v. Kintner*,¹²⁷ wherein he observed that insureds rarely, if ever, read their policies and would not understand them if they did.¹²⁸

One of the leading insurance treatises agrees that “the great majority of persons never read their policies, and 90 percent of those who do read them, including attorneys and jurists, would not understand them.”¹²⁹ Commentators writing in support of the doctrine of reasonable expectations have observed that the proposition “that most policyholders

126. *Id.* at *7.

127. 185 N.E.2d 527 (Ind. 1962).

128. *Id.* at 532-32 (Arterburn, C.J., concurring) (“Coupled with this situation is the recognized fact that rarely, if ever, does an insured read his insurance contract, although the law has said, with reference to contracts generally, that a party is bound by what the instrument says, though ignorant of its terms. In fact, realistically, even if the insured had the inclination to attempt to read the policy, I doubt that he would gain much more knowledge than he previously had because of the technical language he would encounter. I doubt that most lawyers or even judges (who say one is presumed to have read his insurance policy) ever read them.”).

129. APPLEMAN ON INSURANCE LAW AND PRACTICE § 8843 (1981).

do not read their policies after they receive them is nearly universally accepted.”¹³⁰

Even the authors of the *Restatement (Second) of Contracts* believe that insurance policies and other standardized form agreements are unlikely to be read.¹³¹ Professor Corbin, in his seminal work on contracts, also agrees that insurance policies are not likely to be read by the purchaser.¹³² Indeed, the insurance literature is replete with references to the widely held belief that insureds rarely, if ever, read their policies.¹³³

These statements, however, are generally made without any citation to empirical evidence. For example, a federal appeals court applying Wyoming law recently declined to consider promotional materials in construing the insurer’s coverage obligations, even though it observed

130. Eugene R. Anderson & James J. Fournier, *Why Courts Enforce Insurance Policyholders’ Objectively Reasonable Expectations of Insurance Coverage*, 5 CONN. INS. L.J. 335, 363 (1998).

131. RESTATEMENT (SECOND) OF CONTRACTS § 211 cmt. b (1981) (“A party who makes regular use of a standardized form of agreement does not ordinarily expect his customers to understand or even to read the standard terms. . . . Customers do not in fact ordinarily understand or even read the standard terms.”).

132. CORBIN ON CONTRACTS § 24.27 (1960) (“The applicant may not even read the policy, being discouraged by the number of terms and the fineness of print.”).

133. See, e.g., Robert H. Jerry II, *Consent, Contract, and the Responsibilities of Insurance Defense Counsel*, 4 CONN. INS. L.J. 153, 171 (1997) (“Insureds rarely read their policies until they have a reason to do so, and even then they are unlikely to understand much of what they read.”); John Dwight Ingram, *The Insured’s Expectations Should Be Honored Only If They Are Reasonable*, 23 WM. MITCHELL L. REV. 813, 841 (1997) (“We probably must accept the fact that most insureds will not voluntarily read their policies and, at most, merely will scan the first page.”); Amy D. Cabbage, Note, *The Interaction of the Doctrine of Reasonable Expectations and Ambiguity in Drafting: The Development of the Kentucky Formulation*, 85 KY. L.J. 435, 436 (1997) (“Given the incomprehensibility of the language in many insurance policies, it is not surprising that most people do not even bother to read their policies.”); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against The Drafter*, 30 GA. L. REV. 171, 174 (1995) (“Most consumers do not read their policies and would not understand them if they did.”); Hugh L. Wood Jr., Comment, *The Insurance Fallout Following Hurricane Andrew: Whether Insurance Companies Are Legally Obligated To Pay For Building Code Upgrades Despite The “Ordinance or Law” Exclusion Contained In Most Homeowners Policies*, 48 U. MIAMI L. REV. 949, 957 (1994) (“Several respected commentators believe not only that insureds do not read their policies, but also that no one should reasonably expect them to.”); Dina M. Assad, Comment, *Medical Necessity: The Cure For What Ails*, 22 CAP. U. L. REV. 465, 481 (“Since the language of insurance contracts is often technical and written in fine print, it is probably a safe assumption that most policyholders never read their policies.”); Eugene Wollan & Jeffrey S. Weinstein, *Great (Or Reasonable) Expectations*, BEST’S REVIEW: PROPERTY/CASUALTY INSURANCE EDITION, May 1990, at 84 (“In the real world, most individual insureds do not read their policies. They check to make sure their names are spelled correctly, and then they file the policy away without a second thought until a loss occurs.”).

(without citation to any actual evidence) that insureds “generally do not read their policies.”¹³⁴

Likewise, a New Hampshire court applying the “strong” version of the doctrine of reasonable expectations (which honors those expectations even when they are at variance with the explicit and unambiguous terms of the policy) justified its position by stating that if a policy is so long, complex, or technical that a reasonable man “would not attempt to read it,” then the insured’s reasonable expectations will not be limited by that policy language “regardless of the clarity of one particular phrase among the Augean stable of print.”¹³⁵ Again, the remark that insureds are unlikely even to attempt to read their policies was unaccompanied by any survey evidence or hard data. Instead, the “fact” that insureds don’t read their policies is simply treated as conventional wisdom not subject to any serious dispute.

Notwithstanding the near-unanimity of views on the subject, it is devilishly difficult to find any hard data concerning the number of insureds who do read their policies either upon delivery or after a loss occurs. The most comprehensive empirical study conducted to date appears to be that described by Cummins, *et al.*, in their book titled *Consumer Attitudes Toward Auto and Homeowners Insurance*.¹³⁶ This work reports the results of a survey pertaining to automobile and homeowners insurance which was administered to a random sample of 2,462 individuals.¹³⁷ An extensive questionnaire was utilized in the survey, which required one to two hours to complete.¹³⁸ Among others, one question directed to all auto and homeowner insureds asked for the source of information that insureds would use in determining whether a loss was covered.¹³⁹ Just 11 percent of the respondents indicated that they would turn to the policy itself.¹⁴⁰ The question and the tabulated responses follow:

4s. (ASK ALL AUTO/HOMEOWNERS INSUREDS) When you have had questions about just what coverage you had in your auto or homeowners insurance policies, to whom have you turned to find out

134. *Brown v. Royal Maccabees Life Ins. Co.*, 137 F.3d 1236, 1244 (10th Cir. 1998).

135. *Storms v. U.S. Fidelity & Guar. Co.*, 388 A.2d 578, 580 (N.H. 1978).

136. J. DAVID CUMMINS ET AL., *CONSUMER ATTITUDES TOWARD AUTO AND HOMEOWNERS INSURANCE* (1974).

137. *Id.* at 3.

138. *See id.* at 233-81.

139. *Id.* at 240.

140. *Id.*

the answers—to your agent, to the company that insures you, the policy itself, to a friend, or whom?

(RECORD BELOW)

	Turn to Now
Your agent	77%
Insurance company	8%
Policy itself	11%
Friend	3%
Other (write in)	3%
<hr/>	
Not sure	1% ¹⁴¹

Two later studies have been conducted using far smaller samples. In June 1997, a study of 604 Canadians was conducted by KRC Researching & Consulting of New York.¹⁴² The results of that study were reported by *The Financial Post* in December 1997.¹⁴³ That study concluded that “Despite the \$1,000 or more most of us spend every year on car insurance, one-third of survey respondents do not bother to read their policies. And 40 percent with home insurance have not read their policies.”¹⁴⁴

The conventional wisdom was challenged, however, in a survey conducted by the Independent Insurance Agents of America.¹⁴⁵ In that study, the researchers concluded that 48 percent of insurance consumers “always” read and re-read their policies and 29 percent “sometimes” read and re-read their policies.¹⁴⁶

The extent to which insureds actually read their policies—whether upon receipt or after a loss occurs—has not been conclusively established. But the court decisions and expert commentary clearly posit that insureds do not—and are not expected to—read their policies or rely upon its contents to determine whether an actual or hypothetical claim is covered. Given the ubiquitous nature of statements in the literature to that effect, an insurer might reasonably conclude that it is not absolutely

141. *Id.*

142. Jonathan Chevreau, *Home, Auto Insurance Misunderstood*, THE FINANCIAL POST, Dec. 11, 1997, available at http://www.pollara.ca/Library/News/news_1211.html.

143. *Id.*

144. *Id.*

145. The results of this study were reported in USA TODAY, October 23, 1995, at 1A, cited in Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach*, 57 OHIO ST. L.J. 543, 550 n.22 (1996).

146. *Id.*

essential to remove a recently-invalidated policy provision, since few if any insureds would ever even realize that the provision was there in the first place.

7. The Insurer's Duty to Inform Insureds of Their Rights and Coverages Arises Only After a Loss has Occurred

No less an authority than noted insurance scholar Alan Widiss has remarked that an insurer's obligation to inform insureds about the existence of rights and duties regarding coverage for their losses is somewhat vague, and that it arises, if at all, only after a loss has occurred and a claim has been presented.¹⁴⁷ In his article titled *Obligating Insurers to Inform Insureds About the Existence of Rights and Duties Regarding Coverage for Losses*, Widiss suggested that insurers owe no duty to take action to advise the insureds about coverage matters unless and until they receive notice that the insured has sustained a loss.¹⁴⁸

147. See Alan I. Widiss, *Obligating Insurers to Inform Insureds About the Existence of Rights and Duties Regarding Coverage for Losses*, 1 CONN. INS. L.J. 67 (1995).

148. Widiss states:

In virtually all situations, until and unless an insurer received notification that an insured has sustained or may have sustained a loss as a result of a covered occurrence or event, the insurer has no basis for any action

After an insurance company has received notice of an event that may be covered by an insurance arrangement, the insurer is obligated to fulfill the contractual commitment by making an appropriate investigation of the event and then either disbursing the insurance benefits or explaining to the insured why benefits are not being paid. As enumerated by the authors of one article:

When insureds suffer losses and present claims, insurers are required to make initial determinations of the extent of their liabilities, if any. This includes verifying the existence of the losses, determining sufficient facts about the nature and circumstances of the losses to ascertain whether and to what extent there is coverage, interpreting the applicable policies to decide what coverage is available on the facts found, and determining the amount payable for any covered losses

Once an insurer has received notice of an occurrence, there is no reason to restrict the obligation to disclose relevant information about the insured's rights and duties

The substantial body of legislative enactments, administrative regulations, and judicial actions protecting the interests of insureds clearly attests that contractual arrangements for insurance occupy an important and special status in the United States. Consequently, it is not surprising that there is a body of judicial precedents requiring insurers to inform insureds about rights and duties in connection with possible claims for insurance benefits. Some writers have commented that the nature and scope of this obligation is not clearly defined:

One cannot predict how far the courts will ultimately extend the insurer's duty to inform

The other commentators that have examined this issue have arrived at the same conclusion. For example, in 1990, two insurance practitioners wrote an article acknowledging that insurers owe some duty to inform their insureds about available coverage.¹⁴⁹ While they concluded that “[b]ecause the duty is still ill-defined, its limits are unclear,”¹⁵⁰ they also clearly contemplated that the duty arose only after a loss had occurred and had become known to the insurer.¹⁵¹ In reviewing the then-current case law, they concluded that an insurer owed a duty to notify its insureds of their rights under the policy “only where the insurer has received evidence approximating a prima facie case of entitlement to benefits and, perhaps, only where the insurer is on notice (because of policy language that a layman is likely to misunderstand or otherwise) that notice is necessary for the insured to exercise available rights”¹⁵²

Likewise, in Jordan Stanzler’s article titled *The Duty to Disclose Coverage for Environmental Claims*,¹⁵³ Stanzler opined that “[i]nsurance companies have a duty to disclose coverage to their policyholders.”¹⁵⁴ But he too cited and discussed only cases dealing with an insurer’s duties after a loss has occurred, including a duty to refrain from “asserting an interpretation [of the policy] contrary to one’s own understanding, or falsification of facts.”¹⁵⁵

The notion that an insurer’s duty to disclose should arise only after the insurer has received notice of a loss creates problems for insurers and

the insured of the contents of his policy.

There now appears to be an emerging trend to impose on first-party insurers some duty to inform. Because the duty is still ill-defined, its limits are unclear.

When an insurance company is aware of something that may be helpful to an insured—including the existence of coverage, rights related to the coverage, or steps that need to be taken to preserve the right to recover—the insurer should be obligated to inform the insured.

Id. at 70-71, 89, 92, 94.

149. William T. Barker & Donna J. Vobornik, *The Scope of the Emerging Duty of First-Party Insurers to Inform Their Insureds of Rights Under the Policy*, 25 TORT & INS. L.J. 749, 749 (1990).

150. *Id.*

151. *Id.* at 752 (“When a loss occurs which because of its expertise the insurer knows or should know is within the coverage . . . , the obligation to deal with [the insured] takes on the highest burden of good faith.” (quoting *Bowler v. Fidelity & Cas. Co. of New York*, 250 A.2d 580, 588 (N.J. 1969))).

152. *Id.* at 753.

153. Jordan Stanzler, *The Duty to Disclose Coverage for Environmental Claims*, 16 BAD FAITH L. REP. 9 (Feb. 2000).

154. *Id.*

155. *Id.* (citing and quoting RESTATEMENT (SECOND) OF CONTRACTS § 205, cmt. e (1981)).

insureds alike. In most cases, it can fairly be assumed that when the loss occurs, the insured will not bother to read the policy but will instead contact his or her agent or the insurer's claims department. But in those rare instances where an insured does read the policy, it is at least possible that the insured could conclude that there is no coverage for his claim and for that reason refrain from submitting a claim. That perception may be incorrect because—unbeknownst to the insured—courts in that jurisdiction have either conditionally or unconditionally invalidated the provision that negates coverage. If that insured then neglects to file a claim because of his incorrect belief that there would be no coverage, then the insurer will never become aware of the loss and the duty to disclose will—if Professor Widiss is correct—never arise.

8. Some Decisions Implicitly Suggest that it is Not Necessary for Insurers to Remove Policy Provisions that Have Been Judicially Invalidated

Some court decisions not only suggest that it is unnecessary to remove the invalid provisions, but also implicitly hold that invalid provisions will automatically be revalidated if some statutory enactment or judicial change-of-heart makes the provision valid again. For example, in *Benson v. Rosler*,¹⁵⁶ the plaintiff was insured under an auto policy that included UM/UIM coverage.¹⁵⁷ The Supreme Court of Ohio was called upon to decide whether an anti-stacking provision that had been invalid and unenforceable under *Volkman*¹⁵⁸ became enforceable after the statute was amended to allow anti-stacking provisions and after the policy renewed at least once following the statutory amendment.¹⁵⁹ The court held that the previously invalid provision became valid and enforceable after the statute was amended and after there had been a post-amendment policy renewal.¹⁶⁰

An earlier court of appeals decision likewise suggested that there was no wrongdoing by an insurer when it issued a policy containing an

156. 482 N.E.2d 599 (Ohio 1985).

157. *Id.* at 600.

158. *See supra* notes 16-17 and accompanying text.

159. *Benson*, 482 N.E.2d at 601.

160. *Id.* (“The precise question herein is whether anti-stacking provisions contained within insurance policies obtained prior to the effective date of former R.C. § 3937.181 are null and void where such policies are renewed thereafter. Stated another way, where anti-stacking provisions were contained within the original policy issued at the time this court had pronounced such provisions to be against public policy, does the later legislative enactment and renewal of the policies with the original provisions remaining revitalize and give legal force to anti-stacking? We hold that such provisions are not void, and are to be given full legal force and effect.”).

“anti-stacking” provision that had already been declared unenforceable.¹⁶¹ Instead, the court simply ruled that the exclusion was to be treated as if it were never a part of the contract.¹⁶²

In doing so, the court observed that five months before the policy was issued, the Ohio Supreme Court had declared that “antistacking” exclusions—such as the one included in the policy—were contrary to public policy and therefore unenforceable.¹⁶³ But two years later, the governing statute was amended to specifically permit antistacking exclusions in uninsured motorist policies.¹⁶⁴ The insurer argued that the previously invalid exclusion was “given life” on the first renewal date following the statutory amendment, and that it therefore became enforceable at that time.¹⁶⁵ The plaintiff argued that, since the policy provided that its terms could only be changed by an endorsement issued by the defendant, the exclusion was unenforceable because no endorsement ever expressly reinstated the previously invalid exclusion.¹⁶⁶ The court of appeals agreed with the plaintiff, holding that the policy provision that was invalid when the policy was issued should be treated simply as if it were never a part of the policy.¹⁶⁷

Thus, two Ohio decisions have expressly confronted the problem caused by the continued presence of an invalid policy provision. In the earlier of the two, the court simply held that policy should be read as if the challenged provision was absent.¹⁶⁸ And in the second, not only did the court not fault the insurer for keeping the invalid provision in its policy, but it actually permitted the invalid provision to become valid and enforceable after the statute had been amended to permit the exclusion.¹⁶⁹ In each of these decisions, the courts could (and one would expect would) have attacked the practice of maintaining an invalid

161. See *Burkhart v. Motorists Ins. Co.*, No. 1167, 1982 WL 2846 (Ohio Ct. App. 1982).

162. *Id.* at *2.

163. *Id.* at *1.

164. *Id.*

165. *Id.*

166. *Id.*

167. *Id.* at *2 (“At the time that plaintiff’s policy of insurance was issued, it is clear that the existing Ohio law viewed the ‘anti-stacking’ exclusion as repugnant to public policy. Contractual provisions which are contrary to public policy are null and void. We must, therefore, agree with the court below that the exclusion was never a part of the original contract of insurance. Moreover, defendant does not dispute that no endorsements were ever issued containing the exclusion subsequent to the amendment of Ohio Rev. Code Ann. § 3937.18. In light of the contractual provision which expressly limits change in the terms of the policy except by endorsement, we must conclude that the disputed exclusionary language was not a part of the policy at the time of plaintiff’s accident.”).

168. *Id.*

169. *Benson v. Rosler*, 482 N.E.2d 599, 601 (Ohio 1985).

policy provision, if they were inclined to do so. The fact that they did not could be read to suggest that they found nothing wrong with the practice.

C. Reasons Why Insurers Arguably Should Remove Invalid Policy Provisions

There are, as the old bromide has it, two sides to every story. This is no exception. There are a number of reasons why insurers arguably are—or, at any rate, should be—required to remove invalid policy provisions within some specified period of time after they have been unconditionally invalidated. Each of these reasons is discussed at length in the sections that follow.

1. Insurers Occupy a Special Relationship That Imposes a Quasi-Fiduciary Duty

Courts have analogized the relationship between an insurer and its insureds to a fiduciary relationship.¹⁷⁰ There is some dispute as to whether the duty between an insurer and the insured is a fiduciary one. One commentator acknowledged that courts “have on occasion labeled the relationship ‘fiduciary’ without elaboration” but observed that most courts described the relationship as either fiduciary in nature or fiduciary-like without conferring full fiduciary status upon the insurer.¹⁷¹ That commentator therefore described the relationship as “semi-fiduciary.”¹⁷²

An argument could certainly be made that this semi- or quasi-fiduciary relationship poses a duty upon the insurer to disclose to its insureds that certain provisions have become invalid because of

170. See, e.g., *Motorist Mut. Ins. Co. v. Said*, 590 N.E.2d 1228, 1235 (Ohio 1992) (“[T]he duty of an insurance company to its insured is analogous to that of a fiduciary.”); *Red Head Brass, Inc. v. Buckeye Union Ins. Co.*, 735 N.E.2d 48, 59 (Ohio Ct. App. 1999) (“In Ohio, an insurance company has a fiduciary responsibility toward its insured to act in good faith toward its insured in carrying out its duties under the contract.”); *Martin v. Grange Mut. Ins. Co.*, 757 N.E.2d 1251, 1255 (Ohio Ct. App. 2001) (“[T]he relationship between an insurance company and its policyholders is comparable to that of a fiduciary”); *Sammarco v. Anthem Ins. Cos., Inc.*, 723 N.E.2d 128, 135 (Ohio Ct. App. 1998) (“The existence of a duty of good faith and fair dealing between an insurer and an insured is based on the fiduciary duty imposed upon insurers.”); *Moskowitz v. Progressive Ins. Co.*, 811 N.E.2d 174, 183 (Ohio Ct. Com. Pl. 2004) (“[A] breach of fiduciary duty in the context of an insurer/insured relationship arises when the insurer fails to perform under the contract or unreasonably refuses to act in a prompt manner in performing its contractual duties.”).

171. 1 JEFFREY W. STEMPEL, *STEMPEL ON INSURANCE CONTRACTS* § 10.02[A] n.15 (3d ed. Supp. 2009).

172. *Id.*

intervening court decisions. The United States Supreme Court has held that the “duty to disclose arises when one party has information that the other is entitled to know because of a fiduciary or other similar relation of trust and confidence between them.”¹⁷³ Ohio courts have likewise recognized a duty to disclose in instances where there is a business transaction between two parties having a “special” or “confidential” relationship.¹⁷⁴ But having said that, these courts have also held that the quasi-fiduciary or other heightened relationship between insurer and insured does not include a duty to disclose changes in the law that arise from court decisions.¹⁷⁵

Moreover, many bad faith decisions imply that the duty of good faith between the insurer and the insured is limited to the conduct of an insurer with respect to the investigation, handling and payment of claims. For example, in *Hoskins v. Aetna Life Ins. Co.*,¹⁷⁶ the Ohio Supreme Court held that “[b]ased upon the relationship between an insurer and its insured, an insurer has the duty to act in good faith *in the handling and payment of the claims of its insured.*”¹⁷⁷ And while later decisions have noted that “the duty of good faith extends beyond those

173. *Chiarella v. United States*, 445 U.S. 222, 228 (1980).

174. *See, e.g.*, *Binsack v. Hipp*, No. H-97-029, 1998 WL 334223, at *4 (Ohio Ct. App. June 5, 1998) (“A party in a business transaction with another with whom he is in a fiduciary relationship must fully disclose material facts known to him but not to the other.”); *Stern v. The Union Institute*, No. C-960314, 1997 WL 133358, at *2 (Ohio Ct. App. March 26, 1997) (“Where a special relationship is found, there is a duty of disclosure ordinarily imposed, and it includes, or may include, not only a duty to disclose facts, but to furnish honest judgment and advice as well”); *Starinki v. Pace*, 535 N.E.2d 328, 331 (Ohio Ct. App. 1987) (“The duty to speak does not necessarily depend on the existence of a fiduciary relationship. It may arise in any situation where one party imposes confidence in the other because of that person’s position, and the other party knows of this confidence.”).

175. *See, e.g.*, *Martin v. Grange Mut. Ins. Co.* 757 N.E.2d 1251, 1255 (Ohio Ct. App. 2001) (“[A]ppellee did not have a legal duty to notify appellants of Martin and the corresponding effect of the decision on their insurance policies.”); *Cincinnati Equitable Ins. Co. v. Wells*, No. 20286, 2004 WL 1072270, at ¶¶ 18-19 (Ohio Ct. App. May 14, 2004) (holding that an insurer that issued an automobile liability policy did not breach its fiduciary duty to its insured when it failed to explain the significance of the adoption of a new version of R.C. 3937.18); *Stefanov v. Grange Mut. Cas. Co.*, No. 70209, 1997 WL 476829, at *7 (Ohio Ct. App. Aug. 21, 1997), appeal not allowed 687 N.E.2d 296 (Ohio 1997) (“[T]his court is unable to find case law in support of plaintiff-appellee’s position that the analogous duty requires the insurance company to advise the insured regarding the status of the law on uninsured motorist coverage.”); *Walter v. Allstate Ins. Co.*, No. 96-CA-84, 1997 WL 219229, at *2 (Ohio Ct. App. Apr. 10, 1997), appeal not allowed 683 N.E.2d 792 (Ohio 1997) (“The trial court erred in imposing on an insurer a duty to notify its insured of changes in the law, and the corresponding effect on the policy.”).

176. 452 N.E.2d 1315 (Ohio 1983).

177. *Id.* at 1316 (emphasis added).

scenarios involving an outright denial of payment for a claim,¹⁷⁸ those cases nevertheless continue to apply the duty of good faith in the limited context of claims handling.

While there is therefore some uncertainty about whether the heightened relationship between an insurer and its insured could justifiably form the basis for an argument that the insurer is obligated to remove provisions that have been invalidated by intervening court decisions, it is certainly an argument that could be made.

2. Insurers May Be Obligated to Act on Their Superior Knowledge, the Nondisclosure of Which May Be Actionable

Courts have held that insurance companies essentially occupy the status of experts, and that it is incumbent upon them to draft policies that are consistent with state law. For example, in *Donahue v. Associated Indem. Corp.*,¹⁷⁹ a husband and wife brought suit against their insurer presenting an uninsured motorist claim.¹⁸⁰ The uninsured motorist provisions of the policy contained an arbitration clause, which required that any dispute regarding the amount of payment or whether the insured was legally entitled to recover damages from an uninsured motorist be settled by binding arbitration.¹⁸¹ However, contrary to the requirements of the statute, that arbitration provision was not placed immediately before the testimonium clause.¹⁸²

The Rhode Island Supreme Court held that because the insurer failed to place the arbitration clause in the portion of the policy required by statute, the provision was unenforceable.¹⁸³ In doing so, the Court held that the fact that the insured might never see or consult the relevant provisions of the policy was immaterial.¹⁸⁴ Instead, because the insurer had written the policy, the Court held that it was the party obligated to draw an agreement consistent with statutory requirements.¹⁸⁵

178. *Drouard v. United Services Auto Assn.*, No. L-06-1275, 2007 WL 707532, at ¶ 16 (Ohio Ct. App. March 9, 2007).

179. 227 A.2d 187 (R.I. 1967).

180. *Id.* at 188.

181. *Id.* at 188-89.

182. *Id.* at 189.

183. *Id.* at 190.

184. *Id.*

185. *Id.* (“While it may be, as defendant alleges, that this provision is inappropriate for use in the insurance industry, particularly since the insured never or infrequently signs the policy, the wisdom of retaining this requirement is not for us but for the general assembly. It is on the statute books of our state and its mandate must be obeyed. There is a testimonium clause in this policy but it is separated by many pages and various provisions from the clause requiring arbitration. This

The Court went on to say that the insurer was not excused from the statutory requirements by the fact that it had filed a policy form and had received the blessing of the insurance commissioner.¹⁸⁶ Instead, the Court concluded that “[t]he fact that the commissioner approved the provisions of the policy does not give validity to an invalid act.”¹⁸⁷

The same “superior knowledge” argument might be applied where a policy provision was valid when filed with the commissioner, but which later became invalid because of an intervening court decision. The American Law Institute has suggested that might be the case in Section 551 of the *Restatement (Second) of Torts*.¹⁸⁸ A duty to tell insureds that a policy provision has been invalidated could conceivably arise under Section 551(2)(a), (b), or (c). In fact, the official comment on clause (a) specifically mentions insurance as one of the types of contracts giving rise to a duty to disclose under Section 551(2)(a).¹⁸⁹

For precisely the same reasons that underlie Section 551, the Pennsylvania Attorney General has concluded that it is inappropriate for insurers knowingly to file policies for approval that contain invalid

policy has been drawn by the insurer and it is charged with the obligation of drawing an agreement that conforms to the statutory directions of the general assembly.”).

186. *Id.*

187. *Id.* at 190-91.

188. The Restatement provides:

§ 551. LIABILITY FOR NONDISCLOSURE

(1) One who fails to disclose to another a fact that he knows may justifiably induce the other to act or refrain from acting in a business transaction is subject to the same liability to the other as though he had represented the nonexistence of the matter that he has failed to disclose, if, but only if, he is under a duty to the other to exercise reasonable care to disclose the matter in question.

(2) One party to a business transaction is under a duty to exercise reasonable care to disclose to the other before the transaction is consummated,

(a) matters known to him that the other is entitled to know because of a fiduciary or other similar relation of trust and confidence between them; and

(b) matters known to him that he knows to be necessary to prevent his partial or ambiguous statement of the facts from being misleading; and

(c) subsequently acquired information that he knows will make untrue or misleading a previous representation that when made was true or believed to be so; and

(d) the falsity of a representation not made with the expectation that it would be acted upon, if he subsequently learns that the other is about to act in reliance upon it in a transaction with him; and

(e) facts basic to the transaction, if he knows that the other is about to enter into it under a mistake as to them, and that the other, because of the relationship between them, the customs of the trade or other objective circumstances, would reasonably expect a disclosure of those facts.”

RESTATEMENT (SECOND) OF TORTS § 551 (1997).

189. *Id.* at cmt. f (“[C]ertain types of contracts, such as those of . . . insurance . . . , are recognized as creating in themselves a confidential relation and hence as requiring the utmost good faith and full and fair disclosure of all material facts.”).

provisions.¹⁹⁰ In *Time Limitations in Accidental Benefit Policies*, the state insurance commissioner was asked to approve a policy form that included an unenforceable provision.¹⁹¹ The Attorney General concluded that he could not and would not approve a policy form that would mislead insureds about the scope of coverage.¹⁹²

Courts have held that Section 551 imposes an obligation on insurers to make disclosures of material facts to their insureds, regardless of whether the information is specifically requested. For example, in *Wells v. John Hancock Mut. Life Ins. Co.*,¹⁹³ the court held that an insurer was under a duty to inform the assignee of a life insurance policy that, at the time of the assignment, the policy had lapsed for non-payment of premiums.¹⁹⁴ Likewise, in *Butcher v. Truck Ins. Exchange*,¹⁹⁵ the court held that disparity in knowledge could impose an affirmative duty of disclosure on an insurer or its agent.¹⁹⁶

Again, in *Azar v. Prudential Ins. Co. of America*,¹⁹⁷ the court held that material issues of fact existed as to the materiality of undisclosed information about the additional cost of paying policy premiums in installments.¹⁹⁸ A similar conclusion was reached in *Smoot v. Physicians Life Ins. Co.*,¹⁹⁹ The *Smoot* Court held that the plaintiff pled facts sufficient to assert a common law duty to disclose, which the

190. *Time Limitations in Accident Benefit Policies*, 65 Pa. D. & C.2d 17 (Pa. Att’y Gen. Apr. 26, 1974).

191. *Id.*

192. *Id.* at 20-21, 24 (“It has also been contended that no changes need be made in the policies themselves, since the Supreme Court has found them unenforceable, and, perforce, lower courts will be bound by that decision in subsequent cases. But, insurance policies containing such terms, even though unenforceable, are likely to cause policyholders to forego meritorious claims in the mistaken belief that the terms are, in fact, enforceable. The general public relies on the Insurance Department’s duty to approve policies, and, consequently, terms appearing in policies have a greater appearance of State-sanctioned enforceability than terms appearing in ordinary contracts. While your department’s approval of a policy is not a statement that all terms are, in your opinion, enforceable, you should act to eliminate indubitably unenforceable terms in order that claimants will not be misled. Therefore, when court decisions modify interpretations of specific contract language, the Insurance Department must take cognizance of these changes in carrying out its responsibilities under law. . . . Common sense dictates that approval or disapproval of contract forms calls for the exercise of reasonable discretion. The insurer as well as the insured deserves the protection of the commissioner in avoiding unlawful provisions. The same reason exists for similar protection in the avoidance of ambiguous or other unwarranted provisions.”).

193. 85 Cal.App.3d 66 (Ct. App. 1978).

194. *Id.* at 72.

195. 77 Cal.App.4th 1442 (Ct. App. 2000).

196. *Id.* at 1464.

197. 68 P.3d 909 (N.M. Ct. App. 2003).

198. *Id.* at 936.

199. 87 P.3d 545, 549 (N.M. Ct. App. 2003).

insurer breached when it failed to inform the insured of the additional costs associated with paying premiums monthly rather than annually.²⁰⁰

While decisions on the scope of an insurer's obligation to disclose material facts are few, the courts and commentators have held that an insurer's duty of good faith "demands that the insurer deal with laymen as laymen and not as experts in the subtleties of law and underwriting."²⁰¹ Respected insurance scholar Allen Widiss notes that under Section 551, "fraudulent misrepresentations can result from a failure to disclose information, as well as from incorrect statements."²⁰² Further, he notes that the insurer is "in a position to know that a failure to disclose the coverage is likely to result in an insured's not pursuing benefits which are available under the coverage afforded by the applicable insurance."²⁰³

In his article, Widiss quotes Justice Tobriner's majority opinion in *Davis v. Blue Cross of Northern California*,²⁰⁴ wherein the California Supreme Court observed that insurers may have an affirmative obligation to disclose information to insureds, whenever nondisclosure might otherwise result in a loss of benefits or a forfeiture of rights.²⁰⁵ The majority opinion in *Davis* provides in pertinent part that:

[I]n situations in which an insured's lack of knowledge may potentially result in a loss of benefits or a forfeiture of rights, an insurer has been required to bring to the insured's attention relevant information so as to enable the insured to take action to secure rights afforded by the policy.²⁰⁶

These precepts were applied in the case of *Weber v. State Farm Mut. Auto Ins. Co.*²⁰⁷ In *Weber*, State Farm issued an auto insurance policy that contained a family exclusion.²⁰⁸ A reading of the policy alone would suggest to a lay reader that UM/UIM coverage was barred by the exclusion. However, an Iowa Supreme Court decision had held that insureds were entitled to uninsured motorist benefits despite the

200. *Id.* at 549-50.

201. Widiss, *supra* note 147, at 75 (citing *Bowler v. Fidelity & Cas. Co. of New York*, 250 A.2d 580, 587 (N.J. 1969)).

202. *Id.* at 83.

203. *Id.* at 84.

204. 600 P.2d 1060 (Cal. 1979).

205. *Id.* at 1065-66.

206. *Id.* at 1065-66.

207. 873 F. Supp. 201 (S.D. Iowa 1994).

208. *Id.* at 203.

presence of the family exclusion.²⁰⁹ The State Farm policy had never been changed to take this Supreme Court ruling into account.²¹⁰

The plaintiff sustained an injury and retained an attorney.²¹¹ The attorney discussed the case with a State Farm representative.²¹² The attorney was unaware of the Iowa Supreme Court decision, and the adjuster failed to point it out.²¹³ The Court held that State Farm's failure to disclose the existence of this coverage (which was not apparent from the face of the policy) constituted fraudulent nondisclosure.²¹⁴ The Court held that under Section 551, State Farm violated its duty to disclose this information to its insureds.²¹⁵ After citing to and discussing Section 551, the *Weber* Court concluded that "under the circumstances of this case, the defendant was under a duty to exercise reasonable care to disclose the uninsured motorist coverage."²¹⁶

On several other occasions, courts have held that an insurer's retention of an invalid policy provision, coupled with its later failure to disclose that the provision was invalid when a claim was presented, created a jury question on the insurer's bad faith and potential liability for punitive damages. For example, in *Richards v. Allstate Ins. Co.*,²¹⁷ Allstate issued an auto insurance policy that included a clause excluding other owned autos, even though such clauses were unenforceable under applicable state law.²¹⁸ A claim arising out of the use of an other owned auto was presented.²¹⁹ The adjuster who handled the claim denied it, citing the invalid and unenforceable exclusion.²²⁰ The insureds sued for bad faith, alleging that punitive damages were justified not only by the denial of the claim, but also because of the retention of the invalid exclusion in the policy and the failure to provide an adequate procedure to prevent erroneous denials.²²¹ The court held that the continued retention of this invalid exclusion was a sufficient basis to support an award of punitive damages.²²²

209. *Id.*

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.* at 209.

215. *Id.* at 208-09.

216. *Id.* at 209.

217. 693 F.2d 502 (5th Cir. 1982).

218. *Id.* at 504.

219. *Id.*

220. *Id.*

221. *Id.*

222. *Id.*

In doing so, the *Richards* Court observed that Allstate retained the invalid “other owned auto” exclusion in its policy until 1981, even though the state Supreme Court had struck down a similar exclusion in another company’s policy eight years earlier.²²³ While Allstate officials admittedly were aware of this decision and its effect on the other owned auto exclusion, they neither deleted the exclusion from their policy nor made any effort to inform their insureds or sales agents of the effect of the decision or its effect on policy coverage.²²⁴ Instead, claims personnel were simply instructed to honor claims that would otherwise have been denied based on the exclusion.²²⁵ But in the case of the plaintiff, that procedure failed and his claim was denied.²²⁶

The court observed that there was no way to determine how many insureds may have refrained from presenting claims based on the presence of the invalid exclusion.²²⁷ It concluded that the failure to delete the exclusion after it was invalidated may have been sufficiently culpable to warrant the imposition of punitive damages.²²⁸ Allstate then attempted to justify its conduct by referring to a policy provision which stated that “[s]uch terms of this policy as are in conflict with statutes of the state in which this policy is issued are hereby amended to conform.”²²⁹ Allstate argued that “this provision corrected any deficiency in the policy.”²³⁰ The *Richards* Court vehemently disagreed.²³¹

223. *Id.* at 505.

224. *Id.* at 504.

225. *Id.*

226. *Id.*

227. *Id.* at 505.

228. *Id.* (“Allstate urges that its procedure was successful in every case except *Richards*’. Even accepting this as true, this procedure provided no remedy for those policyholders who read Exclusion 2, assumed their injuries were not covered, and failed to file claims. Failure to delete Exclusion 2 in effect represented a corporate decision by Allstate not to inform its policyholders of undisclosed coverage required by Mississippi law. Whether this conduct was sufficiently culpable to justify an award of punitive damages was a question for the jury. The jury obviously believed that it was.”).

229. *Id.* at 505.

230. *Id.*

231. *Id.* (“This argument strains credibility. If it were accepted, Allstate could include in its policies any sort of invalid exclusion and then rely on change provision 5 when challenged. This would mean that policyholders, not insurance companies, would bear the burden of keeping abreast of changes in the law. Clearly this is not the intent of Mississippi’s insurance code. Exclusion 2 as written and as retained in Allstate’s policies from 1973 until well after 1977 was invalid under Lowery. Under the court’s instructions the jury necessarily found that Allstate’s failure to remove Exclusion 2 from its standard automobile policy until after this suit was filed was grossly negligent. This finding is supported by the proof.”).

To the same effect is *Tucker v. Aetna Cas. & Surety Co.*²³² In that case, Aetna issued a policy to the plaintiffs (and to other residents of Mississippi) containing provisions that limited UM coverage in a manner contrary to settled Mississippi law.²³³ After suit was filed, Aetna representatives testified that Aetna knew the provision was illegal under Mississippi law but, despite that knowledge, continued to incorporate the illegal provision into its policies.²³⁴ Aetna contended, however, that the plaintiff had not been harmed because Aetna had made no attempt to enforce the invalid terms in the claim presented by the plaintiffs in this case.²³⁵

In determining whether this conduct justified an award of compensatory and punitive damages, the *Tucker* court cited and discussed the *Richards* decision at length.²³⁶ It then concluded that Aetna's retention of the invalid provision in its policy for more than a decade after it had been declared to be invalid supported an award of both compensatory and punitive damages.²³⁷ Aetna's mistake in retaining the policy was compounded by its continuing to enforce that provision, in clear contravention of the Supreme Court decisions striking down similar exclusions in the policies of other companies.²³⁸ The Court concluded that the dual error of retaining the invalid provision and urging its enforcement was tantamount to an intentional tort that justified the imposition of punitive damages.²³⁹

Also instructive is *Ex parte State Farm Mut. Auto. Ins. Co.*,²⁴⁰ wherein the insured was injured in an accident and requested uninsured

232. 609 F. Supp. 1574 (S.D. Miss. 1985).

233. *Id.* at 1576.

234. *Id.*

235. *Id.* at 1577.

236. *Id.* at 1581-82.

237. *Id.* at 1583.

238. *Id.* at 1582.

239. *Id.* at 1583 ("It is the opinion and finding of this Court that the actions on the part of Aetna Casualty & Surety Company in maintaining the illegal provision in its policy for more than eleven years after the Mississippi Supreme Court had declared similar provisions to be invalid and in maintaining a procedure in its claims manual (which was being used in Mississippi at the time of the initial adjustment of this file) which instructs Aetna's adjuster to enforce the illegal provision of its policy, constitutes gross and willful negligence on the part of Aetna and entitles Plaintiffs to punitive damages. It is further the opinion of this Court that the actions of Aetna were attempts to reduce the uninsured motorist coverage by amounts of payments made under the medical payments coverage of the policy in question. The actions of Aetna were in violation of Mississippi law, and constitute willful and gross negligence and constitute an intentional and independent tort. The Court is further of the opinion that the Defendant, Aetna, has acted in a careless and reckless manner with disregard for the rights of Plaintiffs as insureds under its own policy." (emphasis added)).

240. 452 So. 2d 861 (Ala. 1984).

motorist benefits.²⁴¹ State Farm had retained a clause in its policy limiting UM coverage to a single per person limit, even though that clause had been struck down twelve years earlier.²⁴² After the insured settled for a single \$10,000 limit, he learned that the provision was invalid.²⁴³ He filed suit, alleging that State Farm's actions in retaining invalid provisions in its policies restricting coverage, "without amending those provisions or otherwise notifying its insureds that additional coverage was available, constituted a fraudulent scheme, plan, or devise to defraud its policyholders."²⁴⁴ The court held that information concerning the number of others who had been paid only a single \$10,000 limit was discoverable in support of the fraud claim.²⁴⁵

A similar situation arose in *Employers Mut. Cas. Co. v. Tompkins*.²⁴⁶ In that case, an adjuster "accidentally" enforced an "other owned auto" exclusion that had been held to be invalid and unenforceable.²⁴⁷ Again citing *Richards*, the court concluded that the insurer's continued inclusion of the invalid provision, coupled with its accidental enforcement of that exclusion, was sufficient to send the punitive damage claim to the jury.²⁴⁸ The court was unpersuaded by the argument that the experienced adjuster who handled the claim made a "simple mistake" that did not justify the imposition of punitive damages.²⁴⁹ The court noted that this "simple mistake" was "not in misreading the exclusion but in correctly reading a void exclusion contained in his company's policies."²⁵⁰

Finally, in *Independent Life & Acc. Ins. Co. v. Peavy*,²⁵¹ the insurer wanted a jury instruction that it could not be held liable for punitive damages when its adjuster enforced an invalid exclusion that remained

241. *Id.* at 862.

242. *Id.* at 863.

243. *Id.* at 862.

244. *Id.*

245. *Id.* at 863 ("The plaintiff/insured has charged State Farm with fraud and having engaged in a plan or scheme to defraud its policyholders by retaining a clause in its policies and withholding from its insureds the fact that the clause, limiting its liability to one uninsured motorist coverage, has been invalid in Alabama since 1970, by the holding of *Safeco Ins. Co. of America v. Jones*, 243 So. 2d 736, (Ala. 1970). Evidence of similar fraudulent acts are, of course, admissible to prove the alleged fraudulent scheme. *Cartwright v. Braly*, 117 So. 477 (Ala. 1928). Thus, it would appear that the time period over which the discovery is sought is not unreasonable, since the plaintiff's claim was made in 1972. We hold that the trial court did not abuse its discretion in this regard.")

246. 490 So. 2d 897 (Miss. 1986).

247. *Id.* at 903.

248. *Id.* at 905.

249. *Id.* at 903.

250. *Id.*

251. 528 So. 2d 1112 (Miss. 1988).

in the policy.²⁵² The trial court refused the requested instruction, and the court of appeals affirmed.²⁵³ In doing so, it held that the insurer “cannot simply ignore changes in the law”²⁵⁴ The court ultimately concluded that while the retention of an invalid provision will not *always* justify the imposition of punitive damages, it is equally incorrect to say that it could *never* be held liable (even for compensatory damages) when it attempted to enforce an invalid exclusion.²⁵⁵

In almost all of these cases, the insurer not only failed to remove an invalid provision, but also attempted to enforce it. While that may be a very significant distinction from cases where the provision remained but was never enforced, it does signal an emerging concern being expressed by courts over the retention of invalid policy provisions.

3. Insurers Intentionally Foster Trust Through Their Advertising

As early as 1979, it was observed that by purchasing an insurance contract, a policyholder typically seeks the peace of mind and security which arises from the purchase of protection against calamity.²⁵⁶ That insureds purchase insurance coverage in order to obtain security and peace of mind is well recognized in the literature.²⁵⁷

It is equally well recognized that, in their marketing and promotional activities, insurers focus at least as much on the concepts of security, trustworthiness, integrity and peace of mind as they do on the substantive coverage itself. This observation was made more than two decades ago in Russell H. McMains’ article titled *Bad Faith Claims Handling New Frontiers: A Multi-State Cause of Action in Search of a*

252. *Id.* at 1119.

253. *Id.* at 1120.

254. *Id.* at 1119.

255. *Id.* (“We do not suggest that punitive damages are always appropriate whenever an insurance policy contains a provision which is invalid under state law. An insurer is not, however, entitled to a peremptory instruction on liability to the effect that the insurer can never be liable (even for actual damages) when it acts in accordance with the provisions of its policy, regardless of their invalidity.”).

256. *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal.3d 809, 819 (Cal. 1979), *cert denied* 445 U.S. 912 (1980).

257. DIANE L. POLSCER & BRETT W. SOMMERMEYER, *LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION* § 2:8 (David L. Leitner et al. eds., 2008) (“People insure themselves for peace of mind and security”); STEPHEN S. ASHLEY, *BAD FAITH ACTIONS LIABILITY & DAMAGES* § 2:14 (2008) (“Insurance consumers purchase insurance for the sake of their personal security and peace of mind, not commercial advantage.”); ALLAN D. WINDT, *INSURANCE CLAIMS AND DISPUTES* § 9:24 (5th ed. 2008) (“Moreover, unlike other contracts, an insurance contract is entered into in large part to provide peace of mind.”).

Home.²⁵⁸ One of the earliest observers of this phenomenon was Justice Lent in his dissent in *Farris v. U.S. Fidelity and Guaranty Co.*²⁵⁹

More recent cases have acknowledged that such advertising may be considered by a jury in assessing the relationship between insurer and insured to determine if it is one of trust and confidence (and therefore tantamount to a fiduciary relationship). That was held to be the case in *Dornberger v. Metropolitan Life Ins. Co.*²⁶⁰ In *Dornberger*, a policyholder who purchased policies through a life insurer's allegedly illegal overseas operation brought a putative class action against the insurer alleging RICO violations and seeking rescission in damages under state law.²⁶¹ The insurer moved to dismiss.²⁶² The court for the most part denied the motion to dismiss, finding that the majority of the policyholder's claims were maintainable.²⁶³ The court specifically held that MetLife's advertising activities—which sought out expatriated Americans through an advertising campaign aimed at assuaging their concerns and promising personalized service—was sufficient to create a jury question on whether a relationship of trust and confidence had been established.²⁶⁴ In doing so, the court mentioned that the *Appleman* insurance law treatise had observed that the failure to recognize a fiduciary relationship between insurers and their insureds may be “out of step with current concepts,” particularly in light of insurer advertising activities.²⁶⁵

258. Russell H. McMains, *Bad Faith Claims Handling-New Frontiers: A Multi-State Cause of Action in Search of a Home*, 53 J. AIR L. & COM. 901, 904 (1988) (“A second and related concern is the expectation of the insurance-consuming public which the industry has fostered itself. Allstate's slogan ‘You're in Good Hands,’ Travelers' motto of protection ‘Under the Umbrella,’ and Fireman's Fund's symbolic protection beneath the ‘Fireman's Hat,’ exemplify the industry's own efforts to portray itself as a repository of the public trust. But with the public trust may be visited responsibility for a violation of such trust as evidenced by recent recognition of extra-contractual ‘rights’ of insureds or tortious responsibility of insurers beyond the four corners of its insuring agreement – particularly in the first-party area.”).

259. 587 P.2d 1015, 1028 n.4 (Or. 1978) (“That insurers sell their product as being not only an agreement to indemnify the insured for certain kinds of loss but also to relieve the purchaser from anxiety concerning all aspects of claims is readily apparent in our society. One cannot watch nationally televised entertainment for very long without being exposed to commercials for the sale of insurance which, for example, indicate that the purchaser will be in ‘good hands,’ that he will have the assistance of a troop of mounted cavalry, that he has ‘a piece of the rock,’ or that ‘like a good neighbor’ the insurer will be there. ***As such advertisements reflect, the relationship between insurer and insured does not merely concern indemnity for monetary loss.***” (emphasis added)).

260. 961 F. Supp. 506 (S.D. N.Y. 1997).

261. *Id.* at 513.

262. *Id.*

263. *Id.* at 550.

264. *Id.* at 546-47.

265. *Id.* at 547 n.39.

Regardless of whether the insurer's duty to the insured is described as fiduciary, its knowing inclusion or retention of an invalid policy provision will be problematic. Virtually every insurer would agree, if questioned, that there are times when its policy language must be added, deleted, or changed. Insurers must surely admit that there have been occasions in the past when they have added or changed policy provisions in response to a change in the law (whether it be by statute or a court decision), and many insurers have deleted policy provisions from time to time over the years as a result of changes in the law. It would likely strike an impartial observer that under those circumstances, the knowing inclusion or retention of an invalid provision that is favorable to the insurer is somehow unethical, improper, or unfair.

Most insurance executives would probably agree that an insured should be able to determine what claims are covered by reading their policy. If they do, then the insurer will have indicted itself for failing to remove an invalid provision. If they do not, then a jury might fairly wonder why the insurer bothers to reduce the policy to writing at all, if the customer cannot rely upon it to determine what is covered and what is not.

III. SHORTCOMINGS OF EXISTING REMEDIES

It is fairly easy to make the case that insurers should, at least under some circumstances, be required to remove invalid provisions from their policies. But no statute or regulation currently requires it, and garden variety tort lawsuits are poorly suited as a vehicle to impose such a requirement. The reasons why this is so are discussed in the following sections.

A. Common Law Remedies

1. There Can Be No Tort Remedy Without Reliance and Damages

The principal reason traditional tort remedies fail to meaningfully address the problem of invalid policy provisions is simple. Since virtually no one reads their insurance policy—and since even fewer are acquainted with case law that makes any given provision unenforceable—they never realize that the invalid provision is even present. They do not rely on its presence, or presumptive validity, in making any decisions, and they sustain no damage as a result.

The goal of tort law is to make injured plaintiffs whole for the damages they have sustained as a proximate result of the tortious

conduct.²⁶⁶ In the case of insurers retaining invalid provisions, those remedies will necessarily be based on negligence or some species of nondisclosure. But negligence, nondisclosure, and fraud all require not only a breach of duty by the actor, but also that damages proximately result from that breach. The fraud and nondisclosure torts make this requirement even more clear by explicitly requiring that the plaintiff justifiably *rely* upon the misstatement.

Taking the example, then, of an invalid “other owned auto” exclusion, the fact is that most insureds will never incur an uninsured or underinsured motorist claim while they are operating an auto they own that is not covered under the policy. None of these insureds can have legitimate tort claims arising out of presence of the invalid policy provision.

Of those that do have such claims, the overwhelming likelihood is that they will not check their policy to see if it is covered, but will instead report the claim to the agent or directly to the insurance company. In that case, the insurer will (presumably) investigate, adjust, and ultimately pay the claim, despite the presence of the invalid policy provision. Thus, once again, even the insureds who sustain a loss that would purportedly be excluded by the invalid provision have no damages proximately resulting from its continued presence.

The only insureds who would have damages proximately resulting from the presence of the invalid provision would be those who sustained a loss, consulted their policy, read the provisions purporting to bar coverage, concluded (incorrectly) that any claim would be barred by the provision, and for that reason did not bother to present a claim to their insurer. If any lay insureds have ever gone through this elaborate self-help process to determine whether they have a covered claim (at least in cases involving an invalid policy provision purporting to bar their claim), their identities are not ascertainable from any reported case.

While it seems odd that there would be no tort remedy for the knowing inclusion or retention of an invalid policy provision, the tort requirements of reliance, proximate cause, and damages would vitiate virtually all such claims. And in cases where a provision was valid when the policy was issued, but was later invalidated while the policy was in effect, the “filed form” doctrine next described might also serve to bar such a claim.

266. 22 AM JUR. 2D *Damages* § 28 (2007) (“The sole object of compensatory damages is to make the injured party whole for losses actually suffered . . .”).

2. The Filed Rate/Filed Form Doctrine May Bar Tort Claims

Another potential bar to relief under any common law theory comes in the form of the filed form doctrine. The filed form doctrine is a variant of the more familiar “filed rate” doctrine.

In many states, insurers are required to file copies of the policies, endorsements, riders, and rates that they intend to use. Ohio is one of the states that uses the “file and use” system of form and rate regulation.²⁶⁷ Under that form of regulation, a copy of every policy, endorsement, rider, manual of classifications, rules, rate, and rating plan is filed with the Department of Insurance.²⁶⁸ The filing must state the proposed effective date and indicate the character and extent of the coverage contemplated.²⁶⁹ Under the Ohio statute, except for special situations involving determinations of lack of competition in rates in certain lines of insurance, each form becomes effective immediately upon its filing and is deemed to comply with the applicable statutory requirements, unless explicitly disapproved by the superintendent of insurance.²⁷⁰

This regulatory review and approval of policy forms could well be deemed to have the same effect on creating an indisputable presumption of correctness and immunity from attack as occurs with filed and approved rates and premiums. That so-called “filed rate doctrine” is described at length below.

a. The “Filed Rate” Doctrine

The “filed rate” doctrine—which applies to rates that have been filed with and approved by the governing regulatory agency—holds that those filed rates are “*per se* reasonable and unassailable in judicial proceedings brought by ratepayers.”²⁷¹ The filed rate doctrine applies in any case where the rate was approved by a federal or state agency.²⁷² This doctrine has been specifically applied in the insurance context to

267. See OHIO REV. CODE ANN. § 3937.03(A) (West 2009).

268. *Id.*

269. *Id.*

270. OHIO REV. CODE ANN. § 3937.03(C)(2) (West 2009).

271. *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 18 (2d Cir. 1994). See also *Taffet v. The Southern Co.*, 967 F.2d 1483, 1494 (11th Cir. 1992) (“Where the legislature has conferred power upon an administrative agency to determine the reasonableness of a rate, the rate-payer can claim no rate as a legal right that is other than the filed-rate.”); *Office of Consumers’ Counsel v. Pub. Util. Com.*, 575 N.E.2d 157, 165 (Ohio 1991) (recognizing the “well-established filed rate doctrine”).

272. See *Taffet*, 967 F.2d at 1494 (citing *H.J. Inc., v. N.W. Bell Tel. Co.*, 954 F.2d 485, 494 (8th Cir. 1992)).

bar private lawsuits that directly or indirectly challenge a premium rate which has been filed with and approved by a state department of insurance.²⁷³

The filed rate doctrine serves several important objectives. For example, it preserves the exclusive role of regulatory agencies in approving rates that are “reasonable” by “keeping courts out of the rate-making process.”²⁷⁴ Thus, the filed rate doctrine “precludes any judicial action which undermines agency rate-making authority.”²⁷⁵

As the court explained in *Prentice v. Title Ins. Co.*,²⁷⁶ insurers cannot be forced to conform to both the requirements of an insurance department and also the whims of a lay jury, because doing so “would place insurers in a procrustean bed where one rate must conform to the requirements of both the Insurance Commissioner and a trier of fact.”²⁷⁷

Many courts have applied the filed rate doctrine to preclude class actions asserting that the premiums assessed were excessive and seeking a return or refund of the “excess” premium. For example, in *N.C. Steel, Inc. v. National Council on Compensation Ins.*,²⁷⁸ a group of employers filed suit against their workers’ compensation insurers alleging that the insurers engaged in actions that resulted in higher workers’ compensation premiums.²⁷⁹ In North Carolina, the process of rate making was commenced by an insurer’s filing of its rates with the

273. See, e.g., *Uniforce Temp. Pers., Inc. v. Nat’l Council on Comp. Ins., Inc.*, 892 F. Supp. 1503, 1512 (S.D. Fla. 1995), *aff’d* 87 F.3d 1296 (11th Cir. 1996); accord *Kirksey v. Amer. Bankers Ins. Co. of Fla.*, 114 F. Supp. 2d 526, 529 (S.D. Miss. 2000); *Prentice v. Title Ins. Co.*, 500 N.W.2d 658, 662-64 (Wis. 1993), *cert. denied* 510 U.S. 1114 (1994); *Morales v. Attorneys’ Title Ins. Fund, Inc.*, 983 F. Supp. 1418, 1426 (S.D. Fla. 1997); *Am. Bankers Ins. Co. v. Wells*, 819 So.2d 1196, 1203-04 (Miss. 2001); *Kentucky v. Anthem Ins., Inc.*, 8 S.W.3d 48, 52-53 (Ky. Ct. App. 1999); *N.C. Steel, Inc. v. Nat’l Council on Comp. Ins.*, 496 S.E.2d 369, 372 (N.C. 1998); *Byan v. Prudential Ins. Co. of Am.*, 242 A.D.2d 456, 456 (N.Y. App. Div. 1997); *Calico Trailer Mfg. Co. v. Ins. Co. of N. Am.*, No. LR-C-93-717, 1994 WL 823554 at *6 (E.D. Ark. Oct. 12, 1994); *Fersco v. Empire Blue Cross/Blue Shield of N.Y.*, No. 93-Civ-42226, 1994 WL 445730 at *2 (S.D.N.Y. Aug. 17, 1994); *Anzinger v. Illinois State Medical Inter-Ins. Exch.*, 494 N.E.2d 655, 657 (Ill. Ct. App. 1986); *Banks v. S. Farm Bureau Cas. Co.*, 912 So. 2d 1094, 1099 (Miss. 2005).

274. *Marcus v. AT&T Corp.*, 138 F.3d 46, 58 (2d Cir. 1998).

275. *Katz v. MCI Tel. Corp.*, 14 F. Supp. 2d 271, 274 (E.D.N.Y. 1998); see also *McGuire v. Ameritech Servs., Inc.*, 253 F. Supp. 2d 988, 1012 (S.D. Ohio 2003) (“There are no allegations that the Telephone Defendants are not providing rates or services in conformity with their filed schedules and rates and the like, only that they are not providing services in conformity with such rates and terms to Plaintiffs’ liking.”); *Kutner v. Sprint Communications Co.*, 971 F. Supp. 302, 305-06 (W.D. Tenn. 1997) (holding that the filed rate doctrine prohibits courts from ordering relief that would contravene the filed rate).

276. 500 N.W.2d 658 (Wis. 1993), *cert denied* 510 U.S. 1114 (1994).

277. *Id.* at 663.

278. 496 S.E.2d 369 (N.C. 1998).

279. *Id.* at 371.

Department of Insurance.²⁸⁰ The proposed rates become legal rates unless and until the insurance commissioner rules otherwise.²⁸¹

The defendant insurers in *N.C. Steel* charged the premium rates that had been filed with the Department of Insurance.²⁸² The North Carolina Supreme Court held that because the General Assembly had given the insurance commissioner the duty to set rates, those rates could not be collaterally attacked by the insureds in a lawsuit.²⁸³ In so holding, the Court adopted the filed rate doctrine, which had stemmed from the United States Supreme Court's opinion in *Keogh v. Chicago & N.W. Ry. Co.*²⁸⁴ The *N.C. Steel* Court held that "a plaintiff may not claim damages on the grounds that a rate approved by regulator as reasonable is nonetheless excessive because it is the product of unlawful conduct."²⁸⁵ Because the North Carolina General Assembly had given the insurance commissioner the power and duty to set rates, and because the commissioner had the proper expertise to do so, the *N.C. Steel* Court held that the filed rate doctrine prohibited the plaintiffs from collaterally challenging the insurer's use of rates that had been approved by the insurance commissioner.²⁸⁶

Again, in *Schermer v. State Farm Fire & Cas. Co.*,²⁸⁷ the insureds brought a class action against a property insurer to recover refunds of homeowners and farm insurance policy surcharges, which the insureds alleged were improperly based on the age of a dwelling.²⁸⁸ The Minnesota Court of Appeals held that the filed rate doctrine barred any suit seeking a return of premiums.²⁸⁹ On further appeal, the Minnesota

280. *Id.*

281. *Id.*

282. *Id.* at 372.

283. *Id.*

284. 260 U.S. 156 (1922). *See N.C. Steel*, 496 S.E.2d at 372.

285. *N.C. Steel*, 496 S.E.2d at 372.

286. *Id.* ("We agree with the Court of Appeals for the reasons stated in its opinion that we should adopt the filed rate doctrine. The General Assembly has given the Insurance Commissioner the duty of setting rates. The Commissioner, aided by his staff, has the expertise to determine proper rates. We do not believe that, by the enactment of N.C.G.S. ch. 75, the General Assembly intended that duly set rates be challenged in another forum. When the Commissioner approved the rates, they became the proper rates. As Judge Wynn, writing for the Court of Appeals, points out, chapter 58 of the General Statutes contains a comprehensive regulatory scheme for insurance companies, which includes provisions for punishing violators of the chapter. N.C.G.S. § 58-2-70(g) (1994). It also contains a provision for the appeal of decisions of the Commissioner. N.C.G.S. § 58-2-75(a) (1994). We do not believe that, with this comprehensive regulatory scheme, the General Assembly intended that the rates could be collaterally attacked.")

287. 702 N.W.2d 898 (Minn. Ct. App. 2005), *aff'd* 721 N.W.2d 307 (Minn. 2006).

288. *Id.* at 902.

289. *Id.* at 908.

Supreme Court affirmed.²⁹⁰ In doing so, it held that certain aspects of the ratemaking function, such as the allocation of rates among classes of customers, are legislative in nature.²⁹¹ It held that permitting the rates to be challenged by class actions would “interfere with the regulatory scheme established by the legislature and with the rate making functions” of the department of insurance.²⁹² From the standpoint of separation of powers, comity, and justiciability, the Court concluded that it could not permit plaintiffs in a class action suit to challenge rates approved by the department of insurance in a “file and use” system.²⁹³

The filed rate doctrine has been applied in the specific context of suits alleging that the insurer committed fraud in charging the filed rates to its insureds. In *Horwitz v. Bankers Life & Cas. Co.*,²⁹⁴ the insureds brought suit against a health insurer to challenge increases in premiums.²⁹⁵ They alleged that the manner in which the insurer calculated premiums charged to an insured constituted a breach of contract, a violation of the insurance code, a violation of two consumer acts, and the tort of fraudulent concealment.²⁹⁶ The trial court granted the insurer’s motion for summary judgment, and invoked, *inter alia*, the filed rate doctrine.²⁹⁷ The court of appeals affirmed, holding that it is not the nature of the relief—nor the name of the cause of action—which triggers the application of the filed rate doctrine.²⁹⁸ Because the damages sought by the plaintiff would require the court to ascertain the correct rate, summary judgment was appropriate.²⁹⁹

b. The “Filed Form” Doctrine

With respect to invalid policy provisions (especially those that have been invalidated after they were filed and approved by the regulatory authority), insurers may contend that they are protected from tort liability under a special variation of the filed rate doctrine that applies to policy forms. This doctrine—while only mentioned in a handful of cases—is generally referred to as the “filed form” doctrine.

290. *Schermer v. State Farm Fire & Cas. Co.*, 721 N.W.2d 307, 319 (Minn. 2006).

291. *Id.* at 315.

292. *Id.* at 314.

293. *Id.* at 314-15.

294. 745 N.E.2d 591 (Ill. Ct. App. 2001).

295. *Id.* at 593.

296. *Id.*

297. *Id.*

298. *Id.* at 605.

299. *Id.*

The “filed form” doctrine seems to have had its beginnings in the early twentieth century, when a number of state court decisions held that an insurance commissioner’s approval of a policy form was, at the very minimum, entitled to “great weight” in terms of whether the policy form met all applicable state law requirements. Some decisions (most notably those in Wisconsin) went so far to say that the insurance commissioner’s approval was *conclusive* on the issue of whether the policy met state law requirements.³⁰⁰ Even today, some authorities hold that “the approval or disapproval of the insurance board or official of the form of a policy is binding upon the courts.”³⁰¹

The Texas case of *Manhattan Life Ins. Co. of New York v. Wilson Motor Co., Inc.*³⁰² is typical. In that case, the insurer failed to include a provision required by statute that would permit an insured, on default in payment of premiums, to apply the cash value of the policy to the balance due.³⁰³ The insured argued that because that mandatory provision was omitted, it should be read into the policy by operation of law.³⁰⁴ The court refused to find that the policy form violated the statute, in large part because it was the insurance commissioner’s duty under the law to see that the requirements of the statutes were complied with in all policies placed upon the market.³⁰⁵ The court concluded that since the policy had been filed and approved nearly a decade earlier, the commissioner’s “approval of the policy form used in this case involved an administrative ruling that the same met affirmatively every requirement of said article.”³⁰⁶ The court concluded that “public policy requires the solving of mere doubts concerning its proper construction in harmony with the construction placed thereon by the officers of the department charged with its enforcement.”³⁰⁷

Over time, this doctrine has evolved into what is sometimes referred to as the “filed form doctrine.” The notion behind the filed form doctrine was explained in a 2002 decision from the Southern District of

300. *Berry v. Merchants’ Life & Cas. Co.*, 195 N.W. 335, 336 (Wis. 1923) (“The construction given by the insurance commissioner is certainly a permissible one and under the *Lundberg* Case is conclusive.”). Early cases addressing this issue are collected in *Validity, Construction, and Effect of Approval or Disapproval By Insurance Commissioner (or Similar Official) of Form of Policy*, 119 A.L.R. 877 (1939).

301. 43 AM. JUR. 2D *Insurance* § 33 (2008) (citing *Manhattan Life Ins. Co. of New York v. Wilson Motor Co.*, 75 S.W.2d 721 (Tex. Ct. App. 1934) and *Berry*, 195 N.W. 335).

302. 75 S.W.2d 721 (Tex. Ct. App. 1934).

303. *Id.* at 722.

304. *Id.*

305. *Id.* at 723.

306. *Id.*

307. *Id.*

New York. In *AMEX Assurance Co. v. Caripides*,³⁰⁸ the plaintiff attacked a substantive aspect of a policy form that had been filed and approved by Fredric Bodner, the then-Chief of the Health and Life Policy Bureau of the New York State Insurance Department.³⁰⁹ The plaintiffs obtained an affidavit from Mr. Bodner in which he expressed the opinion that the insurer apparently “made a mistake” in making the default beneficiary class “dependent children” in its policy form, rather than merely “children.”³¹⁰ In his affidavit, Bodner stated that if he had been aware that the default beneficiary provision contained the “dependent” children limitation, he would have asked the attorney reviewing the policy to notify AMEX of the inconsistent use of the term “dependent children” and suggest that AMEX correct it so as to make it consistent with the requirements of the New York insurance statutes.³¹¹

The court found this insufficient to create a genuine issue of fact as to the enforceability of the provision.³¹² The court noted that Bodner had not said that the policy would not have been approved as submitted, nor did he explain how any portion of the New York statute renders the policy unenforceable as submitted and approved.³¹³ Because the form had been approved for use by the Insurance Department, the policy form was held to be unassailable.³¹⁴

The Supreme Court of Mississippi also at least implicitly approved both the filed rate and filed form doctrines in *American Bankers’ Ins.*

308. 179 F. Supp. 2d 309 (S.D. N.Y. 2002).

309. *Id.* at 318-19.

310. *Id.* at 319.

311. *Id.*

312. *Id.* at 320.

313. *Id.* at 319-20.

314. The court said:

Even assuming that what Mr. Bodner *would have* done has any bearing on the instant litigation, Mr. Bodner fails to aver that he would not have approved the AX0910 policy as submitted by AMEX. Moreover, Mr. Bodner fails to explain how sections 3221 and 4235(e) of New York Insurance Law render the AX0910 policy unenforceable as submitted and approved. The court can fathom no way in which they do.

Id. at 319-20. The court continued:

The court notes that a line of cases on the ‘filed rate doctrine’ suggests that the Insurance Department’s review and approval of a policy is presumptively valid and cannot be subsequently judicially challenged as unfair or violative of public policy. Courts normally ‘defer to constructions of statutes by executive branch officials charged with their administration,’ and a judicial challenge to the Insurance Department’s approval of the AX0910 policy can only be maintained if the policy ‘runs counter to the legislative intent or if it violates existing law.’ As indicated below, Cristina has failed to demonstrate that the AX0910 policy runs counter to legislative intent or violates existing law.

Id. at FN5.

Co. of Florida v. Wells.³¹⁵ In that case, certain borrowers brought an action against a secured lender and the collateral protection insurer to recover for breach of contract, bad faith, breach of fiduciary duties, fraud, civil conspiracy, and negligence in connection with the forced placement of insurance.³¹⁶ The trial court entered judgment on a jury verdict for the borrowers.³¹⁷ On appeal, the Mississippi Supreme Court affirmed in part, reversed in part, and remanded the case.³¹⁸ In doing so, it held that the filed rate doctrine (and at least implicitly, the filed form doctrine) barred claims to recover for excessive premiums.³¹⁹ The Court explained that the filed rate doctrine protected the insurer from collateral attack by the plaintiffs with respect to both the rates and the terms of the policy.³²⁰

315. 819 So. 2d 1196 (Miss. 2001).

316. *Id.* at 1200.

317. *Id.*

318. *Id.* at 1211.

319. *Id.* at 1210-11.

320. The court's explanation is worth repeating at length:

Fidelity and American Bankers next argue that the allegations in Wells's and Oliver's complaints are barred by the filed rate doctrine. Under the filed rate doctrine, any 'filed rate' – that is, a rate approved by the governing regulatory agency – is 'per se reasonable and unassailable in judicial proceedings brought by ratepayers.'

The filed rate doctrine is based upon sound considerations of law and judicial policy. A civil juror, who likely has little, if any, expertise in the area of insurance rates and policies, should not be permitted to reject and thereupon impose liability based on the rates of a policy which was expressly approved by the Department of Insurance. *See* Miss. Code Ann. §§ 83-1-1 et seq. (1999). Permitting a jury to impose liability in such circumstances would result in a judicial infringement upon the duties and responsibilities which are expressly delegated by the Legislature to the Department of Insurance. *Id.*

A plaintiff might have a valid cause of action against his lender for a breach of the duty of good faith and fair dealing if it could be shown that the lender engaged in bad faith conduct in the *performance* of a contract approved by the Department of Insurance, rather than in the actual rates of such a policy. However, one of the central allegations of this action is that Fidelity obtained a CPI policy under which the rates were too high and the provisions were slanted in favor of Fidelity. Clearly, Wells and Oliver would have claimed less damages if the CPI policy contained lower rates, but the Department of Insurance, in the exercise of its discretion, opted to approve the rates and policy in question.

Although some jurisdictions have recognized exceptions to the filed rate doctrine, the acceptance of the doctrine's basic applicability is near-universal. At the same time, Wells and Oliver do make allegations which are arguably outside of the scope of the filed rate doctrine.

We remand this case to the trial court for a new trial with directions that Wells and Oliver be limited to recovery for damages (if any) resulting from tortious conduct in the

Only one court appears to have explicitly rejected the filed form doctrine, and it did so with virtually no explanation. In *Southern Farm Bureau Life Ins. Co. v. Banko*,³²¹ the plaintiff insurer filed an interpleader to resolve a dispute over who should receive the proceeds of a life insurance policy.³²² One of the defendants brought a counterclaim alleging that the insurer was negligent in describing the procedures necessary for the decedent to effectuate a change of beneficiary.³²³ The insurer filed a motion to dismiss, based on the filed form doctrine.³²⁴ In a single paragraph, the court rejected the insurer's argument that the counterclaim was barred by the filed form doctrine.³²⁵

If insurance rates and premiums are unassailable by plaintiffs by dint of approval by a regulator having special expertise, then the same argument should apply with equal force to the protection of forms that have been reviewed and approved.

B. Current Statutory Remedies

1. NAIC Model Unfair Trade Practices Act

Every state except Mississippi has adopted some form of an unfair insurance practices act.³²⁶ The purpose of these acts is to reduce the incidence of abusive practices by insurers and insurance adjusters.³²⁷ These statutes and regulatory schemes are generally derived from the National Association of Insurance Commissioners' (NAIC) model Unfair Trade Practices Act (and in some instances, to the later model Unfair Claims Settlement Practices Act).³²⁸

performance, rather than the rates and terms, of the contract in question.
819 So. 2d at 1203-05.

321. No. 8:06CV840T27EAJ, 2006 WL 2935281 (M.D. Fla. Oct. 13, 2006).

322. *Id.* at *1.

323. *Id.*

324. *Id.*

325. *Id.* at *2 ("Plaintiff first argues that the claim should be dismissed under the 'filed form doctrine.' Under federal law, the 'filed rate doctrine' 'forbids a regulated entity to charge rates for its services other than those properly filed with the appropriate federal regulatory authority.' Plaintiff has cited one case in which this doctrine was extended to title insurance premiums. However, there is, as Plaintiff concedes, no 'filed form doctrine' under Florida law. Nor has Plaintiff cited any case that indicates that regulatory approval of an insurance policy form bars suits over policy language.").

326. James P. Diwik, *A State by State Survey of Unfair Insurance Practices Regulations*, in AMERICAN BAR ASSOCIATION, THE FIDELITY AND SURETY DESK REFERENCE BOOK 33 (DeWitte Thompson ed. 2006).

327. *Id.*

328. *Id.* at 35.

The version followed by most states is the 1972 NAIC model statute, the full name of which is “An Act Relating to Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.”³²⁹ The legislative history to this Act notes that the market conduct taskforce recommended changing the title to “Unfair Trade Practices Act” (UTPA).³³⁰ There was no intent that this change should apply any change in concept.³³¹

This change was made in 1990, when provisions relating to claims settlement practices were deleted from the UTPA and incorporated into a free-standing model statute known as the Unfair Claims Settlement Practices Act.³³² The Unfair Claims Settlement Practices Act is not relevant to the present inquiry, since it is directed solely to the handling of claims once they have been presented.

The UTPA as promulgated by the NAIC in 1972 has been enacted without substantial change in approximately 45 states.³³³ In the model act, the NAIC took the position in the model act that no private cause of action could be based on the violation of its provisions.³³⁴ Because states have adopted various versions of this Act and the Uniform Claims Settlement Practices Act, the exclusion of a private cause of action under these statutes is not universally implemented or recognized.³³⁵

The majority view (held by courts in at least 21 of the 26 jurisdictions that have examined the question) is that no cause of action can be implied from these Acts, regardless of whether the action is brought by a third party or by the insured and regardless of whether the policy provides first party or liability coverage.³³⁶ Some states, such as

329. National Association of Insurance Commissioners (NAIC) Model Laws, Regulations and Guidelines 880-1 (2007).

330. *Id.*

331. *Id.*

332. National Association of Insurance Commissioners (NAIC) Model Laws, Regulations and Guidelines 880-1, legislative history (2007).

333. DENNIS J. WALL, LITIGATION AND PREVENTION OF INSURER BAD FAITH § 7.05, 299 (2d ed. 1994). The Statement of Purpose to the Unfair Trade Practices Act says the purpose is of the Act is “to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress) and the Gramm-Leach-Bliley Act (Public Law 106-102, 106th Congress), by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.” National Association of Insurance Commissioners (NAIC) Model Laws, Regulations and Guidelines 880-1, § 1 (2007).

334. Diwik, *supra* note 326, at 47.

335. *Id.*

336. WALL, *supra* note 333, § 7.06, 305.

California, once recognized a cause of action based on the violation of the statute.³³⁷ However, the California Supreme Court later reversed its position and prospectively denied the cause of action based upon violation of the statute.³³⁸ Thus, a majority of states have held that the two NAIC model unfair insurance practices Acts do not recognize a private cause of action for their breach.³³⁹

But even in those few states that permit a private cause of action based upon a violation of the UTPA, it would be exceedingly difficult to make a case. This is in part because the model UTPA states that it is an unfair trade practice for an insurer to commit one of the 16 offenses specified in Section 4 of the Act *only* if the offense is 1) committed flagrantly and in conscious disregard of the Act or any rules promulgated thereunder; or 2) committed with such frequency as to indicate a general business practice to engage in that type of conduct.³⁴⁰

Many states, such as Ohio, further limit this definition. Under Ohio's version of the UTPA (which was promulgated as an administrative regulation rather than as a statute), the definition of an unfair trade practice is limited to those instances where the offense is committed so frequently as to indicate a general business practice.³⁴¹ It is not sufficient for it to have been committed "flagrantly and in conscious disregard" of the provisions of the Act.³⁴²

337. See *Royal Globe Ins. Co. v. Superior Court of Butte County*, 592 P.2d 329 (Cal. 1979).

338. *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58, 68-69 (Cal. 1988) ("[C]ourts retain jurisdiction to impose civil damages or other remedies against insurers in appropriate common law actions, based on such traditional theories as fraud, infliction of emotional distress, and (as to the insured) either breach of contract or breach of the implied covenant of good faith and fair dealing.").

339. A minority of states do permit such a claim. See *Diwik*, *supra* note 326, at 48.

340. Improper Termination Practices Model Act, National Association of Insurance Commissioners (NAIC) 915-1, § 18(A) (2007).

341. OHIO ADMIN. CODE 3901:1-07(C) (2009).

342. Ohio courts have consistently held that violations of the UTPA and the Uniform Property/Casualty Claims Settlement Practices Act (OHIO ADMIN. CODE 3901:1-54 (2009)) do not give right to a private cause of action. *Furr v. State Farm Mut. Auto. Ins. Co.*, 716 N.E.2d 250, 257 (Ohio Ct. App. 1998) (holding that neither Ohio Admin. Code 3901-1-07 nor 3901-1-54 give right to a private cause of action for violations of those rule); *Goodyear Tire & Rubber Co. v. Aetna Cas. & Surety Co.*, No. 16993, 1995 WL 422733 at *5 (Ohio Ct. App. July 12, 1995), *appeal not allowed* 657 N.E.2d 785 (Ohio 1995) ("If the IRB's conduct constituted a violation of the statutory and administrative laws, as alleged, the violations alone do not give rise to a policyholder's private right of action."); *Orra v. Ohio Fair Plan Underwriting Assn.*, No. L-87-233, 1988 WL 36380 at *2 (Ohio Ct. App. March 31, 1988) ("Although appellant lists certain factors which he claims constitutes unfair trade practices pursuant to R.C. Chapter 3901 and regulations promulgated thereunder, '[n]owhere in the Ohio statutory or regulatory framework proscribing deceptive trade practices in insurance does it provide a civil remedy to a private party aggrieved by an insurer.');" *Griffith v. Buckeye Union Ins. Co.*, No. 86AP-1063, 1987 WL 17805 at *6 (Ohio Ct. App. Sept. 29, 1987)

In 1989, the NAIC subgroup that was considering amendments to the UTPA discussed whether a private cause of action for UTPA violations was or should be permitted.³⁴³ The subgroup determined that no private cause of action was intended, and added draft language to that effect.³⁴⁴ The amendment adopted in 1990 included a new final sentence to Section 1 to clarify the NAIC's position on that issue.³⁴⁵ Indeed, the drafting note that accompanied the 1990 revision stated that:

A jurisdiction choosing to provide a private cause of action should consider a different statutory scheme. *This Act is inherently inconsistent with a private cause of action.* This is merely a clarification of original intent and not indicative of any change of position.³⁴⁶

This determination should not have come as a surprise to anyone. A decade earlier, in 1980, an NAIC report unequivocally stated that the model UTPA was not designed to create a private right of action.³⁴⁷

In proving that an unfair act has been committed or performed “with such frequency as to indicate a general business practice,” the courts have typically required evidence that the insurer committed repeated acts of misconduct, generally in cases other than the one involving the plaintiff.³⁴⁸ This presents an obvious—and perhaps

(“The Ohio Department of Insurance rules . . . do not create a private cause of action, but are regulatory in nature. Thus, the rules cannot be considered evidence of the applicable standard of bad faith.”); *Kimpel v. Dairy Farm Leasing Co., Inc.*, No. WMS-86-8, 1987 WL 5310 at *1 (Ohio Ct. App. Jan. 9, 1987) (“R.C. § 3901.21 and Ohio Admin. Code 3901-1-07 did not give appellants a private right of action against appellee for alleged unfair practices.”); *Strack v. Westfield Cos.*, 515 N.E.2d 1005, 1008 (Ohio Ct. App. 1986) (“This court finds that the inference of a private cause of action would be inconsistent with the existing administrative enforcement scheme now in force. Supplying a tort remedy will not necessarily further the policy behind Ohio Adm. Code 3901-1-07.”).

343. Unfair Claims Settlement Practices Act, National Association of Insurance Commissioners (NAIC) 900-1, legislative history.

344. *Id.*

345. Unfair Trade Practices Act, National Association of Insurance Commissioners (NAIC) 880-1, § 1 (“Nothing herein shall be construed to create or imply a private cause of action for a violation of this Act.”).

346. Third Party Causes of Action: Effects on West Virginia Insurance Markets at 12 (Office of Ins. Comm’r Feb. 2005), available at http://www.wvinsurance.gov/reports/pdf/third_party_causes_action_effects.pdf.

347. Proceedings of the National Association of Insurance Commissioners, *Market Conduct, Examination and Reporting (B) Committee*, 1980-2 NAIC Proc. 339, 350 (1980) (“In any event, the intent of the NAIC, as evidenced by the language of the Model [Act] and the NAIC Proceedings, and supplemented by this Report, was clearly not to create a new private right of action for trade practices which are prohibited by the Model Act.”).

348. *Aetna Casualty and Sur. Co. v. Broadway Arms Corp.*, 664 S.W.2d 463, 466 (Ark. 1984); *Mead v. Burns*, 509 A.2d 11, 16 (Conn. 1986); *Quimby v. Kimberly Clark Corp.*, 613 A.2d 838,

insurmountable—difficulty in cases involving the inclusion or retention of invalid policy provisions. If the claimant cannot prove that the insurer has knowingly included or retained policy provisions on other occasions, then the cause of action cannot be established. Finally, it is by no means clear that the inclusion or retention of an invalid provision would constitute an unfair trade practice as defined in Section 4 of the UTPA.³⁴⁹

Subsection 1 of Section 4 appears to be addressed to advertising or promotional literature, rather than to the terms of the policies themselves. In any event, even if a policy includes invalid provisions, it may be difficult to say that the policy language “misrepresents the . . . terms of any insurance policy.”³⁵⁰ Likewise, subsection 2 of Section 4 makes it improper to provide false information in advertising generally.³⁵¹

While this subsection provides plenty of ambiguity due to its inartful drafting, it ultimately prohibits misstatements limited to “the business of insurance or with respect to any person in the conduct of his

840 (Conn. Ct. App. 1992); *Howell-Demarest v. State Farm Mut. Auto. Ins. Co.*, 673 So. 2d 526, 528 (Fla. Ct. App. 1996); *Trempe v. Aetna Cas. and Sur. Co.*, 480 N.E.2d 670, 675 (Mass. Ct. App. 1985); *United States Liability Ins. Co. v. Johnson & Lindberg, P.A.*, 617 F. Supp. 968, 976 (D. Minn. 1985); *Safeco Ins. Co. of Am. v. McAllister*, 785 F. Supp. 119, 121 (D. Mont. 1990), *judgment aff'd* 944 F.2d 909 (9th Cir. 1991); *St. Paul Fire and Marine Ins. Co. v. Cumiskey*, 665 P.2d 223, 226 (Mont. 1983); *Dano v. Royal Globe Ins. Co.*, 451 N.E.2d 488, 489 (N.Y. 1983); *Miller v. Nationwide Mut. Ins. Co.*, 435 S.E.2d 537, 542-43 (N.C. Ct. App. 1993); *Dvorak v. Am. Family Mut. Ins. Co.*, 508 N.W.2d 329, 332 (N.D. 1993); *Turner Const. Co. v. First Indem. of Am. Ins. Co.*, 829 F. Supp. 752, 763 (E.D. Pa. 1993), *judgment aff'd* 22 F.3d 303 (3d Cir. 1994); *Jerry v. Kentucky Cent. Ins. Co.*, 836 S.W.2d 812, 816 (Tex. Ct. App. 1992); *Jenkins v. J.C. Penney Cas. Ins. Co.*, 280 S.E.2d 252, 259-60 (W. Va. 1981), *overruled on other grounds by*, *State ex rel. State Farm Fire & Cas. Co. v. Madden*, S.E.2d 721 (W. Va. 1994); *Kranzush v. Badger State Mut. Cas. Co.*, 307 N.W.2d 256, 268 n.3 (Wis. 1981).

349. Subsection 1 of Section 4 prohibits insurers from “[m]aking, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustrations, circular or, statement, sales presentation, omission, or comparison which . . . (a) misrepresents the . . . conditions or terms of any insurance policy . . .” 1972-1 NAIC Proc. 490, 493-94 (1971).

350. *Id.*

351. This subsection prohibits:

Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

Id. at 494.

insurance business.”³⁵² Again, it is unlikely that a policy constitutes advertising under this section, and it is even less likely that an unenforceable policy provision would be tantamount to a statement “with respect to the business of insurance or with respect to any person in the conduct of his insurance business.”³⁵³

None of the other subsections of Section 4 of the UTPA are likely candidates for providing even an implied cause of action based upon the presence of an invalid policy provision. Thus, the UTPA is an unlikely source of relief for a person aggrieved by the inclusion or retention of an invalid provision in his or her policy.

2. State Law Consumer Sales Practices Act

In some cases, plaintiffs have brought suits claiming that insurers’ unfair claims settlement practices violated various state consumer protection statutes. As one commentator has observed, because these statutes vary so greatly, “one cannot generalize about whether consumer protection statutes apply to insurance cases.”³⁵⁴ That determination “normally turns on . . . whether insurance constitutes ‘goods’ or ‘services’ and whether the plaintiff is a ‘consumer’ within the meaning of the statute.”³⁵⁵

A 2007 California court of appeals decision is instructive. Like most states, California does not recognize a private cause of action for an insurer’s violation of the statutes governing insurance. For that reason, in *Fairbanks v. Superior Court of Los Angeles County*,³⁵⁶ the plaintiffs brought an action under the Consumer Legal Remedies Act (CLRA), which allows a private right of action against providers of goods and services.³⁵⁷ The insured purchased a life insurance policy from an insurer and was told that it would remain in effect indefinitely if she paid a stated premium.³⁵⁸ In point of fact, this amount was insufficient to keep the policy in force to maturity.³⁵⁹ The plaintiff brought a class action suit alleging unfair and deceptive practices under

352. *Id.*

353. *Id.*

354. ASHLEY, *supra* note 257, at § 9:16 and cases cited therein.

355. *Id.*

356. 64 Cal. Rptr. 3d 623 (Cal. Ct. App. 2007), *review granted*, 68 Cal. Rptr. 3d 273 (Cal. 2007).

357. *Id.* at 625.

358. *Id.*

359. *Id.*

the CLRA.³⁶⁰ The insurer filed a motion to dismiss—which the trial court granted—on the grounds that insurance was not a “good” or “service” within the meaning of the statute.³⁶¹ The court of appeals affirmed, holding that insurance is not a good because it is not tangible, and that it is not a service because it is neither “work” nor “labor” nor a “personal service” such as a haircut.³⁶²

The vagaries of the state consumer protection statutes have also been noted in the American Law Reports Annotation titled *Coverage of Insurance Transactions under State Consumer Protection Statutes*.³⁶³ In summarizing the irreconcilable decisions on the subject, the author of that Annotation concluded that the availability of a remedy under state consumer protection statutes must inherently be made on a case and jurisdiction-specific basis.³⁶⁴ Thus, in many if not most cases, there is no meaningful statutory remedy for the inclusion or retention of invalid policy provisions based on state consumer sales practices statutes.

C. Current Administrative Remedies

1. There is No Meaningful Administrative Review of Policy Provisions

Both rates and forms are subject to state regulation. However, the actual extent of review varies widely from state to state. There are seven types of statutory form review systems.³⁶⁵ They are:

360. *Id.*

361. *Id.*

362. *Id.* at 626-27 (“The plain language of the CLRA indicates that insurance is not a ‘good.’ ‘Goods’ are defined as tangible chattels bought or leased for personal, family or household use. (Civ.Code, § 1761, subd. (a).) Insurance is not a tangible item. Thus it cannot be a ‘good.’ It follows that the pertinent issue here is whether insurance can be considered a “service” under the CLRA. The CLRA defines ‘Services’ as ‘work, labor, and services for other than a commercial or business use, including services furnished in connection with the sale or repair of goods.’ (Civ. Code, § 1761, subd. (b)). Insurance, in contrast, is defined by the Insurance Code as ‘a contract, whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.’ (Ins. Code, § 22). Obviously, insurance contracts are not work or labor. Nor can these indemnification agreements easily be described as personal services or services ‘furnished in connection with the sale or repair of goods.’ An insurance contract is not something akin to a haircut, a plumbing repair, or a two-year warranty on a microwave oven—it is simply an agreement to pay if and when an identifiable event occurs. . . . Thus, insurance does not appear to be a service under within the plain meaning of the language of the CLRA.”).

363. Brian H. Redmond, *Coverage of Insurance Transactions Under State Consumer Protection Statutes*, 77 A.L.R. 4th 991 (1989).

364. *See id.* at § 2[a].

365. American Insurance Association, *State Rate and Form Law Guide* (2006).

- 1) *State adopted forms*—the legislature or other regulatory authority provides the wording of the form to be used by insurers;
- 2) *Strict prior approval*—the regulator is required to approve forms prior to their use;
- 3) *Prior approval with an express deemer*—forms must be filed with the regulator, but may be used if the regulator does not disapprove within a specified waiting period;
- 4) *File and use*—requires forms to be filed before or on the proposed effective date, and the forms ordinarily become effective as proposed unless the regulator takes affirmative action to the contrary;
- 5) *Use and file*—the insurer is permitted to develop and use forms, with the only requirement that the form be filed a specified number of days after the effective date;
- 6) *Form filing only*—the insurers must file their forms, but the statutes do not specify when they must be filed; and
- 7) *No form filing*—no filing of policy forms is necessary³⁶⁶

The form review system can vary by the type of insurance, even within a single state.³⁶⁷ Personal lines policies are often subject to higher standards of review than commercial lines policies.

But even with personal lines insurance, it is a rare occurrence for a regulator to actually read a proposed form before it goes into effect. In the case of private passenger automobile insurance, only one state has a “state adopted” policy form, and only two require actual prior approval.³⁶⁸ Thirty-six states utilize a “prior approval with express deemer” review, nine have a “file and use” review system, one requires an informational filing only, and four require no filing at all.³⁶⁹

Likewise, with respect to homeowner policies, no states have a “state adopted” form, and only two require strict prior approval.³⁷⁰ Thirty-eight states have a “prior approval with express deemer” review system, eight have file and use statutes, one requires an informational filing only, and four do not require policy forms to be filed at all.³⁷¹

Within the last decade, the trend has in fact been towards deregulation, where rates and forms are subject to minimal (if any) oversight. While that has particularly been true with respect to commercial lines, it is true with respect to personal lines as well.

366. *Id.*

367. *See id.*

368. *Id.*

369. *Id.*

370. *Id.*

371. *Id.*

In 1998, the NAIC released a White Paper titled *Regulatory Re-engineering of Commercial Lines Insurance*, which proposed deregulation of rates and forms for large commercial buyers.³⁷² Since then, there has been a “rush to deregulate rates and forms.”³⁷³ The Director of Government Affairs for the Risk and Insurance Management Society has been quoted as anticipating an “8 to 10 year effort to chip away” at all rate and form filing requirements.³⁷⁴ And the Government Affairs Advocate for the National Association of Mutual Insurance Companies has observed that “[t]here’s even talk of personal lines deregulation.”³⁷⁵ Even the AEI-Bookings Joint Center for Regulatory Studies urges deregulation of personal lines forms, claiming that “[f]iling should be required, at most, for policy forms sold to small business and personal lines customers, and those forms should not be subject to prior approval.”³⁷⁶

More recently, in January 2008, the Connecticut Insurance Department exempted certain lines of commercial insurance from the form, rate and rule filing provisions.³⁷⁷ In a bulletin issued on January 7, 2008, the Connecticut Insurance Department adopted a one-year pilot program to exempt certain lines of commercial insurance from the form, rate and rule filing provisions that would otherwise apply.³⁷⁸ The stated purposes of allowing this exemption were “(i) to encourage more efficient and economic marketing practices by insurers for these product lines; and (ii) to provide price and other information to enable consumers to purchase [insurance] suitable for their needs and to foster competitive insurance markets.”³⁷⁹ This exemption applies to 13 specified types of commercial insurance, including garden variety commercial forms or commercial inland marine protection, crop and hail damage, commercial flood insurance, boiler and machinery insurance, commercial policies for certain newly developed coverages including computer fraud coverage, all “following form” commercial and excess

372. *Commercial Lines Deregulation Marches Through The States*, 24 VIEWPOINT No. 1 (1999).

373. *Id.*

374. *Id.*

375. *Id.*

376. SCOTT E. HARRINGTON, *INSURANCE DEREGULATION AND THE PUBLIC INTEREST* 45 (2000).

377. Exemption of Certain Commercial Lines Property and Casualty Policy Forms, Rates and Rules, Conn. Ins. Dept. Bulletin No. PC-63 (January 7, 2008).

378. *Id.*

379. *Id.*

umbrella policies, and any other commercial excess and umbrella policy if the underlying policy provides at least \$1 million of coverage.³⁸⁰

The general inadequacy of regulatory review of insurer rate and form filings (when filings are required at all) has been acknowledged by the courts in other contexts. For example, insurers have sometimes asserted that state regulatory oversight provides immunity from antitrust liability. But the federal courts—including the United States Supreme Court—have concluded that “file and use” supervision is inadequate to justify the grant of immunity, since many of those filings are never reviewed at all. Thus, in *Federal Trade Commission v. Ticor Title Ins. Co.*,³⁸¹ the Supreme Court held that rates filed with state agencies under the “negative option rule” (which is equivalent to a “file and use” regulation) were inadequate to justify antitrust immunity.³⁸² The stated reason for that conclusion was the clear track record of inadequate regulatory review of those filings.³⁸³

As shown above, in many states, there is currently no form review mechanism in place at all. And even in those where there is theoretically

380. *Id.* at Appendix A.

381. 504 U.S. 621 (1992).

382. *Id.* at 638.

383. In its opinion, the Court concluded that, regardless of the potential for regulatory review, “active state supervision” simply did not exist:

Where prices or rates are set as an initial matter by private parties, subject only to a veto if the State chooses to exercise it, the party claiming the immunity must show that state officials have undertaken the necessary steps to determine the specifics of the price-fixing or rate setting scheme.

. . .

Respondents point out that in Wisconsin and Montana the rating bureaus filed rates with state agencies and that in both States the so-called negative option rule prevailed. The rates became effective unless they were rejected within a set time. It is said that as a matter of law in those States inaction signified substantive approval. This proposition cannot be reconciled, however, with the detailed findings, entered by the ALJ and adopted by the Commission, which demonstrate that the potential for state supervision was not realized in fact. The ALJ found, and the Commission agreed, that at most the rate filings were checked for mathematical accuracy. Some were unchecked altogether. In Montana, a rate filing became effective despite the failure of the rating bureau to provide additional requested information. In Wisconsin, additional information was provided after a lapse of seven years, during which time the rate filing remained in effect. These findings are fatal to respondents’ attempts to portray the state regulatory regimes as providing the necessary component of active supervision. The findings demonstrate that, whatever the potential for state regulatory review in Wisconsin and Montana, active state supervision did not occur.

Id. See also *Ticor Title Ins. Co. v. Fed. Trade Comm’n*, 998 F.2d 1129, 1139 (3d Cir. 1993) (holding on remand that “the Supreme Court plainly instructed us that a state’s rubber stamp is not enough. Active supervision requires the state regulatory authority’s independent review and approval.”).

a review mechanism in place (as in the use and file, file and use, and prior approval with an express deemer jurisdictions), the degree to which forms are actually examined could well be called into question. The NAIC published a study in 2002 reviewing the degree to which regulators actually engaged in substantive review of rate filings (which are subject to a similar array of review systems ranging from rates established by the state to no review at all).³⁸⁴ That study found that “conventional categories of rate review (such as file and use) are ambiguous in practice . . .” and that “[i]n many states, there was a disconnect between statutory constraints on insurer rating and the Department’s rate review authority or processes.”³⁸⁵ The authors of that study observed that, in many states, “the rate review process was either much more active or much less active than the statutory category might imply.”³⁸⁶ Ultimately, those authors concluded that the diversity in rate review practices between the states was “substantial,” and that “variations among states in their statutes governing insurer rating translate into even greater variation in practice”³⁸⁷

While no similar study has been conducted concerning variations in form review practices, it would be reasonable to expect similar findings. It is unlikely that regulators will catch every instance of an invalid or unenforceable policy provision in every filing submitted to them by every insurer, and it is unrealistic to expect them to do so. Further, when the court of last resort in a state invalidates a previously-valid policy provision, it is wholly unrealistic to expect that the regulator can re-review every policy filed by every insurer to see whether that provision is included in their policy and, if so, to require its removal.

If public policy favors the removal of invalid provisions from insurance policies, then the onus should be placed on the insurers. And if the present trend away from meaningful review of form and endorsement filings continues, it is even more important that insurers be required to regulate their own conduct by refraining from including provisions that are already invalid. Insurers should be given explicit instructions on when and under what circumstances such removal is required, coupled with some penalty for failure to do so. The author’s proposed legislation would do precisely that.

384. Adele M. Kirk & Deborah J. Chollet, *State Review of Major Medical Health Insurance Rates*, 20 J. INS. REG. 3 (2002).

385. *Id.* at 3.

386. *Id.* at 7.

387. *Id.* at 15.

2. Readability Regulations Do Not Address Substantive Content

The NAIC and state regulators have long attempted to make insurance policies both more uniform and more readable. It was the desire for uniformity that led the National Board of Fire Underwriters to adopt a standard policy in 1868.³⁸⁸ A revised form, the 1918 New York Standard Policy, removed many of the clauses that could render the fire insurance voidable by the insurer.³⁸⁹

In 1943, the NAIC entered the fray and adopted the New York Standard Fire Policy.³⁹⁰ Interestingly, some of the language in that policy must be ignored for the policy to make sense. As one commentator pointed out, the “control or knowledge” wording in line 32 of the second page makes the insurance voidable if the insured has knowledge of being exposed to a hazardous condition, even though he is not in control of it. Insurers had to pretend that the word “or” in “control or knowledge” really read “and” in order to avoid the denial of many claims.³⁹¹

Regulators began taking an interest in the readability of insurance policies in the early 1970s. In 1971, the Pennsylvania Insurance Commissioner began rejecting personal lines policies that were not written in simple language.³⁹² Four companies tried and failed to submit compliant policies before Nationwide Mutual Insurance Company received approval of its Century II simplified auto policy in 1974.³⁹³

Many readers of this article will be aware of the Flesch test for readability because it is one of the key elements of the “Readability Statistics” feature used in Microsoft Word.³⁹⁴ What many readers may not know is that it was Rudolph Flesch who in 1975 rewrote the St. Paul Fire & Marine personal liability catastrophe policy to make it more readable.³⁹⁵ Throughout the 1970s and 1980s, many states enacted plain language acts, which required drafters of standardized form contracts to

388. Collier, *supra* note 124, at 80.

389. *Id.*

390. *Id.*

391. *Id.*

392. *Id.* at 81.

393. *Id.*

394. The Readability Statistics in Microsoft Word are broken down into three categories, those being “Counts,” “Averages,” and “Readability.” The “Counts” section includes word counts, character counts, paragraph counts, and sentence counts. The “Averages” category includes the average number of sentences per paragraph, average number of words per sentence, and average number of characters per word. The “Readability” statistics include the percentage of passive sentences, the Flesch Reading Ease score, and the Flesch-Kincaid Grade Level determination.

395. Collier, *supra* note 124, at 81.

avoid jargon and specify the obligations of the other party.³⁹⁶ About half of the states have enacted such legislation, but in some instances the plain language laws are not specific to insurers.³⁹⁷ About 30 states have some form of plain language or readability component of their insurance laws.³⁹⁸

The nature of these readability statutes varies greatly. Some simply require that a consumer contract be written “in a clear and coherent manner using words with common and everyday meaning” and that it be “appropriately divided and captioned by its various sections.”³⁹⁹ Others, by contrast, require certain organization, typeface, and limits on words or syllables.

The statutory requirements in Ohio, for example, fall within the latter case.⁴⁰⁰ By statute, all Ohio policy forms must be filed with the Department of Insurance before they can be used. The text of the form must achieve a minimum score of 40 on the Flesch reading test or an equivalent score on any other comparable test.⁴⁰¹ The statute also requires that the form be printed in typeface that is at least 10 point in size; the style, arrangement, and overall appearance of the policy must not give undue prominence to any portion of the text, endorsements or riders; and the policy must contain a table of contents or an index if the policy is more than 3,000 words or is more than three pages in length.⁴⁰² Each filing must be accompanied by a certificate signed by an officer of the insurer attesting to the fact that the filing meets the minimum reading ease score on the test used.⁴⁰³

The NAIC has joined in the demand for readability. In June 1977, the NAIC endorsed the standard that car and home policies be written at the eighth grade level.⁴⁰⁴ The National Association of Independent Insurers also developed a standard car policy that gets high marks in readability tests. This policy, which is not copyrighted, may be used by anyone, which assists insurers in developing a uniform and readable policy.⁴⁰⁵

396. 1 STEMPER, *supra* note 171, at § 2:05[E], 2-75.

397. *Id.*

398. *Id.* at 2-76.

399. MINN. STAT. ANN. § 325G.31 (West 1995), *cited in* STEMPER, *supra* note 171, at 2-75.

400. *See* OHIO REV. CODE ANN. § 3902.04 (West 2009).

401. OHIO REV. CODE ANN. § 3902.04(A)(1) (West 2009).

402. OHIO REV. CODE ANN. § 3902.04(A)(2)-(4) (West 2009).

403. OHIO REV. CODE ANN. § 3902.04(D) (West 2009).

404. Collier, *supra* note 124, at 81.

405. *Id.*

The NAIC's continued interest in readability issues is evidenced by its current efforts to revise its draft *Disclosure Guidelines and Process*.⁴⁰⁶ That document not only includes instructions for creating readable, plain language documents, but also addresses the presentation and content aspects of making the written word understandable.⁴⁰⁷

In March 2007, the NAIC promulgated its Standards for Individual Disability Income Insurance Application Change Form,⁴⁰⁸ which also addresses readability requirements.⁴⁰⁹ Specifically, it requires that the text of an application change form to achieve a minimum score of 50 on the Flesch reading test (or an equivalent score on a comparable test), that the text appear in at least 10 point type, and that the form give no undue prominence to any text or section.⁴¹⁰

But nothing in these readability rules and regulations addresses content. One insurance commentator has observed that "few if any state insurance laws discuss unconscionable contract provisions *per se*,"⁴¹¹ and as shown above, no statute, rule, or regulation addresses the inclusion or retention of invalid policy provisions.

Readability is useless unless the text accurately describes the coverage provided. If the NAIC and state regulators insist that policies be readable, then they should also insist that the content of the document accurately reflect the coverage. It is simply pointless to make a policy readable if the one will nevertheless come away with an incorrect understanding of coverage after reading it.

3. Regulators Lack the Power to Assess Compensatory or Punitive Damages

It has already been shown that the common law remedies for continued inclusion of invalid provisions are inadequate. While the courts have the power to award compensatory and punitive damages, it is difficult if not impossible to find a plaintiff who has standing to bring

406. National Association of Insurance Commissioners, *Disclosure Guidelines and Process* (Draft Aug. 17, 2006), available at http://www.lisassociation.org/vlsaamembers/files/broker_issues_NAIC_Disclosure_Guidelines_and_Process_08-17-06.pdf (last accessed Feb. 26, 2009).

407. *Id.*

408. National Association of Insurance Commissioners, *Standards for Individual Disability Income Insurance Application Change Form* (Mar. 29, 2007), available at http://www.naic.org/documents/committees_ex_speed_compactstds_app_change_form_disability.pdf (last accessed Feb. 27, 2009).

409. *Id.*

410. *Id.*

411. 1 STEMPER, *supra* note 171, at § 2.05[F], 2-79.

an action complaining of nothing more than an insurer's inclusion or retention of an invalid policy provision. And even if such a plaintiff is identified, it is unlikely that that individual will have sustained any damages in reliance upon its continued presence.

The administrative remedies suffer from similar infirmities. In states where insurers must at least file their policy forms and endorsements before they may be used, an aggrieved policyholder can request a hearing with respect to a filed policy form, and the insurance commissioner can invalidate it. But that is of little consequence where (1) virtually no policyholders bother to read their policy (much less ascertain whether its many provisions are valid and enforceable) and (2) even if they did, while the insured could request and obtain a hearing on the question, the insurance commissioner cannot award compensatory or punitive damages or attorney fees.

Typical of these statutes is the one in Ohio. Under Ohio law, every insurer is required to file with the superintendent of insurance "every form of a policy, endorsement, rider, manual of classifications, rules, and rates . . . which it proposes to use."⁴¹² Any person aggrieved with respect to any filing that is in effect may apply to the superintendent for a hearing, specifying the grounds to be relied upon by the applicant.⁴¹³ If the superintendent finds that the application is made in good faith, that the applicant would be aggrieved if his grounds are established, and that the grounds justify holding a hearing, the superintendent must hold a hearing within 30 days thereafter as to every insurer and rating organization that made the filing.⁴¹⁴ If the superintendent, after the hearing, finds that the filing does not comply with the Ohio statutes, the superintendent must issue an order specifying in what respects he finds that the filing fails to comply and stating when, within a reasonable period thereafter, the filing will no longer be effective.⁴¹⁵

In addition to the problem of finding an "aggrieved person" with standing to bring the claim (and who is aware of the problem), this administrative remedy suffers other failings. First, for the many reasons discussed above (including the fact that no statute forbids the inclusion or retention of an invalid policy provision) it is not clear that such a policy would "not comply with [the specified sections] of the Revised Code"⁴¹⁶ Moreover, an individual policyholder has little incentive

412. OHIO REV. CODE ANN. § 3937.03(A) (West 2009).

413. OHIO REV. CODE ANN. § 3937.04(B) (West 2009).

414. *Id.*

415. *Id.*

416. *See id.*

to bring such a claim where the administrative remedy does not permit an award of compensatory or punitive damages or attorney fees. And it is clear that those remedies are not available.

In Ohio, the superintendent of insurance “has jurisdiction over a simple breach of contract case and portions of the remaining non-negligence claims, but only to the extent of ordering reimbursement of wrongly charged moneys.”⁴¹⁷ The same court noted that “this authority does not extend to awarding attorney, auditor, or accountant fees, compensatory or punitive damages, or costs”⁴¹⁸

The case law in other jurisdictions is to the same effect. For example, in *Griswold v. Union Labor Life Ins. Co.*,⁴¹⁹ the insured employee and his daughter sued on a group health policy for medical and hospital expenses the daughter incurred as a result of injuries sustained in a one-car accident.⁴²⁰ The trial court granted summary judgment to the insurer on several grounds, including the ground that the plaintiffs had not exhausted their administrative remedies.⁴²¹

The Connecticut Supreme Court reversed.⁴²² In the portion of its opinion addressing the exhaustion of administrative remedies, the Court held that it was unnecessary for the plaintiff to exhaust those remedies since the insurance commissioner lacked the authority to grant the requested damages.⁴²³

417. *Lazarus v. Ohio Cas. Group*, 761 N.E.2d 649, 654 (Ohio Ct. App. 2001).

418. *Id.* Other Ohio authorities are to the same effect. *See, e.g., City of Lakewood v. Blue Cross & Blue Shield Mut. of Northern Ohio*, No. 50266, 1986 WL 7714 at *7 (Ohio Ct. App. July 10, 1986) (“The Superintendent . . . lacked authority to adjudicate the hospital’s claim for damages.”); *Barnes v. First Am. Title Ins. Co.*, No. 1:06CV574, 2006 WL 2265553 at *4 (N.D. Ohio Aug. 8, 2006) (“As the Complaint seeks damages outside the scope of the Superintendent’s authority, this Court does not find that referral to the Superintendent for the breach of contract and breach of duty of good faith and fair dealing claims would contribute to the meaningful resolution of the suit.”); *Chesner v. Stewart Title Guar. Co.*, No. 1:06CV476, 2006 WL 2252542 at *4 (N.D. Ohio Aug. 4, 2006).

419. 442 A.2d 920 (Conn. 1982).

420. *Id.* at 921.

421. *Id.* at 922.

422. *Id.*

423. *Id.* at 925-26. Authorities to the same effect from other jurisdictions abound. *See, e.g., Ambassador Ins. Corp. v. Feldman*, 598 P.2d 630, 631 (Nev. 1979) (“The Insurance Commissioner is without authority to award damages caused by defamation; the commissioner’s powers are limited to the regulation of insurance trade practices.”); *Shermoff v. Superior Court of Los Angeles County*, 118 Cal. Rptr. 680, 682 (Cal. Ct. App. 1975) (“Appellant’s complaint seeks damages, and Insurance Code section 790.09 provides specifically that the Commissioner’s action cannot relieve or absolve the insurer from such a claim.”); *Irvin v. Liberty Life Ins. Co.*, No. 00-2716, 2001 WL 246408 at *2 (E.D. La. March 12, 2001) (“Here, the remedies plaintiffs seek include damages, which the Louisiana Department of Insurance cannot provide.”); *Ass’n Cas. Ins. Co. v. Allstate Ins.*

Indeed, in the one case directly addressing the question where an insured brought suit against the health insurer alleging that the “other insurance” provision violated public policy, the court expressly held that the insurance commissioner lacked any authority to adjudicate the policyholder’s claim.⁴²⁴

Clearly, the administrative remedies now in place are not sufficient to address the problem of insurer retention of invalid policy provisions, even in the extremely unusual case where a policyholder may be aware of, and decides to challenge, the continued presence of such a provision.

D. The NAIC Draft “Property and Casualty Rate and Policy Form Best Practices” Provisions Also Fail to Address the Problem.

The NAIC is presently working on a discussion draft of a document known as the *Property and Casualty Rate and Policy Form Best Practices*.⁴²⁵ Its stated purpose is to, *inter alia*, “regulate insurance contracts to the end that they not be contrary to the laws of the state, misleading, illusory, ambiguous, deceptive, contrary to public policy, unreasonably restrictive, or likely to mislead or deceive the policyholder”⁴²⁶

As currently constituted, Section 8 of the draft addresses Policy Form Standards. Subsection A of that proposed draft provides as follows:

A. Policy forms shall not:

- (1) Contain provisions, exceptions or conditions that are misleading, illusory, inconsistent, ambiguous, deceptive, or contrary to public policy, that unreasonably affect the risk purported to be assumed in the general coverage of the policy, or that encourage misrepresentation of the coverage; or
- (2) Violate or fail to comply with any provision of the insurance code or the laws of this state.⁴²⁷

Co., 507 F. Supp. 2d 610, 623 (S.D. Miss. 2007) (“[N]either the Board nor the Commissioner have the authority to grant monetary damages under the administrative remedy provided . . .”).

424. *Hazelett v. Blue Cross and Blue Shield of Ind.*, 400 N.E.2d 1134, 1137 (Ind. Ct. App. 1980) (“There is no hint of establishing any type of administrative remedy for policyholders. In fact they are not mentioned. The Statute is limited to providing the manner in which insurance companies could gain the necessary approval to lawfully issue insurance policies . . . nothing more.”).

425. National Association of Insurance Commissioners, Personal Lines Regulatory Framework (Draft Aug. 28, 2007), available at http://www.naic.org/documents/committees_ex_speed_personal_lines_framework07.doc.

426. *Id.* at Section 1.

427. *Id.* at Section 8(A).

This provision fails to address the problem of invalid policy provisions in two ways. First, this proposed draft fails specifically to address provisions that have been declared to be void, invalid, or unenforceable (or to address the kindred problems of conditional invalidity and the like). But even more importantly, these standards apply to only the forms and the law as it exists at the time of filing. Nothing in the draft addresses whether, or how, insurers are to respond to subsequent judicial decisions invalidating provisions previously thought to be valid, nor does it address the exact response required of the insurer, the time within which the insurer must act, or any penalties that may be imposed by the commissioner for noncompliance.⁴²⁸

Thus, while the NAIC's current draft of its *Best Practices* may be a step in the right direction, it does not sufficiently address the problems of whether an insurer must remove a subsequently invalidated policy provision, or the specific requirements that the insurer is required to follow, and any penalties that may be incurred for noncompliance.

E. Class Actions

1. The NAIC Has Explicitly Rejected Class Action Treatment for Violations of the UTPA

The NAIC advisory committee twice considered whether the UTPA should provide for class action relief. In each case—in language largely echoing the notions that underlie the filed rate doctrine and filed form doctrine—the NAIC determined that permitting class action relief was inadvisable and unwarranted.

In 1971, the Industry Advisory Committee of the NAIC Subcommittee to Review the Model Unfair Trade Practices Act submitted its report.⁴²⁹ When amendments were considered by the Industry Advisory Committee, proposals were made to specifically allow for consumer class actions alleging violations of unfair trade

428. Occasionally, existing state regulations include language similar to that found in Section 8(A) of *Best Practices*. See, e.g., W. VA. CODE ANN. § 33-6-9(b) (West 2009) (providing that policies must not “contain[] or incorporate[] by reference any inconsistent, ambiguous, or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.”). These regulations suffer the same infirmities as the *Best Practices* draft with respect to the duty to remove subsequently invalidated provisions in policies.

429. National Association of Insurance Commissioners, Proceedings, 1971-2 NAIC Proc. 341, 341 (1971).

practices.⁴³⁰ The report submitted by the Industry Advisory Committee on June 16, 1971 noted that the Industry Advisory Committee was specifically directed to consider whether class actions should be permitted.⁴³¹

The result of this was a strong recommendation by the Industry Advisory Committee against the inclusion of any provision for consumer class action suits.⁴³² The committee determined that class action treatment was inappropriate in a heavily regulated industry, and that private class actions would be “wasteful at best and more likely chaotic” than helpful:

F. Consumer Class Actions

The Industry Advisory Committee strongly recommends against the inclusion in the Model Act of any provision for consumer class action suits for damages resulting from violation of the Act, whether accompanied or not by a “trigger” mechanism that is a finding by the commissioner that the Act has been violated. Such a provision is unnecessary and undesirable for the following reasons:

1. The common law in all states recognizes the principle of representative actions, so the consumer is not without remedy in this area;
2. There is less reason for such legislation as applied to a heavily regulated industry such as insurance (characterized by Commissioner Durkin in his testimony on S. 984, S. 1222 and S. 1378 as “pervasive” regulation);

430. *Id.* at 342.

431. The report stated:

The Industry Advisory Committee held its initial meeting, at the request of the NAIC, at the Zone V meeting in Santa Fe, New Mexico on April 26. . . . As a result of that meeting Commissioner Durkin, as co-chairman of the Subcommittee, on May 14th distributed a letter setting forth various items which the Industry Advisory Committee was to consider.

As a result of the various federal proposals to create consumer class actions for damages produced by the commission of unfair trade practices, some of which proposals would include insurance services, the Advisory Committee was asked to be ready to discuss this subject. The proposals in this area include: 1) unlimited class action rights; 2) a right to a class action triggered only by a finding by the Commissioner that an unfair trade practice has been committed; and 3) empower the Commissioner to sue on behalf of injured members of a class for damages sustained.

Id. at 343-44.

432. *Id.* at 350-52.

3. The regulator already has the practical power to accomplish on behalf of the consumer what consumer less actions are designed to accomplish. This is evident from the testimony of Commissioner Barger in connection with Senate Bill 3201 in August 1970 (1970 NAIC Proceedings pages 135-144) and from Commissioner Durkin's testimony on S. 984, S. 1222 and S. 1378 in April, 1971;

4. Insurers will never be able to rely on the decision of the regulator. If policyholders are able to challenge the decision of the Commissioner through the use of the class action, the whole regulatory mechanism will be subverted. A number of class actions have been filed challenging medical pay offsets in uninsured motorists coverage -- forms approved by the insurance department;

5. Consumer class actions will result in "judicial" regulation of the insurance business;

6. The class action principle has been abused in practice. The principal beneficiaries have been the attorneys. There is much criticism of the federal rules because of the basic inequities in this area;

7. The types of class actions being experienced today have industry-wide implications—not restricted to isolated acts by one insurer. There is an obvious impact on loss experience, market capacity, and perhaps solvency of insurers;

8. Class actions tend to encourage champerty, maintenance and the impropriety of attorneys stirring up litigation;

9. Many of the laws regulating the business are not completely clear, particularly in terms of new practices, etc. As a result, an insurer would not be able to safely rely on the opinion of counsel nor perhaps even the decision of the regulator because of the fear of a class action. This will unduly inhibit the industry in developing new forms and procedures; and

10. The costs of defense of class action suits are prohibitive. Litigation minded persons can shop forums until the defendant bows to the yolk of defense costs and agrees to a settlement.

The Industry Advisory Committee is well aware of the Congressional activity in this area. We support the NAIC's action in seeking to exclude insurance services from the ambit of the current legislative proposals. Commissioners Barger and Durkin, in their testimony before the U.S. Senate Committees considering consumer class

actions, gave a number of examples of how the state regulatory process protects the consumer and how the commissioners assist the public in areas covered by the class action suits. These same examples not only support the system of state regulation, but also stand for the proposition that the insurance consumer has no real need for this additional legislation. As applied to the insurance industry, the Industry Advisory Committee endorses the statement of Simon H. Rifkind, Esq., a former federal judge, in testifying on S. 3201 (Hearings before the Senate Judiciary Committee on Consumer Protection Act of 1970, p. 382):

“Finally, the most important question, . . . is whether class actions are the best or even an appropriate means to protect consumers from unfair or deceptive practices. Law suits are most effective when an individual or a discrete group of individuals is seriously harmed by another person’s conduct. When the injurious conduct instead causes widespread, extremely diffuse harm inflicting relatively small individual wounds on many, many people or the population generally, the conduct is normally best regulated by a government.

Difficulties encountered with the administrative approach should not lead us to fly willy-nilly to regulation by private class action that would be wasteful at best and more likely chaotic in its consequences.”

Even without additional special causes of action being created for the consumer, class action law suits against insurers are becoming numerous and troublesome, to say nothing of the expense.

Similar objections lie to any suggestion that the commissioner be entitled to bring class actions for damages arising out of the violation of the Model Act. Such power would change the role of the commissioner from that of a regulator to a collection agency. It will produce conflict between commissioners where there are differences of opinion as to whether the Act has been violated and will engender great public and political pressure upon the commissioners, particularly where a neighboring department has utilized its power in this area. Such conflict will destroy comity between the states, resulting ultimately in federal regulation. The best solution for the consumer is effective regulation.⁴³³

The matter was further debated in a meeting of the Unfair Trade Practices Subcommittee of the NAIC that met in late November and

433. *Id.* at 350-352.

early December of 1971.⁴³⁴ The NAIC Subcommittee determined that strong administrative regulation, rather than class action treatment, was the better approach for handling unfair trade practices claims involving insurers.⁴³⁵ The Subcommittee then recommended the model Unfair Trade Practices Act (without any provision for class action suits) for adoption by the NAIC.⁴³⁶

It is clear that the NAIC and its Subcommittee considered class action treatment for UTPA violations neither practical nor appropriate. This decision is consistent with both the difficulties in maintaining a class action in suits of this type (which will be addressed in the following section), as well as the filed rate and filed form doctrines discussed in Section III(A)(2) above.

1. Class Action Treatment is Inappropriate in Common Law Fraud Actions

Fraud can be based upon either an overt misrepresentation or a failure to disclose. To establish a claim for fraudulent misrepresentation, the plaintiff must prove (1) a representation or, where there is a duty to disclose, concealment of a fact; (2) which is material to the transaction at hand; (3) made falsely, with knowledge of its falsity, or with such utter disregard and recklessness as to whether it is true or false that knowledge may be inferred; (4) with the intent of misleading another into relying upon it; (5) justifiable reliance upon the representation or concealment; and (6) a resulting injury proximately caused by the reliance.⁴³⁷

434. National Association of Insurance Commissioners, Proceedings, 1972-1 NAIC Proc. 490 (1972).

435. It provided:

The Subcommittee points out that several other areas were discussed but are not part of the recommended bill.

...
With respect to class action provisions, the final decision of the Subcommittee was that a provision relating to class actions was inappropriate at this time in view of the circumstances. Furthermore, the Subcommittee felt that the remedies in the model bill provide broad relief, thus affording the insurance consumer the complete protection of the Insurance Department, including Insurance Department complaint handling mechanisms, which has proved to be a most effective mode of redress. In addition, the Subcommittee felt that a provision with respect to class actions might restrict rather than expand the relief possible.

Id. at 491.

436. *Id.*

437. *Gaines v. Preterm-Cleveland, Inc.*, 514 N.E.2d 709, 712 (Ohio 1987); *Burr v. Bd. of County Comm'rs of Stark County*, 491 N.E.2d 1101, 1102 (Ohio 1986); *Yo-Can, Inc. v. Yogurt Exchange, Inc.*, 778 N.E.2d 80, 89 (Ohio Ct. App. 2002); *Watkins v. Cleveland Clinic Found.*, 719

Any attempt to lessen the substantive legal requirements that are required to prove a *prima facie* case by using the vehicle of a class action (rather than just naming individual plaintiffs) would violate due process.⁴³⁸ A presumption of reliance is inappropriate in common law fraud cases not only because reliance and proximate cause are inherently individualized inquiries, but also because presuming injury to a class that includes people who were not injured would violate due process.⁴³⁹ Put differently, the courts have “no power to define differently the substantive right of individual plaintiffs as compared to class plaintiffs.”⁴⁴⁰ Even if a presumption of reliance could be used, due process would require that that presumption be rebuttable for each class member individually.

The use of a presumption of reliance was approved in the context of a Rule 10b-5 securities fraud claim in *Basic, Inc. v. Levinson*.⁴⁴¹ The plaintiffs in *Basic* alleged that material misrepresentations had been made due to the company’s explicit (but false) denial that merger negotiations were taking place.⁴⁴² The question before the Court was whether the plaintiffs were required to prove that each investor in the plaintiff class relied on those misrepresentations.⁴⁴³

The Supreme Court held that they were not.⁴⁴⁴ In part, the Court’s decision was based on the fact that publicly-made misrepresentations would inherently affect the price of stock purchased by the investors, regardless of whether each individual investor was aware of and relied on these misrepresentations.⁴⁴⁵

Post-*Basic* federal decisions have generally held that the presumption of reliance only applies in “fraud-on-the-market” cases, and is not generally applicable to garden variety common law actions. In

N.E.2d 1052, 1063 (Ohio Ct. App. 1998); *Able/S.S., Inc. v. KM & E Services, Inc.*, No. 2000-L-162, 2002 WL 31663550 at *11 (Ohio Ct. App. Nov. 22, 2002).

438. *Eisen v. Carlisle & Jacquelin*, 479 F.2d 1005, 1018 (2d Cir. 1973) (“Even if amended Rule 23 could be read so as to permit any such fantastic procedure, the courts would have to reject it as an unconstitutional violation of the requirement of due process of law.”); *Tucker v. Arthur Andersen & Co.*, 67 F.R.D. 468, 480 (S.D.N.Y. 1975) (“Justification for the use of a presumption of reliance . . . should not . . . be premised on the bringing of the . . . suit as a class action, for this would raise a serious question of modification of substantive rights in violation of the Rules Enabling Act.”).

439. *See Windham v. Am. Brands, Inc.*, 565 F.2d 59, 65-66 (4th Cir. 1977).

440. *Alabama v. Blue Bird Body Co., Inc.*, 573 F.2d 309, 318 (5th Cir. 1978).

441. 485 U.S. 224 (1988).

442. *Id.* at 227.

443. *Id.* at 230.

444. *Id.* at 248-49.

445. *Id.*

fact, in the Official Comment to the Federal Rule of Civil Procedure 23, the drafters indicated that a fraud class action might be inappropriate where individual questions of reliance are at issue.⁴⁴⁶ Given this cautionary statement, federal courts have generally refrained from certifying fraud class actions where individual reliance is at issue.⁴⁴⁷

Federal courts have also resisted expanding the fraud-on-the-market theory to permit the use of a presumption of reliance outside the securities context. In *Gunnells v. Healthplan Services, Inc.*,⁴⁴⁸ the court of appeals reversed the trial court's use of a *Basic* presumption of reliance in a common law fraud case.⁴⁴⁹ The *Gunnells* court held that neither *Basic* nor any other case supported a presumption of reliance in such a case.⁴⁵⁰ The court observed that in the securities context, the "capacity of the capital markets to rapidly assimilate public information into stock prices" justified a presumption of reliance.⁴⁵¹ But the court

446. FED. R. CIV. P. 23, Official Comment ("In this view, a fraud perpetrated on numerous persons by the use of similar misrepresentations may be an appealing situation for a class action, and it may remain so despite the need, if liability is found, for separate determination of the damages suffered by individuals within the class. On the other hand, although having some common core, a fraud case may be unsuited for treatment as a class action if there was material variation in the representations made or in the kinds or degrees of reliance by the persons to whom they were addressed.").

447. *Gariety v. Grant Thornton, LLP*, 368 F.3d 356, 362 (4th Cir. 2004) ("Because proof of reliance is generally individualized to each plaintiff allegedly defrauded, fraud and negligent misrepresentation claims are not readily susceptible to class action treatment, precluding certification of such actions as a class action."); *In re Livent, Inc. Noteholders Securities Litig.*, 211 F.R.D. 219, 223-24 (S.D.N.Y. 2002) (refusing to certify class where individual issues of reliance would predominate because a class-wide presumption was improper); *Yadlosky v. Grant Thornton L.L.P.*, 197 F.R.D. 292, 298-99 (E.D. Mich. 2000) (holding that where securities were not sold in an open and efficient market, investors were not entitled to a presumption of reliance, thereby necessitating individual proof of reliance for claims of common law fraud, negligent misrepresentation, and similar claims); *Castano v. Am. Tobacco Co.*, 84 F.3d 734, 745 (5th Cir. 1996) ("According to both the advisory committee's notes to Rule 23(b)(3) and this court's decision in *Simon v. Merrill Lynch . . .*, a fraud class action cannot be certified when individual reliance will be an issue."); *Thompson v. American Tobacco Co., Inc.*, 189 F.R.D. 544, 551 n.3 (D. Minn. 1999) ("Because recovery under common law fraud requires a finding of individual reliance and because individual proof of reliance precludes class certification, the Court summarily denies class certification of Plaintiffs' common law fraud theory of recovery."); *Andrews v. AT&T*, 95 F.3d 1014, 1025 (11th Cir. 1996) (decertifying class because "the plaintiffs would . . . have to show, on an individual basis, that they relied on the misrepresentations, suffered injury as a result, and incurred a demonstrable amount of damages"); *Broussard v. Meineke Discount Muffler Shops, Inc.*, 155 F.3d 331, 341 (4th Cir. 1998) ("[T]he reliance element of . . . fraud and negligent misrepresentation claims [is] not readily susceptible to class-wide proof. . . . [P]roof of reasonable reliance . . . depend[s] upon a fact-intensive inquiry into what information each [plaintiff] actually had . . .").

448. 348 F.3d 417 (4th Cir. 2003).

449. *Id.* at 435.

450. *Id.*

451. *Id.*

contrasted that with a situation where the plaintiffs alleged ordinary fraud and misrepresentation.⁴⁵² In the latter case, the court concluded that if an individual plaintiff was not aware of the alleged misrepresentations, there was no basis for presuming that they were a proximate cause of their damages.⁴⁵³

Again, in *Sikes v. Teleline, Inc.*,⁴⁵⁴ the parent of a young child who repeatedly called an automated 900-number “Let’s Make A Deal” game brought a class action against the phone company asserting claims under RICO and various state laws.⁴⁵⁵ The district court certified the class, and later denied a separate motion for decertification.⁴⁵⁶ The Eleventh Circuit Court of Appeals reversed, holding that the trial court should have decertified the class.⁴⁵⁷ In doing so, it held that a fraud-on-the-market presumption of reliance was inappropriate in RICO or other fraud cases.⁴⁵⁸ The *Sikes* Court agreed with the conclusion in *Gunnells*, stating that:

The securities market presents a wholly different context than a consumer fraud case, and neither this circuit nor the Supreme Court has extended a presumption of reliance outside the context of securities cases.⁴⁵⁹

As shown above, because it is inappropriate to use a presumption of reliance outside of the Rule 10b-5 context, federal courts have

452. *Id.* at 435-36

453. *Id.*

454. 281 F.3d 1350 (11th Cir. 2002).

455. *Id.* at 1355-58.

456. *Id.* at 1358.

457. *Id.* at 1368.

458. *Id.* at 1363-64.

459. *Id.* at 1363. Other federal circuit cases have rejected the use of the *Basic* presumption outside of the securities law context include. *Poulos v. Caesars World, Inc.*, 379 F.3d 654, 666 (9th Cir. 2004) (“The shortcut of a presumption of reliance typically has been applied in cases involving securities fraud and, even then, the presumption applies only in cases primarily involving ‘a failure to disclose’—that is, cases based on omissions as opposed to affirmative misrepresentations.”); *Appletree Square I, Ltd. Partnership v. W.R. Grace & Co.*, 29 F.3d 1283, 1287 (8th Cir. 1994) (“Courts have generally limited the use of the fraud-on-the-market theory to securities fraud cases.”); *Chudasama v. Mazda Motor Corp.*, 123 F.3d 1353, 1369 n.39 (11th Cir. 1997) (“The fraud on the market theory of securities law, however, is based on concepts and policies that simply do not apply in a products liability case.”); *Summit Properties, Inc. v. Hoechst Celanese Corp.*, 214 F.3d 556, 561 (5th Cir. 2000) (“No court has accepted the use of [the fraud-on-the-market] theory outside of the context of securities fraud, and one circuit has expressly rejected its use in the context of a similar civil RICO case. An efficient market is a critical element of a market’s role as an intermediary. There is no pretense of such a market here and the fraud on the market doctrine is not applicable.”).

consistently held that common law fraud and negligent misrepresentation suits are “poor candidates” for class treatment.⁴⁶⁰

State courts have likewise refused to certify common law fraud class actions because of the inherently individual nature of any alleged reliance. They agree with the federal decisions that hold that a presumption of reliance is inappropriate in such cases. For example, in *Small v. Lorillard Tobacco Co., Inc.*,⁴⁶¹ the court reversed certification of a plaintiff class who alleged that they were deceived into becoming smokers because the defendants lied about nicotine’s addictive properties.⁴⁶² The court held that reliance had to be established on an individual basis, even if that meant that the trial would take “hundreds of years.”⁴⁶³

Again, in *Henry Schein, Inc. v. Stromboe*,⁴⁶⁴ a class of dentists who had purchased dental practice management software filed suit against the seller asserting claims for breach of contract, breach of express and implied warranties, fraud and negligent misrepresentation, and violations of the Texas Deceptive Trade Practices Act.⁴⁶⁵ The trial court certified the class, and the court of appeals affirmed.⁴⁶⁶

The Texas Supreme Court reversed.⁴⁶⁷ In doing so, it held that reliance was an essential element of five of the plaintiffs’ causes of action.⁴⁶⁸ It also held that the procedural class action device was not a shortcut that would allow the plaintiff class members to enjoy a presumption that would not be available to any individual plaintiff had their claim been brought separately.⁴⁶⁹ Rather, each and every one of the 20,000 class members was to be held to the same standards of proof of reliance (and every other element of their claims) that would be required if each had filed suit individually.⁴⁷⁰

The theory of any suit against an insurer for failure to remove an invalid policy provision will almost certainly be based on some species of fraud or nondisclosure. But as the foregoing indicates, it is almost

460. See, e.g., *McManus v. Fleetwood Enterprises, Inc.*, 320 F.3d 545, 549-50 (5th Cir. 2003); *Patterson v. Mobil Oil Corp.*, 241 F.3d 417, 419 (5th Cir. 2001); *Castano*, 84 F.3d at 745.

461. 679 N.Y.S.2d 593 (App. Div. 1998).

462. *Id.* at 597, 606.

463. *Id.* at 602.

464. 102 S.W.3d 675 (Tex. 2003).

465. *Id.* at 678.

466. *Id.* at 679.

467. *Id.*

468. *Id.* at 693.

469. *Id.* at 693-94.

470. *Id.* at 693.

universally accepted that fraud claims are the poorest candidates for constitutionally appropriate class action treatment. They therefore do not represent a suitable vehicle for the resolution of claims based on an insurer's failure to remove an invalid policy provision.

2. Class Action Treatment is Inappropriate Because There is No Way to Identify Policyholders Who Sustained a Loss But Did Not Report it Because of the Presence of the Invalid Policy Provision

The Federal Rules of Civil Procedure (and generally their state counterparts) require that, before a class action can be certified, the members of the class must be identifiable.⁴⁷¹ But as noted above, neither a plaintiff's attorney nor the insurer would know the identity of any insureds who sustained a loss, read their policy, and erroneously concluded that the loss would not be covered because they saw an invalid provision in the policy that appeared to bar coverage.

It has been held that for a class to be identifiable, the class definition must be precise enough to permit identification of class members with "reasonable effort,"⁴⁷² meaning that it must be administratively feasible to determine whether any particular individual is a member of the class.⁴⁷³ The test of identifiability is "whether the means is specified at the time of certification to determine whether a particular individual is a member of the class."⁴⁷⁴ Classic examples of class definitions that are too vague and ambiguous to warrant certification are "all poor people," "all people active in the peace movement," and "all people who have been or may be harassed by the police."⁴⁷⁵

It is not possible for either plaintiffs' counsel or an insurer to identify which insureds (if any) refrained from presenting a claim because of the presence of an invalid condition or exclusion in a policy. Since it is not possible for anyone to identify those class members, a class could be certified only if it was composed of some other group of

471. FED. R. CIV. P. 23.

472. *Hamilton v. Ohio Sav. Bank*, 694 N.E.2d 442, 448 (Ohio 1998) (quoting *Warner v. Waste Mgt., Inc.*, 521 N.E.2d 1091, 1096 (Ohio 1988)).

473. *Petty v. Wal-Mart Stores, Inc.*, 773 N.E.2d 576, 579 (Ohio Ct. App. 2002), *appeal not allowed* 772 N.E.2d 1203 (Ohio 2002).

474. *Hamilton*, 694 N.E.2d at 449 (quoting *Planned Parenthood Assn. of Cincinnati, Inc. v. Project Jericho*, 556 N.E.2d 157, 165 (Ohio 1990)).

475. *Warner v. Waste Mgmt., Inc.*, 521 N.E.2d 1091, 1096 (Ohio 1988) (holding that such classes are "too amorphous to permit identification within a reasonable effort").

individuals, whose definition would almost certainly be over-inclusive. An over-inclusive definition might consist of all persons holding policies issued by the insurer that included the invalid provision over a specified period of time. That is a group of individuals who could be identified from the insurer's own records.

However, that would not be an appropriate class because the overwhelming majority—indeed, perhaps all—of the class members never knew of the presence of the invalid provision in their policies, much less failed to present a covered claim because of its presence. To allow a group of people who sustained no injury and no damage because of the presence of the invalid provision constitutes an unwarranted windfall to these plaintiffs (and their counsel). Tort law is intended to make injured persons whole. It is not intended to provide an unjustifiable windfall to a class of individuals for the sole reason that they happened to be lucky enough to purchase an insurance policy that fortuitously contained an invalid provision that was unrelated to any loss they sustained or any claim they presented.

IV. UNIFORM LEGISLATION IS AN APPROPRIATE MECHANISM TO FASHION RELIEF

A. Since the Passage of the McCarran-Ferguson Act, the NAIC Has Often Promulgated Model Laws

The National Association of Insurance Commissioners (“NAIC”) was founded in 1871 to help coordinate the system of state regulation.⁴⁷⁶ On May 24, 1871—only six years after the end of the Civil War—the chief insurance regulators of 19 of the 36 states met in New York City for the first meeting of the organization that later became known as the NAIC.⁴⁷⁷ By 1872, more than 30 states were represented.⁴⁷⁸ At that time, the organization adopted a statement of objectives at its second meeting.⁴⁷⁹

476. RONALD KESSLER, *THE LIFE INSURANCE GAME* 209 (1985).

477. James W. Schacht et al., *A Study on State Authority: Making a Case for Proper Insurance Oversight* at 63 (Draft July 2007), <http://www.ncoil.org/policy/Docs/2007/PhaseIReport.pdf>.

478. *Id.* at 63.

479. *Id.* at 63-64 (“The objective of this association shall be to promote uniformity in legislation affecting insurance; to encourage uniformity in departmental rulings under the insurance laws of the several states; to disseminate information of value to insurance supervisory officials in the performance of their duties; to establish ways and means of fully protecting the interest of insurance policyholders of the various states, territories, and insular possessions of the United States and to preserve to the several states, the regulation of the business of insurance.” (citing James W.

In 1944, after the U.S. Supreme Court rendered its decision in *United States v. South-Eastern Underwriters Association*,⁴⁸⁰ it rejected nearly a century of prior decisions holding that insurance was not interstate commerce.⁴⁸¹ In response to this ruling, the insurance industry devised a plan to head off federal regulation.⁴⁸² The industry persuaded Congress to pass the McCarran-Ferguson Act,⁴⁸³ which provided a three-year moratorium on federal regulation of the insurance industry.⁴⁸⁴ At the end of that period, federal regulators would be permitted to assert their authority only over those aspects of the insurance industry not regulated by the states.⁴⁸⁵ This moratorium gave the NAIC time to draft model legislation intended to preempt the entire field of insurance industry regulation, thus protecting it from federal regulation by the Federal Trade Commission or any other administrative agency.⁴⁸⁶

When the NAIC was originally created, its first major step in the process of coordinating the regulation of multi-state insurers was the development of uniform financial reporting standards.⁴⁸⁷ The Bylaws of the NAIC⁴⁸⁸ establish eight standing committees, all of which are charged with considering issues relating to their particular aspect of the insurance market.⁴⁸⁹

B. The NAIC Has Often Promulgated Model Statutes and Rules in Other Contexts Where Uniformity is Desirable

The structure of the NAIC, established by its Bylaws, enables it to adopt model laws, regulations, and guidelines on a wide variety of subjects. At this writing, the NAIC has promulgated 219 model laws.⁴⁹⁰ As might be expected from the breadth of the subcommittees and the

Schacht, NAIC Finances and Funding, a discussion paper for the 1995 NAIC Commissioners Conference at 3 (January 1995)).

480. 322 U.S. 533 (1944).

481. *Id.* at 552-53.

482. ASHLEY, *supra* note 257, at § 9:2.

483. 15 U.S.C. §§ 1011-15 (West 2009).

484. ASHLEY, *supra* note 257, at § 9:2.

485. *Id.*

486. *Id.*

487. The NAIC's History and Background, http://www.naic.org/index_about.htm (last visited on Mar. 11, 2009).

488. *Id.*

489. *See id.* at Article VI.

490. The NAIC Model Laws, Regulations and Guidelines are published in five volumes, which can be found in the NAIC database on www.lexis.com. In addition, both a Table of Contents that identifies all extant draft model laws, rules and regulations, plus a subject matter outline, are available on the NAIC website, http://www.naic.org/index_committees.htm.

NAIC's purpose, these 219 model laws address a wide variety of topics in most of the major product lines.⁴⁹¹

The eight standing committees include the Life Insurance and Annuities Committee, the Health Insurance and Managed Care Committee, the Property and Casualty Insurance Committee, the Market Regulation and Consumer Affairs Committee, the Financial Condition Committee, the Financial Regulation Standards and Accreditation Committee, the International Insurance Relations Committee, and the Information Resources Management Committee.

The Bylaws permit the Executive Committee, the Subcommittee of the Executive Committee, and the Standing Committees to establish one or more Task Forces that automatically terminate at the end of the NAIC Winter National Meeting. However, if an existing Task Force is dealing with insurance problems that require continuing study, the Executive Committee may adopt the recommendation of the parent Committee or the Subcommittee that it be designated a Standing Task Force.

In addition to the model laws that have been promulgated, the NAIC also makes available drafts of regulations that are presently under consideration. At the time of this writing, some ten discussion drafts were available on the NAIC website covering topics as diverse as the preferred mortality tables for use in determining minimum reserve liabilities, the fiduciary responsibilities of insurance producers, insurance regulatory class action reform, medical malpractice closed claim reporting, and the creation of a comprehensive national plan for natural catastrophe risk.⁴⁹²

The flagship of the NAIC model acts was its original Unfair Trade Practices Act.⁴⁹³ The UTPA was carefully drafted to confer the same broad regulatory powers over the insurance industry upon state regulators that Congress had delegated to the Federal Trade Commission.⁴⁹⁴ It forbade any insurer from engaging in an unfair method of competition, or an unfair or deceptive act or practice in the

491. The NAIC Model Laws, Regulations and Guidelines specifically address, for example, product lines as diverse as accident and health insurance, licensing and regulations of agents/brokers/producers, regulation of annuities and variable contracts, credit insurance, examination of insurers, HMOs, holding companies, insider trading and proxies, insolvency, life insurance regulation, long-term care insurance, Medicare supplement insurance, property and casualty insurance, reinsurance, unauthorized insurance, and unfair trade practices.

492. NAIC Committees and Activities, http://www.naic.org/index_committees.htm (last visited Mar. 11, 2009).

493. NAIC Model Laws, Regulations and Guidelines, V-880-1.

494. ASHLEY, *supra* note 257.

business of insurance.⁴⁹⁵ Section 4 of the UTPA defined various specific unfair practices, which were for the most part anticompetitive acts.⁴⁹⁶ Section 5 empowered the insurance commissioner to investigate unfair insurance practices, and Sections 6 and 7 authorized the commissioner to hold hearings and issue cease and desist orders.⁴⁹⁷ Section 11 authorized the commissioner to bring a civil action against an insurer who violated such an order, and to collect fines in nominal amounts.⁴⁹⁸

The NAIC promulgated major amendments to the UTPA in 1971, which expanded the definition of unfair practices to include a number of unfair claim settlement practices.⁴⁹⁹ In June 1990, the NAIC again adopted amendments to the UTPA that separated the provisions dealing with unfair claims settlement into a newly adopted Unfair Claims Settlement Practices Model Act.⁵⁰⁰ The purpose of this action was to make clearer the distinction between general unfair trade practices on the one hand and unfair claim settlement practices on the other, and to focus on market conduct practices and market conduct regulation.⁵⁰¹

The NAIC has historically, then, addressed issues comparable to the question here presented. Indeed, the NAIC has even promulgated specific criteria addressing whether and when a new model law or regulation, or an amendment to an existing model law or regulation, should be adopted. Under the NAIC's published standards, a new model law is appropriate where two criteria are met:

- 1) If the issue that is the subject of the Model Law necessitates a national standard and requires uniformity amongst all states; and
- 2) Where NAIC Members are committed to devoting significant regulator and association resources to educate, communicate and support a model that has been adopted by the membership.⁵⁰²

495. *Id.*

496. *Id.*

497. *Id.*

498. *Id.*

499. See *Unfair Claims Settlement Practices*, Web Content for Lawyers, available at http://www.nextclient.com/services/website-\content/sample_articles/getSampleContent.jsp?orderid=78 (last accessed Feb. 27, 2009).

500. *Id.*

501. See Prefatory Note to the 4/17/2008 revisions to the Unfair Trade Practices Act (model 880), available at http://www.naic.org/meetings0806/plenary_agenda_attachments.pdf (last accessed Feb. 27, 2009).

502. The NAIC Procedures for Model Law Development are available from the NAIC website at http://www.naic.org/documents/committees_models_procedures.pdf (last accessed Feb. 20, 2009).

Whether the member regulators of the NAIC would be “committed to devoting significant regulator and association resources” to support the author’s proposed legislation cannot be predicted. But the proposed model law concerning removal or amendment of invalid policy provisions attached as Appendix A is certainly a subject that warrants a national standard and requires uniformity amongst all states. The absence of any meaningful or uniform standards results in a patchwork of inconsistent judicial declarations, rendering it impossible for an insurer to predict what it must do, when it must do it, or the penalty that may be assessed for any failure timely to act. Specifically, uniformity is essential for consistency in identifying:

- 1) whether and when a policy provision has in fact been declared to be unconditionally unenforceable;
- 2) what the insurer must do when a policy provision has been declared to be unconditionally enforceable;
- 3) when the insurer must act;
- 4) the effect of a declaration of invalidity or unenforceability by a trial court or intermediate court of appeals, that has not been accepted for review by the court of last resort in that jurisdiction;
- 5) whether any action is required by an insurer with respect to a policy provision that has only been declared to be conditionally unenforceable;
- 6) whether there is a private right of action for a violation of the duty to remove or amend an invalid provision; and
- 7) whether an insurer is required to notify policyholders of changes in the law occasioned by court decision or by statute, including decisions or statutes that either conditionally or unconditionally invalidate policy provisions.

V. CONCLUSION

In the view of this author, the answer to the question of whether or when an insurer is duty bound to remove invalid provisions from its policy is best made by those charged with ascertaining and setting public policy. If insurers are to be required to remove invalid provisions from their policies, it is preferable that that requirement be imposed by rule or statute rather than case law. The National Association of Insurance Commissioners has long issued model legislation for adoption by state legislatures or departments of insurance. Utilization of model rules promotes the goals of uniformity and predictability. It is only fair that insurers know what is expected of them in this developing area.

The proposed solution set forth in the Appendix A below is fair. It requires insurers to take timely action if—but only if—a policy provision has been unconditionally invalidated by the legislature or by a state’s court of last resort. There will no longer be a question of whether it is permissible for an insurer to permit an invalid provision to remain after it has been unconditionally invalidated by a state’s highest court. By the same token, it will also be clear to insurers that they are not obligated to change their policies in response to lower court decisions invalidating policy provisions, or in cases where that provision is only conditionally unenforceable or where enforceability is merely doubtful.

The rights of the parties to insurance contracts will be clearer from both perspectives. Insureds will receive the timely modifications to their policies in response to unconditional invalidations of policy provisions, while insurers will be insulated from lawsuits challenging the nature or timeliness of their response to judicial decisions impacting the validity of policy provisions.

One of the most fundamental policies of the law is to permit persons and entities accurately to predict what is (and is not) required of them, and the penalties for noncompliance. The proposed legislation set forth below will accomplish precisely that purpose.

APPENDIX A—PROPOSED MODEL LEGISLATION

Removal or Amendment of Invalid Policy Provisions

Section 1. Purpose

The purpose of this Act is to establish rules for determining whether, when, and how insurers are required to remove provisions from their policies that have been held to be void, invalid or unenforceable.

Section 2. Applicability

This Act shall apply to all policies of insurance issued by insurance companies authorized to do business in this state.

Section 3. When the Duty to Remove Exists

A. No duty to remove or amend any policy provision exists unless that provision has been declared to be unconditionally void, invalid or unenforceable by this state's highest appellate court or by the legislature. For the purpose of this section, a provision is not considered to have been held to be unconditionally void, invalid, or unenforceable by the [state court of last resort] in any case where that court 1) has simply declined to accept an appeal of a trial court or an intermediate court of appeals decision holding the provision to be invalid or unenforceable; or 2) invalidated another type of policy provision using language that suggests inferentially that the provision in question might also be invalid.

B. Where a policy provision has been held to be unconditionally void, invalid, or unenforceable by a trial court or by an intermediate court of appeals, then that provision may not be enforced within the geographic boundaries of that intermediate appellate court's jurisdiction. However, no insurer is required to remove or amend a policy provision that has been held to be invalid or unenforceable by any court other than the state's highest appellate court.

C. No insurer shall file with the Department of Insurance, or issue to its insureds, any new or revised policy form or endorsement containing a provision prohibited by statute or by regulation, or which has been declared to be unconditionally void, invalid, or unenforceable by the [state court of last resort].

Section 4. Time for Removal of Invalid Provisions

A. When a policy provision has been rendered unconditionally void, invalid, or unenforceable by the [state court of last resort] or by an act of the state legislature, then each insurer whose policies include that provision must, within 90 days after the date of the decision or the effective date of the statute, file a proposed form revision with the Department of Insurance deleting the provision or amending it to bring it into conformity with the decision or statute.

B. No duty to remove or amend the provision exists unless and until the Department of Insurance has approved the proposed form revision.

C. After the Department of Insurance has approved the proposed form revision deleting the provision, then the insurer must roll the revised form onto new business beginning 30 days after the effective date of the approval, and to existing business upon the first renewal of each existing policy that takes place beginning 30 days after the date of approval.

Section 5. No Private Right of Action

A. There shall be no private right of action for a violation of this Act.

B. No private right of action against an insurance company may be based, in whole or in part, upon an insurer's failure to remove or amend an invalid policy provision if the insurer has complied with the requirements of this Act.

C. No insurer is required to notify policyholders of changes in the law occasioned by any court decision or by statute, or of any corresponding effect on coverage under its policies.

Section 6. Penalties

A. The Commissioner may issue, in accordance with [citation to the applicable state administrative procedure act], a cease and desist order upon any person or organization that violates any provisions of this Act, or regulation or order adopted by the Commissioner promulgated hereunder.

B. The Commissioner may suspend or revoke the license of any insurer that fails to comply with an order of the Commissioner within the time specified in the order, or any extension thereof that the Commissioner may grant. The Commissioner may determine when a suspension of a license shall become effective and it shall remain in effect for the period fixed by the Commissioner, unless the suspension is

modified or rescinded, or until the order upon which the suspension is based is modified, rescinded, or reversed.

C. In addition to any other penalties or enforcement provisions of this Act, any person or organization who violates this Act is subject to civil penalties of up to \$10,000 for each violation, but if the violation is found to be willful, a penalty of not more than \$25,000 may be imposed for each violation. These penalties are in addition to any other penalty or remedy provided by law. For purposes of this section, an insurer who has failed to comply with this Act shall be deemed to have committed a separate violation for each day the violation occurred.

Section 7. Effective Date

A. This Act shall become effective [insert date] and shall apply to all insurance policies in effect at any time on or after the effective date.

