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Post Claim Underwriting

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POST CLAIM UNDERWRITING

Thomas C. Cady*
Georgia Lee Gates**

I. INTRODUCTION...........................................................................810
II. POST CLAIM UNDERWRITING DEFINED AND IDENTIFIED.........812
   A. Post Claim Underwriting Defined ........................................812
   B. Post Claim Underwriting Identified ......................................813
III. POLICY ARGUMENTS .................................................................814
   A. General Policy Principles ...................................................814
   B. The Aleatory Contract .........................................................817
   C. Low-Loss Ratios of Credit Insurance .................................819
   D. Great Potential for Abuse ..................................................821
   F. The Insurer’s Marketing Choice ...........................................823
   G. Patently Unfair .................................................................824
   H. Redux ..............................................................................825
IV. POST CLAIM UNDERWRITING AS PER SE BAD FAITH ..........826
   A. Opportunism and Bad Faith ...............................................826
      1. Opportunism ..................................................................826
      2. Bad Faith .......................................................................827
         a. Post Claim Underwriting and the Gruenberg Model ........829
         b. Post Claim Underwriting and the Anderson Model ........831
   B. Restatement (Second) of Contracts Section 172 Forecloses an Insurer Engaged in Post Claim Underwriting from Asserting the Inception Defense of Misrepresentation ........................................832
   C. Punitive Damages ..............................................................833
V. PRIOR CASES OF POST CLAIM UNDERWRITING DECIDED UPON ALTERNATIVE THEORIES .................................................................838
   A. Waiver ............................................................................839
   B. Estoppel ............................................................................840
   C. Unconscionability .............................................................841

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I. INTRODUCTION

This Article confronts the bane of many an insured: post claim underwriting. It is an underwriting abomination. It is an artificial vehicle for contract avoidance. It is quintessentially opportunistic.

Post claim underwriting facilitates issuance of an insurance policy by insurers, without prior determination of risk. Underwriting is postponed until a claim has been filed. An investigation and assessment of the risk presented by the insured is commenced only after the insurer is confronted with the prospect of contract performance. With the specter of contract performance looming on the horizon, the insurer has new-found energy for investigation. It then marshals its resources to discover any historical minutiae related to the insured that might serve as an arguable basis for an inception defense. Once this minutia is discovered, rescission naturally follows.

This Article posits that insurers are obligated to perform pre-issuance underwriting. The natural corollary to that postulate is also asserted: post claim underwriting is a forbidden practice. The premise of the “forbidden practice” rests upon the reasoned conclusion that post claim underwriting is a vehicle for opportunism in the insurance relationship. It is opportunistic because it permits the insurer to take advantage of the insured’s vulnerabilities created by the sequential character of the insurance contract through a post hoc rationale for rescission.1 In this regard, there is also a proposal for a per se rule of bad faith prohibiting post claim underwriting. Only through such a rule can the post claim underwriting bane be efficiently and forcefully deterred.

The Article is divided into five substantive categories of discussion, com-

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mencing with Part II and ending with Part VI. Part II consists of a compendium of court opinions (most notably the Mississippi Supreme Court) gathered to both define post claim underwriting and contrast it with the standard industry practice of pre-issuance underwriting. This definitional section is followed by a presentation of typology that should afford adequate factual information to allow counsel to readily identify cases of post claim underwriting.

Part III of the Article commences with a discussion of case law directly addressing post claim underwriting, followed by a presentation of general policy principles of both contract and insurance law that necessarily overarch any deliberative process in the insurance context. Part III then sets forth five specific policy rationales for condemnation of the practice of post claim underwriting. First, it is established that post claim underwriting is a purposeful insurer practice designed to defeat the odds of the aleatory contract of insurance. Second is a discussion of the high profitability made possible by the low loss-ratios of credit insurance—a line of coverage frequently associated with the practice of post claim underwriting. The third topic of discussion, “Great Potential for Abuse,” once again relies upon sales practices associated with credit insurance to demonstrate that the remunerative process associated with the line, when coupled with the practice of post claim underwriting, renders the insured particularly vulnerable to insurer abuse. Next is a discussion of “The Insurer’s Marketing Choice.” This subsection sets forth the proposition that an insurer’s marketing choice to forego reasonably thorough underwriting leaves it responsible for any adverse selection of risk it may subsequently encounter. Finally, in “Patently Unfair,” the inherent unfairness of post claim underwriting is examined.

Part IV posits the per se rule of bad faith that is the impetus for the Article. It is first established that post claim underwriting, as a practice, irrespective of any individualized case study, satisfies both the Gruenberg and Anderson models of bad faith. Next it is postulated that because post claim underwriting constitutes bad faith, as defined by Gruenberg/Anderson, any insurer engaged in the practice is foreclosed from asserting an inception defense, regardless of the nature of any alleged misrepresentation. As a consequence, the insurer cannot rescind the policy. This postulate is supported by a discussion of the reasoning of Restatement (Second) of Contracts Section 172. Part IV is finally rounded-out with a discussion of damages, which should prove to be of particular interest to the practitioner.

Part V consists of a survey of cases representative of post claim underwriting but decided on alternative doctrines available for protection of the insured. It is demonstrated that although these doctrines have commendably protected insureds from insurer abuse on an ad hoc basis, the doctrines cannot adequately deter post claim underwriting as a bad faith practice.

Finally, Part VI rebuts the contrary argument to the creation of a per se rule of bad faith. In “The Liar, The Cunning Fraud, and The Innocent Mis-Informer,” it is argued that before a court addresses any alleged misrepresentation by the insured it must first look to the nature of the insurer’s pre-issuance under-

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writing so as to determine fully the true nature of the risk embraced by the insurer. If that assessment reveals a marketing choice to “insure the world” then the insurer must live with its consequences. The insurer cannot be permitted to withdraw from that pre-issuance marketing decision even when it means embracing the cunning fraud. Any other conclusion wrongly places the mark of judicial imprimatur upon a decidedly opportunistic practice that sweeps the innocent insured within its ambit.

II. POST CLAIM UNDERWRITING DEFINED AND IDENTIFIED

A. Post Claim Underwriting Defined

Every second or third year law student comes to learn that the genesis of underwriting is found in Lloyd’s Coffee House, Tower Street, London. Lloyd’s, in the seventeenth century, was a popular establishment frequented by shippers and merchants of international goods who, in the course of imbibing the brew of roasted beans, created the basic precepts of the modern insurance business. One seeking to insure a vessel or cargo would present himself at Lloyd’s and circulate among the coffee house patrons with a written description of vessel, cargo, captain, crew, navigational route, and the desired amount of insurance coverage needed for the voyage. Thus, any Lloyd’s patron interested in pursuing the “business of insurance” would assess the risk associated with individual voyages by evaluating its relevant statistics (ship, cargo, captain, crew, and destination) listed at the top of the circulated piece of paper. After making this assessment, if the risk were found to be an acceptable one, the individual insurer would write his name and the amount of money for which he was willing to undertake liability for any loss that might occur “under” the description on the piece of paper circulated – hence the term “underwriting.”

We begin our discussion of post claim underwriting with this short etymology not to engage in a study of the historic roots of insurance law, but to remind the reader that “underwriting” is a risk assessment conducted pre-issuance and pre-loss. Obviously, this sequence is necessary to allow the insurer to ascertain the probability of its incurring liability for any loss that the insured might sustain and, therefore, whether it wishes to assume the risk of that loss. In addition, by determining the likelihood of any future loss, the insurer is able to set an appropriate premium amount for the applied for coverage.

Concomitantly, the traditional sequence of underwriting enables the insured to determine whether the cost of the risk aversion offered is sufficiently economical to induce the purchase of insurance. In addition, if the insurance is purchased, the insured can rest easy in the knowledge that in the event of a loss there will be coverage. Therefore, the traditional sequence of underwriting naturally gives rise to a judicial mandate that “an insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is

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5 Id.
filed."

Post claim underwriting, however, creates a process that is a complete inversion of the established sequence of underwriting. When an insurer engages in post claim underwriting, it "wait[s] until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued." In other words, the insurer does not assess an insured's eligibility for insurance, according to the risk he presents, until after insurance has been purchased and a claim has been made. Although the insurer may ask an applicant for some underwriting information before it issues the policy, it will not follow up on that information until after a significant claim arises. Only after a claim has arisen will the insurer examine the application and request additional information to see whether the applicant could have been excluded from coverage.

An insurer relying upon post claim underwriting, "instead of looking to pay the claim [for the loss incurred by the insured as promised under the terms of the insurance contract] look[s] for all the things in the application that [it] might be able to dig up . . . to rescind the policy." Thus, the "insurer, rather than refusing to write a policy [as a bad risk] will wait until after a claim is filed to deny coverage on grounds that the policy should not have been written in the first place." In so doing, the insurer abrogates its obligation, as established at Lloyd's three centuries ago, to do its underwriting at the time a policy application is made in favor of conducting its risk assessment after claims are submitted. The insurer implements this post hoc evaluation so that it might rid itself of insureds for whom insurance coverage never should have been underwritten in the first place.

B. Post Claim Underwriting Identified

Alert counsel can easily identify the typical post claim underwriting case. The most obvious factual element presented is that rather than being processed through the claims department of the insurer, the insured's claim is submitted to the underwriting department. The underwriting department then typically either requests a release for past medical records or simply forwards a release, obtained at

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7 Id. at 186.
9 Meyer v. Blue Cross & Blue Shield, 500 N.W.2d 150, 153 (Minn. Ct. App. 1993). Note that the Meyer Court utilizes the synonym of "Retroactive Underwriting" instead of the term "post claim underwriting."
13 Mooneyhan, 684 So. 2d at 589.
the time of application, requesting the same. After the underwriting department
culls through the requested medical records, an inconsistency or omission in the
application is identified. The insurer then denies coverage for the claim on the basis
of an inception defense, such as misrepresentation, concealment or fraud. The in-
sured, subsequently, is advised that the policy has been rescinded and that there is
no coverage for the loss. All premiums paid to date then are returned.

The process of application for insurance also provides clues that an insurer
is engaged in the practice of post claim underwriting. Typically the questionnaire is
simplified. The insurer may ask only whether the insured is in “good health” or
may make no health inquiries at all. If health-related questions are on the applica-
tion, they are generally broad based and subject to interpretation — requiring the
insured to check a box with yes or no. Although the form also may request the
names of treating physicians, the insurer engaged in post claim underwriting will
not follow-up on the information provided until after a claim is filed. In other
words, no proper underwriting investigation will be completed until after a claim.
The policy is issued immediately upon application and the payment of a premium.
No medical examination is requested.

Counsel will also note an extensive delay between the filing of the claim
and the notice of rescission of the policy. This delay occurs because the insurer is
performing its underwriting, in essence, “padding the file.” The acquisition of
medical records and their assessment will take weeks or months. For example, in
one reported case the time between the insurer’s receipt of a medical insurance
claim and rescission of the policy was eight and one half months.\(^{14}\)

Finally, it should be noted that the practice of post claim underwriting is
most prevalent in the group insurance context, particularly credit insurance and
medical insurance. Any time a policy is rescinded for a misrepresentation in these
lines, counsel should be alert to the possibility that a post claim underwriting case
has been presented.

III. POLICY ARGUMENTS

A. General Policy Principles

In the course of the past two decades a number of courts, most notably the
Mississippi Supreme Court, have condemned the practice of post claim underwrit-
ing as either fraudulent and illegal or as a bad faith settlement practice.\(^ {15}\) The Mis-


insured made out claim of bad faith by insurer by presenting evidence of post claim underwriting); James,
506 S.E.2d at 894-95 (post claim underwriting as basis for tort claim of fraud); Nassen v. National States Ins.
Co., 494 N.W.2d 231, 234-36 (Iowa 1992) (stating that expert testimony that nursing home insurer was en-
gaged in post claim underwriting was admissible to show fraudulent underwriting technique); Gardner v.
rescission of credit life and disability insurance policy per post claim underwriting); Meyer v. Blue Cross &
Blue Shield, 500 N.W.2d 150, 154 (Minn. Ct. App. 1993) (finding that question of whether Blue Cross was
engaging in retroactive, i.e., post claim underwriting to avoid paying claims for treatment of AIDS was one
for jury); Mooneyhan, 684 So. 2d at 589-90 (stating that post claim underwriting is clearly not a fair practice;
sissippi Supreme Court, in concluding that an insurer's practice of post claim underwriting could support an award of punitive damages for bad faith settlement practices, employed the following reasoning:

An insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed. . . The insurer controls when the underwriting occurs. It therefore should be estopped from determining whether to accept an insured six months or more after a policy is issued. If the insured is not an acceptable risk, the application should be denied up front, not after the policy is issued. 16

Implicit in the Mississippi Court's reasoning is an affirmation of the utility of a doctrinal approach that adheres to the traditional sequence of underwriting established three centuries ago in Lloyd's Coffee House. That sequence requires the insurer to underwrite after it has completed its risk assessment and before a claim has been filed. In addition, the Lloyd’s sequence of underwriting not only permits the insurer to ascertain the likelihood of a loss occurrence, but also protects the reasonable expectation of an insured that he will be covered in the event of a loss. A judicial mandate that directs an insurer to conform to the traditional sequence is, therefore, necessary because an insurer would otherwise be free to cull through the history of an insured, after a claim has been made, searching for that inevitable detail of medical history that will yield an “arguable basis” for a post hoc refusal to underwrite. Thus, absent a judicial doctrine condemning post claim underwriting as a practice inconsistent with the implied covenant of good faith and fair dealing in insurance contracts, the insurer would be granted virtually uncontrolled discretion to refuse to perform upon the presentation of any claim under a policy.

Insurers should be discouraged from following it); Lewis, 637 So. 2d at 185-89 (stating that insurer was estopped from determining whether to accept an insured after policy issued pursuant to practice of post claim underwriting; post claim underwriting may support an award of punitive damages); National Life & Accident Ins. Co. v. Miller, 484 So. 2d 329, 339 (Miss. 1985) (Hawkins, J., concurring) (stating that with practice of post claim underwriting punitive damages are appropriate); Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 811-812 (Miss. 1983) (stating that post claim underwriting provided ample evidence for a jury question as to whether punitive damages should be awarded); Ingalls v. Paul Revere Life Ins., 561 N.W.2d 273, 284-85 (N.D. 1997) (post claim underwriting as evidence of oppression, fraud or malice for purposes of upholding award of punitive damages for bad faith settlement practices); U.S. Credit Life Ins. Co. v. McAfee, 630 P.2d 450, 455 (Wash. Ct. App. 1981) (finding that an insurer must require evidence of insurability before the insured's death, not after).

16 Lewis, 637 So. 2d at 188-89. The facts of Lewis are enlightening. The policy at issue was an “individual intensive care policy” that Mrs. Lewis purchased from an Equity National agent on April 18, 1989. The policy premium for this decidedly limited coverage was $3 per month. The full extent of coverage was $200 per day of hospitalization in an intensive care unit, only. No other hospitalization coverage was provided. This was the second policy Mrs. Lewis bought from Equity National. The first was purchased in 1986 at a cost of $13.40 per month and covered only cancer. See id. at 184-85.

After eleven months of premium payments on the intensive care policy, Mrs. Lewis was involved in an automobile accident that necessitated a one-night stay in the intensive care unit of the hospital. Equity National denied coverage for that single night; refusing to remit the total policy proceeds of $200. Equity National claimed that Mrs. Lewis made a material misrepresentation on her application regarding a pre-existing heart condition. This alleged misrepresentation was discovered in the course of post claim underwriting. See id.
The Mississippi Supreme Court has correctly condemned post claim underwriting as a practice that constitutes a breach of the implied covenant of good faith and fair dealing. An insurer should not be able to simply "play the odds" by employing "risky [underwriting] practices . . . [and] flippantly 'absolve' itself [of liability]" with a declaration of "Uh Oh!"—the insured should never have been issued a policy. If an insurer chose to insure a risk, without expending the necessary resources and time to underwrite before issuance of a policy, it should be held to the consequences of its unenlightened gamble. Thus, an insured, whose reasonable expectation of coverage is frustrated by post claim underwriting, should be entitled to pursue a cause of action against the insurer under a theory of bad faith settlement practices and seek compensatory damages and, in the appropriate case, punitive damages, as well. This conclusion is consistent with the overriding purpose of contract law.

"[T]he fundamental function of contract law (and recognized as such at least since Hobbes's day) is to deter people from behaving opportunistically toward their contracting parties." Opportunism arises because of the "sequential character of [economic] activity." Simply stated, opportunism occurs when one party to a contract takes advantage of the postponement in fulfilling its promise that is made possible because the promise to perform precedes actual performance. Insurance contracts, like most contracts, require sequential performance.

More particularly, the development of judicial doctrines "in insurance cases is influenced . . . by perceptions about the interests of society in the resolution of the dispute" that has arisen between the insurer and the insured regarding liability for a loss. There is an even greater societal interest in this form of contract because of the "quasi-public" nature of the insurance business. As such, "the relationship between the insurer and insured [and] the

17 Id. at 188.
18 Id.
20 See discussion, infra Part IV.C regarding damages.
21 POSNER, supra note 1, § 4.1, at 103 (footnote omitted).
22 Id.
24 It has long been recognized that the business of insurance is quasi public in character.

The purpose and nature of . . . insurance [contracts], and the duties which the insurer assumes under such contracts, and the manner in which such contracts are negotiated, impress such contracts and the relationship of the parties, even during negotiations, with characteristics unlike those incident to contracts and negotiations for contracts in ordinary commercial transactions.

25 Id. at 681 (Cal. 1969).
rights and obligations of the insurer cannot be determined solely on the basis of rules pertaining to private contracts negotiated by individual parties.”

As a consequence, a judicially created doctrine in the insurance context may place the insurer “under a duty entirely irrespective of contract, one which the law imposes regardless of the company’s desire to assume it . . . a duty peculiar to the business of insurance.” As discussed more fully, infra, a judicial doctrine establishing the practice of post claim underwriting as per se bad faith is fully supported both by the need to deter opportunism and by the public policy concerns uniquely related to insurance contracts.

B. The Aleatory Contract

The Mississippi Supreme Court, in its consideration of post claim underwriting, has infused its opinions with references to the insurer playing the odds. The Court likely employed this metaphor because of the aleatory nature of insurance contracts.

The term “aleatory” is derived from the Latin word for gambler: aleator. A contract is aleatory when a party’s duty to perform is conditional on the occurrence of an event that neither party to the contract is certain will occur. In other words, performance is contingent upon the happening of a fortuitous event. In the context of insurance, this means that the insurer may or may not pay more in benefits than premiums paid. Thus, the insured loses the gamble if there is no loss or if the premiums paid exceed the cost of any loss. Conversely, the insurer loses the gamble when a loss occurs.

The aleatory nature of insurance contracts makes “the recognition and identification of risks . . . an important step” in the insurer’s decision to provide coverage for the fortuitous occurrence. “In most circumstances the greater the awareness and understanding of the . . . facts, the smaller is the role played by guesswork in estimating the risks because it is possible to make more reliable predictions. Although total elimination of uncertainty is not possible, management of risk is an attainable goal.”

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26 Id. at 681-82.
27 Id. at 681 n.6 (Cal. 1969).
28 Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183, 188; see also Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172, 1193 (Miss. 1990); Southern United Life Ins. Co. v. Caves, 481 So. 2d 764 (Miss. 1985); National Life and Accident Ins. Co. v. Miller, 484 So. 2d 329, 339 (Miss. 1985) (Hawkins, J., concurring).
31 Id.
32 BARRON’S DICTIONARY OF INSURANCE TERMS 22 (3d ed. 1995).
33 KEETON & WIDISS, supra note 23, § 1.3(b), at 10.
34 Id.
A reasonable insurer attempts, through underwriting, to reduce the role played by guesswork through an assessment of the risks it agrees to assume. Underwriting, however, requires the insurer to expend monies, up-front, on risk assessment. As a consequence, an insurer engaged in proper underwriting necessarily reduces the amount of profit realized from premiums collected on the policies it issues. In addition, proper underwriting screens out unacceptable risks before issuance of a policy. Therefore, the insurer does not realize any premium income from individuals who present an unacceptable risk because no policy is issued.

An insurer engaged in post claim underwriting, however, does not attempt to reduce the role played by guesswork in assessing the risks it agrees to assume before issuance of the policy. Instead, the insurer “issues policies after only superficial [or no] underwriting to realize large amounts of premium income, and then attempts to deny coverage on the grounds of misrepresentation by engaging in aggressive investigation of the risk after the insured makes a claim.” In essence, the insurer attempts to defeat the odds, not through an enlightened gamble premised upon reliable predictions, but by fixing the odds. The odds are fixed by post claim underwriting because the practice allows the insurer to transform an uncertain event - the loss - into an event that is certain. In other words, an insurer engaged in post claim underwriting seeks to limit its liability for a loss by proclaiming, “Heads I win, tails you lose.” This manipulation of the odds is possible only because of the postponement in performance occasioned by the sequential character of the insurance contract.

Thus, by fixing the odds of the aleatory contract it has agreed to enter, the insurer takes advantage of the insured’s vulnerabilities during the delay between its promise to insure and its contractually obligated performance. As a consequence, the insurer not only profits from insureds who never file a claim, but also receives income generated from questionable policies with knowledge that at a later date it will likely raise inaccuracies in the application as a means of avoiding liability for the loss for which it has become obligated. Although the insurer will be forced to rescind the policy and refund the premiums to avoid liability by claiming a misrepresentation, it will nonetheless profit from premiums paid by ineligible insureds who never file a claim, while refusing to pay on the same policies if claims are ever filed. The insured, however, despite the premium refund, has lost both the opportunity to procure other insurance and the security and peace of mind for which he

36 See generally POSNER, supra note 1, at § 4.1.
37 See generally id.
38 Cordell, supra note 35, at 598.
originally bargained. The insurer, thus, by fixing the odds has opportunistically placed itself in a win-win situation in which the insured is always the loser. Therefore, post claim underwriting renders the "insured especially vulnerable to opportunistic behavior on the part of the insurer."\(^{42}\)

The insurer purposefully renders the insured vulnerable by employing the stratagem of post claim underwriting. That stratagem is employed with the sole objective of defeating the very essence of the aleatory contract. That essence directs that one party must necessarily lose "the gamble" on the occurrence or nonoccurrence of the fortuitous event.\(^{43}\)

Thus, through post claim underwriting, the insurer fixes the odds to avoid its obligations in the event of a loss. The result of this manipulation of the odds is that the insured can never receive the benefit of the contract because the insurer cannot lose. By contrast, the insurer is guaranteed significant profits through either its continued premium collection or performance avoidance - both made possible by post claim underwriting.

C. Low-Loss Ratios of Credit Insurance

Insurers marketing credit insurance frequently rely upon post claim underwriting. Credit insurance is a line of insurance in which exceptionally low loss-ratios are typically reported. The low-loss ratios associated with credit insurance reveal that insurers engage in post claim underwriting for the sole purpose of further expanding an already corpulent profit margin.\(^{44}\)

The loss-ratio of an insurance line is found by computing the percentage of each premium dollar "paid out" to insureds in claims benefits.\(^{45}\) Insurance is a "good buy" for an insured if the low-loss ratio is "high" because it indicates that "most of the premium dollar is spent for the benefit of the insureds."\(^{46}\) By contrast, the lower the loss-ratio the more overpriced the insurance and the greater the profit for the insurer.

The National Association of Insurance Commissioners recommends that insurers have a minimum loss-ratio of 60%.\(^{47}\) The typical loss-ratio for credit life

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41 Graves, supra note 19, at 174.
42 Bob Works, Excusing Nonoccurrence of Insurance Policy Conditions in Order to Avoid Disproportionate Forfeiture: Claims-Made Formats as a Test Case, 5 CONN. INS. L. J. 505, 570 (1999). Professor Works defines “the potential for opportunism,” as “the risk that ‘human agents will not reliably self-enforce promises but will defect from the letter and spirit of an agreement when it suits their purposes.’” Id. at 552 n.95.
43 See RESTATEMENT (SECOND) OF CONTRACTS §§ 76, 226.
44 The loss ratio nationwide for credit involuntary unemployment insurance was 12.6% in 1997 (the most recent year for which figures are available); for credit property insurance, 26.3%; for credit life, 41.6%; and for credit disability insurance, 48.6%. What Price Insurance? CONSUMER REPORTS, July 1999, at 6.
45 Keest, supra note 39, at 779.
46 Id.
47 Id. A loss-ratio as low as 50% may, however, be acceptable in credit insurance policies. See, e.g., 114 W.V.C.S.R. 114-6-1 (stating a loss-ratio of 50% is acceptable for credit policies subject to the Insurance
insurance—the line of group insurance most frequently associated with the practice of post claim underwriting in reported opinions—\(^{48}\) is 41.6%\(^ {48}\).

An Alabama case reported gross statewide premium earnings from credit insurance of nearly $40 million by one insurer.\(^ {50}\) The court also included within its opinion the loss-ratios calculated on the insurance sold through a single lending institution by the insurer from 1988 to 1991.\(^ {51}\) Those ratios for the four accounted years were 20.6%, 21.1%, 16.3% and 17.0%, respectively.\(^ {52}\) Incredibly, in some states, reported loss-ratios on credit life insurance are as low as 10% or 15%,\(^ {53}\) "in some years some lines dip into the single digits."\(^ {54}\)

Although credit insurance may be written as an individual policy, the debtor is more likely to be enrolled in a group policy issued to the creditor by the insurer.\(^ {55}\) Because the creditor is responsible for seeking applicants and completing the application process "[g]roup insurance has administrative economies which should make it cheaper than individual policies, as there is less administrative work for the insurer."\(^ {56}\) The reduced administrative cost of group policies, coupled with the low loss-ratios associated with credit life insurance, suggests little need for an insurer to further reduce its costs by declining to complete its underwriting before issuance of a policy.\(^ {57}\)

Therefore, there can be little doubt that the primary purpose

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\(^{50}\) Crocker, 667 So. 2d at 693.

\(^{51}\) Id.

\(^{52}\) Id.

\(^{53}\) Albert B. Crenshaw, Credit Insurance Costs Are Often Excessive, WASHINGTON POST, Mar. 14, 1999, at H01.

\(^{54}\) Id.

\(^{55}\) Keest, supra note 39, at 776-77.

\(^{56}\) Id. at 777.

\(^{57}\) In Gardner v. League Life Ins. Co., the Michigan Court of Appeals opined that "post-claim underwriting [was] a legitimate vehicle to diminish the cost of insurance." 210 N.W.2d 897, 898 (Mich. Ct. App. 1973). The court, however, noting that its equity conscience was aroused, also observed that "[t]he injustice of informing a disabled borrower at the time the claim is filed that he has no insurance protection is obvious and the need for notice is beyond peradventure." Id. The court ultimately held that the insurer was "estopped from denying liability for its failure to provide plaintiff with notice of the policy and exclusionary provisions." Id. at 899.

There is, however, no indication in the Gardner opinion that the court was provided with evidence of the high profitability and low-loss ratios of credit insurance before concluding that "post-claim underwrit-
for post claim underwriting, at least in the credit insurance context, is the maintenance of corpulent profit margins.

D. Great Potential for Abuse

The remunerative processes employed in the credit insurance industry create a great potential for abuse, especially when insurers are permitted to rely upon post claim underwriting as a vehicle to accomplish rescission. "[C]onsumers spend as much as $6 billion per year on credit insurance." The low loss-ratios associated with credit life insurance, discussed supra, demonstrate that it is an extremely profitable business endeavor for the insurer. It is, however, nearly as profitable for the lender because the "creditor receives significant compensation from the sale of insurance from the insurer whose product they sell."58

"[T]he lender receives commissions at a specified percentage of each premium dollar, sometimes as much as 40%-50%."]60 "In addition to commissions, creditors may receive compensation in other forms."61 The lender may be paid dividends or retrospective rate credits by the insurer, "if the insurer has a favorable claims experience."62 A lender’s profits from insurance sales “can even exceed the profits . . . from [its] credit business.”63 Finally, a creditor’s “individual employees may receive some form of incentive or bonuses based on their insurance sales, thus giving an individual loan officer economic pressures to sell insurance which are personal, as well as institutional.”64 The high profit available from the sale of insurance, created by bonus, profit-sharing and commission plans, combined with the practice of post claim underwriting, yields a high potential for abuse arising from agents filing false applications.

Some jurists have directly addressed this great potential for abuse.65 One concurrence observed, after first noting that the soliciting agent’s sole source of income from the insurer was earned on commission and that the commission was

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59 Keest, supra note 39, at 777.
60 Id.
61 Id.
62 Id.
63 Id. at 778.
64 Keest, supra note 39, at 777.
not earned absent the issuance of a policy, that:

When the soliciting agent, rather than the applicant fills in the application, it is naive to assume there is not a strong temptation on his part to ignore an answer the applicant gives which would prevent the company's issuing a policy, which would "knock out" a sale.

... The insurance companies surely know this. Yet, they permit their agents to be put in such conflict of interest positions, only to assert later, with a presumably straight face, that [the applicant made material misrepresentations in the application and, therefore, there is no coverage].

... It would be quite simple to remove from the agent any responsibility or authority to fill in the application form. The question then follows, why don't insurance companies do so?

... The answer, for insurance companies such as this [one] is not savory.

... [The insurer can] play the odds with its practice of encouraging agents to submit false applications and then ... deny a claim because the application [is] false.

Thus, because an agent and lending institution are not remunerated unless a policy is issued, a system has been created that encourages agents to give false answers on insurance application forms. The insurer then relies upon "the deceit of [its] own agents as a weapon to deny a claim" by asserting a material misrepresentation and seeking rescission of the policy.

A system of incentives that encourages insurer abuse is not, however, limited to the application process. The United States District Court for Wyoming described a bonus plan applied directly to post claim underwriting.

Every ... underwriter is required to amass 100 points per day in

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66 Miller, 484 So. 2d at 339.
67 Id.
order to keep their job. 2.5 points are awarded if an underwriter either pays or denies a claim; however, 5 points are awarded if the underwriter can find a pre-existing condition that would enable [the insurer] to deny coverage.68

The application of such incentive programs directly to post claim underwriting is indicative of a deliberate choice by the insurer to unreasonably defer its underwriting decision69 for the sole purpose of increasing its profits through avoidance of its contractual obligation to perform in the event of an insured’s loss.

F. The Insurer’s Marketing Choice

In analyzing an applicant’s insurability, an insurer must initially decide how much information must be gained from the application to properly underwrite the risk.70 “[T]he more detailed the application, the better an insurer can screen out unacceptable risks.”71 Conversely, the more liberal the underwriting before issuance of the policy, the greater the risk. The decision regarding the extent of pre-issuance underwriting is primarily a marketing decision for the insurer. “[I]nsurers must decide whether to investigate their applicants at the beginning, in which case they will accept fewer applications but also insure better risks, or increase sales by simplifying their underwriting requirements at the time of purchase and risk adverse selection.”72 When the marketing decision is made to increase policy sales by means of a simplified underwriting process, “applications are approved routinely and without further investigation by the underwriter.”73 Instead, the decision to insure the applicant is made on the basis of a short questionnaire with no detailed medical statement or physical examination.74 “In fact, some applications either limit the inquiries to whether the insured is now in ‘good health’ and/or has been diagnosed or treated for certain medical conditions within a specified time period. Or perhaps they don’t ask any health questions at all.”75 Thus, frequently an insurer’s investigation of the applicant is limited only to the ascertainment of information such as “character, general reputation, personal characteristics, and mode of living” with “no follow up procedure to determine the medical status of potential

71 Id. at 243.
72 Id. at 226.
73 Id.
74 See id.
75 Schuman, supra note 70, at 226.
insureds."\textsuperscript{76} “It [is] only after [the insurer has] lost that it proceed[s] to make inquiries and extensive investigations into a medical history – inquiries not a part of [the] usual underwriting procedure.”\textsuperscript{77}

Thus, an insurer relies upon post claim underwriting to avoid the consequences of its reasoned marketing decision to forego underwriting, or engage in simplified underwriting, to increase sales and, concomitantly, profits – a decision that naturally results in adverse selection. Obviously, an insurer should be held to the consequences of a marketing decision that it knows will result in adverse selection. An insured should not lose coverage, as an alleged bad risk, simply to protect an insurer from its own reasoned decision to increase profits by extending insurance coverage to that very same bad risk. In other words, the insured should not be made victim to the very same adverse risk an insurer was willing to embrace in the interest of profit and greed.

G. \textit{Patently Unfair}

Some courts have addressed the inherent unfairness of post claim underwriting.\textsuperscript{78} The Mississippi Supreme Court, however, has made a forthright condemnation of post claim underwriting by proclaiming the practice to be patently unfair.\textsuperscript{79}

It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn after he submits a claim that he is not insured, and therefore, cannot obtain any other policy to cover the loss. The insurer controls when the underwriting occurs. It therefore should be estopped from determining whether to accept an insured six months or more after a policy is issued. If the insured is not an acceptable risk, the application should be denied up front, not after a policy is issued. This allows the proposed insured to seek other coverage with another company since no company will insure an individual who has suffered serious illness or injury.\textsuperscript{80}

By relying upon the insurer’s control of when underwriting occurs as a rationale for its conclusion that post claim underwriting is patently unfair, the Mississippi Supreme Court has tacitly recognized the insurer’s efforts to fix the odds of

\textsuperscript{76} Southern United Life Ins. Co. v. Caves, 481 So. 2d 764, 767 (Miss. 1985).

\textsuperscript{77} \textit{Id.} at 768.


\textsuperscript{79} See Lewis, 637 So. 2d at 189.

\textsuperscript{80} \textit{Id.}
the aleatory contract in an endeavor to maintain exorbitant profit margins through a reasoned marketing decision. In other words, it is patently unfair for an insurer to make a reasoned marketing decision to forego underwriting to increase marketability and profits of an insurance product and then hide "behind a veil of self-imposed nescience"\(^{81}\) in an effort to avoid the naturally resulting adverse selection. Thus, when an insurer has manifested "an intention to 'insure the world,'"\(^{82}\) it is patently unfair to allow it to absolve itself of liability by claiming that the policy should never have been issued in the first place because the insured was not a good risk. "In short, 'the insurer having failed to investigate, cannot be heard to complain now.'"\(^{83}\)

The Mississippi Supreme Court, however, puts forth a second rationale as a foundation for its conclusion that post claim underwriting is patently unfair. That rationale is premised upon the insured’s natural assumption that there is insurance coverage for a specified risk. Under this reasoning, an insurer should be prevented "from lulling the insured, by inaction, into fancied security,"\(^{84}\) and, then belatedly asserting a lack of coverage premised upon underwriting that never took place before issuance. In other words, the court implicitly found that an insured’s reasonable expectations of coverage should not be defeated by an insurer who has "engaged in unreasonable post claim underwriting by unnecessarily deferring an underwriting decision that could have been made at the inception stage"\(^{85}\) of the contract of insurance. To conclude otherwise would "invite manifest abuse of the public in [insurance] relationships."\(^{86}\)

H. Redux

As previously noted, "the fundamental function of contract law . . . is to deter opportunistic conduct."\(^{87}\) Moreover, judicial doctrines in the context of insurance disputes, because of the "quasi-public nature of the insurance business,"\(^{88}\) are influenced by additional societal interests.\(^{89}\) As a consequence, doctrines governing contractual relations in insurance may impose a duty on an insurer "regardless of the company’s desire to assume it."\(^{90}\) The foregoing discussion of insurance company efforts to: (A) "fix the odds" of an aleatory contract; (B) seek additional prof-

\(^{81}\) Caves, 481 So. 2d at 768.

\(^{82}\) Id.

\(^{83}\) Works, Coverage Clauses, supra note 69, at 837.

\(^{84}\) Id. at 813 (describing the limiting dimension of the incontestable clause as a disclosure provision).

\(^{85}\) Id. at 870.

\(^{86}\) Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 811 (Miss. 1983).

\(^{87}\) POSNER, supra note 1, at 103.


\(^{89}\) See generally KEETON & WIDISS, supra note 23.

\(^{90}\) Barrera, 456 P.2d at 681 n. 6.
its despite exceptionally low loss-ratios; (C) rely upon the deceit of its own agents to deny a claim; (D) avoid the consequences of a marketing decision that naturally leads to adverse selection; and, (E) continue the practice of post claim underwriting, despite its inherent unfairness, illustrates a manifest need for a doctrinal limitation on an insurer's invocation of inception defenses, such as misrepresentation, fraud and concealment, if it has unreasonably delayed underwriting that could have been completed at the inception stage of the insurance contract.

A doctrinal limitation is required because insurers have demonstrated an intent to manipulate the sequential character of the insurance relationship so as to deprive the insured of the benefit of the bargain under the terms of the insurance contract. This opportunistic behavior is made possible by the practice of post claim underwriting. Post claim underwriting effectuates the manipulation because it enables the insurer to invoke inception defenses that require rescission of the insurance policy, ab initio. If an "insurer can perpetually postpone the investigation of insurability and concurrently retain the right to rescind" until after a claim has been made, then an insurer can accept premiums, deal with the insured as if there is coverage, lead the insured to believe that he is covered, and never take on the risk that is inherent to the business of insurance. Therefore, if the public is to be protected from such opportunistic manipulation of the insurance relationship, then the insurer must be prevented from raising inception defenses premised upon information acquired from unreasonably delayed underwriting. A doctrine establishing post claim underwriting as per se bad faith will afford such protection.

IV. POST CLAIM UNDERWRITING AS PER SE BAD FAITH

A. Opportunism and Bad Faith

1. Opportunism

Judge Posner has observed that the fundamental purpose of contract law is to deter opportunism in the contractual relationship. In addition, he has opined that good faith performance means "not trying to take advantage of the vulnerabilities created by the sequential character of contractual performance." In other words, for Posner, good faith performance means that a party to a contract does not take advantage of the postponement in fulfilling its promise that is made possible by sequential performance. Conversely, bad faith - opportunism - occurs when one party to the contract takes advantage of that postponement.

91 See Works, Coverage Clauses, supra note 69, at 829.
92 See id. at 870.
93 Barrera, 456 P.2d at 682.
94 See id.
95 See POSNER, supra note 1, at 103.
96 Id.
Performance obligations of the parties to a contract are, typically, not simultaneous. Instead, most contracts call for sequential performance by one or both of the contracting parties. Not surprisingly, insurance contracts, like most contracts, call for sequential performance. Thus, “[the insured] may find himself at the mercy [of the insurer] unless the law of contracts protects him” from opportunism.

Post claim underwriting satisfies Judge Posner’s definition of opportunism. The practice is only effective as a means of contract avoidance because of the vulnerabilities given rise to by sequential performance. As a consequence, the law of contracts must protect the insured from the practice if it is to forcefully and efficiently deter opportunism.

An insurer engaged in post claim underwriting tries to take advantage of the postponement in fulfilling its promise, made possible by sequential performance, by waiting until after a claim has been filed to determine an insured’s eligibility. It takes advantage of the insured because it continues to accept premiums from the insured, knowing that it will later challenge the insured’s eligibility for coverage to avoid contract performance. As a consequence, the law of contracts should protect the insured from an insurer’s efforts to implement post claim underwriting as a means of taking advantage of the vulnerabilities created by sequential performance.

Judge Posner’s observations about opportunism find their way into the law of contracts through the doctrine of good faith and fair dealing. More specifically, Judge Posner’s declaration that the fundamental purpose of contract law is to deter opportunistic behavior when it provides that “[e]very contract imposes upon each party a duty of good faith and fair dealing. As noted, supra, at its core, good faith performance means not trying “to take advantage of the vulnerabilities created by the sequential character of contractual performance.”

The Restatement (Second) of Contracts Section 205 ensures the deterrence of opportunistic behavior when it provides that “[e]very contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.” Thus, good faith performance is an implied term of every contract. Although the Restatement imposes this duty upon each party to a contract, a major-

97 See Wisconsin Knife Works v. National Metal Crafters, 781 F.2d 1280, 1285 (7th Cir. 1986).
98 Id.
100 POSNER, supra note 1, at 103.
102 See generally POSNER, supra note 1, at § 4.1.
ity of courts applying Section 205 to insurance contracts have viewed its dictates as a "one-way street in favor of the insured [because] the insured needs protection but the insurer does not."\(^{103}\)

Approximately forty-three states hold an insurer liable to a first-party insured, in tort for damages, if the insurer acts in bad faith in the course of the claims process.\(^{104}\) There are fundamentally two models of bad faith in the insurance context. Those states embracing the cause of action will generally adhere to one or the other, or fall within a spectrum somewhere between the two.

The first model of insurance contract bad faith was established by the California Supreme Court in the 1973 case of *Gruenberg v. Aetna Insurance Company.*\(^{105}\) The *Gruenberg* inquiry is essentially one of reasonableness. In the court's words, "when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort."\(^{106}\) Thus, under *Gruenberg*, there is a single objective inquiry - whether a reasonable insurer, under the circumstances, would have engaged either in the claims practice\(^{107}\) that culminated in "an irresponsible decision not to pay" the claim or in an unwarranted delay in the payment of benefits.\(^{108}\)

The second model was formulated in *Anderson v. Continental Insurance Co.*, a 1978 opinion of the Wisconsin Supreme Court.\(^{109}\) The *Anderson* model creates a stricter standard of liability for bad faith. To prove bad faith under *Anderson*, a plaintiff must show both: (1) the absence of a reasonable basis for the insurer's denial of benefits under the policy; and, (2) the insurer's "knowledge or reckless disregard of the lack of a reasonable basis for denying the claim."\(^{110}\) Thus, pursuant to *Anderson*, a plaintiff must satisfy a two-pronged inquiry; the first requiring an objective analysis of reasonableness akin to *Gruenberg*, and the second necessitat-

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\(^{103}\) JERRY, *supra* note 4, at § 25G[4].

\(^{104}\) See WILLIAM M. SHERNOFF ET AL., INSURANCE BAD FAITH LITIGATION § 1.01 (1999). It should be noted that West Virginia is not among those states embracing the classic model of the bad faith tort. West Virginia has, instead, established a cause of action for insurer claims misconduct characterized, by one commentator, as a "strict liability test ... on a theory of breach of contract." Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 U. MICH. J.L. REF. 1, 41 (1992-93); Hayseeds, Inc. v. State Farm Fire & Cas., 352 S.E.2d 73, 74 Syl. Pt. 1 (1986) (Whenever a policyholder substantially prevails in a property damage suit against its insurer, the insurer is liable for: (1) the insured's reasonable attorneys' fees in vindicating its claim; (2) the insured's damages for net economic loss caused by the delay in settlement, and damages for aggravation and inconvenience.).

\(^{105}\) 510 P.2d 1032 (Cal. 1979).

\(^{106}\) *Id.*

\(^{107}\) See Crisci v. Security Insurance Co., 426 P.2d. 173, 176 (Cal. 1967) (in the context of third party bad faith settlement claims practices, the inquiry is "whether a prudent insurer without policy limits would have accepted the settlement offer"). The *Gruenberg* Court relied heavily upon the *Crisci* opinion in its extension of bad faith claims to first party insurance. *Gruenberg*, 510 P.2d at 1036-1037.


\(^{109}\) 271 N.W.2d 368 (Wisc. 1978).

\(^{110}\) *Id.* at 376.
ing an evaluation of an insurer's intent.

It is important to recognize, however, that under Anderson, the inquiry as to the insurer's intent may be satisfied through inference. Thus, "the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company" if there is: (a) "a reckless disregard of a lack of a reasonable basis for denial," or (b) "a reckless indifference to facts or proofs submitted by the insured" in relation to the claim.

In originating this standard of bad faith, the Wisconsin Supreme Court noted that the underlying facts in Anderson evinced "purposeful conduct by the insurance company designed to evade payment of the claim." In addition, the court engaged in a definitional interpretation and found: (a) that "bad faith" is defined as "deceit, duplicity, insincerity"; (b) that deceit is defined as "a stratagem, trick, wile"; and (c) that duplicity is defined as "deliberate deceptiveness in behavior or speech." Thus, borrowing from Judge Posner's definition of good faith and stating it in the converse, the second prong of Anderson might best be described as satisfied by a stratagem designed to take advantage of the insured's vulnerabilities created by the sequential character of the insurer's contractual performance under the terms of the insurance policy.

As discussed, infra, post claim underwriting satisfies the requisite standard of bad faith under either Gruenberg or Anderson. As such, these standards of bad faith support the creation of a doctrine of per se liability of any insurer that engages in the practice.

a. Post Claim Underwriting and the Gruenberg Model

As previously noted, the Gruenberg model of bad faith is essentially a reasonableness standard. The question posited, at its core, is whether a reasonable insurer, under the circumstances, would have engaged in the complained of claims practice. In reviewing claims of bad faith, premised upon post claims underwriting, courts have commented upon expert evidence related to standard insurance industry claims practices and underwriting. An inquiry into such practices is appropriate because a deviation from reasonable commercial standards of fair dealing may indicate a contracting party's bad faith in the performance of contractual obligations.

In this regard, one district court noted that "standard industry practice is

111 Id. at 377.
112 Id.
113 Id.
114 Anderson, 271 N.W.2d at 376.
115 Id. at 376-77.
116 See generally POSNER, supra note 1, at § 4.1.
117 See RESTATEMENT (SECOND) OF CONTRACTS § 205, cmt. a (1979) (good faith means honesty in fact and the observance of reasonable commercial standards of fair dealing in the trade).
for the insurer to do a comprehensive investigation before agreeing to insure a person." This conforms with the purpose of underwriting: "to determine whether, and on what basis, [an insurer] will accept an application of insurance." In addition, the conclusion is consistent with the directive that insurers have the primary responsibility for assessing the risk because they control when underwriting occurs. This latter rationale implicitly recognizes that the insurer's position in the contractual relationship gives rise to a greater propensity for manipulation of the vulnerabilities created by sequential performance.

Courts have also held that post claim underwriting may support a cause of action for bad faith claims practices. These holdings implicitly recognize that post claims underwriting is an unreasonable deviation from the standard industry practice of pre-issuance underwriting, and that this unreasonable deviation culminates in either an irresponsible decision not to pay, or an unwarranted delay in payment.

The conclusion that post claim underwriting unreasonably deviates from standard industry practice is necessarily reached because an insurer engages in post claim underwriting so as to rescind the policy only after a claim has been made. Thus, the insurer, rather than processing the claim pursuant to the appropriate coverage provisions of the policy, endeavors to avoid payment of benefits by engaging in an eligibility determination that should have been completed before the policy was issued. More particularly, the performance of a post claim risk assessment is diametrically opposed to the good faith industry practice of pre-issuance underwriting established in the seventeenth century at Lloyd's. This sequence of underwriting ensures good faith and fair dealing in the sequence and performance of the aleatory contract.

Finally, post claim underwriting guarantees that payment of the claim is unreasonably delayed because both underwriting and claims processing are completed after the claim is made, or, the claim is unreasonably denied because the insurer unnecessarily delayed its underwriting decision until the claims process was triggered. Thus, an insurer engaged in post claim underwriting attempts, in bad faith, to take advantage of the sequential character of the insurance contract to avoid its contractual obligations through imposition of an unreasonable claim practice. As such, the "practice" of post claim underwriting satisfies the Gruenberg model of unreasonableness. Because the "practice" alone, absent any consideration

119 Schuman, supra note 70, at 227.
121 See POSNER, supra note 1, at § 4.1.
122 See Ingalls v. Paul Revere Ins. Group, 561 N.W.2d 273, 285 (N.D. 1997) (the insurer engaged in a process of post "claim underwriting," according to one testifying expert, when, "instead of looking to pay the claim," it began to "look for all the things in the application that [it] might be able to dig up that would allow it to rescind the policy"); see also Lewis, 637 So. 2d at 189.
124 See Works, Coverage Clause, supra note 69, at 813.
of individualized facts satisfies the Gruenberg model, the imposition of a *per se* rule of bad faith to deter this inherently opportunistic conduct is appropriate.

b. *Post Claim Underwriting and the Anderson Model*

As discussed, *supra*, the Anderson model of bad faith necessitates the application of a two-pronged analysis. The inquiry under the first prong — the "reasonableness prong" — is satisfied through application of the Gruenberg model. Thus, the foregoing analysis of post claims underwriting and Gruenberg leaves only application of the second Anderson prong for discussion.

The second Anderson prong directs that an insurer may be found to have acted in bad faith if it evidences the requisite intent — "knowledge or reckless disregard of the lack of a reasonable basis for denying the claim." To satisfy this element, an insurer must have engaged in "purposeful conduct . . . designed to evade payment of the claim." In addition, given the Anderson court's definitional interpretation of bad faith and its imprimatur of implied intent, it is clear that the insurer may possess the requisite scienter if it employs a "stratagem" in "reckless disregard of the lack of a reasonable basis for denying the claim," so as to evade payment of the claim. Thus, again borrowing from Judge Posner's analysis, the second Anderson prong prevents an insurer from employing a stratagem designed to take advantage of the sequential character of the insurance contract.

Post claim underwriting constitutes such a stratagem. It satisfies the second prong of Anderson because an insurer engaged in the practice, issues a policy, realizes large amounts of premium income, and then purposefully delays payment of the claim to engage in an aggressive investigation of eligibility with the sole aim of attempting to rescind the policy so as to deny coverage on a theory of misrepresentation. Therefore, the insurer engaged in post claim underwriting evidences the requisite scienter under Anderson because it issues policies with the knowledge that it will later seek out inaccuracies in the application as a means of avoiding liability for the loss for which it has become obligated without regard to the coverage provisions of the policy.

Finally, the fact that post claim underwriting is a stratagem or practice that

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126 *Id.* at 376.

127 *Id.*

128 *Id.*

129 See Cordell, *supra* note 35, at 59 (the insurer issues policies after only superficial underwriting to realize large amounts of premium income and then attempts to deny coverage on the grounds of misrepresentation by engaging in aggressive investigation of the risk after the insured makes a claim).

130 See *id.* (stating that courts often criticize post claim underwriting because it allows an insurer to accept income generated from questionable policies while knowing that the insurer may, at a later date, raise inaccuracies in the application as a means of avoiding its liability on at least some of the purportedly insured risk).
satisfies the Anderson model of bad faith yields the conclusion that a per se prohibition is mandated. If an industry practice facially establishes opportunism, the insurance law should embrace and fully effectuate its obligation to deter opportunism in the insurance relationship by deterring that practice. This goal can be uniformly and efficiently accomplished only through the establishment of a per se rule of bad faith.

B. Restatement (Second) of Contracts Section 172 Forecloses an Insurer Engaged in Post Claim Underwriting from Asserting the Inception Defense of Misrepresentation

A per se rule of bad faith, in the context of post claim underwriting, is further supported by the Restatement position on the availability of defenses to contract breaches. Insurers engage in post claim underwriting - the implementation of an aggressive investigation of eligibility after a claim is filed - so as to deny coverage on a theory of misrepresentation. If a misrepresentation is found, the contract is then voidable. Thus, the insurer, at its option, is relieved of all contractual obligations by rescission. However, “[t]he obligation of good faith and fair dealing [also] extends to the assertion of . . . contract claims and defenses.” As a consequence, an insurer, pursuant to Section 205, is prevented from asserting a defense for nonperformance of its contractual obligations, such as the inception defense of rescission, if it is not relied upon in good faith. Therefore, (á la Posner) the insurer is not only prohibited from engaging in opportunistic conduct in relation to the fulfillment of its sequential performance obligations to its insured; it cannot attempt to justify any breach of that obligation if its defense is occasioned by conduct which seeks to take advantage of the vulnerabilities created by that contractual relationship.

The Restatement, in addition to setting forth a general requirement of good faith reliance upon contract defenses, mandates the satisfaction of four elements to void a contract for misrepresentation. The party seeking rescission must demonstrate the presence of: (1) a misrepresentation; (2) that is either fraudulent or material; (3) which induced the recipient to make the contract; and (4) the recipient’s reliance on the misrepresentation must have been justified. It is the fourth element – the requirement of “justified reliance” – that expressly incorporates within its parameters the implied covenant of good faith and fair dealing. It is this fourth element which prohibits an insurer engaged in post claim underwriting from relying upon the inception defense of misrepresentation.

The fourth element of justified reliance is fully articulated in the converse

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131 See id. (stating that the insurer issues policies after only superficial underwriting to realize large amounts of premium income and then attempts to deny coverage on the grounds of misrepresentation by engaging in aggressive investigation of the risk after the insured makes a claim).

132 See RESTATEMENT (SECOND) OF CONTRACTS, Chapter 7, topic 1 intro. note.

133 Id. § 205 cmt. e (1979).

134 See id., chapter 7, topic 1 intro. note.
by Restatement (Second) of Contracts Section 172. Section 172 instructs when reliance upon a misrepresentation is unjustified because of the fault of the recipient. "A recipient's fault in not knowing or discovering the facts before making the contract does not make his reliance unjustified unless it amounts to a failure to act in good faith and in accordance with reasonable standards of fair dealing." Thus, pursuant to Section 172, if an insurer's fault, in not knowing or not discovering a misrepresentation, results from its failure to act in good faith and in accordance with reasonable standards of fair dealing, then reliance upon the insured's misrepresentation — whether innocent or fraudulent — is unjustified. Therefore, an insurer cannot rely upon a misrepresentation by an insured in the application process — even if fraudulent — as a vehicle for rescission of the policy, if it did not know of or discover the misrepresentation because of its own bad faith. That post claim underwriting deviates from reasonable commercial standards of fair dealing in the insurance industry is irrefutable. Industry practice for underwriting has been established, at least since the seventeenth century; and that industry practice mandates pre-issuance underwriting.

When post claim underwriting is analyzed under both Section 172 and the Gruenberg/Anderson theories of bad faith, it is clear that an insurer is foreclosed from claiming a misrepresentation on a policy application as a basis for rescission of the policy. This holds true because both Gruenberg and Anderson establish post-claim underwriting as a bad faith claim practice. In addition, because the insurer's fault in not knowing or not discovering the misrepresentation, prior to the filing of a claim, directly arises from the purposeful stratagem of post claim underwriting — a stratagem employed in bad faith and not in accord with standard, reasonable industry practices — the insurer's reliance upon the misrepresentation is unjustified and, therefore, cannot result in rescission of the policy. Thus, pursuant to Section 172, regardless of whether the insured's misrepresentation was innocent or fraudulent, an insurer cannot seek rescission if it engaged in post claim underwriting because it acted in bad faith and contrary to reasonable standards of fair dealing by attempting to hide "behind a veil of self-imposed nescience" with the sole aim of subsequently avoiding liability for a loss for which it had contracted.

C. Punitive Damages

Having set forth the parameters of a per se bad faith cause of action for post claim underwriting, the question arises as to what damages a prevailing in-
sured may be due? In successful bad faith actions, the full range of tort damages is generally warranted. Thus, a prevailing insured should, at the very least, be awarded actual and compensatory damages. Therefore, an insured subjected to post claim underwriting should be entitled to: (1) policy proceeds; (2) prejudgment interest; (3) attorney fees; (4) costs; (5) expenses; and (6) net economic loss. In addition, upon proof, the insured should be compensated for any emotional distress occasioned by the bad faith refusal to pay policy proceeds.140

Punitive damages are included within the full range of tort damages. In addition, it is well settled that punitive damages may be awarded in insurance bad faith cases that sound in tort - such as the instant per se cause of action.141 Generally, courts award punitive damages only in the appropriate case.142 Therefore, it naturally follows that the next question to be addressed is what might constitute the appropriate case for an award of punitive damages.

Arguably, because post claim underwriting is per se bad faith under Anderson,143 an insured subjected to the practice should automatically or mechanically be awarded actual, compensatory, and punitive damages.144 This conclusion necessarily arises once it is observed that Anderson’s strict standard of liability for bad faith includes an element of scienter: “knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.”145 Given the high degree of conscious wrongdoing necessary to support a cause of action for bad faith under Anderson, any distinction between conduct giving rise to compensatory damages and conduct sufficient to support an award of punitive damages becomes, at best, illusory.146 Anderson’s second scienter prong should, therefore, satisfy the requirement of conscious wrongdoing necessary for the imposition of punitive damages in most jurisdictions.147

The automatic or mechanical imposition of punitive damages against an insurer engaged in post claim underwriting is further supported by the absence of any defense for an insurer engaged in the practice.148 One longstanding argument against the award of punitive damages in insurance bad faith claims has been that insurers, when making the decision to deny a claim, believe their decision to be reasonable. Therefore, goes the argument, “an assessment of whether to penalize

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140 See generally SHERNOFF, supra note 104, § 7.04.
141 See id. § 8.05.
142 See id.
144 In stating that punitive damages are “automatically” or “mechanically” awarded we mean only that the plaintiff need not surmount any additional legal hurdle.
145 Anderson, 271 N.W.2d at 376.
146 See SHERNOFF, supra note 104, § 8.06[2].
147 See id. § 8.06[1].
148 See discussion supra Part IV.B.
an insurer should not be predicated on the resolution of the coverage dispute.\textsuperscript{149} The per se rule of bad faith submitted for consideration here, however, is not premised upon what one would traditionally describe as a coverage dispute. Once it is determined that the insurer engaged in post claim underwriting, there is no longer a question of reasonableness. No reasonable insurer engages in post claim underwriting.\textsuperscript{150}

Finally, the automatic award of punitive damages to a prevailing insured subjected to post claim underwriting is supported by the manifest need to deter this decidedly opportunistic practice. Mechanically imposing punitive damages against any insurer, found to have engaged in the practice, should ensure its immediate and efficient eradication.

An alternative analysis of what constitutes the appropriate bad faith case is found within the national norm. The appropriate case, in the majority of jurisdictions, is one in which there is evidence of some conscious wrongdoing by the insurer.\textsuperscript{151} The precise formula for establishing the requisite conscious wrongdoing varies somewhat from jurisdiction to jurisdiction. However, the national norm is best represented by the California standard of oppression, fraud, malice, or conscious disregard of the insured's rights.\textsuperscript{152}

The doctrine of insurance law bad faith, as a common law tort cause of action, evolved initially within the California courts.\textsuperscript{153} Toward the end of full effectuation of the doctrine, the California court, sanctioned the imposition of punitive damages in bad faith insurance suits.\textsuperscript{154} The California cases imposing punitive damages, on those insurers in breach of the covenant of good faith and fair dealing, have been cited with approval by courts in jurisdictions throughout the country.\textsuperscript{155} Moreover, at least anecdotally, the threat of imposition of punitive damages has effectively led to claims practice reforms by insurers hoping to avoid such liability.\textsuperscript{156} No clear precedent currently exists in relation to the imposition of punitive damages in cases of post claim underwriting to aid in its deterrence.\textsuperscript{157} Therefore, in

\textsuperscript{149} Keeton & Widiss, supra note 23, § 7.10

\textsuperscript{150} This analysis might be viewed as the inverse of the "right to disagree rule." This rule provides that "an insurer cannot be held accountable for punitive damages for seeking in good faith to pay only the amount required by the contract." Shernoff, supra note 104, § 8.05. In other words, because no good faith argument can be put forward by the insurer for engaging in post claim underwriting, there is no reason to deny the imposition of punitive damages.

\textsuperscript{151} See id. § 8.06[1].


\textsuperscript{153} See generally Jerry, supra note 4, § 25G.

\textsuperscript{154} See Shernoff, supra note 104, § 8.01.

\textsuperscript{155} See id.

\textsuperscript{156} See id.

\textsuperscript{157} The practice has, however, been recognized as evidence that may support an award of punitive damages. See Reserve Life Ins. v. McGee, 444 So. 2d 803, 811-12 (Miss. 1983); Lewis v. Equity Nat'l Life
defining what insurer conduct rises to the level of oppression, fraud, malice, or conscious disregard of the insured's rights in the context of post claim underwriting, the California standard is a logical point of departure.

Punitive damages are awarded to a plaintiff "over and above the full compensation for the injuries, for the purpose of punishing the defendant, of teaching the defendant not to do it again, and of deterring others from following the defendant's example."158 In addition, courts that have concluded that punitive damages should be employed, either to punish insurers or to influence claims practices in the future, including the California courts, have applied notably different standards to the award of compensatory damages and punitive damages.159 Therefore, before applying the California standard for punitive damages, a distinction must be drawn between post claim underwriting conduct that gives rise to an award of actual and compensatory damages, only, and conduct that additionally satisfies the standard of oppression, fraud, malice, or conscious disregard of the insured's rights.

The dividing line between the two levels of conduct is best analyzed by looking to the factual categories that might form the basis of an insured's bad faith claim, premised upon post claim underwriting. An insured's cause of action for bad faith would generally fall into two categories: (1) those cases in which only a single occurrence of the practice of post claim underwriting is factually demonstrated by the insured (an isolated incident); and (2) those cases in which it is established that the insured was subjected to a conscious course of post claim underwriting, "firmly grounded in established company policy" (a deliberate pattern or policy).160

The first category is illustrated by an insurer's endeavor, post claim, to "unfairly stretch" the underwriting inquiries "beyond the scope of their plain meaning" in an effort to manufacture a misrepresentation by the insured in the application for insurance.161 In addition, some instances of agent misrepresentation in completing the application may fall into this category.162

The second category is demonstrated by the insurer's company-wide policy163 of post claim underwriting. Such a policy may be evidenced through claims manual provisions that dictate that all claims or significant claims must be submitted to the underwriting department instead of, or in addition to, the claims department.164 In addition, manual provisions directing claims representatives to request

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159 See Keeton & Widiss, supra note 23, § 7.10(a).
health information only after a claim is filed or which direct that medical records evidencing the insured’s health pre-loss be procured, in addition to records related to the loss, may serve to demonstrate a company-wide policy. Finally, an informal policy of the aforementioned claims practices may be demonstrated through a deliberate and established pattern of conduct engaged in by the insurer.

Obviously, under either factual category the insured should be entitled to recover the policy proceeds and any consequential damages. It is the second category of a company-wide policy that forms the basis for application of the California standard permitting an award of punitive damages.

The California Supreme Court has recognized that the requisite scienter for the imposition of punitive damages may be inferred from a “conscious course of conduct, firmly grounded in established company policy.”\(^\text{165}\) In addition, the court has sanctioned reliance upon provisions within claims manuals\(^\text{166}\) as evidence that the insurer “acted maliciously, with an intent to oppress, and in conscious disregard of the rights of its insured.”\(^\text{167}\)

California intermediate appellate courts, analyzing the appropriateness of punitive damage awards premised upon insurer “conduct firmly grounded in established company policy,” have recognized that “a central theme common to those cases which have sustained punitive awards is the existence of established policies or practices in claims handling which are harmful to insureds.”\(^\text{168}\) Thus, the California courts have sought to deter what is perhaps more facilely described as an insurer’s systematic course of opportunistic breaches by equating repeated institutional misconduct (i.e., conduct firmly grounded in established company policy) with malice, oppression, fraud, or conscious disregard of the rights of insureds. The decision to equate an insurer’s established policies or practices with malice, oppression, fraud, or conscious disregard of the rights of insureds is logical because the insurer has evidenced intent through a reasoned institutional decision.

Furthermore, equating malice, oppression, fraud, or conscious disregard of the rights of insureds with a deliberate pattern or policy of post claim underwriting is consistent with the reasoning of the California courts. Such an insurer has evidenced an intent to engage in a systematic course of opportunistic breaches. In other words, the insurer has made a conscious institutional decision to disregard the rights of its insureds by breaching its obligation to pay policy proceeds through strategic behavior designed to: (1) exploit its monopoly on the timing and sequence of underwriting; and (2) exploit insureds who are “bad risks” by collecting premiums until a claim is filed – never allowing them the benefit of their bargain.\(^\text{169}\)

Therefore, in applying the California court’s reasoning to post claim underwriting, it becomes clear that an insured subjected to a single incident of post claim underwriting is entitled to actual and compensatory damages only. In con-

\(^{165}\) \textit{Neal,} 582 P.2d at 987.

\(^{166}\) See \textit{id.} at n. 8.

\(^{167}\) \textit{id.} at 986-87.


\(^{169}\) See \textit{supra} Parts III.A and III.D.
Contrast, an insured subjected to a deliberate pattern or policy of post claim underwriting by an insurer is entitled to an award of actual, compensatory, and punitive damages.

Finally, imposing punitive damages upon an insurer engaged in a deliberate pattern or policy of post claim underwriting is consistent with Judge Posner’s observation that opportunistic conduct “has no economic justification and ought simply to be deterred.” Moreover, the imposition of punitive damages for a company-wide policy of post claim underwriting fully effectuates Judge Posner’s declaration that “we might as well throw the book at the promisor” who breaches opportunistically. More importantly, imposing punitive damages against the insurer that relies upon a deliberate pattern or policy of post claim underwriting to defeat the reasonable expectations of coverage of its insureds is obviously necessary if the bad faith practice is to be forcefully and efficiently deterred.

We have set forth two alternative doctrinal approaches to the award of punitive damages because a court could easily adopt either one. The mechanical approach, establishing an appropriate case for the award of punitive damages through reliance upon the Anderson scienter prong, is arguably the equivalent of the national norm. There is, also, a decided ease of application in a mechanical rule. On the other hand, there is security in the time-tested standard of the national norm. In addition, the clear delineation between compensatory and punitive damages under the national norm preserves the traditional tort principle that punitive damages are to be awarded over and above full compensation for injuries. As a consequence, the best avenue is likely not the road less traveled. We submit that the better course is adoption of the national norm. Therefore, punitive damages may be imposed against an insurer engaged in the practice of post claim underwriting if the plaintiff establishes a conscious course of conduct firmly grounded in established company policy.

V. PRIOR CASES OF POST CLAIM UNDERWRITING DECIDED UPON ALTERNATIVE THEORIES

Post claim underwriting has been known to masquerade its way through the judicial system by assuming different aliases. Many courts confronted with the practice of post claim underwriting (either explicitly or factually without label) have ruled in favor of insureds and rejected insurer claims of misrepresentation, on a case-by-case basis, by relying upon theories previously applied to insurance disputes. Although these decisions have provided relief for some individual insureds, the analysis has been less than uniform because no formal doctrine has developed. In addition, the theories that have been employed fail to eliminate, uni-

170 A company-wide policy of post claim underwriting; a conscious course of post claim underwriting firmly grounded in established company policy.

171 POSNER, supra note 1, § 4.8, at 130.

172 Id.

173 One court even opined that “post-claim underwriting [is] a legitimate vehicle to diminish the cost of insurance,” without further comment, while, nonetheless, holding for the insured on a failure to notice
formly, the misrepresentation defense. Therefore, courts inevitably wrestle, either expressly or impliedly, with problems of comparative fault of insurer and insured, frequently drawing a distinction between fraudulent and innocent misrepresentations or agent versus insured misrepresentations. Nonetheless, these judicial forays into post claim underwriting have provided a foundation from which a more uniform doctrinal approach may be asserted. Consequently, a review of the theories upon which courts have previously denied insurers the right of rescission of a policy is enlightening.

A. Waiver

"Waiver is an intentional, voluntary relinquishment of a known right." In the insurance context, "[w]aiver should only be applied when an insurer intends to relinquish a known right because it entails volition in relation to an act and to the legal consequences of the action." Courts may employ waiver as a means to avoid operation of policy limitations on liability and coverage exclusions. However, waiver may not be applied to "extend insurance coverage beyond the terms of an insurance contract." In the typical case, waiver is implied from the conduct of the insurer or its agents. For example, an insurer may waive the provisions of an exclusionary clause by voluntarily making payment to an insured for a loss when the insurer had full knowledge of the facts surrounding the circumstances of the loss and the insured "neither withheld information nor distorted the facts presented to the [in-

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175 See, e.g., Dixie Ins. Co. v. Mooneyhan, 684 So. 2d 574 (Miss. 1996); National Life & Accident Ins. Co. v. Miller, 484 So. 2d 329 (Miss. 1985); Reserve Life Ins. v. McGee, 44 So. 2d 803 (Miss. 1984); Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183 (Miss. 1994).

176 The key article is KEETON & WIDISS, supra note 23, § 6.1(b)(3). The text provides perhaps the best explanation of the difference between waiver and estoppel - an important distinction as courts frequently fail to distinguish between the two. As shown infra, the evidentiary requirements of the two doctrines are decidedly divergent. Waiver, unlike estoppel, does not require the insured to show detrimental reliance.


The key post claim underwriting case is Southern United Life Ins. Co. v. Caves, 481 So. 2d 764, 767 (Miss. 1985).

177 JERRY, supra note 4, § 25E(a).

178 KEETON & WIDISS, supra note 23, § 6.1(b)(3).

179 See JERRY, supra note 4, § 25E(a).

180 Potesta, 504 S.E.2d at 137, Syl. Pt. 5.

181 See Hartford, 434 N.E.2d at 1192.
surer].\textsuperscript{182} Thus, waiver is perhaps best defined as a doctrine that precludes forfeiture if "the insurer acts in recognition of the validity of insurance, with knowledge that there exists a ground to void the policy."\textsuperscript{183}

Waiver has been applied to the practice of post claim underwriting to prevent insurers from relying upon misrepresentations for rescission of the policy. In one case, an insurer was found to have waived a condition of insurability because its agent "accepted payment of the premium knowing of the serious pre-existing condition of the insured which she failed to communicate to the company."\textsuperscript{184} The knowledge of the agent was imputed to the insurer to establish a knowing waiver of a known right. As such, concluded the court, "[t]he condition of insurability was effectively waived."\textsuperscript{185} Thus, the court applied waiver to the individualized facts to reject the insurer's claim of a misrepresentation.

B. Estoppel\textsuperscript{186}

To invoke estoppel, a party must satisfy two factors: (1) an actual misrepresentation; and (2) detrimental reliance upon that misrepresentation.\textsuperscript{187} In the insurance context, estoppel permits "the imposition of liability [upon the insurer] . . . on the basis of acts that usually were not intended to produce the consequences which are sought by the [insured]" and the intent of the insurer is usually not relevant.\textsuperscript{188} Thus, through application of the doctrine of estoppel, insurers have been precluded from denying liability if their action or inaction has "induced the insured to pursue activities contrary to the insured's best interests."\textsuperscript{189}

The elements of estoppel may be satisfied when an insurer with knowledge of an innocent misrepresentation delivers the policy to the insured, and later endeavors to deny coverage. The insurer is estopped from asserting the misrepresentation because delivery of the policy caused the insured to detrimentally rely upon it as evidence of coverage. In other words, the insured was induced not to obtain

\textsuperscript{182} ld. at 1191.
\textsuperscript{184} Southern United Life Ins. Co. v. Caves, 481 So. 2d 764, 767 (Miss. 1985).
\textsuperscript{185} ld.
\textsuperscript{186} The key article is KEETON & WIDISS, supra note 23, § 6.1(b)(3). As mentioned, supra, the text provides perhaps the best explanation of the difference between waiver and estoppel – an important distinction as courts frequently fail to distinguish between the two. As shown both infra and supra the evidentiary requirements are divergent. Estoppel, unlike waiver, requires the insured to show detrimental reliance.
\textsuperscript{188} The key West Virginia case is Potesta v. United States Fidelity & Guar. Co., 504 S.E.2d 135 (W.Va. 1998).
\textsuperscript{189} See JERRY, supra note 4, § 25E(a).
\textsuperscript{188} KEETON & WIDISS, supra note 23, § 6.1(b)(3).
\textsuperscript{189} JERRY, supra note 4, § 25E(b).
other insurance because the delivery of the policy (the actual misrepresentation) caused the insured to believe that the needed coverage had already been purchased.\(^{190}\) Thus, estoppel may be used to bar a defense, such as misrepresentation, in an action on an insurance policy.\(^{191}\)

Courts have relied upon estoppel to reject the defense of misrepresentation put forward by insurers engaged in the practice of post claim underwriting. The most straightforward application of estoppel, in this regard, is premised upon the detrimental reliance of the insured in paying premiums and the concomitant assumption (misrepresentation) that because the insurer continues to accept the premiums there is coverage in the event of a loss. The rationale for applying estoppel is that the insurer is obligated to perform underwriting at the time of application for insurance so that the insured may seek other coverage if the insurer finds the insured an unacceptable risk.\(^{192}\) Estoppel as a basis for foreclosure of the defense of misrepresentation, however, requires a factual analysis on a case-by-case basis.

### C. Unconscionability\(^{193}\)

The doctrine of unconscionability is premised upon "the judicial recognition that most insurance contracts, rather than being the result of anything resembling equal bargaining between the parties, are truly contracts of adhesion."\(^{194}\) Unconscionability permits a court to deny operation of contract terms if they are so one sided that enforcement would be patently unfair.\(^{195}\) The doctrine may be invoked to prevent enforcement of unambiguous terms if found to be "too restrictive or otherwise against policy."\(^{196}\) In this regard, if a court determines that a contract term is unconscionable it may: (1) refuse to enforce the contract; (2) enforce the contract absent the unconscionable term; or, (3) limit the application of the uncon-

\(^{190}\) See id. § 25E(a).

\(^{191}\) See generally Harr, 255 A.2d at 218 (speaking broadly, equitable estoppel is available to bar a defense in an action on a policy).

\(^{192}\) See Lewis v. Equity Nat'l Life Ins. Co., 637 So. 2d 183, 189 (Miss. 1994).


\(^{194}\) There is no key West Virginia case.

\(^{195}\) The key post claim underwriting case is Kraus v. Manhattan Life Ins. Co., 700 F.2d 870 (2d Cir. 1983).

\(^{196}\) See Russ, supra note 194, § 22:11.
scionable term to avoid an unconscionable result. Finally, contract terms may be unconscionable “even if the parties were both aware of the intended effect of such provision at the time of the contract.” Unconscionability may be applied to any policy provision that adversely affects an “insured’s ability to obtain benefits under [the] policy.”

Although applicable to any policy provision, unconscionability is typically “raised in connection with [those] provisions that narrow or exclude coverage” in such a way as to render the contracted for coverage illusory. For example, a definition of burglary in an insurance policy that required that the exterior of the building evidence “visible marks of force and violence” was found to be an unconscionable “liability-avoiding provision . . . in the circumstances of [the] case.” The provision was unconscionable because it permitted the insurer to deny coverage for a burglary loss that evidenced only visible marks of force or violence on the interior doors of a warehouse. The policy term was construed to include the interior signs of burglary so as to limit application of an unconscionable term to avoid an unconscionable result. Thus, the insured was allowed to recover for the loss, despite the unambiguous definitional term of the policy.

The doctrine of unconscionability may appropriately be applied to post claim underwriting because it allows an insurer to issue a policy, collect premiums, and subsequently defeat coverage after a loss occurs. As such, the coverage afforded the insured prior to the loss “is illusory, unconscionable and against public policy.” An insurer may not collect a premium for a period during which it had no risk. Thus, the insured obtains no benefit from the premium paid for coverage, purportedly effective from the date of the application, because the insurer reserves the right to defeat such coverage in the event of a loss.

Unconscionability has been relied upon, in a tertiary fashion, to reject the

197 See C&J Fertilizer, 227 N.W.2d at 180 (citing RESTATEMENT (SECOND) OF CONTRACTS § 234).
198 Russ, supra note 194, § 22:11.
199 Id.
200 Id.
201 Id.
202 C&J Fertilizer, 227 N.W.2d at 179.
203 See id. at 171-72.
204 Anderson v. Country Life Ins. Co., 886 P.2d 1381, 1383 (Ariz. Ct. App. 1994). Anderson is not a true example of a post claim underwriting case. However, its reasoning applies equally well to the practice of post claim underwriting. At issue in Anderson was an “approval conditional receipt” for which the insurer required advance payment of premiums but conditioned temporary insurance on the issuance of a permanent policy of insurance. Id. at 1386. The court, applying the doctrine of unconscionability, concluded that “public policy prohibits an insurer from taking an advance premium and placing conditions in the receipt so that it incurs no risk during the interim period for which it retains the premium.” Id.
205 Id. at 1383.
206 See id. at 1388.
207 See id. at 1391.
defense of ineligibility\footnote{207} of an insured when the insurer engaged in post claim underwriting.\footnote{208} This application is illustrated by an insurer’s efforts to reduce the maximum coverage provided under a group life insurance policy because the insured was a part-time worker, not a full-time employee.\footnote{209} The limitation on the maximum coverage limits for part-time employees was never brought to the attention of the insured and a certificate of insurance was issued in a greater amount for which increased premiums were paid over ten years.\footnote{210} The insurer never inquired into the insured’s “part-time status on its application forms [nor] at any time prior to his death.”\footnote{211}

The insurer was estopped from asserting ineligibility as a defense because the facts “would make it unjust, inequitable or unconscionable to allow [it] to be interposed.”\footnote{212} Thus, “it was neither just nor equitable” to allow the insurer to make representations of coverage and then avoid such representations “on the basis of a conflicting provision in the master policy which was not previously brought to the attention of the insured.”\footnote{213}

\textbf{D. \hspace{0.7cm} Reasonable Expectations\footnote{214}}

The doctrine of reasonable expectations is premised upon the fundamental principle that “the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expec-
Thus, "the existence of an ambiguity in the policy is not a predicate for the doctrine's application." The doctrine of reasonable expectations is best described as one that is relied upon by the courts in an effort to protect consumers. The doctrine's operation is demonstrated by comparing the express language of a policy's definition of burglary, in one reported case, with the reasonable expectation of the insured as to what constitutes burglary. The policy at issue contained the following definition of burglary:

the felonious abstraction of insured property (1) from within the premises by a person making felonious entry therein by actual force and violence, of which force and violence there are visible marks made by tools, explosives, electricity or chemicals upon, or physical damage to, the exterior of the premises at the place of such entry . . . .

The covered building was burglarized with no visible signs of entry on its exterior. However, an interior door "was physically damaged and carried visible marks made by tools." The insurer denied coverage for the loss occasioned by the burglary, based upon the unambiguous, express policy language that excluded burglaries that did not evidence visible signs of force or violence on the exterior of the premises.

The court, however, found the insured covered for the loss. Although it recognized that the policy definition was both unambiguous and express, it noted that the doctrine of reasonable expectations attends to "substance over form." In applying the doctrine, the court reasoned that the burglary definition "which crept into this policy comports neither with the concept a layman might have of that


216 Id. It should be noted that West Virginia requires the presence of an ambiguity in the policy as a predicate to application of the doctrine of reasonable expectations. See Silk v. Flat Top Construction, Inc., 453 S.E.2d 356 (W.Va. 1994). In West Virginia, the doctrine of reasonable expectations is limited to those instances in which the policy language is ambiguous. See id. at 359 (citing Soliva v. Shand, Morahan & Co., 345 S.E.2d 33, 36 (W.Va. 1986), overruled on other grounds by National Mutual Insurance Co. v. McMahon & Sons, Inc., 356 S.E.2d 488 (W. Va. 1987)). There are approximately eight other states that maintain the same requirement (Montana, Wyoming, New Jersey, Nevada, Washington, Alaska, Minnesota, Hawaii). See JERRY, supra note 4, § 25D, n.8.

217 See JERRY, supra note 4, § 25D.

218 C&J Fertilizer, 227 N.W.2d 169, 171.

219 See id.

220 Id.

221 See id. at 171-72.

222 See id. at 177.

223 C&J Fertilizer, 227 N.W.2d at 177.
crime, nor with the legal interpretation.” Therefore, based upon the policy’s language, the most the insured might have expected from the definition was “a requirement of visible evidence (abundant here) indicating the burglary was an ‘outside’ not an ‘inside’ job.” Thus, because the insured would reasonably expect coverage for any outside job burglary, it was entitled to the policy proceeds for its loss.

The doctrine of reasonable expectations has been employed in the context of post claim underwriting to defeat an insurer’s efforts to rescind a policy as void ab initio for material misrepresentations made in the application for insurance. The reasonable expectation of coverage arose from the insurer’s regular acceptance of premium payments and lack of rejection of the application and the “reasonable expectation of both the public and the insured . . . that the insurer will duly perform its basic commitment: to provide insurance.” Thus, the reasonable expectation of the insured and the public defeated the stipulation in the application for insurance providing that the company was not bound to provide coverage until the application was both received and approved.

The application had not been approved before the loss claim because it was the insurer’s alleged practice to postpone underwriting of insurability “until after the assertion of a ‘significant’ claim.” This practice was inconsistent with the reasonable expectation of coverage because the insurer has a “duty to conduct a reasonable investigation of insurability within a reasonable period of time after issuance of the policy.” In addition, the reasonable expectation of coverage would not allow the insurer to take the chances of a loss and then “repudiate the contract and compel the insured to bear the loss.” The doctrine of reasonable expectations, as applied to post claim underwriting, is a factual inquiry necessarily to be determined on a case-by-case basis.

224 Id.
225 Id.
226 See id.
227 See, e.g., Barrera v. State Farm Mut. Auto. Ins. Co., 456 P.2d 674, 680 (Cal. 1969). The court in Barrera, as in other cases, does not rely upon the term “post claim underwriting.” However, the conduct of the insurer as described in the factual account clearly evidences the practice.
228 See id. at 682.
229 Id.
230 See id.
231 Id. at 684.
232 Barrera, 456 P.2d at 685.
233 Id.
234 See id. at 690.
E. Cause of Action for Statutory Unfair Claims Settlement Practices

All but six states have adopted statutes that prohibit insurers from engaging in unfair settlement claims practices. These statutes are fashioned after Model Acts promulgated by the National Association of Insurance Commissioners (NAIC). Depending upon the reference source consulted, anywhere from five to ten states allow a private cause of action for a violation of a statutory provision prohibiting unfair settlement claims practices. The remainder restrict an insured to administrative remedies provided within the statutory framework.

The private cause of action, if not statutorily provided, is premised upon an implied right that arises from the statute. Generally a court will apply a test similar to the following to ascertain whether a judicially created implied cause of action is consistent with legislative intent:

1. the plaintiff must be a member of the class for whose benefit the statute was enacted;
2. consideration must be given to legislative intent, express or implied, to determine whether a private cause of action was intended;
3. an analysis must be made of whether a private cause of action is consistent with the underlying purposes of the legislative scheme; and
4. such private cause of action must not intrude into an area delegated exclusively to the federal government.

In addition, because statutes prohibiting unfair settlement claims practices frequently contain a requirement for evidence of a “general business practice,” an insured may be obligated to show “proof of several breaches by an insurance com-

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235 There is no key article.


239 See Cady, supra note 236, at 34.

240 Jenkins, 280 S.E.2d at Syl. Pt. 1.

241 W.VA. CODE § 33-11-4(9) (1999). See also Jenkins, 280 S.E.2d at 259.
pany to sustain the cause of action." The requirement of multiple breaches, generally, may be satisfied by evidence of either multiple violations in the same claim or by proof of multiple violations involving different claimants. However, in some states, a single violation knowingly committed may be sufficient.

One state has held that post claim underwriting may be indicative of a statutorily prohibited unfair settlement claims practice that may give rise to an implied private cause of action. The court, however, also concluded that it was a jury question as to whether the insurer, in fact, violated the statute.

**F. Insurer Fraud**

Claims of insurer fraud are premised upon the same factual allegations as the classic tort action. As such, five elements must be satisfied to sustain a cause of action for insurer fraud. Those elements are: (1) the defendant made a false representation; (2) the defendant knows or believes the representation is false, or knows that he has an insufficient basis of information upon which to make the representation; (3) the defendant has an intent "to induce the plaintiff to act or refrain from acting in reliance upon the misrepresentation"; (4) the plaintiff is justified in the reliance upon the misrepresentation; and (5) damage to the plaintiff resulted from the reliance upon the misrepresentation.

In the insurance context, fraud has been relied upon as a basis for a cause of action when false representations were made by the insurer's agent to the insurer. The claim arose because the agent "did falsely and fraudulently fill in the

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242 Jenkins, 280 S.E.2d at 259.
243 Id.
244 See, e.g., Royal Globe Ins. Co. v. Superior Court, 592 P.2d 329 (Cal. 1979), overruled by Moradi-Shalal v. Fireman's Fund Ins. Co., 758 P.2d 59, 67 (Cal. 1988) (holding that an insurance statute prohibiting insurance companies from engaging in unfair practices, such as not making good-faith effort to reach prompt and fair settlement of claim, did not create any private cause of action in favor of insured or third-party claimants).
246 See id. at 282.
247 The key article is RUSS, supra note 194, § 59:56. The key national case is Gardner v. Mut. Benefit Health & Accident Ass'n, 84 S.E.2d 637 (S.C. 1954) (cause of action for fraud - false representations made by insurer's agent to insured). It should be noted that Gardner is, factually, a post claim underwriting case. The key West Virginia case is Romano v. New England Mut. Life Ins. Co., 362 S.E.2d 334 (W.Va. 1987). Romano, factually, could be classified as a post claim underwriting case. The key post claim underwriting case is Nassen v. National States Ins. Co., 494 N.W.2d 231 (Iowa 1992) (expert testimony regarding post claim underwriting admissible to support claim of fraud). It should be noted, however, that the Nassen court did not address the merits of the insured's fraud claim because it duplicated damages available under the bad faith claim.
248 See PROSSER & KEETON, supra note 158, § 105.
249 Id. § 105, at 728.
application with answers that were not the same nor as complete as those given by
the plaintiff and his wife.”

The errors were brought to the attention of the agent
before the insured signed the application. The agent, however, assured the in-
sured that the application was properly completed and complied with the insurer’s
needs. The insured had coverage under another policy that was dropped after
purchase of the new coverage. Claims were made, and the insurer denied cover-
age, asserting material misrepresentations in the application. These facts were
held sufficient to support a tort law fraud action.

More recently, expert testimony regarding post claims underwriting has
been found to be relevant to a tort law fraud action. The expert testimony charac-
terized post claim underwriting as a fraudulent underwriting technique relied upon
by the insurer to deliberately delay or deny

G. Misstatements on Application Prepared by Agent

"Most courts have held that an agent who procures an application for in-
surance and reduces it to writing acts as the insurer’s agent.” The rationale for
this normative rule lies in the general agent’s authority “to accept risks, to agree
upon the terms of insurance contracts, to issue and renew policies, and to change or
modify the terms of existing contracts.” Therefore, the errors or misstatements
made by the agent in completing the application are generally treated as those of

251 Gardner, 84 S.E.2d at 638.
252 See id.
253 See id.
254 See id.
255 See id.
257 See id. at 235.
258 Id.
259 There is no key article.
There is no key national case, presumptively because the cases are so fact dependent that it is
difficult to present a single case fully articulating the normative rule. However, a fairly exhaustive list of
relevant cases can be found in Russ, supra note 194, §§ 85:26, .57.
The key West Virginia case is McDonald v. Beneficial Standard Life Ins. Co., 235 S.E.2d 367
(W.Va. 1977) (if the facts regarding the risk are correctly stated to the agent but erroneously recorded, the
insurer is chargeable with the agent’s error).
The key post claim underwriting case is Lewis v. Equity Nat’l Life Ins. Co., 637 So. 2d 183 (Miss.
1994).
260 JERRY, supra note 4, § 35[g][3].
261 Joseph K. Powers, Pulling the Plug on Fidelity, Crime, and All Risk Coverage: The Availability of
Rescission as a Remedy or Defense, 32 TORT & INS. L.J. 905, 930 (1997).
This rule holds true so long as the agent making the misrepresentations in the insurance application did so without the knowledge or collusion of the insurer. However, knowledge of the agent’s misrepresentations will generally not be imputed to the insured if the agent represented “that the answers were properly recorded in the application in such a way as to satisfy the requirements of the insurer.” In other words, the insured will not be deemed to have knowledge of the misrepresentation if the insured relied upon the expertise of the agent concerning such matters.

The normative rule that misstatements made by the insurer’s agent in completing an application will be chargeable to the insurer has been discussed in the context of post claim underwriting as a means of defeating an insurer’s claim of rescission for misrepresentations. It was, however, a jury question as to whether the misrepresented information disclosed by the insured created an arguable basis upon which to deny a claim. There is, however, judicial recognition that post claim underwriting permits an insurer to profit by self-imposed nescience. In other words, the insurer ignores the temptations for agents to include misrepresentations in the application so as to increase sales and then subsequently performs underwriting to discover such falsehoods as a vehicle for rescission.

In this regard, a commissioned agent’s falsification of information on a credit life insurance application has been relied upon to support a fraud action within the context of post claim underwriting. The agent testified that “he knew that if he indicated on the application form that [the insured] suffered from any health problems, the credit life policy would not be issued.” In addition, the agent knew that post claim underwriting could be completed up to one year after

issuance under the policy’s incontestability clause. It was held that the agent had a duty to disclose that the policy proceeds would not be paid if the insured had any health problems. Therefore, the agent’s failure to disclose “induced [the insured] to obtain the credit life coverage, for which premiums were paid [but no coverage was available].” The analysis here, as with all instances of agent misrepresentation, is exceedingly fact dependent and, therefore, may only be properly analyzed on a case-by-case basis.

H. **Incontestability**

All life insurance policies contain an incontestability clause. The clause may also be found in other lines of insurance, in particular health insurance. Generally, the inclusion of such clauses is mandated by statute. An incontestability clause prohibits the insurer from contesting the validity of the policy after a certain period of time has expired, usually two years. Thus, the incontestability clause in a policy of insurance may bar the defenses of misrepresentation, fraud and concealment. The clause, however, cannot operate to prevent an insurer’s challenge premised upon a policy’s coverage provisions.

This division between defenses that challenge the validity of a policy and defenses premised upon coverage provisions of a policy, although facile in articula-

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272 See id.
273 See id.
274 Id.
276 There is a split of authority, and so there is no true national case. One school adheres to the reasoning employed in *Crawford v. Equitable Life Assurance Society of United States*, 305 N.E.2d 144 (Ill. 1973) (when information as to whether an insured is indeed a member of the class of those insured under a group policy is furnished by the employer, the question of coverage is intertwined with the question of whether coverage was obtained by false pretenses). The second school follows *Simpson v. Phoenix Mutual Life Insurance Co.*, 247 N.E.2d 655 (N.Y. 1969) (incontestable clause bars defenses, including those related to the scope of coverage and risks assumed, if the insurer could have discovered the facts at the policy’s inception).
278 The key post claim underwriting case is *Amex Life Assurance Co. v. Superior Court*, 930 P.2d 1264 (Cal. 1997).
279 See JERRY, *supra* note 4, § 104B[a], at 703 (The incontestability clause bars an insurer from contesting the policy’s validity. It cannot, however, bar insurer coverage defenses).
280 See id.
281 See JERRY, *supra* note 4, § 104B[b][2], at 705-06.
tion, has proven difficult to apply, particularly in the context of group insurance.\textsuperscript{282} The difficulty is especially prevalent in the group context because, arguably, "[t]o ascertain whether a person is insured necessitates a determination of whether he is in fact a member of the class" of the "collection of unnamed persons" for whom insurance is provided under the policy.\textsuperscript{283} Thus, information provided by the employer or employee in regard to satisfaction of class criteria (coverage) "tends to become intertwined with [questions related to misrepresentation.\textsuperscript{284} The result has been a split of authority as to whether misrepresentations as to eligibility in the application for insurance are coverage defenses or validity defenses.\textsuperscript{285}

It has been suggested, however, that the difficulty created by the validity vs. coverage distinction could be avoided through a policy-directed approach. This approach recognizes that the incontestability clause stands "as a bulwark against the effects of unreasonable post-claim underwriting.\textsuperscript{286} As such, it is argued, the policy-directed approach sets forth a more reasoned and pragmatic premise from which to commence analysis.\textsuperscript{287} Under this construct, the appropriate inquiry is whether the policy provision relied upon by the insurer, in asserting the defense, "functions as a device for post-claim underwriting in a setting in which pre-issuance underwriting would provide a workable alternative.\textsuperscript{288} Given this analysis, it is not surprising that courts, in raising the incontestability clause as a bar to the misrepresentation defense, have implicitly condemned the practice of post claim underwriting.

This implicit condemnation of post claim underwriting is illustrated by a recent California case in which the insured sent an imposter to a medical examination to give blood and urine samples in an effort to hide his HIV infection.\textsuperscript{289} The imposter, however, as reflected in the medical examination report, was four inches taller and thirty pounds heavier than the insured.\textsuperscript{290} In addition, the signature of the

\textsuperscript{282} See id. at 706.

\textsuperscript{283} Crawford v. Equitable Life Assurance Society of United States, 305 N.E.2d 144, 149 (Ill. 1973).

\textsuperscript{284} Id.

\textsuperscript{285} Compare Crawford, 305 N.E.2d 144 (when information as to whether an insured is indeed a member of the class of those insured under a group policy is furnished by the employer, the question of coverage is intertwined with the question of whether coverage was obtained by false pretenses) with Simpson v. Phoenix Mut. Life Ins. Co., 247 N.E.2d 655 (N.Y. 1969) (incontestable clause bars defenses, including those related to the scope of coverage and risks assumed, if the insurer could have discovered the facts at the policy's inception). See also Russ, supra note 194, § 8:37 (In many jurisdictions the incontestable clause is held to prevent claims of ineligibility, but in many others group eligibility requirement defenses are not barred by the clause. The rationale for allowing the defense is that the policy presupposes the eligibility criteria; therefore, the failure to satisfy such criteria renders the policy void \textit{ab initio}).

\textsuperscript{286} Works, \textit{Coverage Clauses}, supra note 69, at 813.

\textsuperscript{287} See id.

\textsuperscript{288} Id.

\textsuperscript{289} See Amex Life Assurance Co. v. Superior Court, 930 P.2d 1264 (Cal. 1997).

\textsuperscript{290} See id. at 1266.
imposter "[was] transparently different" from that of the insured. Therefore, the insurer had sufficient information before issuance of the policy to alert it to fraud. The insurer, however, failed to investigate until after a claim for life insurance proceeds was made by the beneficiaries.

The California Supreme Court rejected the insurer's "imposter defense" and concluded that its affirmative defense of fraud could not be asserted beyond the two-year period provided by the incontestability clause. The court reached this conclusion because "[t]he incontestability clause requires the insurer to investigate fraud before it issues the policy or within two years afterwards." In this regard, the court noted that the insurer did nothing to protect its interests but collect premiums until the insured died. In addition, the insurer could have protected its interests, prior to inception of the policy, by the simple expedient of requesting identification at the medical examination. Thus, an "insurer may not accept the premiums for two years and investigate a possible defense only after the beneficiaries file a claim," and subsequently seek to avoid the prohibitions of the incontestability clause by averring fraud at the policy's inception.

In the course of arriving at its holding, the court expressly acknowledged the insured's fraudulent conduct as abhorrent. Nonetheless, it focused its analysis on the insurer's conduct instead of the insured and recognized that the purpose of the incontestability clause is to encourage the insurer to be diligent in its obligation to investigate the risk within a reasonable time. In the court's words:

[Incontestability] clauses are designed to require the insurer to investigate and act with reasonable promptness if it wishes to deny liability on the ground of false representation or warranty by the insured. It prevents an insurer from lulling the insured, by inaction, into fancied security during the time when the facts could best be ascertained and proved, only to litigate them belatedly,

291 Id. at 1271.

292 See Amex Life, 930 P.2d at 1271. The imposter defense allows an insurer to avoid the prohibitions of the incontestability clause because "where a man, pretending to be someone else, goes in person to another and induces him to make a contract, the resulting contract is with the person actually seen and dealt with and not with the person whose name was used." Id. at 1269. The imposter defense could not, in Amex Life, defeat the provisions of the incontestability clause, however, because the insured, himself, applied for coverage with the insurer and utilized the services of the imposter only for the purposes of the medical examination. Therefore, the court concluded, a contract was formed through mutual assent of the parties. Thus, the insurer could only rely upon the affirmative defense of fraud in its efforts to avoid its obligations under the insurance contract. Id. at 1271.

293 Id.

294 See id.

295 See Amex Life, 930 P.2d at 1272.

296 Id. at 1271.

297 See id.
possibly after the death of the insured.\textsuperscript{298}

Therefore, even though dishonest people are given advantage by the incontestability clause – an advantage that "any right-minded man is loath to see"\textsuperscript{299} – "the sense of security given to the great majority of honest policyholders"\textsuperscript{300} by the clause outweighs the cost occasioned by the actions of a few dishonest persons.\textsuperscript{301}

Thus, the incontestability clause may serve to prevent the practice of post claim underwriting if engaged in by an insurer after the expiration of the time established by the policy or statute. The clause, however, cannot dissuade insurers from engaging in the practice if claims are submitted during the time in which validity of the policy may be contested. Nor can it protect insureds from the opportunistic conduct of insurers if the policy does not contain such a clause or there is no statutory mandate. Finally, the clause cannot fully protect insureds in those jurisdictions in which a challenge to eligibility for group insurance is not barred by the clause.\textsuperscript{302}

\section{Redux}

Although all of the doctrines discussed \textit{supra}\textsuperscript{303} have afforded relief to individual insureds victimized by post claim underwriting (with the possible exception of the incontestability clause),\textsuperscript{304} each requires a factual inquiry on a case-by-case basis. The consequences of this \textit{ad hoc} analysis are two-fold.

First, there is a decided lack of uniformity of opinion regarding the opportunistic nature of post claim underwriting, despite the clear policy rationales for its eradication.\textsuperscript{305} Second, because none of the doctrines unconditionally forecloses an insurer’s reliance upon rescission as a defense, an insurer is reinforced in its decision to continue to play the odds on bad risks, mindful that it may avoid its marketing decision to forego underwriting by pointing to an insured’s misrepresentation. The result – there is currently no doctrine to dissuade insurers from engaging in

\begin{footnotesize}
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\item \textsuperscript{298} \textit{Id.} at 1267 (citing Russ, \textit{supra} note 194, § 72.2).
\item \textsuperscript{299} \textit{Id.} at 1269.
\item \textsuperscript{300} \textit{Amex Life}, 930 P.2d at 1269.
\item \textsuperscript{301} \textit{See id.}
\item \textsuperscript{302} \textit{See Krauss v. Manhattan Life Ins. Co. of N.Y.}, 700 F.2d 870, 872 (2d Cir. 1983) (under Illinois law the incontestability clause does not bar the insurer from raising ineligibility as a special defense).
\item \textsuperscript{303} Waiver, estoppel, unconscionability, reasonable expectations, cause of action for statutory unfair settlement practices, insurer fraud, agent misrepresentation in the application for insurance, and incontestability.
\item \textsuperscript{304} The incontestability clause is ostensibly a bright-line rule. However, because courts have muddied the distinction between challenges based upon validity and coverage, its application does not always result in a bar to claims of fraud. In addition, at least one court has held that the incontestability clause does not bar an insurer’s inception defense based upon fraud. \textit{See Paul Revere Life Ins. Co. v. Haas}, 644 A.2d 1098 (N.J. 1994). \textit{See also} discussion \textit{infra} regarding Contra Arguments in relation to Googins’s article.
\item \textsuperscript{305} \textit{See supra.}
\end{enumerate}
\end{footnotesize}
opportunistic post claim underwriting. By contrast, a *per se* rule of bad faith combined with *Restatement (Second) of Contracts* Section 172 forecloses the misrepresentation defense and thereby removes the impetus for the insurer to engage in post claim underwriting.


A. The Cases

As previously noted, no formal doctrinal approach to post claim underwriting has developed.\(^{306}\) Thus, judicial analysis of the practice has been less than uniform. More importantly, because a fully developed approach has not been forthcoming, courts encountering the practice have either endeavored to distinguish clear incidences of post claim underwriting by giving exceptionally narrow constructions to those cases that have provided individual relief to insureds or simply denied that the practice is one in which insurers engage in bad faith.

Both analyses have been employed in an effort to avoid giving an ostensive advantage to insureds alleged to have lied.\(^{307}\) Such constructions, however, have generally led to absurd and illogical legal analyses. More importantly, as demonstrated by the spectrum of alleged misrepresentations found within the three cases discussed, *infra*, judicial approaches that do not first hold the insurer accountable for its underwriting conduct, sweep within their ambit the innocent mis-informer. An intermediate Arkansas appellate court opinion well illustrates the plight of an insured who innocently fails to disclose a non-impairing medical condition, in the absence of a *per se* doctrine designed to deter post claim underwriting.\(^{308}\)

1. *Richison v. Boatmen's Arkansas, Inc.*\(^{309}\)

At issue was the insurer’s refusal to pay the policy proceeds of a $2500 credit life insurance policy issued in connection with the purchase of a used pick-up truck.\(^{310}\) The insurer’s application for this coverage required only a general statement of good health. That statement, in its entirety, consisted of the following: “I am now in good health, mentally and physically; I know of no physical impairment

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\(^{306}\) See supra Part V.

\(^{307}\) Courts are loath to see dishonest people given an advantage by judicial doctrine. Thus, in the context of the lying insured, it is difficult for a court to endorse coverage for such an individual. However, as with the incontestability clause, courts must focus attention on the insurer’s conduct and recognize that the purpose of a prohibition against post claim underwriting is to encourage the insurer to be diligent in its obligation to investigate the risk before issuance of the policy. *See Amex Life Assurance Co. v. Superior Court*, 930 P.2d 1264, 1271 (Cal. 1997).


\(^{309}\) Id.

\(^{310}\) See *id.* at 113.
or disease now affecting my health.”\textsuperscript{311} No details were requested concerning the insured’s health.\textsuperscript{312}

The insured was an asthmatic. He was not, however, impaired by this condition. In addition, aside from periodic visits to a physician for prescription refills, he had not sought treatment of his asthma in over four years.\textsuperscript{315} It is reasonable to infer from these facts that the insured believed himself to be in good health and unaffected by any disease that might adversely impact upon his health.

The insured “died as a result of a fatal asthmatic reaction to the drug Tora-dol, that was prescribed by his dentist during root canal treatments.”\textsuperscript{314} His widow filed a claim with the insurer seeking the policy proceeds.\textsuperscript{318} After the claim was filed, the insurer commenced its underwriting investigation.\textsuperscript{316} Upon discovering the insured had asthma, it denied the claim on the grounds of a misrepresentation.\textsuperscript{317} The insurer claimed that had the insured “indicated that he suffered from asthma, [it] would have denied coverage.”\textsuperscript{318}

The insured’s widow challenged the policy rescission, arguing that because the insurer had engaged in post claim underwriting it had, \textit{prima facie}, acted in bad faith.\textsuperscript{319} The court of appeals rejected this argument, holding that “[t]he elements for recovery under the tort of bad faith require the establishment of affirmative misconduct by an insurer.”\textsuperscript{320} Under Arkansas law, concluded the court, a failure to investigate, alone, could never support a claim of bad faith because a failure to investigate does not involve any affirmative conduct taken by the insurer.\textsuperscript{321} Affirmative conduct, said the court, is evidenced by actions such as, altering insurance records, actively lying about available coverage, or actively concealing an insured’s coverage.\textsuperscript{322}

In requiring an affirmative act of bad faith, however, the appellate court misconstrued the duty of good faith as set forth in \textit{Restatement (second) of Con-}

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\textsuperscript{311} \textit{Id.}
\textsuperscript{312} See id.
\textsuperscript{313} See Richison, 981 S.W.2d at 113.
\textsuperscript{314} See id. It should be noted that under Arkansas law, had the insured died of a cause other than an asthmatic reaction, the insurer would not have been able to raise this alleged misrepresentation. Arkansas is one of a minority of jurisdictions that require a causal connection between any alleged misrepresentation and the claimed loss to support the defense. Schuman, \textit{supra} note 70, at 232.
\textsuperscript{315} See Richison, 981 S.W.2d at 113.
\textsuperscript{316} See id.
\textsuperscript{317} See id.
\textsuperscript{318} Id. at 114.
\textsuperscript{319} See id.
\textsuperscript{320} Richison, 981 S.W.2d at 114.
\textsuperscript{321} See id. at 115.
\textsuperscript{322} See id.
tracts Section 205 – the cornerstone of the doctrine of bad faith in insurance law. The commentary to Section 205 instructs that “bad faith may be overt or consist of inaction, and fair dealing may require more than honesty.” In light of the Restatement explanation, there can be little doubt that the appellate court’s primary premise for refusing to recognize post claim underwriting as per se bad faith is misplaced. There is no doctrinal support for a requirement that an insurer must engage in an affirmative act of bad faith before it can be held liable in tort.

More importantly, in erroneously focusing on the Chimera of action versus inaction, the appellate court abdicated its primary obligation to deter opportunistic breaches of contractual obligations. Recall that “the fundamental function of contract law . . . is to deter people from behaving opportunistically toward their contracting parties.” Thus, at its core, good faith performance means not trying “to take advantage of the vulnerabilities created by the sequential character of contractual performance.” Therefore, a party to a contract behaves opportunistically and in bad faith when it takes advantage of the sequential character of performance under a contract. The record evidence, as reported by the appellate court, reveals that the insurer acted in bad faith because it sought to avoid performance by taking just such an advantage.

According to the testimony of its own underwriter, the insurer had no written underwriting policy related to asthma. More tellingly, the underwriter testified that he knew of no applications for insurance rejected by the insurer, as a bad risk, because the applicant was an asthmatic. Thus, there was absolutely no credible evidence of record to support a conclusion that the insurer would have refused to underwrite any risk created by asthma, even if its underwriting practices had been reasonable and not confined to the cursory general good health questionnaire.

Given the underwriter’s testimony, there can be no question that the insurer engaged in post claim underwriting for the sole purpose of taking advantage of the insured’s beneficiary. Furthermore, such advantage would not have been possible but for the sequential character of the insurance contract. Thus, the insurer acted in bad faith, and the insured’s beneficiary should have had available an adequate remedy for the breach. By not recognizing a cause of action for post claim underwriting, the appellate court clearly failed in its duty to deter opportunistic conduct in contractual relationships.

The same abdication of the judicial imperative to deter opportunistic conduct in contractual relationships is apparent in an Illinois appellate court deci-

323 See discussion supra Part IV.A.2. (bad faith).
325 See Posner, supra note 1, § 4.1.
326 See id.
327 See Richison, 981 S.W.2d at 114.
328 See id.
sion. There, despite the manifest absence of any evidence establishing the insured as the author of the misrepresentation at issue and the insurer’s obvious reliance upon post claim underwriting, the court foreclosed relief to the insured.

2. **Brandt v. Time Insurance Co.**

An insured was denied health insurance coverage, ostensibly because a preexisting condition (diabetes) was not disclosed on the application for insurance. It was undisputed that the application was completed by a broker with knowledge of the preexisting condition, on behalf of the insured. Moreover, the insured never saw the application completed by the broker until the insurer sought rescission of the policy.

Approximately five months after the policy was issued, the insured was diagnosed with terminal stomach cancer. After a claim for medical benefits was made and before paying the contracted-for medical costs incurred in connection with this disease, the insurer undertook an investigation of the insured’s medical history. This investigation revealed that the insured had been treated for diabetes within five years of her application for coverage. The insurer, thereafter, sought rescission of the policy on the basis of a misrepresentation.

The insured challenged the policy rescission, averring that post claim underwriting “constituted common law fraud . . . and an unfair and deceptive trade practice under the [state] Consumer Fraud Act.” The appeals court rejected this argument, holding that “Illinois law imposes no duty on an insurer to conduct an independent investigation of insurability before issuing an insurance policy.” This holding clearly opens all insureds within Illinois to opportunistic manipulations of the aleatory contract of insurance.

Recall that if an “insurer can perpetually postpone the investigation of insurability and concurrently retain its right to rescind” until after a claim has been made, then an insurer can accept premiums, deal with the insured as if there is coverage, lead the insured to believe that he is covered, and never take on the risk that

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330 Id.
331 See id. at 845. The application contained the following question, answered negatively by the broker: “Within the last five years, have you . . . ever received any medical or surgical diagnosis or treatment including medication for . . . diabetes?” The plaintiff had a seven-year history of diabetes at the time of application. Id.
332 See id.
333 See Brandt, 704 N.E.2d at 845.
334 See id.
335 See id.
336 See id. at 846.
337 Id.
338 Brandt, 704 N.E.2d at 846.
is inherent to the business of insurance. The "no investigation rule" of the Illinois court thus permits insurers to defeat the very nature of the aleatory contract of insurance. Furthermore, given sufficient impetus – such as chronic illness – it is likely that any health insurer will be able to find some detail within an insured's medical history that, post hoc, amounts to misrepresentation.

In addition, because the insurer has dealt with the insured as if there is coverage, the insured has stopped seeking additional sources of insurance. Recall that an insurer must do its investigation before issuance of the policy to allow "the proposed insured to seek other coverage with another company [in the event of rejection] since no company will insure an individual who has suffered serious illness or injury." This rationale is particularly pertinent to the Illinois appellate court's opinion, because no health insurer would provide coverage for an individual with terminal stomach cancer. However, some insurers might provide coverage to a diabetic. Therefore, if the reasonable expectations of the insured are to be protected from opportunistic manipulation of the insurance relationship, then the insurer must be held to a duty of investigation before issuance of a policy, or at the very least before a claim is filed. The Illinois appellate court's reasoning is, thus, clearly faulty.

As discussed, supra, courts, in addition to simply denying that post claim underwriting constitutes bad faith, have endeavored to artificially distinguish the practice by simply applying a new moniker. A federal district court opinion, applying Mississippi law, well illustrates this artificial distinction. In addition, the case brings to the fore an alleged outright lie that, but for post claim underwriting, would readily have been discovered pre-issuance.

3. Wesley v. Union National Life

Plaintiff, the beneficiary of her son's life insurance policy, brought suit against the insurer after it rescinded the policy, claiming a misrepresentation. In her cause of action, plaintiff alleged the insurer violated Mississippi law by engaging in post claim underwriting.

The policy the plaintiff sought to enforce was taken out on May 11, 1992, and provided for $10,000 in whole life benefits. An additional $10,000 was payable in the event of an "accidental" or "unnatural death."

342 Id.
343 See id. at 233.
344 See id.
345 See id.
346 Wesley, 919 F. Supp. at 233.
Plaintiff’s son was shot and killed on June 21, 1992. Only after learning of the insured’s death did the insurer “beg[an] to investigate whether [his] answers on the application [for insurance] were truthful.” In the course of this post claim underwriting, the insurer discovered that its insured “had been confined to a chemical dependency unit at a hospital in California due to cocaine addiction.” Based upon this post claim underwriting information, the insurer averred its insured, plaintiff’s son, lied in the application process because the application did not disclose the cocaine use and substance abuse hospitalization.

In addressing plaintiff’s claim that the insurer should be prohibited from rescinding the policy because it had engaged in post claim underwriting, the district court correctly defined the practice as “an insurer’s waiting until after the insured makes a claim to determine whether the claimant is eligible for insurance according to the risks he presents.” The court also acknowledged the Mississippi Supreme Court’s condemnation of the practice with a direct quote from the leading post claim underwriting case: “an insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed.” The district court, however, sought to circumvent the clear meaning of that admonition by endeavoring to draw an ersatz distinction between post claim underwriting and post claim investigation of eligibility. This fallacious distinction in terminology, in turn, prompted the court to declare that the insured, through lying, had bypassed the insurer’s legitimate underwriting process.

The district court’s distinction is one without a difference and is a legal hair that cannot be split. Both post claim underwriting and the newly created “post claim investigation of eligibility” determine eligibility after a claim has been filed. The district court, nonetheless, attempted to drive a wedge between the two by maintaining that the insurer met its underwriting obligations through the simple expedient of an application questionnaire. In the district court’s words, “[t]he questions on the insurance application were one method for screening out applicants who presented unacceptable risks.” Thus, the insurer “made an underwriting
decision not to insure applicants who answered yes” to the relevant questions on the application questionnaire.\(^{358}\) Therefore, concluded the district court, *propter hoc*, it was the insured, not the insurer, who “bypassed” the underwriting process.\(^{357}\)

The error in the district court’s analysis is its failure to fully consider the legal ramifications of *that* very underwriting decision by the defendant insurer. Recall that decisions as to the extent of pre-issuance underwriting are primarily a marketing choice. Insurers can “decide whether to investigate their applicants at the beginning, in which case they will accept fewer applications but also insure better risks, or increase sales by simplifying their underwriting requirements at the time of purchase and risk adverse selection.”\(^{358}\) Thus, the district court, in attempting to distinguish between post claim underwriting and, so-called, “post claim investigation of eligibility,” failed to hold the insurer accountable for its marketing decision. That decision not to investigate naturally resulted in adverse selection of insureds—including those who lie.\(^{359}\) In other words, reasonable underwriting practices by the defendant insurer would have prevented any alleged “lying bypass.”

More particularly, the facts as reported in the opinion do not indicate that the defendant insurer came to learn of the insured’s “confine[ment] in a chemical dependency unit” from sources outside the chain of its application process.\(^{360}\) Therefore, more likely than not, the insurer had the means available to ascertain information rendering the insured ineligible for coverage before issuance of the policy, but chose not to expend the monies necessary to effectuate those means. Thus, the insurer chose to receive the income generated by the insured’s questionable policy with knowledge that at a later date, should it be faced with a covered loss, it would raise any inaccuracies in the application to avoid paying the policy proceeds.

Unfortunately, the district court, in focusing on the allegations of the individual insured’s dishonesty, lost sight of the insurer’s bad faith stratagem.\(^{361}\) As a consequence, the district court granted the insurer’s motion for summary judgment, concluding that it “properly rescinded the insurance contract because of the material misrepresentations . . . on the application for insurance.”\(^{362}\) This holding is,
obviously, in direct contravention of Restatement (Second) of Contracts Section 172.\textsuperscript{363} Had the district court properly focused \textit{first} on the bad faith stratagem of post claim underwriting, it would have found the insurer’s reliance upon misrepresentation as a defense, unjustified. Such reliance was unjustified because any alleged misrepresentation by the insured in the application was not discovered before issuance only because of the insurer’s own bad faith reliance upon the practice of post claim underwriting.\textsuperscript{364} Finally, as discussed more fully, \textit{infra}, it is appropriate to hold the insurer responsible for its decision to post claim underwrite because the alleged cunning fraud, now deceased, cannot rebut the allegation.

4. Redux

The three cases (\textit{Richison},\textsuperscript{365} \textit{Brandt}\textsuperscript{366} and \textit{Wesley}\textsuperscript{367}) illustrate much more than the failure of courts to apply sensible legal analyses and policy rationales. More fundamentally, these cases demonstrate a spectrum, or continuum, of alleged insured misrepresentations and concomitant levels of arguable culpability for that misinformation. This spectrum, in turn, reveals just how facilely the innocent mis-informer is swept within the ambit of doctrinal approaches that respond viscerally to allegations of lies and fraud, and as a consequence, fail \textit{first} to assess the insurer’s underwriting conduct.

Few reasonable persons could argue that Mr. Richison’s affirmative response to the general statement of good health in his application for credit life insurance was made with the intent to misinform the insurer.\textsuperscript{368} This view is consistent with the conclusion reached by the majority of courts that responses to general good health questions are statements of subjective opinion.\textsuperscript{369} Mr. Richison, more likely than not, genuinely believed that he was in good health and that his asthma was not “indicative of a lack of good health.”\textsuperscript{370} Thus, his response to the insurer’s cursory general good health inquiry was likely truthful. Therefore, Mr. Richison’s conduct should not be viewed as the cause of any alleged mistaken decision to underwrite the risk he presented. As such, Mr. Richison characterizes the quintessential innocent mis-informer, wrongly denied coverage for which he bargained because the court failed \textit{first} to assess the underwriting conduct of the insurer.

Standing in direct contrast to the absence of a causative nexus within Mr. Richison’s conduct is the \textit{Richison} insurer’s post claim underwriting scheme. It was this scheme that caused the insurer to underwrite a risk that \textit{post hoc} was declared

\textsuperscript{363} \textit{See} discussion \textit{supra} Part IV.
\textsuperscript{364} \textit{See} \textit{RESTATEMENT (SECOND) OF CONTRACTS} § 172 (1981).
\textsuperscript{367} \textit{Wesley}, 919 F. Supp. 222.
\textsuperscript{368} \textit{See} \textit{Richison}, 981 S.W.2d at 113.
\textsuperscript{369} \textit{See} Schuman, \textit{supra} note 70, at 235.
\textsuperscript{370} \textit{Id}.  


erroneous. Had the insurer expended the time and monies necessary to investigate Mr. Richison's medical history, it would have discovered that he suffered from asthma. Then, in the event the insurer determined that asthma was not a risk it wished to embrace, it could refuse to extend coverage before policy issuance.

Ms. Brandt's alleged misrepresentation is conducive to similar analysis. Ms. Brandt did not lie; the broker lied.\textsuperscript{371} As such, Ms. Brandt should not be seen as the cause of any alleged, erroneous underwriting decision.

The broker, of course, was likely compensated for his services through commissions paid by the insurer.\textsuperscript{372} Commissions are, naturally, not earned if a policy is not issued. Thus, the broker confronted a manifest temptation to misinform in order to sell the policy and procure his commission.\textsuperscript{373} The Brandt insurer was likely well aware of this temptation.\textsuperscript{374} Nonetheless, it made a reasoned decision to ignore the potential for misinformation, built into the process of remuneration, and relied instead upon a scheme of post claim underwriting to avoid contract performance, in the event a broker lied. Therefore, just as in Richison, it was reliance upon post claim underwriting that caused the insurer to make an impoverished underwriting decision, not the insured.

The reader may now exclaim, "Ok, I can accept that Richison and Brandt were innocent mis-informers; they should have been afforded the benefit of their bargain. But what about Wesley? He was clearly a cunning fraud!" In response to that exclamation we posit, "Maybe, but we don't really know."

The difficulty created in Wesley through absolution of the insurer's marketing decision to engage in post claim underwriting arises from the distinct possibility that he, like Ms. Brandt, was the victim of misstatements in the application prepared by the insurer's agent.\textsuperscript{375} Because Wesley was dead, the court could not be advised of the true circumstances associated with his insurance application.\textsuperscript{376} The court, however, did know that the insurer engaged in post claim underwriting.\textsuperscript{377} More importantly, the Wesley facts support a conclusion that, but for the insurer's

\begin{footnotes}
\item[371] "The relationship between most brokers and the insurance companies they place coverages with typically involves significantly greater ongoing contacts and interactions than the relationship with any individual applicant for insurance or insured. Accordingly, so long as the general rule prevails that an agent may not serve two principals simultaneously, it seems clear that in most contexts there is more justification for treating a broker as an agent of an insurer than as an agent for the purchaser." \textit{Keeton & Widiss, supra} note 23, § 2.5(b)(3), at 84.
\item[372] \textit{See id.}
\item[373] There can be no question that the broker knew that Ms. Brandt was a diabetic. He previously procured two short-term medical insurance policies for her that excluded the diabetes from coverage as a pre-existing condition. Brandt v. Time Ins. Co., 704 N.E.2d 843, 845 (Ill. App. Ct. 1998).
\item[374] \textit{See National Life & Accident Ins. Co. v. Miller, 484 So. 2d 329, 339 (Miss. 1985) (Hawkins, J., concurring), as discussed supra Part III.D.}
\item[375] \textit{See discussion supra Part V.G.}
\item[376] This difficulty of proof, faced by the beneficiaries of deceased insureds such as Mrs. Wesley, when an insurer raises an inception defense, provides the primary rationale for the incontestability clause. \textit{See Jerry, supra} note 4, § 104B, at 703, 707-09; \textit{see also} discussion \textit{infra} Part VI.B.
\end{footnotes}
reliance upon post claim underwriting, the insurer, through reasonably thorough underwriting, would have discovered that Wesley had undergone treatment for substance abuse in the past.\textsuperscript{378} Had it done so, the adverse risk it sought to throw off \textit{post hoc} could have been avoided pre-issuance.

Thus, this tripartite of contra-cases actually instructs that the dividing line between the innocent mis-informer, the liar, and the cunning fraud is not so brightly drawn as visceral responses might indicate. Given this absence of clear delineation, courts should \textit{first} look to the insurer's conduct so as to ascertain its \textit{true} underwriting decision. It may well be that the insurer, implicitly, through a reasoned marketing decision, chose to insure not only the innocent mis-informer but the liar and the cunning fraud as well. Thus, insurers who have made such perilous underwriting decisions should not be protected when it is impossible to distinguish with certainty between the innocent insured and the cunning fraud.

\section*{B. The Literature}

Courts are not the only source of legal analysis to erroneously abandon the directive to deter opportunistic conduct after having been blinded by a visceral response to allegations of misrepresentation and fraud. Some in the academic community decry a phantasmic plague of insured fraud and consequently seek its eradication at virtually any cost. Robert R. Googins is representative of this school of thought.\textsuperscript{379}

1. Googins

In a 1996 article in the Connecticut Insurance Law Journal, Robert R. Googins posits that "the legitimate purpose of the incontestable clause can be honored without payment to cunning frauds."\textsuperscript{380} He reaches this conclusion through the vehicle of \textit{Paul Revere Life Insurance Co. v. Haas},\textsuperscript{381} a New Jersey Supreme Court opinion holding that despite an insurer's obvious marketing choice to reject a statutorily provided clause "that would have allowed the perpetual contestability of the contract as to any fraudulent misstatements made in the [insurance] application,"\textsuperscript{382} an insured could not recover disability proceeds "for a disease that he or she intentionally concealed when applying for the policy."\textsuperscript{383} The New Jersey Supreme Court reached this conclusion even though the contestability period had expired.\textsuperscript{384} Both the New Jersey Supreme Court and Mr. Googins rationalize this

\begin{flushleft}
\textsuperscript{378} See id. at 233.
\textsuperscript{380} Id. at 88.
\textsuperscript{381} 644 A.2d 1098 (N.J. 1994).
\textsuperscript{382} Googins, \textit{supra} note 379, at 53.
\textsuperscript{383} Id. at 60, 89 n.39 (citing \textit{Haas}, 644 A.2d at 1100).
\textsuperscript{384} See id. at 55.
\end{flushleft}
holding by averring "that insurance fraud is a problem of 'massive proportions' that . . . results in substantial cost to the general public."385 Both the New Jersey Supreme Court and Mr. Googins recognize that the holding is ultimately one of public policy.386 Thus, in their view, sound public policy necessitates a standard that would allow any insurer to raise the inception defense of a fraudulent misrepresentation without regard to the prohibitions of the incontestability clause and, by implication, a dearth of underwriting notwithstanding.

Although neither Mr. Googins nor the New Jersey Supreme Court directly addresses the issue of post claim underwriting, the postulate that insurance fraud "is a problem of massive proportions" has obvious implication for much of the reasoning on which this Article is premised. In addition, any discussion of the incontestability clause is closely related to post claim underwriting, because the incontestability clause is said to be "a bulwark against the effects of unreasonable post-claim underwriting."387

Notably lacking from Mr. Googins's article is any empirical evidence to support an assertion that individual insureds defraud insurers in massive numbers. Instead it is reasoned, rather fatuously, that because he has observed that traffic signal disobedience is tolerated; that more people cheat on their tax returns than twenty years ago; and, that people call in sick when they want an extra vacation day, it follows that "little frauds" upon insurers are practiced daily when insureds apply for insurance or file proofs of loss.388

Mr. Googins attempts to bolster this analysis by asserting that while "nobody knows for sure" just how frequently individual insureds endeavor to defraud insurers, "those in the business believe the figure is staggering involving billions of dollars annually."389 He subsequently cites an unpublished survey of twenty-five of the largest life insurance companies revealing that, in 1993, $83.3 million in claims were resisted by insurers on the basis of alleged fraud or misrepresentation with an additional $95.9 million in such claims still unresolved.390 Googins then concludes, post hoc ergo propter hoc, that despite the "sparsity of information on the aggregate cost of fraud in connection with individual life, accident and disability insur-

385 Id. at 62. See Schuman, supra note 70, claiming that "insurance fraud has reached epidemic proportions, costing insurers and the public at least $15 billion a year and increasing some policy premiums by as much as 25 percent." Mr. Schuman, like Googins, provides no reliable statistics in relation to any alleged fraud by individual insureds. However, unlike Googins, Schuman recognizes that the extent and degree of underwriting is essentially a marketing decision. See Schuman, supra note 70, at 226.

386 See Googins, supra note 379, at 62.

387 Id. at 69.

388 See Googins, supra note 379, at 74.

389 Id. at 75.

390 See id. at 51 n.121 (citing Philip E. Stano, Recent Developments in Life and Health Insurance Fraud Legislation, 1995 ALIC Proc. (1995)).

Of course the large number of claims "resisted" by insurers through reliance upon misrepresentation provides additional support for the conclusion that courts must be vigilant in ensuring that insurers do not assert inception defenses in contravention of RESTATEMENT (SECOND) OF CONTRACTS § 172. See discussion supra Part IV.
ance policies, [t]here is . . . nothing to suggest that fraud is not a serious problem in this area,"; therefore, there is a massive fraud problem.

Googins then calls upon the judiciary to combat this phantasmic plague of fraud with the arsenal of its equity powers—"a system of jurisprudence collateral to, and in some respects independent of 'law,' the object of which is to render . . . justice more complete, . . . affording relief where the courts of law are incompetent to give it."392 Thus, for Googins, the insurer has been so victimized by massive numbers of cunning, fraud-bent, insureds that only the extraordinary remedies of equity can save the day.

As for the conduct of insurers, Googins believes that they "do not take questionable risks up front in hope of catching them during the contestable period."393 Furthermore, "[a]ny allegations of a perverse 'retroactive underwriting' are without merit"; "whatever underwriting investigation that is going to be done is done prior to a policy's issuance."394 In addition, he insists that "insurers are [not] predisposed to assert defenses to avoid otherwise legitimate claims"395 and such defenses are not relied upon as a "result of some unseemly use of an alleged marketing advantage."396 Finally, Googins states that "hopefully . . . insurers will not mount post contestable period challenges unless the alleged fraud can be clearly shown."397 His hopefulness is, for him, apparently sufficient safeguard for innocent insureds faced with post hoc allegations of misrepresentations.

Googins's supposition that insurers are victims in need of protection from insureds is, of course, contrary to the generally held notion. For example, although Restatement (Second) of Contracts Section 205398 imposes the duty of good faith and fair dealing upon each party to a contract, the majority of courts applying its dictates, in the insurance context, have done so as a "one-way street in favor of the insured [because] the insured needs protection but the insurer does not."399 This conclusion is consistent both with the lack of empirical evidence of pervasive insured fraud (recognized and ignored by Googins) and with the insurance industry's history of marketing abuses, particularly in the context of warranties—one of the "technical defenses" for performance avoidance that initially gave rise to the inclusion of incontestability clauses within policies.400

Googins, of course, discounts any abusive marketing decisions by the in-

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391 Googins, supra note 379, at 77.
392 Id.
393 Id. at 71.
394 Id. at 71-72.
395 Id. at 73.
396 Id. at 71.
397 Id. at 73.
399 JERRY, supra note 4, § 25G[4], at 162.
400 See id. § 104B[a], at 703-04.
He asserts that it is unlikely that any prospective purchaser of a policy is thinking about the subtlety of various incontestability clauses at the time of sale. Nor, says he, would a sales agent point out such subtleties at the time of sale. These assertions naturally beg the question — if there is a choice of alternative incontestability clauses provided by statute (as there was in *Haas*) and one of the choices allows the insurer perpetual contestability for fraudulent misstatements, what insurer, absent marketing concerns, would choose a clause that does not allow the defense? Obviously, insurers do make marketing choices. Therefore, if opportunistic breaches of the sequential character of the insurance contract are to be avoided, insurers must be held to the consequences of those marketing choices.

Finally, Googins’s bald assertion that insurers do not engage in post claim underwriting is clearly without merit. The survey of cases within this Article alone is evidence that insurers post claim underwrite. In addition, insurers have admitted to the practice. Moreover, the informal monetary figures offered by Googins as circumstantial evidence for his assertion that insureds are cunning frauds more readily transfer to the conclusion that post claim underwriting is rampant. Contested claims amounting to $95.9 million withheld from individual insureds by only twenty-five companies asserting inception defenses (both fraud and misrepresentation) is simply beyond ken. This figure is even more shocking when one recognizes that there is apparently no empirical data to support the assertion of rampant fraud perpetrated by individual insureds against insurance companies.

The flaw in Googins’s policy argument is not, however, restricted to the paucity of empirical support and his apparent non-recognition of the industry practice of post claim underwriting. The key defect is, in fact, postulated by Googins himself when he observes that the “important objective [of protecting innocent insureds from the consequences of unintentional misrepresentations] does not demand the protection of defrauders unless it is not possible to distinguish the innocent misrepresenter from the deceiver.” This of course, is the primary rationale for the protections afforded the insured by the incontestability clause. In other words, the clause protects the insured from unreasonable post claim underwriting because it is not always possible to differentiate between the innocent insured and the cunning fraud. As Jerry has noted,

Incontestability clauses first appeared . . . in the late nineteenth

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401 See Googins, *supra* note 379, at 72.
402 See *id.* at 73.
403 See *id.*
404 See *id.* at 86-88.
405 See, e.g., Meyer v. Blue Cross Blue Shield of Minnesota, 500 N.W.2d 150, 153 (Minn. 1990).
406 See discussion *supra* note 390.
407 See discussion *supra* note 390.
408 Googins, *supra* note 379, at 74 (emphasis added).
 century. In an era where the public’s perception of insurers was particularly negative and it was widely assumed, with some justification, that insurers would seek to escape their obligations through the assertion of technical defenses, insurers created the clause to help dispel the general public’s fear that insurers would refuse to pay death benefits under life insurance policy due to the insured’s errors in the application. If an insurer should decline to pay a death claim, the danger to the insured’s beneficiaries was obvious; the insured would not be available to testify about the application, which may have been submitted many years earlier.409

Thus, because there is considerable danger that an innocent insured’s beneficiaries would be denied coverage and find themselves unable to contest that denial because their primary witness is dead, the clause requires the insurer to complete its investigation of the risk before its expiration.410 The clause, therefore, provides the insured with the security and peace of mind for which he had bargained in seeking coverage “by preventing the insurer from lulling the insured, by inaction, into fancied security.”411

The same rationale transfers with ease to the doctrine set forth within this Article. Insurers engaged in post claim underwriting, like their brethren at the turn of the century, seek to assert technical defenses to avoid contract performance. Thus, the insurer “instead of looking to pay the claim [for the loss incurred by the insured]” – as promised under the terms of the insurance contract – “look[s] for all the things in the application that [it] might be able to dig up that would allow [it] to rescind the policy.”412 The insured, however, ignorant of the insurer’s intent to engage in post claim underwriting, goes about his life with the fancied security that in the event of a loss there will be coverage.

This sense of security, given to the majority of innocent policy holders, is ample basis upon which to found a public policy rationale for a per se rule of bad faith in the context of post claim underwriting. Even though some dishonest people are given advantage under the doctrine – “which any right minded man is loath to see them get”413 – the honest policyholder should not be put to the trouble and expense of litigating for coverage for which he contracted, simply because the insurer made a marketing decision to forego the expense of reasonable underwriting before issuance of the policy. The great potential for opportunism created by post claim underwriting far outweighs any cost associated with its prohibition. Therefore, the assertions of both the New Jersey Supreme Court and Mr. Googins that fraud is rampant notwithstanding, sound public policy necessitates a per se rule of bad faith foreclosing reliance upon inception defenses if an insurer has engaged in post claim

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409 JERRY, supra note 4, § 104B, at 703.
410 Recall Wesley, as discussed supra Part VI.A.3.
411 Works, supra note 69, at 813.
2. Redux

Those courts and academics that have focused upon the cunning fraud have failed to factor in the conduct of the insurer in their calculus. Before assessment of the insured's actions can be made, the nature of the insurer's underwriting, pre-policy issuance, must be fully ascertained. It is only after such an assessment that the true nature of the risk taken on by the insurer can be determined. If the insurer has engaged in underwriting that evidences a desire to "insure the world," then the insurer must truly insure the world, cunning fraud and all. The insurer cannot be permitted to withdraw from that decision in the event of suspected fraud.

Any other conclusion renders the innocent insured victim to the very fraud the insurer was willing to risk embracing, in the interest of profit and greed. Any other conclusion wrongly places the mark of judicial imprimatur upon the decidedly opportunistic practice of post claim underwriting.

VII. CONCLUSION

The java sipping patrons of Lloyd's Coffee House got it right more than three centuries ago – all reasonable underwriting is completed pre-issuance, never post-claim. This traditional sequence of underwriting both permits the insurer to reduce the risk played by guesswork in assessing the risk it agrees to assume under the terms of the aleatory contract of insurance and protects the insured's reasonable expectations of coverage. The traditional sequence of underwriting provides adequate protection for both the insurer and the insured. There is no justification in policy or law for extending to the insurer the right to invoke an artificial post hoc mechanism for avoidance of obligations under the aleatory contract of insurance. By contrast, there is ample support in both policy and law for protection of the insured from the opportunistic practice of post claim underwriting. It is, therefore, time to sound the judicial death knell for the post claim underwriting bane. A per se rule of bad faith will fully effectuate that end.