

**BAD FAITH AT MIDDLE AGE: COMMENTS ON “THE  
PRINCIPLE WITHOUT A NAME (YET),” INSURANCE LAW,  
CONTRACT LAW, SPECIALNESS, DISTINCTIVENESS, AND  
DIFFERENCE**

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*In this article, Robert Jerry expounds on Professor Abraham’s article on insurer liability for bad faith by pointing out that the concept of institutional bad faith is not a new phenomenon, but rather, one that is as old as the insurance industry itself. Jerry focuses on Abraham’s depiction of the “specialness” and “distinctiveness” of insurance, while exploring additional instances of “rotten to the core” systemic bad faith dating as far back as the nineteenth-century. Much like Abraham did in his article on bad faith, Jerry uses these examples of systemic bad faith to further his assertion that the insurance industry, due to its “specialness,” is held to higher standards of care than other realms of “ordinary business.”*

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In “Liability for Bad Faith and The Principle Without a Name (Yet),” Professor Kenneth Abraham discerns an original and compelling way to express one of the core insights upon which much of the modern law of insurance is built: that insurance has special characteristics not found in the other things, services, information, etc. which individuals and institutions value and acquire, and that the law governing insurance transactions is itself special, distinctive, and different.<sup>1</sup> Through the decades, this insight has been expressed, if not always entirely accurately, in a number of different ways: insurance is a special kind of chattel or

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<sup>1</sup> See Kenneth S. Abraham, *Liability for Bad Faith and the Principle without a Name (Yet)*, 19 CONN. INS. L.J. 1 (2012).

quasi-chattel;<sup>2</sup> insurance, as an aleatory contract instead of a commutative contract, involves an uneven exchange of values that leads to the “peculiar legal aspects” of the contract;<sup>3</sup> the relationship between insurer and insured is fiduciary, or quasi-fiduciary, in nature;<sup>4</sup> an insurance contract is more than an “ordinary contract” and insurance law is more than “ordinary contract law”;<sup>5</sup> insurance contracts are imbued with heightened obligations of good faith and fair dealing;<sup>6</sup> in insurance contracts the duty of good faith is a “one way street,” unlike general contracts where the duty runs both directions;<sup>7</sup> and so on.

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<sup>2</sup> 7 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 900, at 34 (3d ed. Jaeger 1963). See *Estrin Constr. Co. v. Aetna Cas. & Sur. Co.*, 612 S.W.2d 413, 424 n.10 (Mo. Ct. App. 1981) (describing “equally valid” analysis that treats insurance policy as “in the nature of a special chattel rather than a contract”). Imagining insurance as a chattel leads to the argument that insurance policies contain an implied warranty of fitness for an intended purpose, but implied warranty analysis has not gained traction in the insurance cases.

<sup>3</sup> EDWIN M. PATTERSON, ESSENTIALS OF INSURANCE LAW 62 (2d ed. 1957).

<sup>4</sup> See *PolSELLI v. Nationwide Mut. Fire Ins. Co.*, 126 F.3d 524, 531 (3d Cir. 1997) (insurer’s duty of good faith toward insured is predicated on fiduciary relationship created when the contract is formed); *Rawlings v. Apodaca*, 726 P.2d 565, 571 (Ariz. 1986) (relationship between insurer and insured is not fiduciary relationship, but has some elements of a fiduciary relationship). Cf. *Lyerla v. AMCO Ins. Co.*, 536 F.3d 684, 694 (7th Cir. 2008) (applying Illinois law, no fiduciary relationship exists between insurers and insureds). For more discussion, see Douglas R. Richmond, *Trust Me: Insurers Are Not Fiduciaries to Their Insureds*, 88 KY. L.J. 1 (2000).

<sup>5</sup> See, e.g., *Victor v. Turner*, 496 N.Y.S.2d 761, 764 (N.Y. App. Div. 1985) (“[I]nsurance industry transactions with consumers are not governed by ordinary contract law.”); Jay M. Feinman, *Relational Contract Theory in Context*, 94 NW. U. L. REV. 737, 744 (2000) (“Insurance is a contractual relationship, but courts and legislatures have developed a body of insurance law that is distinct from the mainstream of contract.”); Dudi Schwartz, *Interpretation and Disclosure in Insurance Contracts*, 21 LOY. CONSUMER L. REV. 105, 113 (“[I]nsurance law’s rules, including interpretive rules, were designed to distinguish the insurance industry from other fields of contract law.”) (citation omitted).

<sup>6</sup> See, e.g., *Love v. Fire Ins. Exch.*, 271 Cal. Rptr. 246, 251-52 (Cal. Ct. App. 1990) (“[B]ecause of the ‘special relationship’ inherent in the unique nature of an insurance contract, the insurer’s obligations attendant to its duty of good faith are heightened.”); *Nugent v. Unum Life Ins. Co. of Am.*, 752 F. Supp. 2d 46, 56 (D.D.C. 2010) (insurance contracts have special characteristics that “warrant heightened liability” for breach of the duty of good faith) (citation omitted).

<sup>7</sup> See, e.g., *Johnson v. Farm Bureau Mut. Ins. Co.*, 533 N.W. 2d 203 (Iowa 1995) (Iowa does not recognize tort action for “reverse” bad faith by insurer

The common theme running through the foregoing expressions emerges from the unique characteristics of insurance itself. All contracts involve transfers of risk in some way, typically at the margin of some other sale or exchange, but what distinguishes insurance contracts is the fact that they exist for the *purpose* of transferring risk. Courts have sought to capture this idea, usually when deciding the boundaries of state regulatory authority over transactions that have the look and feel of insurance but may be something else, in the principle that to constitute an insurance contract, the transfer and distribution of risk must be the “principal object and purpose” of the contract,<sup>8</sup> the very essence of the exchange that gives the contract its “distinctive character.”<sup>9</sup> Because the party casting off risk through an insurance contract has such an extreme amount of reliance on the presumed enforceability of the contract and puts so much financial and emotional well-being at stake in the transaction, all in circumstances where the insurer knows from the beginning of the magnitude and importance of this investment (indeed, the insurer markets the product through assurances of security to the insureds), the protections afforded by law to this party must be safeguarded with utmost rigor. Through the years, these ideas have presented themselves in insurance law through pro-insured results and outcomes that would ordinarily not be predicted if the laws of contract, tort, agency, equity, or remedies were applied in their expected ways.

Working in ground well plowed by others for decades, Professor Abraham finds a new and creative way to describe insurance law’s “specialness.” He invites us to visualize placing insurance law on a continuum: insurance law puts obligations on insurers that are more rigorous than what are placed on ordinary contracting parties, but less rigorous than the principles under which we test the actions of governments and state actors. The lens that Professor Abraham uses to capture this insight is systemic or institutional bad faith.

The law of bad faith is the thread in insurance law where insurers can be held liable in tort for bad faith performance of the contractual duties they owe insureds; “[t]he tort duty contemplates that insurers must deal fairly with insureds and conduct their affairs in good faith.”<sup>10</sup> As Professor

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against insured who brings frivolous bad faith claim against insurer); Douglas R. Richmond, *The Two-Way Street of Insurance Good Faith: Under Construction, But Not Yet Open*, 28 LOY. U. CHI. L.J. 95 (1996).

<sup>8</sup> See *Jordan v. Group Health Ass’n*, 107 F.2d 239 (D.C. Cir. 1939).

<sup>9</sup> See *GAF Corp. v. Cnty. School Bd.*, 629 F.2d 981 (4th Cir. 1980).

<sup>10</sup> ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 156 (5th ed. 2012).

Abraham explains, systemic, institutional bad faith is the most recent evolution in this thread. The cases in which the law of bad faith was routinely applied after the doctrine's emergence and development in the 1970s and 1980s typically involved an individual insured's claim that the insurer in the specific claims processing sequence in which the insured and insurer were involved committed breaches in claims handling that caused damage to the insured, and this damage can be remedied adequately only under the remedial regime of tort law.

In contrast, the institutional or systemic bad faith claim involves a situation where an insured takes a dispute over a single loss and challenges the insurer's practices and procedures as those occurred in claims processing for all similarly situated claimants, essentially arguing that the insurer's practices were designed to reduce, or perhaps even eliminate, fair payments to all claimants.<sup>11</sup> Thus, the notion is that institutional bad faith is a new kind of bad faith claim that has emerged in the past couple of decades, and policing these questioned systemic practices under the law of bad faith represents an expansion of the territory in which bad faith law operates.<sup>12</sup>

Although the bad faith cases of recent years in which plaintiffs allege systemic or institutional insurer bad faith conduct are departures from the circumstances in which bad faith was alleged in the past, this does not mean that claims against insurers for institutional, systemic misconduct are new. Professor Abraham refers to these alleged systemic practices as ones that are "rotten to the core";<sup>13</sup> I would suggest that allegations of

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<sup>11</sup> See Douglas R. Richmond, *Defining and Confining Institutional Bad Faith in Insurance*, 46 TORT TRIAL & INS. PRAC. L.J. 1, 1 (2010) ("Essentially, the theory of institutional bad faith allows a plaintiff to expand a dispute over a single loss into a widespread attack on an insurance company's practices and procedures"; citing MICHAEL R. NELSON ET AL., EXTRA-CONTRACTUAL LITIGATION AGAINST INSURERS § 2.11, at 2-59 (2009)); James A. Varner, Tiffany R. Drust & Debra T. Herron, *Institutional Bad Faith: The Darth Vader of Extra-Contractual Litigation*, 57 FED'N DEF. & CORP. COUNS. Q. 163, 163 (2007) ("Institutional bad faith is the 'Ebola' virus of extra contractual litigation . . . . [I]t can . . . grow explosively and wreck not only litigation management budgets, but can also seriously deplete corporate equity and shareholder value.").

<sup>12</sup> Richmond observes that "[t]here is a surprising lack of case law on institutional bad faith given the frequency with which such allegations are made. This disparity is probably attributable to the fact that carriers settle many institutional bad faith cases to avoid discovery costs and potentially severe damage exposure." Richmond, *supra* note 11, at 4 n.8.

<sup>13</sup> See Abraham, *supra* note 1, at 12.

systemic, “rotten to the core” insurer practices have been made for decades, with the major and important difference between those older allegations and the more modern ones is that the earlier claims did not have a law of bad faith in which the allegations could be packaged and presented. If these practices existed today and were being challenged today, they would be packaged in the same wrapping in which the modern systemic, institutional bad faith claims are alleged.

If the amount of litigation and commentary in the literature in the early twentieth century are reliable guides, one of the prominent early examples of systemic, institutional bad faith conduct by insurers involved insurers’ delay in action on applications. Like today, insurers took the first premium payment with the application, but did not issue the policy until a period of time passed during which the insurer evaluated whether to accept the risk. During this period the insurer would have use of the insured’s money, but, in the absence of a binder providing temporary coverage, the applicant had no protection. Even with a temporary written binding receipt, the coverage was often so conditional that the applicant who suffered a loss during the period the binder was in force received no compensation. Many binders by their terms purported to eliminate coverage if the application would be unacceptable to the insurer’s underwriting department. The frequency of *ex poste* determinations of ineligibility was itself a matter of concern for insureds, and the longer the insurer could delay acting on applications, the less exposure the insurer would have on the risk. Yet if no loss occurred during the period between application and policy issuance, the policy’s coverage upon issuance would be backdated to the time of the application, so the insurer engaged in this practice essentially received a payment for nothing. Delaying action on the application lengthened the period during which this imbalance existed. Like a number of other insurer practices that caught the attention of the public, legislators, regulators, and the Armstrong Commission, this practice was one of those that was “rotten to the core,” and it was one that, apparently, was institutional and systemic.

Courts confronting this practice in the early twentieth century had considerable trouble regulating insurers’ delay in acting on applications because the legal doctrines of that time were inapplicable.<sup>14</sup> Unless a temporary binder was issued, there was no contract between applicant and insurer to which contract law principles could be applied; furthermore,

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<sup>14</sup> For examples of cases declining to hold the insurer liable for delay in acting on an application, see *Savage v. Prudential Life Ins. Co. of Am.*, 121 So. 487, 489 (Miss. 1929) (fact that insurer is granted franchise to do business in the state does not impose upon them a duty to consider promptly all who apply).

there was no basis for finding that the insurer had taken action that would create a contractual obligation. The applicant made the offer to form the contract with the application; if the application was not accepted, no contract was formed. Courts correctly described the insurer's inaction on the application as "silence," but under the rules of contract law, silence did not constitute acceptance absent special circumstances,<sup>15</sup> none of which existed in the typical fact pattern. Construing the insurer's retention of the premium as a promise to be bound was not a plausible interpretation of the usual circumstances. Estoppel, as it was understood both then and now under the label "equitable estoppel," did not fit because there was no false or misleading statement inducing reliance.<sup>16</sup> Promissory estoppel as a basis for recognizing the existence of a contract was a doctrine in its infancy; yet the insurer made no promise that might induce detrimental reliance, which was essential from the beginning of the doctrine's history to finding an enforceable promise in the absence of offer, acceptance, and a consideration that was the object of a bargained-for exchange.<sup>17</sup>

As we now know, many courts attempted to regulate the insurer misbehavior, and these courts, looking for ways to extend the established doctrines of that era, approved the principle of imposed responsibility grounded in the recognition of a duty to act.<sup>18</sup> The circularity of this

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<sup>15</sup> See RESTATEMENT (SECOND) OF CONTRACTS § 69 cmt. a (1981) ("Acceptance by silence is exceptional. Ordinarily offeror does not have power to cause the silence of the offeree to operate as acceptance. . . . The exceptional cases where silence can be acceptance . . . [are] those where the offeree silently takes offered benefits, and those where one party relies on the other party's manifestation of intention that silence may operate as acceptance.").

<sup>16</sup> The elements of equitable estoppel are generally described as: (1) belief and reliance on a representation; (2) a change of position because of the representation; (3) detriment or prejudice caused by the change of position. See, e.g., *Cothorn v. Vickers, Inc.*, 759 So.2d 1241, 1249 (Miss. 2000) (discussing elements in context of former supervisor's action against employer); *Lybbert v. Grant Cnty.*, 1 P.3d 1124, 1128 (Wash. 2000) (discussing elements of equitable estoppel in context of county's effort to assert insufficient service of process as affirmative defense).

<sup>17</sup> See RESTATEMENT (SECOND) OF CONTRACTS § 90 (1981) (elements of promissory estoppel are a promise and substantial reliance that is actual and reasonably foreseeable, in circumstances where enforcing the promise is necessary in the interests of justice).

<sup>18</sup> See, e.g., *Boyer v. State Farmers' Mut. Hail Ins. Co.*, 121 P. 329, 331 (Kan. 1912) (hail insurance policy that issued policy day after crop was destroyed by hailstorm is liable in damages due to unreasonable delay by its soliciting agent in forwarding the application); *Wilken v. Capital Fire Ins. Co. of Lincoln*, 157 N.W. 1021, 1022-23 (Neb. 1916) (bank's delay in returning application was act of agent

reasoning begs the question of exactly where this duty came from. Some courts found it in the idea that a company doing business under a franchise assumes a duty toward the public,<sup>19</sup> but why this would be so is not obvious. Presumably the intended logic underlying this conclusion is that the protection afforded the franchise through its enforcement by the state created a reciprocal obligation – essentially, a *quid pro quo* – on the part of the franchise holder to serve the state, i.e., the public, with prompt action on the public’s requests, applications, etc. Failure to do so breached the duty, and damages caused by the breach could be remedied in tort.

This reasoning sounded plausible and authoritative, and, expressed as a rationale for a decision, seemed to have its anchor in other more familiar legal principles with which we are comfortable. But as frequently illustrated during the centuries in which the common law has evolved, new reasoning when applied to other similar situations can cause extreme havoc. For example, if the existence of the insurance franchise is what establishes the duty, the duty to act must presumably exist in the business activities of other kinds of corporations and business organizations operating under franchises. An obvious example is a bank; thus, does it follow that a bank which receives an application for a loan and delays acting upon it breaches the duty to act and thereby commits a tort?<sup>20</sup>

Of course, if we sense that this goes too far and that a bank should not be liable for delay in acting on an application for a loan, we are challenged to explain why a franchise to engage in the insurance business imposes a more robust duty to act without delay. Taking up the challenge, we would argue that “ordinary business” is not the same as the insurance business. Banks and other lenders acting on applications for loans are engaged in “ordinary business,” like those who sell products, services, licenses, information, and so forth. These products, services, etc. are not the

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of insurer, and insurer is responsible for damage caused by delay in acting on application); *Behnke v. Standard Acc. Ins. Co.*, 41 F.2d 696, 699 (7th Cir. 1930) (under Wisconsin law, insurance company may be liable for delay in passing upon application).

<sup>19</sup> See *Duffy v. Bankers’ Life Ass’n*, 139 N.W. 1087, 1090 (Iowa 1913) (insurance company “holds and is acting under a franchise from the state”).

<sup>20</sup> See, e.g., *Mfrs. Hanover Trust Co. v. Yanakas*, 7 F.3d 310, 315 (2d Cir. 1993) (affirming district court’s finding that “the Bank had no fiduciary duty to accept or respond promptly”); *Armstrong Bus. Servs., Inc. v. AmSouth Bank*, 817 So. 2d 665, 681 (Ala. 2001) (“There is . . . no tort liability for nonfeasance for failing to do what one has promised to do in the absence of a duty to act apart from the promise made.” (quoting *Morgan v. S. Cent. Bell Tel. Co.*, 466 So. 2d 107, 114 (Ala. 1985))).

same as insurance -- which is special, distinctive, and different. Because insurance is special, the duties that attach to the corporation or business organization engaging in the insurance business are greater. If the principle we use to justify finding a duty to act would also make those engaged in “ordinary business” liable, then we must be applying the wrong principle to the problem arising in the “ordinary business.” Insurance is special; it is distinctive; it is different. The insurance business is imbued with the public interest in a way that “ordinary business,” such as the business of banks making loans) is not.

Interestingly, the framework just described is exactly where the law is landing in the early twenty-first century. On the issue of whether lenders ought to have liability in tort for negligent delay in processing an application for a loan, it is easy to see that an applicant for a loan could be harmed with the loss of favorable financing terms due to the passage of time during which the lender delays. Yet the consensus, at least thus far, from cases that date back to shortly after the explosion in insurance bad faith litigation, is that recognizing tort liability for lenders in the financial industries is problematic, and, except for rare exceptions that have not garnered a strong following,<sup>21</sup> courts have not embraced the idea.<sup>22</sup> It appears that the insurance business is special, but the lending business is not, and the more rigorous analysis applied to insurance industry practices by insurance law is not something that is or will be applied in similar fashion in the lending industry.

Thus, perhaps the decisive reason for recognizing an insurer’s tort duty to act promptly on an application for insurance is not the existence of the franchise but is instead the existence of a relationship imbued with the public interest. To what other analogous situations might this principle apply? Consider markets for employment: it is certainly in the public interest that those who are able to work have jobs that enable them to earn salaries or wages sufficient to support themselves and their dependents. But are we willing to use public interest analysis to create a rule that employers, many of whom obviously do not operate under franchises, are obligated to act promptly on applications for employment? The answer is, apparently, no. So here, as with lending, we conclude that employment, notwithstanding its obvious importance, is “ordinary business” -- or it is

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<sup>21</sup> See *Jacques v. First Nat. Bank of Md.*, 515 A.2d 756, 762 (1986) (bank that agrees to process application for loan owes customer duty of reasonable care in processing and determination of the application).

<sup>22</sup> See Nan S. Ellis & John A. Gray, *Lender Liability for Negligently Processing Loan Applications*, 92 DICK. L. REV. 363, 366-68 (1988).

not “business” at all under some kind of conclusory rule that “employment is labor, and business is business.” As we keep delay in acting upon applications for employment out of the realm where courts will provide a remedy, we embrace the idea that insurance is somehow special, distinctive, different, and in need of a different legal framework than what applies to other “ordinary” business practices in other markets, notwithstanding the obvious importance of the transactions that occur in those other markets.

The foregoing, of course, is exactly Professor Abraham’s point. Upon a close look, the decades-old recognition of the insurer’s tort duty to act promptly on applications comes from the legal system’s negative reaction to institutional, systemic, rotten-to-the-core bad faith practices that compromise the value of seeking and securing insurance protection. In other words, insurers have a responsibility to act promptly on applications; this obligation is embedded in the nature of the insurance business, where security from the risks of loss is the subject of the bargain; damage is foreseeable in the absence of the insurer’s reasonably diligent action on the application; negligent retention of the application without prompt action sounds like a tort; and courts are comfortable finding a tort-based duty to act promptly on an insurance application, with damages flowing from the breach of this duty. If the delay in acting on the application cases had arisen in the late twentieth and early twentieth-first century, they surely would have been pleaded as bad faith cases, consistently with the other examples referenced by Professor Abraham and other commentators. Reduced to its essence, the practice of insurer delay in responding to applications appears to have been a systemic, institutional practice sharing the “rotten to the core” characteristics of the practices that have produced the bad faith claims processing litigation of recent years. The law’s response to the older practices reveals the specialness and distinctiveness of insurance as profoundly as the modern responses continue to demonstrate.

In addition to the duty to act on applications, there are other examples in the past of what we would today label institutional, systemic bad faith. Of the four modern examples of institutional, systemic bad faith discussed by Professor Abraham, the one involving contingent commissions does not involve bad faith claims processing. How much is wrong with contingent commission arrangements and the manner in which such secret commission deals should be regulated are unresolved questions today; the regulatory options range from disclosure of the arrangements on

the one hand to outright prohibition on the other.<sup>23</sup> This controversy is reminiscent of a past widespread industry practice – premium and commission rebating -- where the question was whether to regulate and, if so, how. Early in the twentieth century, the question of whether premium and commission rebating was valid was settled in the legislative arenas with the answer “no.”<sup>24</sup> This history is revealing on the subject of insurance law’s specialness, distinctiveness, and difference.

The anti-rebate statutes have their roots in the rapid expansion of the life insurance industry in the late nineteenth century, and it is fair to characterize that period of expansion as endemic with high pressure sales tactics, deceptive trade practices, and very high agent commissions.<sup>25</sup> In this wild-west market, agents created a variety of ways to refund portions of their commissions to customers, and rebating gradually became perceived as an evil that led to inequality and discrimination among applicants, with the privileged getting good deals unavailable to the general public. Rebating came to be considered a threat to the integrity of the insurance business, and insurance regulators acting in the public interest sought to prohibit it. That rebating of commissions in the insurance setting is an untoward business practice remains the prevailing view today.

Yet, interestingly enough, rebates of commissions, payments, or other consideration through renegotiated business arrangements are met with less hostility when they occur outside the insurance business. In real estate transactions, for example, it is common for a person represented by a broker during negotiations with a prospective buyer over price to simultaneously renegotiate the commission to be paid her agent in the transaction. Similarly, cash-back rebates when a consumer buys a product and meets certain eligibility conditions are not seriously questioned as unfair price discrimination, and cash-back rebates for making purchases with a credit card are virtually the norm. By analogy to these practices, one can legitimately wonder what would be wrong with negotiating an

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<sup>23</sup> See generally, Hazel Beh & Amanda M. Willis, *Insurance Intermediaries*, 15 CONN. INS. L.J. 571, 591-94 (2009); Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, 25 YALE L. & POL’Y REV. 289, 321-23 (2007).

<sup>24</sup> For discussion of the history of this practice, see Robert H. Jerry, II & Reginald Robinson, *Statutory Prohibitions on the Negotiation of Insurance Agent Commissions: Substantive Due Process Review Under State Constitutions*, 51 OHIO ST. L.J. 773, 776-80 (1990).

<sup>25</sup> See Constitutionality of Ins. Anti-Rebate Law, 1996 Alaska Op. Att’y Gen. (Apr. 22).

individualized commission with an insurance agent based on the value of the agent’s services and the prospective insured’s interest in using them.

Yet as a matter of statutory law, the insurance agent is required to decline summarily any such request for a refund of a portion of the commission on the grounds that doing so would be illegal.<sup>26</sup> Whether this regulatory framework is wise is a question for another day (and if contingent commissions are declared illegal, the wisdom of that prohibition will also continue to be debated). The fact remains, however, that a practice tolerated in other contexts is prohibited in insurance, reminding us that insurance is special, distinctive, and different. What we tolerate in other business settings with regard to commission splitting, rebating, etc. is not tolerated in insurance under the reasoning that this would create impermissible inequities among classes of purchasers and might even threaten the solvency of insurers if premium rebates became too common. This has the effect of treating insurance as a quasi-public good; just as similarly situated consumers should pay the same rates for water, electricity, or fire protection, similarly situated consumers should not be able to strike back-room deals that change the price paid for the same product, and insurers should not be able to engage in systemic, institutional practices that advantage a privileged few at the expense of the many. This, again, is precisely the point made by Professor Abraham:

[T]he bad faith behavior in each instance is something that we probably would tolerate, and have the law tolerate, if it were a different sort of business enterprise that engaged in this behavior. . . . *If an auto parts retailer had a secret deal with some manufacturers that it would be paid an*

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<sup>26</sup> See *Chicago Title Ins. Co. v. Butler*, 770 So. 2d 1210, 1221 (Fla. 2000) (declaring anti-rebate statutes unconstitutional “to the extent they prohibit title insurance agents from rebating a portion of their risk premium”); *Dep’t of Ins. v. Dade Cnty. Consumer Advocate’s Office*, 492 So. 2d 1032, 1033 (Fla. 1986) (holding the Florida statute unconstitutional “to the extent they prohibit rebates of insurance agents’ commissions”). The California rebate law was repealed by Proposition 103 in 1988. See, *The McCarran-Ferguson Act Before the Antitrust Modernization Comm’n* (Oct. 18, 2006) (statement of Jay Angoff, Of Counsel, Roger Brown & Associates), available at [http://govinfo.library.unt.edu/amc/commission\\_hearings/pdf/Statement\\_Angoff.pdf](http://govinfo.library.unt.edu/amc/commission_hearings/pdf/Statement_Angoff.pdf) (last visited July 22, 2012). Despite the invalidity of the statutes in those two states, there are no readily available indications that consumers are seeking to negotiate rebates or commission returns with agents, brokers, or insurers.

*annual rebate that increased if products liability suits against the manufacturer decreased, we would consider this no business of those who purchased the auto parts in question, even if this affected which customers were influenced to buy which kinds of parts.* These would be examples of harsh, slightly unsavory dealing, but that's about it.<sup>27</sup>

This point is correct not only with respect to the examples discussed by Professor Abraham but also with respect, in the insurance setting, to the act of rebating itself.

Another example of institutional, systemic bad faith from the past is found in claims processing regulations created in the early twentieth century. Insurers' use of the defense of misrepresentation has a long and interesting history, but the portion of the narrative relevant here involves the late nineteenth and early twentieth century practice where life insurers frequently alleged misrepresentation by the applicant when a claim for proceeds was filed many years after the policy had been issued. In these circumstances, the beneficiaries had great difficulty refuting, and would perhaps be unable to refute, the insurer's assertion of the defense. Aware of the mismatch between beneficiaries and the insurer in this setting, many insurers took advantage and pressed the disparity to their financial advantage, or at least so the common wisdom ran. This systemic, institutional, "rotten-to-the-core" practice led to the widespread enactment of incontestability statutes early in the twentieth century. If a similar kind of regulation exists in another contracting context, it is obscure. Once again, this systemic, institutional insurer practice, and the regulatory response to it, illustrates that insurance has a special, distinctive status among the relationships, products, and services that consumers purchase and acquire. Not surprisingly, the law governing insurance recognizes this specialness and assumes the characteristics and dimensions of a body of law operating in its own field with its own principles and rules.

I like the statement "[l]ife is uncertain"<sup>28</sup> because it expresses in three words the basic truth upon which all of the business and law of insurance, not to mention most human behavior, is based. I also like Professor Leonard Moldinow's observation that "our clear visions of

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<sup>27</sup> See Abraham, *supra* note 1, at 13.

<sup>28</sup> Robert H. Jerry, II, UNDERSTANDING INSURANCE LAW 9 (1st ed. 1987).

inevitability are often only illusions.”<sup>29</sup> Blending these two insights yields a third: In life and in law, one can always look back and say “there are many different ways this could have unfolded.” Just as the core insight that insurance law is special, distinct, and different can be articulated in different ways,<sup>30</sup> the path through which this core insight is manifested in the law could have evolved differently than it did, and there are multiple paths that its future evolution might take. Looking backwards, we might observe that the core insight has been in the middle of some jurisprudential currents that flowed parallel to those of insurance law during most of the twentieth century. A notable example is the analysis of Friedrich Kessler presented in his 1943 article in the *Columbia Law Review* on standardized forms,<sup>31</sup> arguably the most prominent of the early explorations of the challenges standardization poses to the principles of contract law. Kessler used insurance policies as his principal example, discussed the problem of insurers’ delay in acting on applications, and presented what was probably the first articulation of the doctrine of reasonable expectations.<sup>32</sup> Early in the article, Kessler explained how courts had succeeded in reaching just decisions in construing ambiguous claims against the policies’ drafters – even in cases where there was no ambiguity. He then observed that these techniques, however, were unable to address a problem arising in contract formation – delay in acting on an application. He observed that courts

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<sup>29</sup> LEONARD MLODINOW, *THE DRUNKARD’S WALK: HOW RANDOMNESS RULES OUR LIVES* 218 (2008).

<sup>30</sup> *See supra* pp. 1-2.

<sup>31</sup> Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 *COLUM. L. REV.* 629 (1943).

<sup>32</sup> Kessler plainly recognized “reasonable expectations” permeates “our whole law of contracts,” and embraced the notion that contract terms should be rewritten to fulfill reasonable expectations. *Id.* at 629, 637. However, credit for recognizing the doctrine of reasonable expectations is given to Professor Robert Keeton, who while a professor at Harvard Law School wrote a seminal article titled *Insurance Law Rights at Variance With Policy Provisions*. Robert Keeton, *Insurance Law Rights at Variance With Policy Provisions*, 83 *HARV. L. REV.* 961, 967 (1970). Professor Keeton’s thesis was that many courts had applied familiar rules to the end of not enforcing clear contract language based on one of the parties’ “reasonable expectations” of coverage. *Id.* This two-part article is a remarkable work that brought together a large number of related principles, all of which serve to demonstrate why insurance and the law governing it are special. Kessler, however, put squarely on the table the notion that with standardized contracts, “[i]t can hardly be objected that the resulting task of *rewriting, if necessary*, the contents of a contract of adhesion is foreign to the function of common law courts.” Kessler, *supra* note 31, at 637 (emphasis added).

seeking to solve this problem had invoked a tort law duty to act promptly on an application as the solution.

Kessler's broader point was essentially to advocate, like some other scholars of that era, that contract law be divided into dual frameworks: one for negotiated contracts between parties with roughly equal information and bargaining power, and one for contracts created through the use of standardized forms. He wrote:

[Here is the] basic issue with which the courts in the insurance cases are confronted. It is: *can the unity of the law of contracts be maintained* in the face of the increasing use of contracts of adhesion? The few courts which allow recovery in contract and the many which allow recovery in tort feel more or less clearly that insurance contracts are contracts of adhesion, and try to protect the weaker contracting party against the harshness of the common law and against what they think are abuses of freedom of contract. The courts denying recovery, on the other hand, cling to the belief that an application for insurance is not different from any other offer, and they are convinced that efforts to build up by trial and error *a dual system of contract law* must inevitably undermine the security function of all law, particularly since courts are ill equipped to decide whether and to what extent an insurance contract has compulsory features.<sup>33</sup>

Kessler favored a dual system where standardized contracts received heightened regulation. Importantly, a major reason he came to that conclusion was because he understood that insurance involved a different kind of contract, where the subject of exchange was more important than the ordinary commodities exchanged in other contracts. To preserve and promote this value, he proposed that the law of torts be used to “nullify those parts of the law of contracts *which in the public interest* are regarded as inapplicable.”<sup>34</sup>

Professor Abraham's continuum, where insurance law rests in the middle between ordinary contract law on the one hand and government regulation on the other, is entirely consistent with Professor Kessler's observation that contract law's unity was not sustainable, and that

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<sup>33</sup> Kessler, *supra* note 31, at 636 (emphasis added).

<sup>34</sup> *Id.*

standardized contracts (e.g., insurance contracts) needed a different system of governance than ordinary contracts freely negotiated between parties of roughly equivalent bargaining power. Kessler’s embrace of tort principles to deal with the problem of an insurer’s delay in acting on applications was essentially the equivalent of putting the tort-driven new principles of the “new contract law” in the center of the continuum.

Later in the twentieth century, Professor Robert Keeton addressed the question of the insurers’ delay in acting on an application in his 1971 *Basic Text on Insurance*.<sup>35</sup> He began with an overview of the limitations of existing estoppel, contract, and tort doctrines to address the harm caused by insurers’ delay.<sup>36</sup> Having catalogued various reasons these doctrines were inadequate to address the issue, he advanced arguments for “a somewhat broader liability than that imposed in tort.”<sup>37</sup> His initial argument was essentially an economic efficiency rationale without the dressing of the vocabulary of law and economics; he essentially suggested that insurers could spread the risk of delay’s harm across premium-paying insured more efficiently.<sup>38</sup> His second argument came back to the fundamental premise that insurance law is different, distinctive, and special. Invoking and citing Kessler, he observed that insurance transactions almost always involve “the standardized mass contract” and “courts should develop a different set of doctrines for such cases, rather than allowing technical doctrines of contract law to defeat liability when public interest would be served by imposing it.”<sup>39</sup> Moreover, just as “railroad companies have been required to furnish transportation to all qualified passengers and shippers, . . . an insurance company might similarly be regarded as a public service company, under a legal duty to insure upon reasonable terms all properly qualified applicants.”<sup>40</sup> Keeton wrote that the case law as of 1971 had not yet reached the ‘insurance as public service company’ principle, but he believed a ‘different kind of contract law’ was already being applied, even if courts “seldom expressed [it] in this way.”<sup>41</sup>

Bad faith has now reached middle age. With the helpful insights of Professor Abraham, we can now see in bad faith’s evolution additional evidence that insurance law is special, distinctive, and different, and we

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<sup>35</sup> ROBERT E. KEETON, *BASIC TEXT ON INSURANCE LAW* (1971).

<sup>36</sup> *Id.* at 45-48.

<sup>37</sup> *Id.* at 48.

<sup>38</sup> *Id.* at 48-49.

<sup>39</sup> *Id.* at 49.

<sup>40</sup> *Id.*

<sup>41</sup> *Id.* at 50.

have another way to express it. As a result, “our understanding of what insurance law is, and what insurance does” is, in fact, now deeper.<sup>42</sup>

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<sup>42</sup> See Abraham, *supra* note 1, at 13.