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Reevaluating Standardized Insurance Policies

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Abstract: This Article empirically debunks the common claim that homeowners insurance policies do not vary across different insurance carriers. It demonstrates that carriers’ homeowners policies differ radically with respect to numerous important coverage provisions. It also reports that a substantial majority of these deviations produce decreases in the amount of coverage relative to the presumptive industry standard, though some deviations increase coverage. Additionally, the Article describes the surprising absence of any mechanisms by which even informed and vigilant consumers could comparison shop among carriers on the basis of differences in coverage. It closes by reviewing various regulatory and judicial options for responding to this lack of transparency in homeowners insurance markets. It also considers the broader theoretical implications of the findings for regulatory theory and the efficiency of standardized form contracts.
Introduction

Insurance policies are prototypical contracts of adhesion: they are standard forms offered to ordinary consumers by sophisticated firms on a take-it-or-leave-it basis.¹ But consumer insurance policies in property/casualty insurance markets (or “personal lines”) are often described as “super contracts of adhesion.”² This label refers to the claim that these insurance policies are collectively drafted by insurers via an industry organization known as the Insurance Services Organization (ISO), resulting in standardization of policy language across different insurers.³ In

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¹ See Friedrich Kessler, Contracts of Adhesion—Some Thoughts About Freedom of Contract, 43 COLUM. L. REV. 629, 629 (1943); Todd D. Rakoff, Contracts of Adhesion: An Essay in Reconstruction, 96 HARV. L. REV. 1173, 1226 (1983); W. David Slawson, Standard Form Contracts and Democratic Control of Lawmaking Power, 84 HARV. L. REV. 529, 546 (1971). One might plausibly contest the true “take it or leave it” nature of insurance policies given the wealth of potential endorsements that are available to policyholders.

² See, e.g., JEFFREY W. STEMPEL, LAW ON INSURANCE CONTRACT DISPUTES, § 4.06[b], at 4-37 (2d ed., 1999) (“In a sense, the typical insurance contract is one of ‘super-adhesion’ in that the contract is completely standardized and not even reviewed prior to contract formation.”).

a world of super contracts of adhesion, comparison-shopping on the basis of policy language makes no sense.

Legal commentary, regulatory practice, and consumer behavior have all been shaped to varying degrees by this conventional wisdom that personal lines insurance policies are uniform. Various law review articles, casebooks and treatises offer explanations for policy standardization, ranging from historical practice, economies of scale, network effects, coordination, and insurers’ partial immunity from antitrust laws. They also build normative arguments about the ideal content of insurance law on the basis of presumed industry-wide uniformity of policy forms. Insurance regulation is similarly influenced by this conventional wisdom, as state regulators have historically done nothing to inform consumers about potential differences in coverage among different insurers. Finally, outside of a narrow market for high-value homes, consumer shopping is driven by the assumption that policy forms do not matter: ordinary consumers shop among competing insurers based almost exclusively on price, service, and general reputation.

industry uses are prepared by the Insurance Services Office (“). The ISO does have one moderately-sized competitor – the American Association of Insurance Services (AAIS) – that often gets ignored in the literature. See http://www.aaisonline.com/company/who.html

4 See Susan Randall, Freedom of Contract in Insurance, 14 CONN. INS. L.J. 1 (2007) (“[I]n some lines of insurance, all insurance companies provide identical coverage on the same take-it-or-leave-it basis”); Kenneth S. Abraham, A Theory of Insurance Policy Interpretation, 95 Mich. L. Rev. 531, 534 (1996); Kenneth S. Abraham, Insurance Law and Regulation: Cases and Materials 31 (5th ed. 2010) (“[T]he same standard-form policies often are used by many insurance companies. Thus, standardization in insurance not only involves a take-it-or-leave-it offer of the same policy by one company to all its customers, but (in the extreme case) a take-it-or-leave-it offer of the same policy, to all customers, by all companies.”); Stempel, supra note 2, § 4.06[b], at 4-37; Jonathan Macey & Geoffrey Miller, The McCarran Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation, 68 NYU L. Rev. 13 (1993) (“Similarly, accurate information cannot be developed-and consumers cannot easily comparison shop on the basis of price-unless firms in the industry have access to standardized forms.”); Jeffrey Fischer, Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text versus Context, 24 ARIZ. ST L J 995 (1992) (“The only part of the standard contract that is generally customized to the consumer is the declarations sheet… there is little if any freedom to negotiate the standardized language of the insurance contract that determines the scope of coverage.”); Kent D. Syverud, The Duty To Settle, 76 VA. L. Rev. 1113, 1116 (1990) (“But automobile and property owner’s liability insurance contracts are standardized across insurers in a form few insureds have the power or experience to bargain around”); Robert H. Jerry II, The Antitrust Implications of Collaborative Standard Setting by Insurers Regarding the Use of Genetic Information in Life Insurance Underwriting, 9 CONN. INS. L.J. 397, 400 (2003) (“Insurers have long cooperated in drafting standardized policy forms, sharing data regarding the identification and quantification of risks, and collecting and disseminating loss and expense data.”); Michelle Boardman, Insuring Understanding: The Tested Language Defense, 95 IOWA L. REV. 1027 (2010) (describing the “hyperstandardization” of insurance policies). In previous work, I too have echoed this conventional understanding. See, e.g., Daniel Schwarcz, A Products Liability Theory for the Judicial Regulation of Insurance, 48 WM & MARY L. Rev. 1389 (2007).


6 See Part III. A, infra.

7 See Part III. B, infra.
This Article demonstrates that this conventional wisdom is no longer accurate with respect to a core area of personal lines coverage, homeowners insurance. Some of the most prominent national insurers employ policy language that is systematically less generous than that provided in the standard ISO policy. These downward deviations are not limited to policy terms that are designed to avoid judicial determinations of ambiguity, but also include unambiguous and purposeful reductions in coverage. Moreover, while some coverage reductions certainly involve risks that have become prominent in recent years, such as mold, pollution and lead, others involve substantial reductions in traditional coverages. These span the gamut of issues addressed in prominent insurance law casebooks and treatises, including subrogation rights, concurrent causation, intrinsic loss, increase of hazard clauses and numerous other issues. At the same time, several insurers (though fewer) have policy forms that are more generous than the ISO form in important ways. These more generous forms do not simply involve “bells and whistles,” but key coverage provisions, such as liability protection for emotional distress claims and coverage for mold/fungus remediation.

Although these empirical results disrupt conventional wisdom among academics, lawyers, regulators, and even insurance agents, they would perhaps have uncertain normative implications were it not for the present state of insurance policy transparency. Despite massive marketing campaigns by insurers emphasizing the importance of coverage in addition to premiums, it is currently virtually impossible for ordinary consumers to compare the scope of coverage that different carriers provide. Insurers do not make their policy language available to consumers until after they purchase coverage. Apart from several high-end carriers, insurers’ marketing materials do not describe policy coverage with sufficient specificity to allow for an assessment of their comparative breadth. And preliminary evidence suggests that many insurance agents are both unaware of potential differences in coverage among carriers and unfamiliar with many details of the coverage they sell.

Even more disturbing, state insurance regulators currently do essentially nothing to fill this informational void, providing consumers with virtually no information regarding the comparative breadth of different insurers’ policies. In fact, in many cases, state insurance regulators do not even have on file partial copies of the policies that different homeowners

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8 See Part II, infra.
9 Existing scholarship has generally assumed that changes to policy terms are implemented on an industry wide basis to “fix” terms that courts have found ambiguous. See, e.g., Michelle E. Boardman, Contra Proferentem: The Allure of Ambiguous Boilerplate, 104 MICH. L. REV. 1105, 1113-14, 1117 (2006).
10 See Part III, infra.
11 See Part III, infra.
insurers are using. In many other cases, states have partial copies of insurers’ forms, but have no idea which forms are being used or which endorsements among hundreds of filed forms the insurer requires to be included with basic homeowners forms. And with the exception of only a small handful of states that make insurers’ filings available online, the limited information about different insurers’ policy forms that regulators do possess is virtually impossible for an ordinary consumer to access. Even with respect to the states that make form filings available online, only a seasoned expert with a substantial amount of time and patience can wade through this material to locate partial copies of the forms that some companies use.

Collectively, these findings demonstrate that state insurance regulators have failed to evolve along with the marketplaces they are regulating. While insurers have experimented significantly with their own distinctive policy language – usually secretly and in ways that limit coverage – insurance regulation has remained structured in a way that can only be defended on the assumption that insurance policies remain completely uniform. This Article calls on insurance regulators to rectify this situation by implementing a robust and comprehensive regime to facilitate insurance policy transparency.

Fortunately, preliminary versions of this Article, along with the focused efforts of several consumer representatives, have already convinced the National Association of Insurance Commissioners (NAIC) – the national organization of state insurance regulators – to form an “Insurance Policy Transparency Working Group” to study this issue and propose solutions. In order to correct the problems described herein, that Working Group must propose broad-ranging and comprehensive reform designed to promote transparency. Such reform should go beyond historic mechanisms for promoting transparency in insurance, such as quantitative readability scores, and rely on modern regulatory theory – such as the power of sticky default rules – to improve consumer decision-making. To the extent that true transparency proves impossible, states should impose mandatory floors

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12 The findings detailed in this paper were initially presented to insurance regulators at the August, 2010 meeting of the NAIC. See Daniel Schwarz, Presentation on Deficient Consumer Protection in Form Regulation, National Association of Insurance Commissioners, Consumer Liaison Meeting, Seattle, WA., 8/13/10; Mark E. Ruquet, Insurance Policies Do not Serve Consumers’ Needs, Advocate Says, P & C NATIONAL UNDERWRITER (8/19/10). Prior to the next tri-annual meeting of the NAIC, Robert Hartwig, President of the Insurance Information Institute, wrote an op-ed in an industry trade journal arguing that differences in insurance policies reflected healthy competition. Robert Hartwig, Greater Choice Key to Homeowners Market, P & C NATIONAL UNDERWRITER (10/11/10). At the winter NAIC meeting, the author presented updated data to the Property/Casualty Committee of the NAIC and simultaneously published an op-ed responding to Hartwig. See Daniel Schwarz, The Need for Insurance Policy Transparency, P & C NATIONAL UNDERWRITER (10/25/10). The Property/Casualty Committee then voted to adopt a charge to establish an Insurance Policy Transparency Working Group. See Mark E. Ruquet, NAIC to Review Personal Lines Contract Transparency, P & C NATIONAL UNDERWRITER (10/21/10).
on homeowners policies in much the same way they historically did with fire insurance policies.

Judicial doctrines governing the interpretation and construal of insurance policies are also importantly impacted by this Article’s findings. The core doctrines of insurance law – contra proferentem and the reasonable expectations doctrine – are designed primarily to promote consumer awareness of policy terms. Yet these doctrines have clearly failed to achieve these goals. For this reason, this Article provides further support for revised rules of insurance law that more directly limit the capacity of insurers to deny coverage in ways that surprise policyholders and undermine their reasonable expectations of coverage.

The empirical findings presented in this Article also have a number of implications beyond insurance law and regulation. First, they have important implications for the efficiency of standard form contracts – one of the central issues in contract law scholarship. In particular, the Article provides some of the first empirical evidence that firms may be exploiting consumer ignorance by drafting inefficiently one-sided contracts. It reveals that various specific terms in deviant policies raise obvious efficiency concerns and that insurers using the least generous policy forms are actively shrouding the terms of their coverage. Nonetheless, further study and better data is needed before any conclusions regarding efficiency can be reached. But at the very least, the evidence raises reason for concern regarding the efficiency of standard contracts in personal lines insurance markets.

Second, the Article’s findings illustrate important limitations in the capacity of insurance regulators in particular, and financial regulators in general, to evolve along with the markets they regulate. At the same time, they illustrate the capacity of independent, consumer-oriented, “regulatory contrarians” to promote regulatory adaptation despite political economy factors pushing in the opposite direction.¹³

Part I of this Article begins by providing an overview of the standardization of policy forms in the property/casualty insurance industry, with a focus on the homeowners market. It explores both why insurers historically employed the same forms as well as why explanations for this practice may no longer apply. Part II then uses simple empirical methods to assess variation in policy forms in several different states. It focuses on two related questions: (i) how do carriers’ policies differ, and (ii) to what extent do the policies that different carriers sell differ in the total amount of coverage they provide. Part III presents evidence gathered from various sources showing that homeowners insurance markets operate with

¹³ See generally Brett McDonnell & Daniel Schwarcz, Regulatory Contrarians, 73 N.C. L. REV. (forthcoming 2011) (exploring the role that regulatory contrarians can play in promoting more effective adaptation by financial regulators to changes in the marketplaces they are regulating).
consumers having access to virtually no information concerning crucial deviations in homeowners insurance policy forms. Finally, Part IV offers some common-sense solutions for regulators and courts to improve consumer information regarding differences in policy language. It also discusses some broader implications of this research for contract law scholarship and regulatory theory.

I. The Super-Standardization of Property/Casualty Insurance Policies

A. A Brief History of Policy Standardization in Insurance

The standardization of property/casualty insurance policies in the United States dates back to the late nineteenth century, when Massachusetts promulgated a mandatory policy form for fire insurers.\(^{14}\) The state’s goal was to address a classic “race to the bottom” among companies who had sought to save money by ratcheting back coverage without informing consumers.\(^{15}\) Various states followed Massachusetts’ lead, but by far the most influential was New York, whose mandatory standard fire insurance policy was widely – but not universally – copied by other states.\(^{16}\)

Standardization of insurance policy forms gained further traction in the early Twentieth Century, when numerous insurance companies failed after a massive earthquake. According to the Merritt Committee – a prominent commission established to study the issue – the cause of these insolvencies was “ruinous competition” among insurers.\(^{17}\) In particular, individual insurers lacked adequate information to predict future losses, especially when they were relatively new in the industry or simply wrote business in a new region.\(^{18}\) At the same time, these insurers could profitably adopt a high-risk strategy of setting excessively low premiums: insurers profited if losses were light, but policyholders ultimately bore the risk that losses would exceed premiums collected.\(^{19}\) Taken together, these forces resulted in systematically inadequate premiums and, consequently, mass insurer insolvencies in the wake of a large disaster.

\(^{14}\) See Charles Gobel, The Moral Hazard Clauses of the Standard Fire Insurance Policy, 37 Colum. L. Rev. 410, 410 (1937) (“Before the advent of the standard fire insurance policy there were in use in the United States almost as many policy forms as there were companies.”). Outside of the United States, the standardization of policy forms dates back to sixteenth century Florence. See generally Thomas L. Wenck, The Historical Development of Standard Form Policies, 35 J. Risk & Ins. 537, 537 (1968).

\(^{15}\) Wenck, supra note 14, at 539-41; Kenneth J. Meier, The Political Economy of Regulation: The Case of Insurance 54 (1998); Tom Baker, Insurance Law and Policy 7 (2d Ed. 2007).

\(^{16}\) Gobel, supra note 14, at 410. Standardization in automobile insurance policies followed a similar trajectory, with companies initially using their own distinctive policy forms but eventually finding that this created substantial consumer confusion. See Wenck, supra note 14, at 546. Unlike with fire insurance, however, insurers independently developed various “standard provisions” that could be voluntarily inserted into policies. See id. at 547.

\(^{17}\) Meier, supra note 15, at 59-60.

\(^{18}\) See Abraham, supra note 4, at 31-32.

\(^{19}\) See Meier, supra note 15, at 59-60.
To address these problems, the Merritt Committee proposed establishing state-sanctioned rate-making bureaus. As their name suggests, the central concern of these bureaus was insurers’ premium rates rather than their policy forms. In particular, bureaus would set premiums based on the aggregate loss experiences of all insurers. Such collective rate-making would prevent ruinous competition among insurers and ensure that premiums reflected the best estimate of future losses. But in order to pool insurers’ loss experiences and set rates accordingly, member-insurers would be required to use the same standardized policy forms. Only by using the same policies could rate-making bureaus meaningfully pool insurers’ loss data and set their rates accordingly. Otherwise, different insurers’ loss data would be based on different contractual definitions of loss and the prices that the bureaus set would not reflect the degree of coverage provided by each insurer.

Although explicit rate-setting is now largely understood as anti-competitive, the role of industry organizations in aggregating and distributing collective loss data has generally continued to be lauded as pro-competitive. Not only does aggregating and distributing loss data improve the accuracy of insurance pricing, but it also reduces barriers to entry that would otherwise severely limit the ability of a new entrant to price its policies. For these reasons, the dominant explanation for standardized policy language in property/casualty insurance markets continues to be that it facilitates the collection and aggregation of insurers’ loss data.

**B. Alternative Explanations and Justifications for Policy Standardization**

Of course, there are various justifications and explanations for policy standardization other than facilitating data sharing. First, many continue to emphasize that standardization allows consumers to more easily

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20 Meier, supra note 15, at 59-61 (describing the Merritt Committee’s endorsement of rate making bureaus in 1911).

21 See id.

22 See Clarence W. Hobbs, State Regulation of Insurance Rates, 11 PROCEEDINGS OF THE CASUALTY ACTUARIAL SOCIETY 218, 255, 267 (1925) (noting that some bureaus were allowed to insist that companies “use the policy forms established by the Commission” and that “to secure equal treatment there must be standardization of policy provisions”); Herbert C. Brook, Public Interest and the Commissioners’ --- All Industry Laws, 15 LAW & CONTEMP. PROBS. 606, 612 (1950) (noting that “bureau companies. . . in general, had to use standard bureau forms”).

23 See Abraham, supra note 4, at 31-32.

24 See, e.g., Meier, supra note 15, at 60. Price setting remained remarkably persistent, with the ISO publishing “advisory rates” as late as the 1980s. See Abraham, supra note 4, at 34.

25 See, e.g., Macey & Miller, supra note 4, at 20–26 (“[A]ccurate information cannot be developed and consumers cannot easily comparison shop on the basis of price-unless firms in the industry have access to standardized forms.”); Abraham, supra note 4, at 32-34; Paul Jaskow & Linda McLaughlin, McCarran-Ferguson Act Reform: More Competition or More Regulation, 4 J. RISK & UNCER. 373, 383 (1991) (emphasizing the “need for joint activities associated with loss costs and insurance forms”).

26 See Abraham, supra note 4, at 33-34.
comparison shop on the basis of price and service. Improved comparison-shopping through standardization not only prevents a race to the bottom, but it also arguably limits competition among insurers on the basis of “misleading comparisons, fringe coverages, and other non-price considerations.”

Collective policy drafting has also been explained as a mechanism for promoting economies of scale and limiting regulatory costs. The policy drafting process is unusually resource-intensive. Unlike most consumer contracts, insurance policies must be filed and – to varying degrees – “approved” by state regulators. They must also comply with various state laws and regulations regarding their content. By collectively drafting their policies, insurers can limit these expenses by incurring them only once on a collective basis.

Yet another explanation for policy standardization involves the network effects generated by judicial interpretations of property/casualty insurance policies. Unlike insurance policies in the life insurance context, for instance, property/casualty insurance policies attempt to categorize a tremendous range of potential future scenarios. A wealth of case law has gradually developed applying this contract language. Only by employing the same language as others can insurers effectively tap into this pool of precedent. This, in turn, lends insurers an important degree of certainty about how their contract language applies, which helps them to price their policies accurately.

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27 See Macey & Miller, supra note 4, at 20–26; Jaskow & McLaughlin, supra note 25, at 383; ISO, supra note 3 (“[I]f standardized coverages did not exist, consumers would face an unintelligible array of different forms”).

28 See Wenck, supra note 14, at 550.

29 Jeffrey Stempel, Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role, 5 CONN. INS. L.J. 181, 257 (1998) (“[T]he generally agreed that the use of standardized forms and the marketing mechanism of insurance facilitates the operation of the primary, excess, and reinsurance systems as well as providing economies of scale that should (at least in theory) lower the cost of insurance.”).

30 JEFFREY W. STEMPEL, STEMPLE ON INSURANCE CONTRACTS § 2.06(j) (3d ed. 2006) (“Changing the standard form insurance policy is a somewhat arduous process, requiring contributions from legal, claims, actuarial, and other industry personnel, as well as from customers and state insurance regulators.”)

31 See generally HOLMES’ APPELLEMAN ON INSURANCE §§ 2.10, Regulation of Policy Forms (2d ed. 1996).


33 Several other factors contribute to the absence of a comparable network effects in the health arena. First, ERISA allows employers to utilize discretionary clauses that relegate the role of courts simply to arbitrary and capricious review. Second, coverage disputes in the health insurance arena take place against an ever-changing landscape of medical knowledge and treatment protocols. Third, there is unique degree of factual specificity in the health insurance arena, meaning that cases often turn more on individual circumstances and expert testimony.
C. The Mechanics of Standardization in Homeowners Insurance

Today the dominant industry organization that facilitates collective policy drafting among property/casualty insurers – as well as the collection and dissemination of loss data – is the Insurance Services Organization (ISO). The ISO maintains various different types of standard forms for different lines of coverage. In the homeowners insurance arena, the most commonly used form for stand-alone homes (rather than condominiums or mobile homes) is the “HO3” policy. The distinguishing features of this policy are that it provides “all risk” coverage for one’s home and other structures (known as Coverages A and B in the ISO policy), but “named peril” coverage for personal property (known as Coverage C in the ISO policy). All risk coverage protects property against all perils except for those that are explicitly excluded, whereas named peril coverage protects property only against specifically enumerated perils. In many states, insurers bear the burden of proof with respect to the cause of loss and its exclusion when coverage is all-risk, whereas the insured bears the burden of proof to establish coverage under a named-peril policy. The HO3 policy also provides coverage for certain liability risks.

The ISO also maintains several alternative insurance policies that cover stand-alone homes. The “HO5” policy is similar to the “HO3” policy, except that it provides all risk coverage for personal property as well as structures. By contrast, the “HO2” policy provides only named perils coverage on one’s dwelling.

In addition to these various base policy forms, the ISO maintains numerous different endorsements that amend policy language. In some cases insurers require that all policies be accompanied with an endorsement, whereas in others the company sells, or offer a refund, in exchange for a

34 See ISO, supra note 3, at 33-34.
35 See Grace, et al., Homeowners Insurance with Bundled Catastrophe Coverage, 71 J. RISK. & INS. 351, 355 (2004) (reporting that 93% of policies sold in Florida and 72% of policies sold in New York correspond to the HO3 form).
36 See INSURANCE SERVICES OFFICE, HO3 POLICY FORM, reprinted in Abraham, supra note 4.
37 See HOLMES’ APPLEMAN ON INSURANCE §§ 1.10–11 (2d ed. 1996) (in all states except Texas is that “the insurer has the burden of proof to prove no coverage under an all-risks policy,” whereas under a named peril policy, “the majority American rule requires the insured to prove that the insured event has transpired, that is, the specified risk (fire, windstorm, lightning, etc.) was the cause . . . of the loss.”); See also Jeffrey Stempel, A Mixed Bag for Chicken Little: Analyzing Year 2000 Claims and Insurance Coverage, 48 EMORY L.J. 169, 196 (1999).
38 See INSURANCE SERVICES OFFICE, HO5 POLICY FORM, p. 10. Grace and his coauthors incorrectly describe the differences between the HO3 and HO5 form as based on the difference between “repair” coverage and “replacement.” See Grace, supra note 35, at 453. In fact, the ISO HO5 policy provides ACV loss settlement for personal property, just like the HO3 policy. See HO5 Policy Form, supra, at 14. Grace et al were likely misled by the fact that some individual company’s versions of the HO5 form include replacement cost settlement.
40 In 1999, these included 73 country-wide endorsements and 113 state-specific endorsements. See ISO, supra note 3, at 33-34.
particular endorsement. Some insurers only make certain types of endorsements available to policyholders. Examples of commonly purchased endorsements include enhanced loss settlement procedures for personal property, coverage for specifically scheduled valuable items, and sewer back up coverage.41

D. The Questionable Persistence of Policy Standardization

The current state of insurance policy standardization is much less clear than its historical legacy, supporting institutional architecture, and long list of justifications would suggest. In fact, courts and commentators in recent years have sporadically observed that some companies have particularized language in their policies that deviates from the industry norm.42 And the last systematic attempt to examine the content of different insurance policies was a 1937 law review article.43

At the same time, the various theoretical explanations of policy standardization are quite contestable, especially given recent regulatory and technological innovations. First, insurers today have less need than they historically did to rely on aggregate loss data. Many modern insurers are quite large, and consequently have at their disposal a tremendous amount of loss data that is specific to their company.44 Irrespective of policy language, this data is likely more accurate than collective data in predicting future losses, as it reflects the insurer’s particular claims paying culture and practice. This is significant, as “the vast majority of insurance claims are resolved according to the insurance law of the insurance adjustor.”45 Advances in information technology also enhance insurers’ capacity to use limited historical data to predict future losses.

Second, even if an insurer did need to rely on aggregate loss data (as some small insurers no doubt do), it is unclear why this would compel it to use the standardized policy form on which the data was based. An individual insurer could presumably start from the aggregate loss data associated with a standard form, and then make adjustments to the data based on its own contractual deviations. This strategy might be particularly

41 See BAKER, supra note 15, at 312 (“[T]he different between replacement cost and actual cash value may be one of the few aspects of property insurance coverage that is actually explained to consumers by insurance agents.”). In some cases insurers simply maintain different base policies that provide different loss settlement procedures.
45 BAKER, supra note 15, at 54.
sensible if the insurer’s contract deviations all reduced coverage, as collective loss data would still set an upper bound on expected losses. To be sure, insurers might collectively suffer if many of them followed this path, as the usefulness of the collective data would decrease. But the public good nature of collective loss data means that no single insurer would be deterred by this risk in choosing whether to deviate from standardized forms.\footnote{See Daniel Schwarz, Regulating Insurance Sales or Selling Insurance Regulation? Against Regulatory Competition in Insurance, 94 MINN. L. REV. 1707, 1738 (2010) (noting similar collective action problem could negatively impact insurers’ selections among competing regulators).}

Third, the regulatory burdens faced by insurers who utilize their own forms have decreased substantially in recent years. Insurers can now submit their policy forms quickly and easily through an electronic platform known as SERFF.\footnote{See Serff Website, About Serff, available at http://www.serff.com/about.htm.} Although deviant policies must nonetheless be approved individually by each state where they are used, this process is hardly arduous in many states. Anecdotal evidence suggests that state regulators rarely use their admittedly broad discretion to disapprove policy forms because they are unfair, ambiguous, unreasonable, or contrary to public policy.\footnote{Baker, \textit{supra} note 15, at 47 (noting that while “[t]here has been no systematic, scholarly study of the effectiveness of state regulation of insurance forms,” most commentators assume that such regulation is inadequate); Robert Keeton, Insurance Law Rights at Variance with Policy Provisions, 83 HARV. L. REV. 961, 967 (1970); Schwarz, \textit{Products Liability Theory, supra} note 4, at 1424-26.} Rather, the author’s informal conversations with state regulators suggest that review of policy filings is often focused exclusively on ensuring that policy forms are technically compliant with states statutes and regulations.\footnote{One regulator reported that insurers challenged the department’s use of discretion in reviewing policy forms as an exercise of rule-making authority, forcing the department to devote resources to hearings and developing a formal record. Another simply explained that his office has a “check list” of requirements that they go through for each form.} These requirements are uneven across states. However, many states have very few specific constraints on the content of homeowners policies, aside from rules governing cancellation, non-renewal, and the prompt payment of claims.\footnote{See NAIC product tool, available at https://eapps.naic.org/prl/do/search/dialog (providing product requirements of specific states for various insurance lines).}

Finally, although network effects may lend some value to historical language, the extent of this value is not clear. One provocative article suggests that the network effect benefits of historical policy language are substantial, because insurers “care more that a clause have a fixed meaning than a particular meaning.”\footnote{Boardman, \textit{supra} note 32 at 1107.} Insurers can then simply include the cost of that coverage in the premiums they charge.\footnote{See id.} But this argument overstates the value of historical policy language. Some types of coverage create underwriting problems – such as moral hazard or adverse selection – such that the increase in coverage they provide is not worth the increase in
premiums they generate. To the extent that policy language is construed to provide such coverage, insurers would be unable to pass this cost on to policyholders completely. In any event, insurers’ profits will suffer from passing on the cost of judicially-created insurance if policyholders focus on the nominal cost of coverage in their purchasing decisions.

II. Empirically Assessing Homeowners Policies

Motivated by the uncertain persistence of policy form standardization, this Part seeks to answer two related empirical questions. First, it asks whether homeowners policies differ and, if so, with respect to what provisions. Part A shows that there are substantial deviations among carriers’ policies within individual states, and that these deviations involve various important, though often esoteric, terms. Readers with limited interest in the precise details of how insurers’ policies vary may wish to skim Part A, focusing on the interpretation, limitations and qualification towards the end.

Second, Part B asks whether some carriers’ policies are substantially less generous, in the aggregate, than others. This analysis reveals that heterogeneity in policy terms is concentrated among a subset of large, national carriers. Most of these carriers’ policies are substantially worse than the presumptive industry default of the 1999 ISO HO3 form (“HO3 policy”). However, a small number of carriers maintain policies that are more generous than the HO3 policy. Notably, the carriers who employ the least generous policy forms disproportionately use captive agents to distribute their policies, whereas the companies with unusually generous policies tend to rely on independent agents.

A. How Do Homeowners Policies Differ?

1. Data and Methodology

In order to assess how homeowners policies differ, policies from carriers in six states were compared: North Dakota, South Dakota, Pennsylvania, Illinois, California, and Nevada. For reasons discussed more completely in Part III, the only reliable method for gaining access to complete copies of different carriers’ homeowners forms was to convince state insurance regulators to demand or request these documents directly from insurers. Insurance regulators in each of the six identified states were willing to do this in response to author requests. The majority of states

53 See Schwarcz, Products Liability Theory, supra note 4, at 1448.
54 Although insurance markets are generally thought to be competitive with respect to nominal pricing, it is hardly clear that they are competitive with respect to policy content and design (and thus “true” price). Schwarcz, Products Liability Theory, supra note 4, at 1397–98.
55 I also acquired policies in Texas. However, Texas’s market made it difficult to compare carriers’ policies with those found in other states, as the HO3 policy does not operate as the presumptive baseline in Texas. See infra, Part III.B.2. However, policies in Texas seem more heterogeneous than policies in other states. See http://www.opic.state.tx.us/hoic.php
56 In convincing state insurance regulators to spend time and resources on this, the author invoked his status as a “funded consumer representative” to the National Association of Insurance Commissioners
contacted either explicitly refused to cooperate or did not respond to repeated inquiries. Section 4 addresses the degree to which this raises selection-effect concerns.

For each state, polices were collected from the top ten insurance groups in the state, as measured by premium volume for homeowners policies. Consequently, a single insurance group was often included in the data from multiple states. To take an extreme example, a State Farm policy was included in the sample from all six states. This approach proved necessary because the policies from a single insurance group occasionally varied across state lines. In total, policies from 24 different insurance groups were examined. This includes the top thirteen insurance groups in the country, which cumulatively represent over 2/3 of the market.

For each insurance group within a state, the homeowners forms covering stand-alone structures were collected. This includes both the “base” policy as well as any mandatory endorsements that the insured has no option to reject. Only those policies currently being issued to new policyholders were analyzed. Where insurers maintained multiple forms corresponding to ISO distinctions, forms corresponding to the HO3 form

(“NAIC”). Additionally, he made use of various informal connections with state regulators and insurance commissioners. Due to resource constraints, only some states were contacted.

This includes, among others, Iowa, Rhode Island, New York, Arkansas, Colorado, Michigan, Minnesota, Wisconsin, and New Mexico.

See Part II.A.4, infra.

See 2009 MARKET SHARE REPORT, supra note 44. The top ten groups are as follows. In California they are State Farm, Zurich (Farmers), Allstate, California State Auto, Liberty Mutual, Auto Club Enterprises, United Service Auto (USAA), Nationwide (AMCO), Mercury, and Travelers. In Illinois they are State Farm, Allstate, Country Insurance (Countrywide), Zurich (Farmers), American Family, Liberty Mutual, Travelers, Metropolitan Group, USAA, and Chubb. In Nevada they are Zurich (Farmers), State Farm, Allstate, California State Auto, Hartford, American Family, Liberty Mutual, USAA, Travelers, and Country Insurance (Countrywide). In North Dakota they are State Farm, American Family, Farmers Union, Auto Owners, Nodak, Zurich (Farmers), North Star, EMC Insurance, State Auto, and Country Insurance. In Pennsylvania they are State Farm, Allstate, Erie, Nationwide, Travelers, Liberty Mutual, Chubb, USAA, Zurich (Farmers), and Donegal. Finally, in South Dakota, they are State Farm, American Family, Zurich (Farmers), North Star, USA, EMC Insurance, State Auto Mutual, and Iowa Farm Bureau.

See id. (State Farm among the top insurers in every state sampled).

In some cases this variation reflected differing state regulatory requirements. In others, differences in policy terms appeared attributable either to state-specific risks or idiosyncratic variation of related companies.

These are: State Farm, Zurich (Farmers), Allstate, California State Auto, Liberty Mutual, Auto Club Enterprises, United Service Auto (USAA), Nationwide, Mercury, Travelers, Country Insurance (Countrywide), American Family, Metropolitan Group, Chubb, Hartford, Farmers Union Insurance, Auto Owners, Nodak, North Star, EMC Insurance, State Auto Mutual, Erie, De Smet, and Iowa Farm Bureau.

See 2009 MARKET SHARE REPORT, supra note 44.

The ISO designation of homeowners forms covers condo policies, policies for renters, and policies covering mobile homes. I did not systematically collect these policies.

Mandatory endorsements include endorsements that are mandatory as a result of law or required as a result of a business decision by the insurer.

In many cases, insurers continue to issue old policies to old customers, but have discontinued use of those policies for new customers. Conversations with some agents revealed that some insurers have had concerns with trying to switch long time customers to new forms, at least partially for “legal” reasons. See Part III.B, infra.
were isolated for review. In some cases, companies maintained multiple forms that did not correspond to ISO distinctions. In those cases, the policy that most closely corresponded to the HO3 form was selected.

In several instances, fewer than ten policies were examined in a state. With respect to the property coverage sections of the homeowners policies, this was true of two states – California (9 policies) and Pennsylvania (7 policies). In both instances, regulators limited their requests to the top ten insurance companies rather than insurance groups. This produced fewer than ten distinct policies because multiple companies within the top ten were from the same underwriting group. With respect to the liability coverage sections of the homeowners policies, there was an additional decrease of one policy in Pennsylvania (6 policies) and South Dakota (9 policies). In these cases, insurers provided only copies of their property coverage forms and follow up requests were unsuccessful.

Having isolated these policies, various provisions were analyzed for discrepancies in coverage. Terms that figure prominently in insurance litigation or are otherwise important were isolated for analysis. So too were several terms where informal review of policies suggested potential deviations in policy language.

2. Results: Property Coverage

Homeowners insurance policies package together property and liability insurance. This Section reports results for the property insurance section of the homeowners policy.

a. Concurrent Causation

Concurrent causation is one of the most commonly litigated insurance coverage issues. It involves losses that are the product of both covered and excluded perils. The most well known example is from Hurricane Katrina, where wind (a covered peril) and flood (an excluded peril) both contributed to produce massive damage to property throughout the Gulf Coast. In most jurisdictions, the default rule is the efficient proximate cause rule (“EPC rule”), which states that a loss is covered if the

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67 See Part I.C., supra. In two cases, a company apparently did not offer a form corresponding to the ISO3 policy. One only offered all risk coverage for personal property and the other apparently offered only replacement coverage for personal property. See id.

68 Typically this meant selecting the form that provided Actual Cash Value Loss Settlement for personal property. See id.

69 In California, Traveler’s policy was not collected because Zurich/Farmers owns both Mid-Century Insurance Company and Fire Insurance Exchange, which were both counted among the top ten companies.

70 In Pennsylvania, the policies of Donegal, Zurich/Farmers, and USAA were not collected.

71 Insurance “groups” include all insurers within the same corporate family.

72 These companies either used the same form, or used different forms because one of the companies was no longer writing new business.

73 The Chubb liability insurance policy was not included in the Pennsylvania data and the DeSmet liability insurance policy was not included in the South Dakota data.

74 See Knutson, supra note 42.

75 See, e.g., Broussard v. State Farm, 523 F.3d 618 (5th Cir. 2008).
"dominant" or "primary" cause of the loss was a covered peril. Most states, however, permit insurers to opt out of this rule through specific language in their policies. In the HO3 policy, the default EPC rule applies for most perils, with several important exceptions. In particular, the prefatory language to the nine "exclusions" opt outs of the EPC rule, specifying that there is no coverage if an exclusion contributes in any way to a loss.

Figure one tabulates different carriers’ policies with respect to concurrent causation in each state. As with all subsequent figures, the vertical axis reflects potential variations in a policy term, with more favorable terms situated above less favorable terms. The term in the HO3 policy is indicated in parenthesis next to the applicable term. The horizontal axis represents the numbers of policies falling into that category, organized by state. The numbers in parenthesis next to the individual states represent the total number of policies reviewed for that state.

Figure One reports substantial variation among different carriers with respect to concurrent causation. In most states, about half of the carriers followed the HO3 approach by only opting out of the default rule for policy exclusions. The remaining insurers generally decreased coverage by expanding the scope of the EPC opt out, thus increasing the number of perils that could not contribute in any way to a covered loss. Notably, some carriers actually were more generous than the HO3 policy by subjecting fewer causes of loss to the EPC opt out. Where this occurred, it was usually accomplished by moving certain “exclusions” elsewhere in the policy so that they were not subject to the EPC opt out.

b. Affirmative Coverage Grants

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76 Couch on Insurance § 101:45 (3d ed. 2010) ("The majority of jurisdictions permit the parties to an insurance contract to contract out of the efficient proximate cause doctrine.").

77 The HO3 policy also provides that, with respect to the perils excluded from Coverages A and B, any ensuing loss that involves a covered peril is covered. See Baker, supra note 15, at 251, 277. This is technically more expansive than the EPC rule, as an ensuing loss may not always be the efficient proximate cause of a loss.

78 See HO3, supra note 36, at 11.

79 In some cases insurers shifted perils into the exclusion section from the “perils not insured” section, whereas in others insurers redrafted the prefatory language to the “Perils not insured” section.
The HO3 form covers one’s home and other structures on an “all risk” basis, meaning that all perils are covered unless they are explicitly excluded.\textsuperscript{80} The HO3 policy conveys this concept by stating “We insure against risk of direct physical loss to property” but “do not insure for loss… caused by” specifically enumerated perils.\textsuperscript{81} Figure two shows that many insurers substantially alter this affirmative “all risk” coverage grant.\textsuperscript{82} First, many carriers provide that “We insure against risk of accidental direct physical loss.” (Emphasis added). Taken to the extreme, one could read this to foreclose coverage for damage caused by vandalism and arson. Even if one understood this provision to mean “accidental from the standpoint of the insured,” it could easily be used to justify expansive claims denials. This is because it effectively increases the scope of the “intentional loss provision,” which excludes “loss arising out of an act an insured commits or conspires to commit with the intent to cause a loss.”\textsuperscript{83} There may be a range of losses that do not involve acts “intended to cause a loss” but which are nonetheless arguably not “accidental.” Consider, for instance, an improperly installed air conditioner that falls from a window or a water hose pulled out of a sink by a rambunctious young child.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure2.png}
\caption{Affirmative Coverage Grants}
\end{figure}

Other policies are even more restrictive, providing coverage only for “sudden and accidental” direct physical loss. There is extensive caselaw interpreting the meaning of this phrase in the context of pollution liability exclusions.\textsuperscript{84} But it is quite surprising to find this coverage limitation for all losses that a homeowners policy covers. Various losses that might be covered by an HO3 policy would be excluded by this clause, including structural decay, mold growth, and gradual falling down of a tree.

\begin{itemize}
\item \textsuperscript{80} Stempel, supra note 37, at 196.
\item \textsuperscript{81} See HO3, supra note 36, at 8.
\item \textsuperscript{82} In most cases, the qualifier found in the open perils statement for Coverages A and B is also used to limit Coverage C (coverage for personal property). Thus, policies that provide coverage for “sudden and accidental” direct loss for Coverages A and B also provide for “sudden and accidental” direct loss caused by the specified perils in Coverage C. Because some Coverage C perils include the terms “sudden” and “accidental,” this results in these policies containing duplicative coverage restrictions.
\item \textsuperscript{83} See HO3, supra note 36, at 12.
\item \textsuperscript{84} See Kenneth Abraham, The Rise and Fall of Commercial General Liability Insurance, 87 VA. L. REV. 85, 97-98 (2001).
\end{itemize}
Alternatively, this language might well shift the burden of proof onto policyholders in the event of a dispute regarding the sudden and/or accidental nature of a loss.\(^{85}\)

c. Increased Risk

One of the central aims of insurance policies is to reduce moral hazard, or the prospect that policyholders will take less care knowing that they are insured.\(^{86}\) At the same time, many losses are at least partially the result of carelessness or thoughtlessness. These competing facts create an “irreducible minimum of tension.”\(^{87}\) Traditionally, insurers have dealt with this tension by excluding coverage for specific losses that inherently or predominantly involve moral hazard – such as theft from a vacant home.\(^{88}\) By contrast, most assume that there is an “absence of any general exclusion in standard policies of coverage for harm caused by the insured’s own negligence.”\(^{89}\) Such an approach – which was historically available through the defense of “barratry” – resulted in excessive uncertainty for policyholders and discretion for insurers.\(^{90}\) The one exception is that insurance policies do indeed broadly exclude coverage for losses exacerbated by ex post moral hazard: the failure to mitigate a loss after it occurs.\(^{91}\) This distinction is easy to understand: once a loss occurs, ordinary care is to be expected because the loss places the insured on notice of the need for enhanced care.

Figure Three shows that various carriers’ policies do not adhere to these distinctions. Instead, many carriers require policyholders to take care not just at the time of a loss, but also once property is endangered. The import of this requirement depends on whether property might be endangered even though an insured was not reasonably on notice of this fact. Consider again the improperly installed air conditioner or the tree on the verge of collapse.

\(^{85}\) See note 37 supra.


\(^{87}\) ABRAHAM, supra note 4, at 224-225.

\(^{88}\) Id. (“The insurance solution has been to place no general limitation on coverage of losses caused in whole or in part by such insufficient care, but to exclude losses caused by or occurring during certain generally described or specifically excluded risk-increasing actions.”).

\(^{89}\) Id. at 259.


\(^{91}\) See HO3, supra note 36, at 12 (excluding coverage for “neglect of an insured to use all reasonable means to save and preserve property at and after the time of loss”).
Much more distressing, however, is the fact that a number of carriers place no temporal restrictions on insureds’ obligations to take care, requiring that policyholders do nothing to increase the risk of hazard at any time. Several policies accomplish this by denying coverage whenever there has been “any substantial change or increase in hazard, if changed or increased by any means within the control or knowledge of the insured.” Others state that there is not coverage “for any loss occurring while hazard is increased by a means within the control or knowledge of the insured.” These provisions upend the conventional wisdom about how homeowners policies manage moral hazard, essentially contractually reestablishing the barratry defense.

d. Mold and Water Damage to Insured Property

Several years ago, controversy erupted over the extent to which homeowners insurers must cover mold damage. Although several insurance departments took action to regulate this coverage, most did not. The HO3 form excludes coverage for mold or fungus unless it is (i) hidden within the walls, floors or ceilings and (ii) caused by an accidental discharge or overflow of water or steam. As Figure 4 reveals, existing policies differ substantially on this issue. Several carriers in South and North Dakota retain the HO3 language on mold, but most carriers in most states have abandoned this language. The alternative they have selected differs dramatically among carriers. Figure four shows a roughly even split between insurers that completely exclude mold-related property damage and those that place monetary caps on such losses. Both the size of the monetary cap – which ranged from $2,500 to $50,000 – and the precise

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93 See 3 Envtl. Ins. Litig.: L. and Prac. § 24:3 (2010) (“In addition to California, New Jersey, Florida, Maryland, Ohio, and New York, are among the states that have enacted either statutes or state insurance commissioner rules/regulations on mold coverage.”).
94 See HO3, supra note 36, at 9.
95 Some policies completely excluded mold except to the extent that it resulted from a covered fire loss. See Liritis v. American Family, 204 Ariz. 140 (2002). Such policies were coded as providing an “absolute exclusion” for mold.*
language describing the mold damage that enjoyed this limited protection varied by carrier.

Insurance policies also differ with respect to the related issue of whether they cover gradual water damage to property. The HO3 policy covers this risk, so long as the water is the result of “accidental discharge.” As Figure 5 shows, although a few carriers retain this language, most absolutely exclude coverage for any seepage or leakage of water. Moreover, five companies associated with a single insurance group radically transform coverage for water damage to structures from all risk to named peril, in the process excluding both gradual water damage and various other forms of water damage.

e. Pollution Damage to Insured Property

The extent to which Commercial General Liability (CGL) policies cover pollution liability has been the subject of extensive litigation and debate. But the issue has received less attention in the context of first party insurance. Although the issue may seem arcane, it can be quite important given the breadth of the “pollutants” definition found in most policies: pollutants include “any solid, liquid, gaseous, or thermal irritant or

96 HO3, supra note 36, at 9.
97 Policies differed with respect to the interaction between a seepage exclusion and limited mold coverage. Whereas the seepage exclusion did not impact the limited mold coverage in some policies, in others it appeared to circumscribe this coverage, thus presumably creating coverage only for mold resulting from a sudden discharge of water or steam.
contaminant, including smoke, vapor, soot, fumes, alkalis, chemicals and waste.” The HO3 policy excludes any loss to a home or other structure caused by “the discharge, dispersal, seepage, migration, release or escape of pollutants unless... caused by a Peril Insured Against under coverage C.” Under this provision, for instance, property damage resulting from a fire that caused a fuel tank to explode would be covered, as fire is a peril insured against.

As Figure 6 shows, homeowners policies differ substantially in their coverage of property damage caused by pollution damage. While approximately half of all carriers retain the HO3 language, the other half employ an absolute exclusion of pollution damage. A small number of carriers cover pollution damage up to a specified internal limit.

![Figure 6: Pollution Coverage](image)

<table>
<thead>
<tr>
<th>Coverage if Pollution caused by Peril Insured Against (ISO Standard)</th>
<th>Number of Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monetary Cap</td>
<td>0 1 2 3 4 5 6 7 8</td>
</tr>
<tr>
<td>Absolute Exclusion</td>
<td></td>
</tr>
<tr>
<td>South Dakota (10)</td>
<td></td>
</tr>
<tr>
<td>Nevada (10)</td>
<td></td>
</tr>
<tr>
<td>Ill. (10)</td>
<td></td>
</tr>
<tr>
<td>Cal. (9)</td>
<td></td>
</tr>
<tr>
<td>N.D. (10)</td>
<td></td>
</tr>
<tr>
<td>Penn. (7)</td>
<td></td>
</tr>
</tbody>
</table>

f. Theft Coverage

One of the most basic protections a homeowners policy provides is coverage against the risk of theft. In many cases, of course, property can be stolen without obvious evidence of theft. Some commercial property insurers historically attempted to exclude coverage in such cases by requiring that there exist “visible marks ... or physical damage ... to the exterior” of a covered building. However, several courts held that these exclusions violated policyholders’ reasonable expectations of coverage. Perhaps for this reason, this exclusion apparently did not migrate into homeowners policies; the HO3 policy specifically covers “loss of property from a known place when it is likely that it has been stolen.”

Figure Seven shows that several insurers have reestablished exclusions for theft when there is limited physical evidence of the theft. First, several insurers exclude coverage for theft resulting from “swindle” or “trick.” These exclusions could be interpreted quite broadly, extending not only to email frauds but also to classical burglaries in which entrance is gained.

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101 In several instances, a policy contained an absolute exclusion, but exempted smoke damage caused by a covered fire. Such policies were coded as containing an “absolute exclusion.”
through surreptitious means. Second, the policies of five companies associated with one insurance group specifically exclude coverage for the “mysterious disappearance” of covered property (as well as for theft by swindle or trick). In doing so, they arguably exclude coverage well beyond the “visible marks” exclusion that courts have found to violate the reasonable expectations of commercial property policyholders.

**g. Collapse Coverage**

All homeowners policies reviewed provide coverage against the risk that a covered structure will collapse. However, unlike most coverage for building structures, this coverage is provided on a named perils basis, meaning that loss from collapse is only covered if it is caused by a specifically enumerated peril.\[^{104}\] Covered perils include all of the standard perils covered for personal property, such as fire and falling objects. But they also include several additional collapse-specific perils, including collapse resulting from hidden decay or animal damage.\[^{105}\] As Figure 8 shows, however, some policies exclude collapse caused by hidden decay or animal damage.\[^{106}\]

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\[^{104}\] This is accomplished by excluding collapse as a covered loss, except to the extent such coverage is provided as an “additional coverage.” The additional coverage then provides coverage for collapse on a named perils basis. HO3, *supra* note 36, at 7, 8. Typically “collapse” is defined as “the abrupt falling down or caving in of a building or structure,” *see id.* at 7.

\[^{105}\] *see id.* at 7.

\[^{106}\] There was substantial variation regarding whether the weight of ice and snow were covered causes of a collapse. Although the HO3 policy does not specifically include these as covered causes of loss, many policies did. However, “weight of ice and snow” is a named peril in Coverage C of the HO3 policy, suggesting that the HO3 policy covers this peril by covering collapse caused by named perils.
h. Damage to Personal Property from Artificially Generated Electrical Current

All homeowners policies reviewed cover the risk that personal property will be damaged by artificial changes in electrical current. However, under the HO3 policy, this coverage does not include damage to “electronic components or circuitry.” Depending on how this restriction is interpreted, it could be quite broad given the increasing prevalence of electronics in personal property.

As Figure Nine demonstrates, carriers’ policies vary significantly with respect to this issue. Many carriers simply eliminate the HO3 exclusion for damage to “electronic components and circuitry,” thus increasing coverage. Other insurers follow this approach, but add an internal limit to damage from this peril, usually approximately $1,000 per property item. Whether this is more or less generous than the HO3 approach is difficult to say. Finally, several carriers (again, five affiliated with a single insurance group) dramatically limit coverage by applying a $1,000 cap to all property damage from a change in electrical current. Given that such an event is likely to damage numerous items simultaneously, this subtle shift in coverage can have dramatic effects.

107 HO3, supra note 36, at 11.
i. **Internal Limits for Specific Types of Property**

In addition to aggregate coverage limits, homeowners policies also contain various internal limits for specific *types* of property. These limits improve risk classification by forcing those with particularly valuable types of property – including jewelry, furs, china, and art – to separately purchase coverage for these items through riders. They may also help to reduce moral hazard by limiting coverage for losses that can be prevented through increased vigilance, such as theft of valuable jewelry.\(^{108}\)

In order to assess variability in internal policy limits, each internal limit in each policy was compared to the corresponding limit in the HO3 policy. Where a policy limit was less generous than the HO3 limit, it was scored as (-1). If the policy’s limit was more generous, it was scored as (+1). A limit received a (0) if it matched the HO3 policy. Where a policy imposed a limit on a new type of property a (-1) was added to its score. Correspondingly, a (+1) was added to the policy’s score if it did not impose a limit on a type of property that was limited in the HO3 policy.\(^{109}\) These scores were then aggregated for each policy.

The aggregate scores of the sample policies are reported in Figure 10. As above, there is substantial heterogeneity in the market place. The predominant trend appears to involve decreases in coverage, with many carriers incorporating into their policies internal limits that are systematically less generous than those contained in the HO3 policy.\(^ {110}\)

![Figure 10: Internal Limits for Specific Types of Property](image-url)

Unlike all of the other terms described to this point, specific internal limits within policies can be changed by endorsement. Most individuals,

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\(^{109}\) Some policies applied separate limits to property that was grouped together in the HO3 policy. In such cases, I scored the ISO policy as more generous if the sum of the separate limits was less than the sum of the ISO policy. If the sum of the separate limits was the same or more than the combined HO3 limit, I scored the comparison policy as more generous. If the two limits were both less than the HO3 policy limit, but the sum was more, I scored zero as the comparative generosity of the policy would depend on the particular nature of the loss.

\(^{110}\) A single carrier generated the two data points in the “8 or more better” category.
however, have only a limited amount of scheduled property with their homeowners policy – most commonly a valuable piece of jewelry. Moreover, specifically-scheduled property does not eliminate the relevance of internal limits. For instance, a policyholder with a scheduled anniversary ring would still be subject to the internal limit on jewelry for all other jewelry that she owned.

j. Coverage for Increased Costs due to an Ordinance or Law

When buildings or structures are rebuilt or repaired after they are damaged, they are sometimes subject to building codes or ordinances that were not in effect when they were constructed. Whether the increased costs of complying with such rules are covered by homeowners policies became a significant source of dispute in the early 1990s. The HO3 policy resolves this issue by specifying that up to 10% of the liability limit can be used for increased costs resulting from compliance with new building ordinances or laws.

As Figure 11 shows, carriers vary significantly with respect to this issue. While roughly half of the policies in the sample replicated the ISO approach, many policies absolutely excluded these costs from coverage. Several carriers take an in-between approach, either limiting the percentage of the limits that can be used for these costs or verbally limiting the scenarios in which this coverage is available. Three policies in the sample offer more generous coverage than the HO3 policy, increasing the percentage of limits that can be used for these costs. Notably, at least some carriers that do not include this coverage in the base policy do indeed offer it as an endorsement.

![Figure 11: Increased Costs due to Ordinance or Law](image)

k. Water Damage from Off-Premises Sources

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112 HO3, supra note 36, at 8.
113 This exclusion can be justified on moral hazard grounds, as an insured is arguably better off after a loss if the damaged property is “upgraded” to comply with new building codes or ordinances.
114 Several carriers limited this coverage to 5% of the limits.
Property damage from flooding is excluded from all homeowners policies. Floods can produce extensive damage to numerous households in the same geographic area. This type of correlated risk is difficult to insure, as insurers cannot mitigate risk simply by insuring multiple homes and relying on the law of large numbers. Given this explanation for flood exclusions, it is perhaps not surprising that the HO3 policy does indeed cover “accidental discharge or overflow of water or steam from within a (i) storm drain, or water, steam or sewer pipe, off the ‘residence premises...’” This species of water damage is likely to be centralized to a relatively small geographic area given the amount of water carried in pipes and the fact that such problems are typically contained relatively quickly by city officials.

As figure 12 demonstrates, however, a substantial majority of carriers no longer cover this risk. The complete absence of such coverage in Illinois, Pennsylvania, and California may reflect the possibility of genuinely correlated losses in certain parts of these states. But it is harder to understand the fact that some carriers in South Dakota, North Dakota, and Nevada retain the HO3 approach to water damage from off-premises sources, while the majority of carriers do not. In any event, the data again suggest substantial and important heterogeneity in coverage terms.

<table>
<thead>
<tr>
<th>L. Subrogation Priority</th>
</tr>
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<tbody>
<tr>
<td>Subrogation is the right of a first-party insurer to recoup insurance payouts from anyone who is liable to the policyholder for causing the underlying harm. Subrogation prevents accident victims from recovering twice for the same loss, thereby keeping insurance costs low and fulfilling the principle that policyholders should not benefit from a loss. But subrogation can become quite controversial when a policyholder’s legal recovery is not fully compensatory, either because the defendant is partially judgment proof or because a settlement reflects the possibility of losing at</td>
</tr>
</tbody>
</table>

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116 HO3, supra note 36, at 9-10.
117 See generally Stempel, supra note 2, at 11.01.
trial on liability. In such cases, subrogation dollars can be used either to fully compensate the policyholder or to subrogate the insurer, but they cannot completely accomplish both goals. First dollar subrogation prioritizes full subrogation of the insurer over complete compensation of the policyholder. The make-whole rule, by contrast, allows the insurer to recover in subrogation only after the policyholder is fully compensated for a loss.

The vast majority of homeowners policies – including the HO3 policy – do not specify how this issue should be resolved, leaving the issue to the courts. But, as Figure 13 shows, some carriers do indeed resolve this issue. Once again, five companies from a single underwriting group depart from the trend, explicitly adopting the insurer-favorable first-dollar rule. By contrast, one Nevada carrier specifies the policyholder-favorable make whole rule.

3. Results: Liability Coverage

Differences in the content of homeowners policies are not cabined to first-party property insurance. Much to the contrary, they also extend to the liability insurance contained in these policies. All of the policies examined provide coverage if a claim is made or a suit is brought against an insured for damages because of "bodily injury" or "property damage" caused by an "occurrence" to which the policy applies. But as the first three sub-sections show, the policies differ in important ways with respect to each of these three elements of the affirmative grant of liability coverage. Moreover, as the subsequent sub-sections reveal, policies also differ meaningfully with respect to various exclusions from this affirmative coverage grant.

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118 See generally Alan Sykes, Subrogation and Insolvency, 30 J. LEG. STUDS. 383 (2001) (arguing that first-dollar subrogation is likely optimal and that, for this reason, courts should refrain from interfering with contract terms specifying this rule).
119 See id.
120 HO3, supra note 36, at 22.
121 Interestingly, several related companies from the same underwriting group, but operating in different states, do not resolve this issue. This is true even though Nevada law explicitly permits opting out of the default make-whole rule. Canfora v. Coast Hotels & Casinos, Inc., 121 Nev. 771, 777 (2005).
a. Bodily Injury

One of the two core liability coverages in homeowners policies covers liability stemming from “bodily injury.” The definition of such injury is thus crucially important. The HO3 policy defines “bodily injury” as “bodily harm, sickness, or disease including required care, loss of services and death that results.” A commonly litigated issue is whether this definition encompasses psychological harms that rise to the level of a “sickness or disease.” In a minority of jurisdictions, this question is resolved in favor of coverage on the basis of contra proferentem – the principle that ambiguities are interpreted against the drafter. But as Figure 14 shows, while many carriers retain the ISO definition of bodily injury, a slim majority of policies in the sample explicitly define “bodily injury” to exclude any mental, emotional, or psychological harm that does not itself arise out of physical harm to one’s body. Consequently, lawsuits alleging only psychological or emotional harm would not be covered by these policies.

![Figure 14: Liability Coverage and Bodily Injury](image)

b. Property Damage

Homeowners policies also cover liability stemming from “property damage.” The HO3 policy defines this as “physical injury to, destruction, or loss of use of tangible property.” But Figure 15 shows that many insurance policies subtly, but importantly, shift this definition so that “loss of use” of property does not constitute property damage unless it results from physical damage or destruction to that property. Under this definition, lawsuits based on the inability of a plaintiff to occupy her home or use property such as an automobile would not be covered. Consider, for instance, a homeowner who is sued by neighbors alleging that they needed

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122 HO3, supra note 36, at 1.
123 See generally 3-18 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 18.02[3]; STEMPEL, supra note 2, §14.03.
124 See id.
125 See generally APPLEMAN, supra note 123, § 18.02[4]; STEMPEL, supra note 2, §14.04.
126 HO3, supra note 36, at 2.
to abandon their home due to a noxious smell, loud noise, or dangerous living conditions.\textsuperscript{127} 

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure15.png}
\caption{Liability for Property Damage}
\end{figure}

c. Occurrence Definition

Irrespective of whether a policyholder’s potential liability stems from “property damage” or “bodily injury”, homeowners policies only provide coverage if the injury resulted from an “occurrence.” The definition of this term consequently constitutes yet a third key component of the liability insurance that a homeowners policy provides. The HO3 policy defines an “occurrence” as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions, which results, during the policy period, in (a) ‘bodily injury’ or (b) ‘property damage.’”\textsuperscript{128} This definition extends coverage to scenarios in which continuous or repeated conditions begin prior to the policy period, so long as the resulting bodily injury or property damage occurs during the policy period. By contrast, as reflected in Figure 16, several homeowners policies define an occurrence to require that any “continuous or repeated exposure to substantially the same general harmful conditions” itself occur during the policy period. These policies do not cover liability stemming from any conditions that began prior to the policy period. Although this scenario has been litigated most extensively in the context of asbestos liability of commercial entities,\textsuperscript{129} it could plausibly extend to a variety of scenarios more relevant to a homeowner. For instance, consider a homeowner who is sued for damage caused by a dog that continuously escapes the back yard, or for tree damage that has long encroached on a neighbor’s property.

\textsuperscript{127} See, e.g., Continental Ins. Co. v. Bones, 596 N.W.2d 552, 556–58 (Iowa 1999) (lawsuit for loss of use of leased premises resulting from wrongful eviction did not result from property damage and thus was not covered); Guelich v. Am. Prot. Ins. Co., 772 P.2d 536, 537–38 (Wash. App. 1989) (lawsuit for obstruction of a neighbor’s view does not qualify for coverage under a homeowners policy because the loss of use did not involve physical damage).

\textsuperscript{128} HO3, supra note 36, at 2.

\textsuperscript{129} See generally APPLEMAN, supra note 123, § 18.02[6]; STEMPEL, supra note 2, §14.02.
d. Expected or Intended Injury Exclusion

Perhaps the most important term in any liability insurance policy is the exclusion for injury that is intentional or expected. Almost all acts that generate liability can be framed as involving intentional conduct or expected harm – indeed, these factors are often key elements of liability. As such, a broad exclusion for expected or intended injury can largely gut liability coverage.\(^{130}\) The HO3 policy provides no coverage for liability when bodily injury or property damage was “expected or intended by an insured even if the resulting bodily injury or property damage (a) is of a different kind, quality, or degree than initially expected or intended; or (b) is sustained by a different person, entity, real or personal property, than initially expected or intended.”\(^{131}\) However, the policy exempts from this exclusion “bodily injury resulting from the use of reasonable force by an insured to protect persons or property.”\(^{132}\)

The corresponding exclusions in the sampled homeowners policies differ in multiple respects from this language. First, as reported in Figure 17, some policies appear to be more generous than the HO3 policy in that they do not address coverage when the liability-generating act is substantially different than initially intended or expected.

\(^{131}\) HO3, *supra* note 36, at 17.  
\(^{132}\) Id.
Once again, though, the broad trend was largely in the other direction, with most deviations from the HO3 policy restricting, rather than expanding, coverage. First, as shown in Figure 18, many policies do not carve-out intentional or expected acts that are the result of self-defense. Second, Figure 19 reports that many policies exclude coverage for liability stemming from criminal acts that do not otherwise constitute intentional or expected injury.

**Figure 17: Intentional Injury and Degree/Target of Harm**

**Figure 18: Intentional Injury and Self Defense**

**Figure 19: Criminal Acts**

e. **Contractual Assumption of Liability**

Standard form contracts are omnipresent in the modern world. In a variety of contexts, such contracts require individuals to assume liability risk, often by specifying that the signor will indemnify the other for any

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133 See Gray v. Zurich Ins. Co., 419 P.2d 168 (1966) (insurer refuses to defend insured sued for assault, despite claim he was acting in self-defense, because insured’s acts were nonetheless intentional).

134 See generally Baker, supra note 42.
liability relating to the contract. Such provisions, for instance, are a common condition when real or personal property is rented, with the lessor agreeing to indemnify the lessee for any liability arising out of the rental.\textsuperscript{135} Given the pervasiveness of these types of agreements, it is not surprising that the standard HO3 policy covers liability resulting from the assumption of another’s liability, so long as this occurs prior to the liability-generating occurrence.\textsuperscript{136} As reported in Figure 20, however, this is not true of many homeowners policies.

\textbf{Figure 20: Contractual Assumption of Liability}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|c|c|c|}
\hline
\textbf{Number of Policies} & \multicolumn{8}{c|}{\textbf{Contractual Obligation to Indemnify}} \\
\hline
& Coverage (ISO standard) & Exclusion & \textbf{South Dakota} (9) & \textbf{Nevada} (10) & \textbf{Ill.} (10) & \textbf{Cal.} (9) & \textbf{N.D.} (10) & \textbf{Penn.} (6) \\
\hline
0 & & & & & & & & \\
1 & & & & & & & & \\
2 & & & & & & & & \\
3 & & & & & & & & \\
4 & & & & & & & & \\
5 & & & & & & & & \\
6 & & & & & & & & \\
7 & & & & & & & & \\
8 & & & & & & & & \\
9 & & & & & & & & \\
\hline
\end{tabular}
\caption{Contractual Assumption of Liability}
\end{table}

\textbf{f. Liability Stemming from Illegal Consumption of Alcohol}

Liability related to the illegal consumption of alcohol poses an obvious risk for households that include teenagers. Perhaps for this reason, the HO3 policy does not exclude this liability. Nor, as Figure 21 shows, do most other insurers. Surprisingly, though, several insurers do indeed exclude this liability risk in their policies.\textsuperscript{137}

\textbf{Figure 21: Liability Arising out of Illegal Consumption of Alcohol}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|c|c|c|}
\hline
\textbf{Number of Policies} & \multicolumn{8}{c|}{\textbf{Liquor Liability}} \\
\hline
& Coverage (ISO standard) & Exclusion & \textbf{South Dakota} (9) & \textbf{Nevada} (10) & \textbf{Ill.} (10) & \textbf{Cal.} (9) & \textbf{N.D.} (10) & \textbf{Penn.} (6) \\
\hline
0 & & & & & & & & \\
2 & & & & & & & & \\
4 & & & & & & & & \\
6 & & & & & & & & \\
8 & & & & & & & & \\
10 & & & & & & & & \\
\hline
\end{tabular}
\caption{Liability Arising out of Illegal Consumption of Alcohol}
\end{table}

g. Lead, Pollution, and Mold Liability

As noted above, one of the major modern coverage issues involved the degree to which commercial liability insurance policies cover pollution-


\textsuperscript{136} HO3, supra note 36, at 18; See STENPEL, supra note 2, § 14.14 (noting that this coverage does not violate the principle of fortuity).

\textsuperscript{137} One insurance group accounts for the data points in four of the states, with a second insurance group accounting for the additional data points in North and South Dakota.
related liability. Presently, most general commercial liability policies contain an “absolute pollution exclusion.” But the insurance problems that exist in providing businesses with pollution liability coverage do not necessarily apply to homeowners. Most obviously, homeowners generally do not maintain and make use of large amounts of chemicals or pollutants. Even more importantly, unlike commercial businesses, homeowners are generally exempt from federal liability for contamination that occurred prior to their ownership of property.

The ISO policy does not contain any exclusions for liability involving lead, pollution, or mold. However, the ISO does maintain various endorsements that can be added to the HO3 policy to exclude or limit these sources of liability. Figures 22 and 23 report that a majority of homeowners insurers do indeed explicitly exclude coverage for these forms of liability. However, they also suggest that some insurers continue to cover these liability risks.

**Figure 22: Liability for Pollution/Lead**

<table>
<thead>
<tr>
<th>Coverage (ISO standard)</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Dakota (9)</td>
<td></td>
</tr>
<tr>
<td>Nevada (10)</td>
<td></td>
</tr>
<tr>
<td>Ill. (10)</td>
<td></td>
</tr>
<tr>
<td>Cal. (9)</td>
<td></td>
</tr>
<tr>
<td>N.D. (10)</td>
<td></td>
</tr>
<tr>
<td>Penn. (6)</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 23: Mold Liability**

<table>
<thead>
<tr>
<th>Coverage (ISO standard)</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Dakota (9)</td>
<td></td>
</tr>
<tr>
<td>Nevada (10)</td>
<td></td>
</tr>
<tr>
<td>Ill. (10)</td>
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<td>Cal. (9)</td>
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<tr>
<td>N.D. (10)</td>
<td></td>
</tr>
<tr>
<td>Penn. (6)</td>
<td></td>
</tr>
</tbody>
</table>

h. Liability for Personal Injury

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138 See Note 98, *supra*.
141 See ISO, endorsement.
As suggested at the outset of this Section, standard homeowners policies cover only liability involving bodily injury or property damage. By contrast, most policies do not cover liability stemming from harms such as mental anguish, false imprisonment, or humiliation. Rather, these potential sources of liability are typically grouped together under the heading “personal injury” and offered as an optional endorsement or as an add-on to umbrella coverage. As reflected in Figure 24, however, several companies include protection from this form of liability in their base policy.

![Figure 24: Personal Injury Coverage](image)

4. Interpretation, Limitations and Qualifications

The data reported above clearly establish that, in the states studied, there is substantial variation among the top homeowners carriers with respect to numerous important policy terms. But they do not represent a complete account of how homeowners policies differ. As described above, the specific terms identified for study were not a random sample, but were chosen because they are commonly litigated, particularly important, or reflective of initially-observed variability. Numerous terms in the sample policies varied even though they were not isolated for study. At the same time, the data may obscure the fact that there does indeed remain some degree of standardization with respect to certain terms and exclusions.

Additionally, the results must be understood in light of the fact that the sampled policies came from a non-random group of states that were willing and able to issue data calls. The sampled states may have more extensive regulatory resources or more pro-consumer dispositions, which could in turn impact the degree of variability in policy terms (although this would presumably reduce such variability). At the same time, the similarity in results across the sampled states provides reason to suspect that they are

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142 See TAN, supra notes 121-122.
143 See Part II.A.1.
144 A highly incomplete list of such variation includes: coverage for land stabilization; coverage for students’ property; definitions of “vacancy;” additional coverage for ID theft, refrigerated products, and damage to grave markers; exclusions for damage from root and tree pressure; coverage for mine subsistence; liability coverage for dog bites; liability coverage of prejudgment interest; liability coverage of punitive damages, and articulations of the duty to defend.
145 For instance, all observed policies included all of the named perils for personal property and property exclusions from the HO3 form.
146 See Part II.A.1, infra.
indicative of a national trend. This is particularly true given that policies from the top thirteen insurance groups nationally were included in the sample, and affiliated companies operating in different states usually used very similar, or identical, forms with minimal state-specific amendments.\(^{147}\)

A third qualification applies to those policy terms isolated for study that can be changed by endorsement: law and ordinance exclusions, personal injury liability coverage, and – to some degree – internal limits.\(^{148}\) The variability reflected in these categories simply involves the setting of a default by the insurer. Carriers that do not include these coverages in their base policy may simply be offering consumers enhanced choice or improving their own risk classification by allowing consumers to self-select into different groups.\(^{149}\) Interpretation of these forms of variability is thus quite complicated, turning on issues such as how well agents inform consumers about potential endorsements and whether comparison shoppers take into account different defaults when comparing different companies.

A final qualification is that differences in policy terms are only imperfectly indicative of differences in coverage. It is well known that companies occasionally give agents discretion to waive contractual violations.\(^{150}\) This could be particularly true in the insurance context, where trained adjustors routinely apply policy language.\(^{151}\) At the same time, though, much policy variability is potentially relevant precisely because it expands the discretion of adjustors and their claims handling superiors. Such discretion is itself troubling, as the sequential, contingent structure of insurance can create incentives for insurers to over-reach in claims handling.\(^{152}\) As such, variability in policy language is relevant even if it is not presently generating differences in claims handling approaches, as it impacts insurers’ discretion to approach claims handling differently in the future. Were this irrelevant to policyholders, insurance contracts could be replaced by an insurer’s promise to use its best judgment in paying claims.

A much more tentative implication of the data – which is explored further in the next section – is that some carriers may be exploiting consumer ignorance to ratchet back their coverage obligations. A substantial majority of the observed variability in policy terms reflects downward deviations from the presumptive HO3 baseline. To be sure, coverage decreases may

\(^{147}\) See TAN 62-63.

\(^{148}\) See Part II.A.1.i.j & 2.h.


well be efficient or reflect heterogeneity in consumer trade-offs between coverage and price. But the content of some of the deviations reported above raise various efficiency-related concerns.

First, several deviations – including “increase in hazard” clauses and global requirements that covered losses be “sudden and accidental” – arguably grant insurers excessive discretion in making claims decisions. Indeed, it was precisely this fact that contributed to the barratry defense falling out of favor in insurance law.153 And it is for similar reasons that discretionary clauses in insurance policies – that purport to give insurers discretion to deny claims with only limited judicial review – are so troubling.154 Simply put, it is hard to justify granting insurers so much discretion in claims handling given their inherent incentive to deny (certain) large claims and the vulnerability of policyholders who have suffered substantial losses.

Second, a disturbing trend in the data is the reemergence of policy terms that courts have repeatedly rejected in the past. This is most apparent with respect to terms that exclude coverage for theft resulting from swindle or trick or involving mysterious disappearance.155 These terms strongly resemble the infamous “visible marks” clauses that many courts rejected decades ago. Although there are indeed efficiency-based arguments for such coverage restrictions, they place a substantial amount of risk on policyholders to achieve minimal decreases in moral hazard.

Third, at least some of the exclusions found in deviant policies are very difficult to justify on efficiency-based grounds.156 Consider here, for instance, the aggregate limit of $1,000 that one carrier places on all loss resulting from artificial changes in electrical currents.157 Given the virtual certainty that such an event would simultaneously damage multiple pieces of property, a low aggregate limit on coverage seems hard to justify.158

Finally, several of the terms in deviant policies appear to have been imported from the commercial liability sphere despite important differences in the liability risks facing homeowners and commercial enterprises. The best example of this involves liability coverage restrictions for pollution, mold, and lead. As discussed earlier, the liability regime that motivated

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153 See Part II.A.2.c, supra.
156 See Part II.A.2.f, supra.
157 See Part II.A.2.h, supra.
158 Yet other deviations – such as those purporting to preserve the insurers’ right to first dollar subrogation – raise difficult issues regarding optimal coverage design. See Sykes, supra note 118.
insurers to exclude these risks in their commercial policies does not apply to
homeowners, who are specifically exempt from liability under CERCLA.159

B. Does the Quality of Different Homeowners Policies Differ Substantially in the Aggregate?

Section A conclusively refutes the myth that all personal lines
insurance policies are the same. But it leaves largely unanswered the
important related question of whether some carriers’ policies are
systematically worse or better than others. This Part seeks to answer that
question.

1. Data and Methodology

As revealed more fully below, the coding required for this Section
was quite resource intensive. For this reason, the sample in this Section was
limited to the policies collected from North Dakota and Pennsylvania.160
These states were selected for several reasons. First, both states have limited
product requirements for homeowners insurance policies.161 As a result,
they provide a good set of test cases for policy variability in the absence of
legal intervention. Second, homeowners in these states are exposed to a
similar set of perils. Third, these states have only a single overlapping
carrier among the policies collected, resulting in a set of policies from sixteen
distinct insurance groups. Finally, North Dakota includes several relatively
small regional insurers,162 which produces a more varied set of carriers.

With this set of sixteen insurance policies in place, each policy was
assigned a score reflecting its generosity. To do so, approximately 200
individual terms in the HO3 policy were compared with the corresponding
terms in each of the sampled policies. When a term in a sample policy was
unambiguously more generous than the corresponding term in the HO3
policy, it was assigned a value of 1. When a sample policy’s term was
unambiguously less generous, it was assigned a value of -1. And if the
terms were substantially identical, or it could not be determined which was
more generous, it was assigned a value of 0. This approach produces an
aggregate score of between -200 and 200 for each of the sampled policies
(“Measure One”).

159 Part II.A.3.g, supra.
160 As reflected in the data in Part II, one Pennsylvania carrier did not provide either (i) its enumerated
perils property coverage, or (ii) its liability coverage in response to the data call. Rather than eliminate
this carrier, I supplemented these missing pieces of its policy with the corresponding pieces from the
carrier’s Illinois policy. Although Illinois has more extensive content regulation than Pennsylvania,
such regulation did not appear to influence these portions of the policy.
161 For a list of their product requirements in homeowners insurance, see NAIC Product Requirements
tool, supra note 50. Apart from regulations governing cancellation, declination and non-renewal,
North Dakota has a valued-policy law, Section 26.1-39-05, and requires coverage for innocent co-
insureds who are the victims of domestic abuse Section 26.1-39-24. The North Dakota Insurance
Department also prohibits absolute pollution exclusions and requires that prejudgment interest be paid
in addition to the limits of liability. Pennsylvania’s product requirements are also limited, and include
after-death continuation of coverage. 40 P.S. § 636.1 and coverage for innocent co-insureds who are
the victims of domestic abuse, Pennsylvania Protection From Abuse Act.
162 See 2009 MARKET SHARE REPORT, supra note 44.
This approach largely mirrors the methodology of the leading empirical studies of consumer contracts. Nonetheless, it obviously involves some degree of subjectivity by the coder. For instance, defining the terms to compare inherently admits of some subjectivity, as much depends on how particular sentences and clauses are grouped together to form terms. Similarly, identifying the language in a sample policy that corresponds to a defined term is not always straightforward. Nor is determining how a sample policy term compares to the corresponding ISO term. These limitations were managed by adhering to specific criteria in defining terms and by the author doing all the coding, using a Research Assistant only to perform spot checks on consistency over time. Additionally, the fact that all policies evolved from a common HO3 form substantially simplifies many of these tasks.

Although this approach is reasonably objective, it is also inherently limited. First, it does not capture the degree to which sample policy terms deviate from the corresponding HO3 policy term. For instance, a policy that contains a term that is slightly less generous than the corresponding HO3 term is coded the same way as a policy with a much less generous term. Second, this approach ignores differences in the relative importance of policy terms.

163 See generally Florencia Marotta-Wurgler, What's in a Standard Form Contract? An Empirical Analysis of Software License Agreements, 4 J. Emp. Leg. Stu. 677 (2007); Florencia Marotta-Wurgler, Competition and Standard Form Contract Quality, 5 J. Emp. Leg. Stu. 447, 475 (2008); Florencia Marotta-Wurgler, Are “Pay Now, Terms Later” Contracts Worse for Buyers? Evidence from Software License Agreements, 38 J. Leg. Stu. 309 (2009). Marotta-Wurgler’s important empirical work is based on a sample of software license contracts. From these contracts, she selects 24 important terms and codes them according to whether each term was the same, more, or less favorable than the UCC default. These resulting consumer-friendliness scores figure prominently in much of her work.

Marotta-Wurgler’s approach for selecting terms mirrors my approach in Part A. In this Section, by contrast, I rely on the contract’s internal structure to define each term and attempt to capture virtually all meaningful terms in the contract.

164 Occasionally a term that is in one place in the ISO policy is contained in an entirely different place in the sample policy. For instance, some policies exclude coverage of emotional distress liability in the definition of “bodily harm” whereas others exclude such coverage in the grant of liability coverage. In other cases, a term in the HO3 policy is split among several places in the sample policy. For instance, the ISO policy contains a single term exempting from several exclusions liability owed to a residence employee, while other policies place this exemption in each of the exclusions.

165 This is particularly true when policy language is structured differently in the ISO policy than in the sample policy. For example, the ISO policy contains an exceptionally complex term excluding "motor vehicle liability" from liability coverage. The exception contains (i) three affirmative conditions that trigger its applicability and, (ii) in the event none of these conditions are met, five other conditions, one of which must be met in order for the exclusion not to apply. By contrast, many other policies contain a much simpler exclusion from liability coverage. In some cases, determining the relative generosity of these provisions is immensely difficult.

166 Terms were defined using the following principles: (i) Organizational breaks within the policy were respected; (ii) All provisions at the same outline level of the policy were similarly treated, (iii) Specific language that has been litigated frequently is separately defined as a term, (iv) Language with no appreciable impact on coverage is not included, (v) Definitions or concepts employed elsewhere are not treated as separate terms unless their impact on coverage is clear-cut, and (vi) approximately twenty terms are included that are found in non-ISO policies and not otherwise captured.
To address these limitations, several additional coding approaches were employed. First, in addition to assigning each term a “difference value” of 1, 0, or -1, each term was also assigned a “departure value” ranging from -3 to +3, reflecting the author’s subjective assessment of the degree to which the sample policy term differs from the corresponding HO3 term. Thus, small deviations from the HO3 form were assigned a 1/-1, moderate deviations a 2/-2, and large deviations a 3/-3. Second, terms were assigned an “importance value” from 1 to 10 depending on the author’s subjective judgment of its importance to coverage.

This approach produces three metrics of contract quality in addition to measure one, which simply aggregates difference measures. Measure two aggregates “departure values,” thus producing aggregate scores for sample policy that can range between -600 and 600. This measure introduces additional subjectivity, but captures the degree of deviation in each term. Two additional measures of contract quality are generated by multiplying either the difference values or departure values by the “importance values” of each term. These four measures of contract quality are summarized below

<table>
<thead>
<tr>
<th>Calculation Method</th>
<th>Benefits</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure 1</td>
<td>Summation of Difference Score (0, 1, -1)</td>
<td>Most objective, follows literature</td>
</tr>
<tr>
<td>Measure 2</td>
<td>Summation of Departure Scores (-3 to +3)</td>
<td>Captures extent of difference between HO3 policy and comparison</td>
</tr>
<tr>
<td>Measure 3</td>
<td>Summation of Difference score (0, 1, -1) multiplied by importance score (1 to 10)</td>
<td>Captures relative importance of terms</td>
</tr>
<tr>
<td>Measure 4</td>
<td>Summation of Departure Score (-3 to +3) multiplied by importance score (1 to 10)</td>
<td>Captures both extent of difference between terms and degree of importance</td>
</tr>
</tbody>
</table>

Ultimately, of course, each of these measures is as an inherently crude measure of a sample policy’s generosity.\[167\] At the same time, large deviations in scores clearly reflect something about the relative consumer friendliness of different policies.

2. Results

Figure 25 reports Measure One – the summation of the “difference scores” – for each of the sixteen insurers in the data set. Scores above zero indicate that the sample policy is more generous than the HO3 policy and

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\[167\] Armed with more data, it might be possible to quantify the expected value of deviant policy terms.
scores below zero indicate the opposite. Although individual insurers are not named, both their distribution system and their geographic reach are identified. The figure suggests that several carriers' policies are more generous than the HO3 policy. Consistent with Section A, though, many more insurers have policies that are substantially worse than the HO3 policy. Finally, many insurers' policies are close to the HO3 policy in overall generosity.

These results are not sensitive to which of the various measures of contract quality are used. Figure 26 reports each of the four scores for each insurer, after normalizing each of the measures to correspond to Measure One.
3. Implications, Limitations, and Qualifications

Irrespective of the approach used to measure contract generosity, there are substantial deviations among carriers in the generosity of their policies. These deviations suggest that five carriers among the sixteen studied employ policies that are substantially less generous than the HO3 policy. All five carriers are national in scope, with four exclusively employing a captive agency system and the fifth using a mixed distribution system of captive and independent agents. By contrast, three carriers – two of which rely exclusively on independent agents – have policies that are more generous than the industry norm. Only one of these carriers is national in scope and it specifically markets its services as providing high-end insurance. Finally, the remaining seven carriers have policies that are relatively close to one another as well as the HO3 policy.

Standing alone, these data do not necessarily reflect differences among carriers in contract quality or efficiency. It is possible that the five carriers with the least generous policies actually offer the most efficient policies because they eliminate coverages that some consumers do not want given the price of supplying them. Although the discussion above suggested that this is not a compelling explanation for some specific policy terms, it is quite plausible for others.\(^{168}\) Alternatively, heterogeneity in policy terms may simply reflect heterogeneity in consumer preferences and characteristics.\(^{169}\) Future work could provide further insight on these

\(^{168}\) See Part II.A.A, supra.

questions by assessing whether carriers with less generous policies offer lower premiums.\textsuperscript{170} Unfortunately, it is hard to get meaningful data on differences in price, as price in the insurance context reflects not only the product itself, but also the characteristics of policyholders.\textsuperscript{171}

At the same time, the data presented in this Section, when considered in combination with some of the more troubling result from Part A, do raise the concern that individual carriers are exploiting consumer ignorance to ratchet back coverage. Although term heterogeneity may indeed reflect heterogeneity in consumer preferences, it is also consistent with market scenarios in which some firms “specialize” in exploitation via non-salient contract terms.\textsuperscript{172} This interpretation seems to better explain the data for several reasons. First, Part A suggested various specific instances where deviations in terms were seemingly based on shaky underwriting justifications.\textsuperscript{173} Second, the explanation that firms are appealing to heterogeneous consumer preferences is hard to square with the results presented in Part III, which show that insurers are actively seeking to shroud differences in product attributes.\textsuperscript{174}

Third, the exploitation hypothesis is more consistent with the fact that all five companies with substantially less generous policies utilize a captive agency system, whereas two of the three carriers providing the most generous policy forms use independent agents. In particular, insurers are likely to be much better able to exploit consumer ignorance of company-specific differences if those consumers do not have access to an intermediary that is informed about these differences.\textsuperscript{175} Captive agents, who only work for such companies, are substantially more likely than independent agents to meet this specification. By contrast, the heterogeneity theory would be more consistent with the prediction that firms deviating from the

\textsuperscript{170} Even if carriers with less generous policies did indeed charge lower prices, this would only be partially suggestive of an answer to the efficiency question.

\textsuperscript{171} Price differences, even in the aggregate, may therefore represent either differences in the policyholder pool or differences in the underwriting approaches of different carriers.

\textsuperscript{172} See Russell Korobkin, Bounded Rationality, Standard Form Contracts, and Unconscionability, 70 U. CHI. L. REV. 1203, 1237-38, 1243-44 (2003) (noting that standard models suggest that term heterogeneity reflects different consumers’ perspectives, but that “heterogeneity of terms is also possible if buyers have identical preferences for the content of certain terms but those terms are salient for some buyers and non-salient for others”); Oren Bar-Gill, The Behavioral Economics of Consumer Contracts, 92 MINN. L. REV. 749 (2008) (if sellers offer “different terms to different consumers, tailoring their contracts in response to consumer heterogeneity” and “if some consumers are imperfectly informed and imperfectly rational and sellers design their contracts in response to mistakes made by these consumers, the resulting contracts might be welfare-reducing”).

\textsuperscript{173} See Part II.A.

\textsuperscript{174} See Part III, infra.

\textsuperscript{175} See Daniel Schwarcz, Differential Compensation and the Race to the Bottom in Consumer Insurance Markets, 15 CONN. INS. L. J. 723 (2009). This intuition is supported by the relative knowledge of captive and independent agents regarding policy variability, reported in Part III. See infra.
standardized form in either direction would utilize independent agents. Admittedly, there are various alternative explanations for this correlation. Most notably, large insurers are both more likely to utilize captive distribution systems and more likely to find deviating from standard forms to be economically feasible.

Finally, the exploitation hypothesis is also more consistent with the apparent practice of some companies who recently developed new, less generous forms, of keeping existing policyholders on older versions of their policy forms. Several of the insurers utilizing the least generous policy forms continue to issue older, more generous, versions of their policies to their long-time policyholders, at least in some states. To the extent that their new, less generous, policies were truly more efficient, one would expect them to encourage those policyholders to switch to these new forms. By contrast, to the extent that the new forms were exploitative, one would expect insurers to be hesitant to move existing business to the new forms, as such policyholders would be well situated to inquire about, and determine, the differences in the two forms. In fact, one agent revealed in an interview that he was specifically instructed by his carrier not to switch old policyholders on to the new form, as doing so could generate “legal problems.”

Ultimately, the data does not clearly demonstrate consumer exploitation. But it does raise the prospect of such exploitation and it suggests that further research of this issue is warranted. At the same time, the data show that many insurers do largely match the coverage found in the HO3 policy, and some companies offer substantially more generous policies. All this suggests that, even if some carriers are exploiting uninformed consumers, most are not. Some carriers may have shied away from cutting coverage because of the fear of reputational consequences, whereas others may have been deterred by the prospect of regulatory or judicial backlash. But whether the majority of insurers will continue to refrain from decreasing the generosity of their coverage in the future is less clear.

III. The Lack of Insurance Policy Transparency

Recent marketing campaigns for large national insurers emphasize the generosity of the coverage they offer. One national insurer promises “more coverage, less spendage.” Another warns in a series of amusing commercials featuring various personified perils that “cut-rate insurance”

176 See generally Laureen Regan & Sharon Tennyson, Agent Discretion and the Choice of Insurance Marketing System, 39 J. L. & ECON. 637, 639 (1996) (describing the factors that lead insurers to select a captive or independent distribution system).
177 See Part I, supra.
178 Interview with Agent 2 (MN).
179 See State Farm Advertisement (on file with author).
may not cover certain losses. Yet a third notes that “[y]ou need the best homeowners insurance coverage available – at a reasonable price.” Given these insurer exhortations for consumers to consider coverage along with premiums, one might think carriers would do all they could to facilitate comparison-shopping among consumers on the basis of coverage.

As this Part details, nothing could be further from the truth. Even an incredibly informed and vigilant consumer would face virtually insurmountable obstacles in attempting to comparison shop on the basis of different insurers’ policy terms. As Part A describes, consumers simply cannot access insurance policy forms on a pre-purchase basis, and the policies they receive after purchase are virtually indecipherable. Part B demonstrates that alternative sources of information including insurance agents, marketing materials, and reputation – are insufficient to allow consumers to select among carriers on the basis of their policy forms. Considered in combination with Part II, this Part demonstrates the failure of both market and regulatory mechanisms to evolve to meet consumers’ needs. The entire market for personal lines insurance continues to operate as if the conventional wisdom of insurance policy super-standardization remained operative.

A. Consumer Access to Insurance Policy Forms

1. Physical Availability of Forms on a Pre-purchase Basis

(a) Why Pre-purchase Availability Matters

Modern law and economics scholarship on standard form contracts emphasizes that standard form contracts will tend to be efficient – matching the preferences of consumers – to the extent that a sufficient percentage of consumers are informed about the content of these terms and rationally maximize their self-interest on the basis of that information. Traditionally, most assumed that informed minorities that policed the content of standard form contracts would do so through pre-purchase, comparison shopping. Starting with ProCD v. Zeidenberg, however, scholars suggested that an informed minority could protect the interests of consumers even if contracts were not made available to consumers until after purchase of the underlying

See Allstate Advertisements (on file with author).

See Farmers Advertisements (on file with author).


Consumers would also find it impossible to comparison shop on the basis of different insurers’ claims-handling practices, as regulators have refused to make insurer-specific data on this – which they collect to facilitate market conduct regulation – publicly available. See Schrartz, Regulating Insurance Sales, supra note 46, at 1761.


See id.

59 F.3d 1447.
good. Others, not surprisingly, questioned the effectiveness of market mechanisms in this context, arguing that such rolling contracts present special risks of consumer exploitation.

In light of the findings presented in Part II, the pre-purchase availability of insurance policies is crucially important to the efficiency of insurance markets irrespective of which side is correct in the larger rolling contracts debate associated with ProCD. First, and most importantly, the pre-purchase availability of policy terms is important to promote consumer choice. Efficiency is not a monolithic concept – different contracts can be efficient for different consumers depending on their preferences and circumstances. This may be particularly true in the insurance context, as consumers exhibit varied degrees of risk aversion and insurance needs vary greatly. Moreover, research suggests that the value of insurance can be quite particular and idiosyncratic. Finally, the fact that the insurance policy is the sole “product” that a consumer purchases elevates the presumed importance relevance of individual terms to consumers. For these reasons, even if all existing insurance policies were efficient for some consumers, their lack of availability on a pre-purchase basis would nonetheless produce inefficient matching of consumers with policies. Some consumers would purchase coverage more generous than they desire (given the price) and, more importantly, other consumers would purchase coverage less generous than they truly desire.

Second, whereas ordinary rolling contracts are normally accessible on a pre-purchase basis to motivated comparison shoppers, different carriers’ policies are not. In the ordinary rolling contract scenario consumers could acquire the contract on a pre-purchase basis if they were so motivated. Indeed, in the leading empirical study of rolling contracts, the author was able to collect most of the contracts studied directly from the firms with a simple request. This is not surprising: usually, the only reason consumers do not receive the contract on a pre-purchase basis is that something about the purchasing context makes this practically difficult, as

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187 See Marotta-Wurgler, Pay Now, Terms Later Contracts, supra note 163 (reviewing literature); Clayton P. Gillette, Rolling Contracts as an Agency Problem, 2004 WISC. L. REV. 679 (reviewing literature).

188 See Korobkin, supra note 172, at 1265; Robert Hillman, Rolling Contracts, 71 FORDHAM L. REV. 743 (2002).

189 In other words, there is no reason to suspect homogeneity in the preferences of consumers generally, much less readers and non-readers. See Gilette, supra note 187, at 691.


191 See Schwarcz, Products Liability, supra note 4.

192 See Marotta-Wurgler, Pay Now, Terms Later Contracts, supra note 156, at 315; Gilette, supra note 187, at 691.

193 See Marotta-Wurgler, Pay Now, Terms Later Contracts, supra note 156, at 315.
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in the case of an over-the-phone purchase. By contrast, as detailed below, it is essentially impossible even for highly informed and motivated consumers to acquire carriers’ policies on a pre-purchase basis. This distinction is important – one of the key arguments for why rolling contracts do not present distinctive efficiency concerns is that consumers could comparison shop on the basis of differences in terms if they were so inclined.

Third, the insurance context is distinctive because consumers would face non-trivial costs if they canceled coverage when they received their contract after purchase. Policyholders are usually practically required to maintain homeowners insurance as a condition of their mortgage. A consumer who was dissatisfied with a policy she received in the mail could not, therefore, simply cancel coverage. Rather, she would first have to purchase coverage elsewhere. Yet such a consumer would have no basis for determining the relative generosity of alternative insurers’ policies. Moreover, purchasing coverage from a new carrier is hardly trivial. The policyholder may already have invested resources in finding an agent and supplying all necessary underwriting information. Unless the initial agent was independent, switching carriers would include the costs of switching agents as well. Once again, this distinctive feature of insurance contracts is crucially important: aside from accessing policy forms on a pre-purchase basis, the core mechanism by which theory suggests that informed minorities can influence the efficiency of rolling contracts is through post-purchase return.

In sum, the pre-purchase availability of insurance policy forms is crucially important in light of the findings in Part II that such policies are heterogeneous. This is true irrespective of whether rolling contracts present unique efficiency risks. At the same time, the lack of pre-purchase availability of policy forms described below raises even larger concerns to the extent that rolling contracts do indeed present substantial efficiency concerns.

(b) The Lack of Pre-Purchase Availability

There are three basic ways that a consumer might plausibly acquire insurers’ policy forms on a pre-purchase basis: through insurers, insurance agents, or state insurance regulators. Each of these is examined in turn.

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194 See Hill v. Gateway, 105 F.3d 1147, 1149 (7th Cir. 1997) (Easterbrook, J.) (emphasizing the difficulty that over-the-phone sellers would have in disclosing contract terms).
197 A substantial majority of personal lines insurance products are sold through captive agents. See Schwarcz, Differential Compensation, supra note 175.
198 See, e.g., Gilette, supra note 187, at 691; Marotta-Wurgler, Pay Now, Terms Later Contracts, supra note 156, at 315; Gateway, 105 F.3d at 1149.
i. Accessibility of Policy forms through Insurers

An information-seeking consumer might first look to insurers’ websites to access copies of policy forms. A thorough review of these websites reveals that such an effort would be fruitless: not a single one of the top twenty homeowners insurers in the nation makes their homeowners policies available online.199 This fact help explain the business model of a website, run by an independent third party, that actually sells copies of 91 different policy forms to the public.200 To download a single policy, the user must pay $9.95.201

ii. Accessibility of Policy forms through Insurance Agents

Insurance agents are a second potential source of insurance policies. In order to assess whether agents would provide unfamiliar consumers with policy forms on a pre-purchase basis, twenty randomly selected agents in two states (Minnesota and Pennsylvania) were contacted. Posing as a consumer, the caller asked the agents for copies of their homeowners insurance policy form.203

These calls suggest that it is very difficult, but not impossible, for an ordinary consumer to acquire homeowners policies from insurance agents. In total, two agents – one from Pennsylvania and one from Minnesota – provided blank homeowners forms.204 The other eighteen either explicitly refused to provide a policy form or repeatedly deflected requests for such a form. Approximately half of the agents explained that it would either violate company policy to provide a customer with a policy form on a pre-purchase basis or that it was technically not feasible to do so. Many of the agents explained that it was not necessary to acquire a policy form before purchasing coverage because all insurers offer the same (or “essentially” the same) HO3 policy. Several agents mentioned that their company differed from others in that it offered an HO5 policy form or provided the option of

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199 A Research Assistant exhaustively searched each of these websites, clicking both intuitive-seeming and less intuitive links within the site and searching terms such as “homeowners policy” and “policy form” in sites’ internal search bars.


201 See id.

202 Although one might well be able to acquire an insurance policy through one’s long time agent, the key question for assessing the possibility of comparison shopping is whether a shopper could acquire copies of policy forms from unfamiliar agents with whom he or she does not have a preexisting relationship.

203 A research assistant contacted the Minnesota agents whereas the author contacted the Pennsylvania agents. Both captive and independent agents were contacted. In each case, the caller introduced himself and stated that he was interested in homeowners insurance. He explained that he was looking to buy a home in the near future, and that as part of the home-buying process he was doing some research into various potential insurance carriers. Further, he explained that as part of this research he was hoping to look over the insurer’s basic policy form and compare it to other insurer’s policy forms. Then he asked if he could obtain a copy of their most popular homeowners form. If asked, he would explain he was a first-time homebuyer, t was not a current customer, and did not have a closing date, purchase agreement, or preapproved mortgage loan.

204 The Minnesota agent mailed a copy of a blank form, which did not include the Minnesota mandatory endorsement. The Pennsylvania agent e-mailed a copy of the blank policy form.
endorsements that other companies would not sell. In general, though, the agents suggested that the caller’s attempt to compare insurers on the basis of policy forms was misguided, and emphasized that purchasing decisions should be based on price, financial rating, reputation and/or service.

iii. Accessibility of Policy forms through State Insurance Regulators

All states require that insurers file personal lines policy forms with state regulators.\(^{205}\) Moreover, the vast majority of states require that these filings be made available to the public upon request.\(^{206}\) Taken together, these two facts might suggest that consumers could easily compare different insurers’ homeowners insurance policies via state insurance regulators. In fact, though, nothing could be further from the truth.

The most fundamental problem with acquiring an insurer’s homeowners policy from state insurance regulators is that regulators often do not have these policies in their records. An assessment by North Dakota’s own personnel determined that its records contained the policies of only two of the top ten homeowners insurers in the state.\(^{207}\) South Dakota’s personnel similarly reported that many of the policy forms of the top ten insurers were not available in their records.\(^{208}\) Michigan apparently did not have any of the top ten carriers’ policy forms in their records, as it only recently began requiring insurers to file such forms with the department.\(^{209}\) Ohio’s records contained policies from only approximately half of the top ten carriers in their state, many of which may not have included mandatory endorsements.\(^{210}\) Illinois was able to secure partial copies of the policy forms of seven of the top ten carriers in the state, but required a data call to determine which policies were presently in use and to identify mandatory endorsements.\(^{211}\) A ten-hour search at the Minnesota Department of Commerce did not turn up a single “base” insurance policy for any of the top five homeowners insurers in the state. Author correspondences with regulatory officials in Pennsylvania, California, Wisconsin, and

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\(^{205}\) See Holmes’ Appleman on Insurance § 2.10, Regulation of Policy Forms (2d ed. 1996).

\(^{206}\) In a recent survey of state insurance departments, 89% of respondents reported such a requirement. See Survey, Filing Access Working Group, SERFF (June 30, 2010) (on file with author).

\(^{207}\) See Letter from Larry Musklowski, North Dakota Department of Insurance, to Daniel Schwarcz (May 3, 2010) (on file with author).

\(^{208}\) See Email from Randy Moses, South Dakota Department of Insurance, to Daniel Schwarcz, (May 6, 2010) (on file with author).


\(^{210}\) See Telephone Interview with Maureen Motter, Ohio Department of Insurance (April 22, 2010); Letter from Christi Washburn, Ohio Department of Insurance, to Daniel Schwarcz (on file with author).

\(^{211}\) See Emails from Cathi Armstrong, Illinois Department of Insurance, to Daniel Schwarcz (May 11, 12; Oct. 13).

\(^{212}\) See Emails from Carolyn Morris, Pennsylvania Department of Insurance, to Daniel Schwarcz (June 18-23) (on file with author).
Nevada similarly suggested that these states had, at best, quite incomplete copies of insurers’ homeowners policy forms on record.

There are several explanations for why regulators’ records are so incomplete with respect to insurers policy forms. First, state record retention laws generally require states to maintain records, including insurers’ forms filings, only for a specific period of time—often five years, at which point they are often destroyed. Yet insurers only submit filings to regulators when they change their policy forms. Even more importantly, when insurers change their policy forms, they typically only submit for review the specific language they are altering in their forms, without providing a new copy of the policy form as a whole. As a result, regulators typically only have at their disposal various amendments to an underlying policy, but not the policy that is being amended. Second, some insurance departments apparently do not require insurers to note whether filed endorsements are optional or mandatory. As a result, regulators often cannot determine either whether specific amendments are mandatory or whether all of the mandatory endorsements can be accounted for. Many insurers maintain numerous mandatory endorsements that substantially change the terms of their policies.

Even the information that states do possess is incredibly difficult to access. As of August 30, 2010 insurers’ filings are not available online in any states other than Wisconsin, Washington, Arkansas and North Carolina. In many cases, these documents must be accessed either by physically visiting the insurance department or hiring a private company to do so. In any event, these records are incredibly difficult to search. Insurers’ filings are almost universally contained in an electronic filing system known as SERFF. This system is very poorly designed from the standpoint of retrieving specific filings. For instance, while the system distinguishes between rate and form filings, it does not distinguish between different types of form filings, such as optional endorsements, mandatory endorsements, or base forms. In order to determine the content of a filing, the searcher must therefore click on the document link. Similarly, while

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213 See Telephone Interview with Joel Laucher, California Department of Insurance (May 13, 2010).
214 See Emails from Roger Frings, Wisconsin Department of Insurance, to Daniel Schwarz (April 21, 2010) (on file with author).
215 See Emails from Gennady Stolyarov, Nevada Division of Insurance, to Daniel Schwarz (August 20, 2010) (in file with author).
216 SERFF Survey, supra note 206.
217 This was the case in Iowa and Indiana, for instance. See Email from Kate Kixmiller, Indiana Department of Insurance, to Daniel Schwacz (May 13, 2010) (on file with author); Email from Tom O’Meara, Iowa Department of Insurance, to Daniel Schwarz (April 21, 2010).
219 See American Association of Insurance Services, Information from Filings Moves on to Public Websites, 32(2) VIEWPOINT (Fall 2007) (“While public access is intended to benefit consumers and citizens, few non-specialists can navigate through the categories of filing documents and make sense of the technical information found therein.”).
searches can be limited to a specific company, a single insurance group typically has numerous insurance companies licensed to do business in a state. Consumers often do not know which of these companies is providing their insurance. None of this is surprising: SERFF was designed only to facilitate the electronic submission of filings, not public records searches.

In some states, a consumer can obtain copies of policies by submitting a request for records directly to regulators. Departments typically charge a per-page copying fee, an hourly fee, or both to fulfill such requests. Departmental employees tasked with fulfilling these requests must, like the consumer, do so through SERFF. As a result, they face the same limitations that a consumer would face in navigating SERFF. Although they are likely to be relatively familiar with the SERFF interface, pulling up desired forms can thus take a significant amount of time (and money for the consumer). For instance, one insurance department estimated that it would take 3 hours for an official to locate the available policy forms of the top ten insurers in its state.

2. Consumer Comprehension of Policy Forms

Consumers typically receive their insurance policies in the mail several weeks after they purchase coverage. Although the lack of pre-purchase availability of policy forms is nonetheless problematic, this concern might be mitigated to the extent that post-purchase disclosure of policy terms were meaningful. For instance, a consumer who realized that he had inadvertently purchased a policy containing unusually broad exclusions might well cancel coverage or inform neighbors or friends of his dissatisfaction with the company. This, in turn, could exert a disciplining force on insurers and limit large mismatches between a consumer’s preferences and the insurance they actually purchase.

Yet every facet of the post-purchase delivery of policy forms inhibits consumer comprehension of the coverage that is purchased. First, insurers typically mail the entire policy to consumers shortly after purchase, sending only a copy of the declarations pages at renewal. Consequently, the sole instance when consumers usually receive their policies is several weeks after purchase. This is likely to be a stressful and busy time for many consumers,
when they are purchasing a new home and/or moving to a new geographic region.\textsuperscript{226} Under such circumstances, few consumers will devote substantial attention to reading the fine print of their insurance policies.\textsuperscript{227}

Second, even motivated consumers are ill-equipped to comprehend the meaning of typical homeowners policies, which are, in many ways, uniquely impenetrable.\textsuperscript{228} Consider the basic structure of the property coverage provided by a typical homeowners policy.\textsuperscript{229} The contract is subdivided into four sub-sections: (i) Property Covered, (ii) Perils Insured Against, (iii) Exclusions, and (iv) Conditions. Although most policies do not clearly sub-divide these four sub-sections in outline form,\textsuperscript{230} a policyholder who has suffered property damage is only entitled to coverage if the provisions in all four sections are satisfied: (i) the property damaged must be described in the “Property Covered” section; (ii) the peril that damaged the property must be described in the “Perils Insured Against” section; (iii) no provision from the “Exclusions” sub-section can apply; and (iv) the policyholder must comply with all terms in the “Conditions” section. Frequently terms in these sections are defined at the outset of the policy in the “Definitions” section in a way that restricts coverage. Additionally, the policyholder must also comply with a second “Conditions” section contained at the end of the policy. Thus, to understand whether a policy provides coverage for property damage, the policyholder must understand the relationship among six different portions of the contract.\textsuperscript{231}

Insurance policies are also indecipherable because they rely on verbose and confusing grammatical structures and word choices.\textsuperscript{232} To be sure, many states require insurance policies to meet minimum “readability” scores, which are based on objective, quantitative metrics.\textsuperscript{233} The typical

\textsuperscript{226} See Schwarz, Consumer Dispute Resolution, supra note 152, at 744.

\textsuperscript{227} See Korobkin, supra note 172, at 1226.

\textsuperscript{228} Although many consumer contracts are hard to understand, insurance policies are often singled out as being uniquely indecipherable. See generally Boardman, Allure of Ambiguous Boilerplate, supra note 32, at 1107 (quoting a recent South Carolina Supreme Court decision as stating that “[a]mbiguity and incomprehensibility seem to be the favorite tools of the insurance trade in drafting policies”).

\textsuperscript{229} See Daniel Schwarz, Testimony to NAIC Readability Committee (March 2010); Brenda Cude, Testimony to NAIC Readability Committee (March 2010); Amy Bach, Testimony to NAIC Readability Committee (March 2010); available at http://www.naic.org/documents/committees_d_ccwg_100328_testimony_consumer.pdf.

\textsuperscript{230} Most policies have these terms under headings such as “Section I – Property Covered,” “Section I – Perils Insured Against,” etc. These policies would be much clearer if the headings read: “Section I.A. Property Covered,” “Section I.B Perils Insured Against” etc. While a small example, this illustrates a much larger point.

\textsuperscript{231} For further elaboration of this point, see Daniel Schwarz, Testimony to NAIC Readability Committee (March 2010) (noting, among other things, that the conditions sub-section of policies contains various provisions that are not conditions, various exclusions are contained outside of the exclusions section, and the logical structure of the contract is inconsistent).

\textsuperscript{232} See generally Boardman, Allure of Ambiguous Boilerplate, supra note 32, at 1107.

\textsuperscript{233} See Cude Testimony, supra note 229; Edward B. Fry, The Varied Uses of Readability Measures Today, 30 J. READ. 338, 340 (1987) (“The insurance industry is also a prominent user of readability formulas. As of March 1984, 28 U.S. states required that personal auto and home-owners' policies must have a Flesch Reading Ease Score between 40 and 50, or about a 10th grade level.”).
requirement is that insurance contracts score 40 on the Flesch-Kincaid scale, which equates to the reading level of an early college student. Yet most Americans read below their grade level -- high school graduates typically read at the eighth-grade level and college graduates typically read at the tenth grade level.\textsuperscript{234} In any event, anyone who has attempted to comprehend even a small part of an insurance policy will recognize that crudeness of quantitative readability scores.

The immense complexity and opaqueness of insurance policies is not surprising. Absent regulation, insurers have very little reason to care about the clarity of their contracts to consumers, as the intended audience of their drafting efforts is the courts.\textsuperscript{235} In fact, holding precision constant, insurers may even benefit from impenetrable contracts. That way, consumers will not challenge coverage denials and ordinary lawyers will not have the skill or expertise to identify questionable coverage decisions.

**B. Availability of Information that Proxies for the Generosity of Insurance Policy Forms**

Various forms of information can proxy for the generosity of an insurer’s coverage. For instance, an insurer that never paid claims would presumably soon find a corresponding number of customers. This Section explores various potential informational proxies for the relative generosity of carriers’ policy terms. It provides preliminary evidence that various informational proxies, including insurance agents, marketing materials, and general reputation do a poor or limited job of informing consumers of potential differences in policy form generosity.

**1. Information from Agents**

The most important informational proxy that consumers have for the content of their policies is their insurance agent.\textsuperscript{236} Most consumers rely on insurance agents to describe the basic features of the coverage they are purchasing and advise them as to any necessary endorsements. This is true irrespective of whether they purchase coverage through a captive agent who works for a single company or an independent agent who can bind coverage with multiple different companies.\textsuperscript{237} In earlier work, however, I suggested that agents are likely to be limited proxies for coverage details such as those at issue in this article, because they “generally tend to focus on basic coverage terms and avoid coverage nuances that cannot be altered with supplemental coverage.”\textsuperscript{238}

\textsuperscript{234} Cecilia Conrath Doak, Leonard G. Doak, & Jane H. Root, Teaching Patients with Low Literacy Skills (2d ed. 1996).
\textsuperscript{235} Boardman, Allure of Ambiguous Boilerplate, supra note 32, at 1107 (“[T]he insurers’ audience from start to finish is the courts, a practice that leaves policyholders by the wayside, and one that courts unwittingly encourage.”).
\textsuperscript{236} See Schwarcz, Products Liability Theory, supra note 4, at 1415-16.
\textsuperscript{237} See Schwarcz, Differential Compensation, supra note 175, at 727-29.
\textsuperscript{238} Schwarcz, Products Liability Theory, supra note 4, at 1416; see also Abraham, supra note 3, at 56.
In order to gather some preliminary empirical evidence about the accuracy of this claim, eleven insurance agents in four different states were interviewed. Five interviews were conducted in person with Minnesota insurance agents, with the remaining six interviews conducted over the phone with non-Minnesota agents. Eight of the interviews were with captive agents, and three were with independent agents. Pursuant to IRB protocol, all interviews were conducted on an anonymous basis. Interviewees were selected randomly, with some effort to interview a range of captive agents from different companies as well as independent agents. The vast majority of agents contacted refused to be interviewed. Many agents initially agreed to be interviewed, but later declined after receiving an IRB disclosure form. In several cases, agents explained that they were explicitly instructed by their affiliated insurer not to be interviewed.

Interviews were semi-structured, centering around two ways that agents might promote consumer knowledge about differentials in coverage generosity. First, agents might directly inform consumers of the importance of comparison-shopping based on differences in policy generosity. To assess this, agents were questioned about whether they believed that carriers’ policy forms differed in their generosity. Second, agents might inform consumers about specific policy details, such that a consumer independently motivated to comparison shop on the basis of coverage could do so by speaking with multiple different agents. To assess this, agents were asked various questions regarding the coverage provided by the policy forms they sold, with a focus on coverage issues described in Part II.A. With respect to both issues, agents were asked how often these issues came up in discussions with consumers shopping for coverage.

All eight of the captive agents interviewed were unfamiliar with the variation in policy language described in Part I, though their precise beliefs about insurance policy variability ranged along a spectrum. Four of the eight agents indicated that all homeowners policies are “standard on the market” or “the same across the board,” because they are all based on the HO3 policy. Among these, several did suggest that an individual carrier could add “bells and whistles” onto the standard HO3 policy, such as identity theft. Two of the remaining captive agents indicated uncertainty about whether carriers’ policies differed. These agents both explained that

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239 Most of the non-Minnesota agents were located in Illinois. However, I also interviewed a Nevada agent and a Pennsylvania agent.
240 An assistant initially contacted agents to gauge their willingness to be interviewed. Although records were not kept about how many agents refused, my assistant estimates that over a hundred agents were contacted. For this reason, the agents interviewed were likely not representative. But selection effects likely resulted in agents who were more confident in their knowledge base, thus only enhancing the findings described above.
241 Interview with Agent 2 (MN); Interview with Agent 3 (MN), Interview with Agent 6 (IL); Interview with Agent 11 (NV) (quotations from Agents 6 and 11).
242 Interview with Agent 5 (MN); Interview with Agent 7 (IL).
they were only familiar with their own carriers’ coverage and that they had not examined other carriers’ policies. Finally, the remaining two captive agents indicated that there were indeed differences in carriers’ policy language, but that they did not know what those differences were.\footnote{Interview with Agent 8 (IL); Interview with Agent 9 (IL).}

All eight of the captive agents indicated that customers looking to purchase coverage do not ask questions about potential differences in carriers’ policy language. Several of the agents who acknowledged the possibility of differences in carriers’ policy language affirmatively indicated that precise contract terms should not figure into a customer’s decision-making among different carriers.\footnote{Interview with Agent 5 (MN); Interview with Agent 7 (IL).} Instead, they emphasized service from the agent and their carrier’s reputation. As one of these agents put it: “A contract is a contract. They are all going to do the same thing.”\footnote{Interview with Agent 7 (IL).}

The captive agents ranged in their knowledge of the coverage that their carrier’s policy provided with respect to the issues described in Part II. On one end of the spectrum, none of the interviewed agents were familiar with how their carrier’s policy dealt with issues such as concurrent causation or liability arising out of a contractual agreement to indemnify another. With respect to issues such as mold damage, pollution damage, and damage from artificial electrical current, the agents often provided a basic explanation of coverage that was almost always incomplete and, in several instances, incorrect. For instance, several agents told me that their policies covered all loss from changes in artificial current, even though their carriers’ policies contained sublimits or limits on types of damages covered. In virtually every case, captive agents indicated to me that detailed questions about policy language involved claims issues rather than sales issues.\footnote{See Baker, Claims Stories, supra note 182.} One such agent explained “I know just enough to be dangerous, but that’s all the insurance company wants me to be.”\footnote{Interview with Agent 6 (IL).} Another explained his lack of knowledge about precise terms by noting that “agents tend to be generalists – we sell home, car, life, health, lots of policies.”\footnote{Interview with Agent 9 (IL).}

The three independent agents I interviewed varied substantially in their knowledge of different carriers’ policy forms. On one end of the spectrum, one independent agent was quite knowledgeable about policy language variation in the homeowners market.\footnote{Interview with Agent 1 (MN).} This agent, whose clientele were wealthy individuals typically referred by financial advisors, explained that the policy forms of “high end” companies are usually systematically better than the standard HO3 forms. Indeed, he said that the first thing he did with new clients was to compare, side-by-side, the
differences between a standard policy form and the policy forms that one of his carriers provided. This agent indicated familiarity with a broad range of issues, including concurrent causation and mold coverage. He stated that the high-end companies tend to match one another in terms of coverage terms.

The second independent agent similarly explained that carriers’ forms differ in important ways with respect to their basic design.\textsuperscript{250} Relative to the first agent, this agent was more familiar with broad differences in policy design than differences in specific policy language. For instance, he noted that policies differed with respect to whether they built into the base form options like guaranteed replacement coverage, sewer back-up coverage, I.D. theft, and ordinance or law coverage. He indicated less familiarity with how the policies that he sold differed in specific policy language and was not personally familiar with how his carriers’ policies differed with respect to issues such as concurrent causation, mold, pollution, and coverage for liability arising out of contract. However, he indicated that the agency maintained a “cheat sheet” that laid out the major differences in different policies.

The third independent agent echoed the notion that carriers’ policies differ in important ways, such as whether they cover I.D. theft, provide replacement cost, or provide coverage on a named peril or all perils basis. However, this agent indicated that all policies – both those that he sold and those sold by all other carriers – were identical with respect to the core “cookie cutter” coverages. These coverages, he explained, were all taken from the standard HO3 policy, meaning that there were no differences in the policy language. This agent indicated lack of familiarity with many of the issues canvassed in Part II, repeating the explanation that these involved claims issues rather than sales issues.

Of course, these interviews are only suggestive given the limited number conducted and the semi-structured, qualitative methodology employed. At the very least, though, they provide strong reason to suspect that the information available from many insurance agents is not sufficient to allow consumers to comparison shop on the basis of differences in policy language.\textsuperscript{251} An exception appears to be that independent agents serving high end clients may specifically emphasize the generosity of certain insurers’ policies in steering their customers.\textsuperscript{252}

As I have explored at length in earlier work, however, even independent insurance agents who are informed about differences in

\textsuperscript{250} Interview with Agent 4 (MN).
\textsuperscript{251} See also Boardman, Insuring Understanding, supra note 4, at 1093-98; Baker, Claims Stories, supra note 182.
\textsuperscript{252} This is consistent with the finding that carriers with the worst forms employ a captive distribution system whereas carriers with better forms tend to employ an independent distribution system. See Part II.B, supra.
carriers’ policies are not properly incentivized to fully inform consumers about these differences. Such agents typically receive different amounts of compensation based on the insurers to which they refer policyholders. Of course, most independent agents nonetheless provide quality guidance to their clients, especially with respect to basic issues, such as acquiring proper endorsements, securing appropriate discounts, and recommending reliable carriers. But, whether consciously or subconsciously, the financial incentives that independent agents face to refer clients to particular carriers are likely to influence their advice, particularly with respect to issues that customers are not likely ever to notice. Nuanced differences in policy language among different carriers are precisely such an issue.

2. Information from Insurers

Not surprisingly, insurers’ marketing materials reflect the same basic information that agents provided. A comprehensive review of these materials is beyond the scope of this article. But to get a preliminary sense of these insurers’ marketing materials, the websites of the top twenty homeowners insurers nationally were reviewed for explanatory materials regarding the coverage details of homeowners insurance.

Although the sampled websites differed substantially with respect to the specificity of information available about the content of homeowners coverage, none of them explained coverage with sufficient specificity to allow for cross-company comparison. The best websites provided a good amount of basic information about homeowners policies generally, such as an explanation of the difference between all risk coverage for dwelling/structures and named peril coverage for personal property; a description of replacement cost and ACV; a listing of some sub-limits for specific types of property; a list of basic exclusions (i.e. flood, earth movement, etc.); a list of covered perils for personal property (i.e. fire, lightning, etc.); and a one to two sentence description of liability insurance and guest medical coverage.

254 Schwarcz, Products Liability Theory, supra note 4, at 1419 (describing role and importance of marketing information).
255 For a good, recent review of insurers’ marketing, see Boardman, Insuring Understanding, supra note 4, at 1093-98 (concluding that “a consumer looking to learn about insurance and insurers should turn off the television”).
256 See Schwarcz, Products Liability Theory, supra note 4, at 1419 (“Because written literature must be accessible and relevant to a wide range of readers, it can explain only the most basic coverage exclusions and endorsement options.”). See also Michael B. Rappaport, The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Constrained Against the Drafter, 30 GA. L. REV. 171, 240 n.187 (1995) (noting concern that insurers’ marketing materials may be misleading).
257 An example from the American Family website, which was comparatively quite comprehensive, follows: “If you are legally responsible for a covered accident that injures another person or damages someone else’s property, your policy will provide liability coverage up to the amount specified in your policy. We are also required to defend you against a suit for damages payable under the policy until your liability limit has been offered or paid.” The “Liability Coverage” tab also provides several
loss would or would not be covered. These websites also tend to provide some detail about available supplemental coverages, such as back up sewer coverage, contents replacement, guaranteed replacement, personal injury protection, flood coverage and scheduled personal property.

Most websites provide less detailed information. For instance, rather than listing the various covered perils for one’s personal property, one website simply explains that, with the standard policy, insureds have “[c]overage for many types of damage and for many causes of loss or damage (subject to exclusions) to . . . home and separate structures, such as a detached garage.” Along these lines, another insurer promises simply that it provides “Broad, flexible protection for your home, possessions and YOU!” These websites often make generalizable statements such as “[w]e protect the roof over your head and everything under it, especially your sense of security.” Specifics are often cabined to basic examples, such as if “something like fire” causes the insured to lose use of the dwelling, we “cover the increased costs of a place to live.”

The websites and other marketing materials of the companies with the most generous forms do, to some extent, tout that fact. One company with a relatively strong overall policy score explains on its website that its policy contains “50 Xtra features” and lists seven of them. Another company with a form that scores very well provides that its policy contains features “not usually found in other policies” such as a complimentary home appraisal, extended replacement cost option, rebuilding to code, additional living expense, and replacement cost settlement options. A quick Google search for this company pulled up marketing material that describe in more detail the various ways in which the company’s policy is more generous than the standard HO3 form. In sum, insurers’ marketing materials largely matched the limited information that was available from insurance agents.

examples of losses that liability coverage “may” protect the insured against, including “[l]iability to others such as sports activities” and “[a]cts of pets.” See www.amfam.com. By comparison, the Nationwide website explains simply that the policy includes “Protection against claims you’re legally obligated to pay”, “Payment of the cost of defending claims against you”, “Medical expenses of others”, and “Accidental death benefits.” See www.nationwide.com.

258 See, e.g., www.metlife.com; www.libertymutual.com. The FAQ in the Liberty Mutual website includes a lot more details as to what the policy covers (the questions detail coverage for bursting pipes, freezing pipes, vandalism, living expenses, damaged trees, debris removal, and items not covered by the personal property coverage). See id.


263 See www.erieinsurance.com. The extra features listed include “up to $3,000 for jewelry, furs, and watches, payment for stolen automatic garage door transmitters.” Id.


3. Information from Regulators

Only one state provides its consumers with any information at all regarding the relative generosity of different carriers’ policy forms. The Texas Office of Public Insurance Council (“OPIC”) – an independent agency charged with representing Texas consumers as a class regarding insurance-related issues266 – maintains an excellent website that allows consumers to compare the coverage that different insurers provide along twenty-one pre-specified dimensions.267 Unfortunately, even this website only partially and imperfectly captures differences in carriers’ policies, and it does not provide consumers with the capacity to actually acquire different companies’ forms on a pre-purchase basis.

There are two reasons why Texas is so distinctive in its provision of this type of information. First, Texas is one of the few states to maintain an independent entity such as OPIC, whose sole mission is to protect insurance consumers’ interests.268 Second, and even more importantly, Texas has a unique background with respect to the regulation of insurance policy forms. Prior to 2003, all insurers in Texas were required to offer one of three state-approved insurance policy forms.269 In response to a perceived mold crisis, the state overhauled its system for regulating insurers, allowing them to complete freedom to customize their policy forms. In response to this sudden and publicly visible change in the regulation of homeowners policy forms OPIC established its website for the comparison of policy forms.270

Most insurance regulators do provide consumers with company-specific consumer complaint information. Although this information continues to be inconsistent and difficult to interpret, ongoing reforms may make this information more accurate and reliable.271 But even so, complaint data is a poor proxy for the generosity of insurance policy forms. In part, this is because most of these complaints involve claims handling, cancellation, or non-renewal decisions.272 And while a company’s deficiencies in claims handling may correlate to the generosity of its coverage, it will also capture many other variables as well.

4. Reputation and Price Signals

Carriers’ reputations clearly are an important constraint on their capacity to limit the scope of coverage in their policy forms. Indeed, this is

266 See Office of Public Insurance Counsel, Sunset Self-Evaluation Report 3 (August 24, 2007), available at http://www.opic.state.tx.us/docs/487_sunset_self_evaluation.pdf. OPIC was created by Tex. Ins. Code Ann. § 501, et seq. For discussion of the value that institutions such as OPIC can provide in the regulatory Process, see McDonnell & Schwarze, Regulatory Contrarians, supra note 12.
268 See McDonnell & Schwarze, Regulatory Contrarians, supra note 12.
270 See id.
271 See Schwarze, Redesigning Dispute Resolution, supra note 152, at 756.
272 See id.
likely the primary explanation for why many insurers have not followed the lead of the some of the most aggressive companies in cutting back on the scope of coverage. But carriers’ reputations are an imperfect proxy for the quality of their coverage, as insurance is a classic “credence good,” meaning that most consumers cannot evaluate its quality even after purchase. This is for two reasons: most insureds do not experience a large claim at all (protection against which is the most important feature of insurance) and, even when they do, they are ill equipped to evaluate the “quality” of an insurers’ response. It is perhaps for these reasons that insurers spend so much on establishing their reputation through advertising. An additional limitation of reputation is that it is unlikely to discourage insurers from employing terms that afford them substantial discretion to deny claims. The mere fact that an insurer retains such discretion hardly obligates it to deny claims where it stands to lose more reputational capital than it stands to gain. Of course, the principal value of an insurance contract is precisely to limit an insurer’s capacity to make this cost-benefit analysis at the point of claim.

A second potential proxy for coverage generosity is price, as consumers can often reasonably assume that products that cost more are also higher quality. Not so insurance markets. Insurance is unique in that its price is contingent on the characteristics of the purchaser and each carrier uses proprietary approaches to assessing those characteristics. As a result, differences in price across companies may be more reflective of differences in those companies’ underwriting methodologies than differences in the quality of the underlying products that consumers purchase.

IV. Implications and Recommendations

The practical and theoretical implications of Parts II and III of this Article are wide ranging. This Part considers several of the most significant of these implications. First, and perhaps most obviously, insurance regulators must act quickly to substantially improve the transparency of insurance policy terms in personal lines markets. In fact, there is a strong

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273 Path dependence and the prospect of regulatory scrutiny are also important potential explanations.
275 See Korobkin, supra note 172, at 1240 (“In the large majority of transactions in which the content of the boilerplate never becomes an issue, there is no reason to believe a non-salient term would suddenly become salient to a repeat buyer, or to anyone with whom the buyer communicates.”).
276 See Boardman, Insuring Understanding, supra note 4, at 1093-98.
277 As argued earlier, such discretion is particularly troubling in insurance, yet is increasingly found in deviate policies. See Part II.A, supra.
278 See Cass Sunstein & Richard Thaler, NUDGE 78 (2008) (“Most of the time, Competition ensures that price serves as a good signal of quality”).
279 But cf. id. (suggesting that price may be a reasonable proxy of quality in some insurance markets).
argument that lawmakers should respond to present market conditions by mandating standardized policy forms to reduce information costs to consumers. These issues are discussed in Part A. Part B then considers the implications of this Article for coverage litigation, arguing that courts should refuse to enforce policy terms that decrease coverage relative to the HO3 ISO form unless insurers can establish that consumers were sufficiently informed, on a pre-purchase basis, of the existence of those terms. Finally, Part C considers the theoretical implications of this Article with respect to regulatory design and the efficiency of standard form contracts.

A. Implications for the Content of Insurance Regulation

1. Insurance Policy Transparency

Part III reveals a surprising lack of transparency in personal lines insurance markets. Such transparency is vital for markets to operate effectively – for consumers to select carriers that match their preferences and for firms to have appropriate incentives in drafting these policies in the first place. Improved transparency can have these effects through several different mechanisms. First, at the level of the individual consumer, improved transparency can help consumers understand the available range of coverage options so that they select carriers consistent with their insurance preferences. Second, improved transparency can enhance comparison shopping among active and informed consumers, which, in turn, can have positive externalities that benefit consumers as a whole. Third, improved transparency can more tightly link insurers’ reputations to the quality of their products by facilitating the efforts of third parties such as Consumer Reports. Finally, transparency helps to deter overreaching by firms because it increases the chance of being exposed in the future.

As noted at the outset of this Article, a working group of state regulators has recently formed to study ways to improve transparency in personal lines insurance markets. If this Working Group is to successfully modernize insurance regulation to reflect current market conditions, it must avoid easy, but ineffective, solutions. For instance, evidence suggests that simple disclosure mandates are typically not effective in remedying market problems. While disclosure may nonetheless be desirable for non-consequentialist reasons, a mere requirement that firms provide consumers with policies on a pre-purchase basis would therefore likely do little to

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280 See Part II.B., supra.
281 See Schwartz & Wilde, supra note 184.
282 See Introduction, supra.
improve matters. Rather, what is needed is a comprehensive suite of reforms that can improve transparency on multiple levels.

Some reforms are obvious and should be embraced immediately. Most notably, regulators should collect and make easily available via the Internet competing insurers’ policy forms. There is recent precedent for such an approach, as the Credit Card Act of 2009 required credit card issuers to publish on the internet their cardholder contracts. This should include all mandatory endorsements as well as optional endorsements. This information must be presented in a simple and straightforward way that allows consumers to access a basic summary of each carrier’s homeowners program along with searchable, pdf files of carrier’s forms. Insurers have no plausible proprietary interest in these policies given that they are mailed to millions of consumers and define the content of the product that insurers are selling.

Second, and perhaps even more importantly, regulators should develop tools that would allow consumers and information intermediaries to easily compare carriers’ policy forms. The admirable website of the Texas Public Insurance Council, described earlier, would be an excellent starting point. However, the Working Group should substantially expand the number of different dimensions along which consumers can compare policy forms. In doing so, it should pay particular attention to policy terms that empirical research suggests deviate from the standard ISO policy. To avoid substantial costs, regulators should require insurers to populate these comparison charts initially.

Third, regulators should require insurers to provide effective disclosures to consumers about the content of their policies. These disclosures should be publicly available on insurers’ websites and should focus on the ways in which a carrier’s policy form differs from the HO3 baseline. They should be tested for effectiveness and agents should be required to provide consumers with these disclosures early in the sales process. These disclosures should not replicate the basic coverage information that insurers already have an incentive to communicate to consumers.

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284 Cf. Hillman, supra note 195. Hillman suggests that online boilerplate may do little to correct market failures, but insulate companies from claims of procedural unconscionability. See id. at 855. This is a reasonable concern, and is a legitimate reason for considering some of the more interventionist reforms discussed infra.

285 Credit Card Act of 2009, Pub. L. No. 111-24, § 204, 123 Stat. 1734, 1736 (2009). The Act also requires card companies to submit their contracts to the Board of Governors of the Federal Reserve System which must then be made available via a public website. Id.

286 See Part III.B, supra.

287 See Schwarz, Products Liability Theory, supra note 4, at 1440-45 (arguing that adequate disclosure requires disclosure of “the basic ways in which [insurers’] policies deviate from any existing industry norms.”)
Fourth, the Working Group should explore various reforms that would enhance the intellectual accessibility of the insurance policy itself. This might well include increased readability scores, but this alone would be insufficient. Regulators should also require insurers to devote more effort to properly formatting their policies and to simplifying policy language. These are admittedly difficult tasks, as insurance policy language has indeed evolved over time in response to judicial decisions. Tinkering with the evolved language might consequently increase coverage in ways that are not efficient or introduce new uncertainty into insurer’s coverage obligations. Regulators should be sensitive to this legitimate concern of insurers in promoting the intellectual accessibility of policy forms.

One promising option that straddles disclosure and intellectual accessibility of the contracts themselves is to build on the model of transparency found in ERISA, the primary federal statute governing employee benefits. ERISA requires the plan administrator to provide each participant with “a summary plan description.” Under the statute, this description must be “written in a manner calculated to be understood by the average plan participant and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan.” Although this plan description is not itself the contract that defines the plan’s precise obligations, it is binding on the plan to the extent that it either conflicts with the underlying contract or is misleading.

2. Mandatory Minimum Floors

Ultimately, insurance policy transparency may not be a sufficient response to the findings described in this article. Rather, it may be sensible for regulators to impose mandatory floors on homeowners policies in much the same way they historically did with fire insurance policies. In this respect, it is notable that fire insurance policies still do provide a mandatory minimum floor in many states with respect to the peril of fire. The lack of a coverage floor in these states is therefore attributable to market evolution towards a comprehensive homeowners policy and away from a fire insurance policy.

288 See Boardman, Allure of Ambiguous Boilerplate, supra note 32, at 1107
289 See Jesse A. Hamilton, Property/Casualty Concerns Mount at NAIC’s Seattle Meeting AMBEST (8/16/10) (quoting David Snyder, vice president and associate general counsel at the American Insurance Association, as stating that “[t]he policies themselves are legal instruments that reflect case law and statute. In many ways, it’s impossible to make them simple.”).
290 29 USCS § 1024 (b)(1).
292 See, e.g., Hansen v. Continental Ins. Co., 940 F.2d 971, 982 (5th Cir. 1991) (“[T]he summary plan description is binding, and that if there is a conflict between the summary plan description and the terms of the policy, the summary plan description shall govern.”).
293 See Part I, supra.
Whether or not mandating a minimum coverage floor is sensible depends on several related factors. First, it depends on the degree to which reforms can allow consumers to make fully informed comparisons regarding the quality of different carriers’ policies. To the extent that industry impedes genuine transparency, regulators shy away from comprehensive reform, or informed consumer decision-making proves impossible given cognitive limitations and the complexity of the underlying contractual documents, then mandatory minimum floors may be an effective second-best solution. Second, the desirability of mandatory minimum floors turns on the extent to which such floors could be well-designed. It may be that regulators could effectively collaborate with the ISO, which has substantial experience generating standard form contracts, to set a minimum floor. Third, the desirability of mandatory minimum floors depends on the extent to which some carriers are currently exploiting consumer ignorance to inefficiently ratchet back their coverage obligations. As discussed earlier, while the findings in this article provide reason to suspect such inefficiencies in the current marketplace, further research and evaluation is needed before conclusions on this issue can be reached.

3. Default Policies

One alternative to mandating minimum coverage floors is to attempt to nudge consumers towards standard policy provisions by requiring that all insurers initially provide consumers with a state-approved default policy. Insurers would then be free to offer consumers a company-specific package of amendments to this policy in exchange for an increase or decrease in premiums. Empirical studies have repeatedly shown that individuals generally tend to stick with defaults. This phenomenon has been shown specifically in the insurance context. In New Jersey, consumers who wished to purchase complete UIM coverage, which would include emotional distress damages, could do so through an endorsement. Only 20% of drivers opted out of the default to full UIM coverage. In Pennsylvania, by contrast, the default was set at full UIM coverage, such that consumers who did not want full UIM coverage were required to select an endorsement in exchange for a partial refund. Required to opt out in order to select the more limited coverage, 75% of consumers stuck with the

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295 See Abraham L. Wickelgren, Standardization as a Solution to the Reading Costs of Form Contracts (draft on file with author).
296 See Part II, supra.
297 See generally Sunstein & Thaler, supra note 278, at 103-116 (exploring the importance of defaults generally); Schwarcz, Regulating Consumer Demand, supra note 190, at 38-45 (exploring a range of libertarian paternalistic interventions in insurance markets, including setting defaults consistent with the prescriptions of Expected Utility Theory).
298 Cf. Sharon Tennyson, Rethinking Consumer Protection Regulation in Insurance Markets, Networks Financial Institute Policy Brief 10-11 (Sept. 2010) (suggesting that regulators restrict product approval to a narrow range of “plain vanilla” products, require insurers to offer these products, but also allow insurers to offer additional products not subject to regulatory review, subject to clear disclosure).
299 See Schwarcz, Regulating Consumer Demand, supra note 190, at 44-45.
default of full UIM insurance. By requiring that insurers only offer company-specific provisions in the form of optional endorsements, regulators could thus simultaneously nudge consumers towards a presumptively reasonable policy while preserving choice for consumers who genuinely preferred a different package of policy options.

Requiring insurers to only offer company-specific policy provisions via an endorsement would have a second, information-forcing benefit as well. This is because it would effectively create a penalty-default rule. Given that many insurers currently depart significantly from the presumptive default of the ISO policy, these insurers would presumably have reason to convince insurers to opt out of the default in this alternative regime. To do so, however, they would have to convince consumers of the benefits of opting out and provide them with sufficient information about the content of the company-specific policy. Thus, setting the default in this case to penalize the more informed party could well result in better-informed consumers by affirmatively encouraging firms to sell consumers on their particular package of policy amendments.

B. Implications for Coverage Litigation

In past work, I have argued that courts could profitably draw from the parallels between insurance policies and ordinary consumer products to develop a products liability framework for understanding how and why courts should depart from the unambiguous language of insurance policies. In particular, I suggested that insurance law could implement both a defective warnings doctrine and a defective design doctrine that was patterned on products liability law. The defective warnings doctrine would “impose insurance coverage for risks that insurers do not ‘adequately disclose’ to consumers.” The findings in this Article provide renewed support for this proposal.

Courts not inclined to embrace a new doctrinal structure could easily accomplish this result within the confines of more traditional contract law. For instance, under the reasonable expectations doctrine, the objectively reasonable expectations of policyholders will be honored even though painstaking review of policy would have negated those expectations. Although the indeterminacy of this doctrine has been criticized by

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300 See id.
302 See Schwarcz, Products Liability Theory, supra note 4. For extensions of this work, see Jeffrey Stempel, The Insurance Policy as Thing, 44 TORT TR. & INS. L. J. 813 (2009); Kenneth Klein, Following the Money: The Chaotic Kerfuffle When Insurance Proceeds Simultaneously are the Only Rebuild Funds and the Only Mortgage Collateral, 46 CAL. W. L. REV. 305 (2010).
303 Schwarcz, Products Liability Theory, supra note 4, at 1441.
numerous scholars, one effective way to operationalize it in practice would be to note that, in the present market environment, consumers cannot reasonably expect coverage terms that differ from the ISO standard policy. Insurers could rebut this presumption with specific evidence that they sufficiently informed consumers about the deviant terms in their policies.

Even jurisdictions that refuse to enforce the reasonable expectations doctrine could reasonably find deviant terms in insurance policies that reduce coverage to be unconscionable. Without a doubt, these terms are procedurally unconscionable in the status quo, with insurers going to remarkable lengths to conceal these terms from consumers. The substantive unconscionability of individual terms would obviously depend on the specifics of the term. But many jurisdictions employ a sliding scale test, such that minimal levels of substantive unconscionability can be offset by large degrees of procedural unconscionability.

C. Theoretical Implications

1. Regulatory Theory

The failure of state insurance regulators to provide some modicum of transparency in personal lines insurance markets is troubling. Perhaps the least controversial element of consumer protection regulation is that it should promote transparency so that consumers understand the products they are purchasing. To be sure, insurance regulation has traditionally gone beyond mere transparency and disclosure in protecting consumers. But such efforts certainly do not eliminate the need for keeping consumers informed about their options in the market place. How can it be that regulators ignored this basic feature of regulation for so long?

There are at least two answers, both of which have important implications for how best to structure financial regulation more generally. First, the heterogeneity in insurance policies and lack of transparency in the market place are not the types of market problems that will produce consumer complaints. Indeed, in opposing transparency-oriented reforms, one important insurance lobbyist emphasized just this point, suggesting that designated consumer representatives were pursuing pointless regulations.


306 Cf. Boardman, Tested Language Defense, supra note 4, at 1099 (proposing that “If an insurer uses consumer research to test policy language before adopting it, the insurer can present the results of the research to rebut a finding of ambiguity”).


308 See Hillman, supra note 195, at 854.

309 See Jackson, supra note 283.

310 See Hamilton, supra note 289 (noting that David Snyder, Vice President and Associate General Counsel at the American Insurance Association, emphasized the lack of consumer complaints in arguing against enhanced readability protections).
Unlike issues such as premiums, cancellation, and prompt claims-payment, consumers do not know what they do not know when it comes to lack of insurance policy transparency. But just as this is precisely why regulation is so necessary, it also means that the political pressures on regulators to address this problem are limited. Less cynically, it may be that consumer ignorance means that regulators are not particularly likely to learn about this issue, as regulators often rely on consumer complaints to identify market problems.

The second key explanation for the failures of state insurance regulators in this context is historical. The regulatory regime of state regulators makes perfect sense in a world where insurance policies are indeed completely standardized, as they used to be. It is therefore no wonder that, in initially designing insurance regulation, policymakers did not develop any mechanisms for keeping consumers abreast of the content of different insurers’ policies. As with all financial markets, however, insurers evolved over time such that it is no longer necessary, or apparently desirable, for many large insurers to simply use the standardized ISO policy. Insurance regulators failed to evolve along with this market change.

2. Theory on Standard Form Contracts

Although this Article obviously focuses on insurance markets, it also contributes to the larger literature on the efficiency of standardized consumer contracts. In particular, the Article suggests that the theoretical literature – which focuses on the degree to which an “informed minority” of consumers can discipline firms to draft “efficient” contracts – may have under-appreciated the extent to which mass segmentation of consumers among different firms can undermine the efficiency of standard form contracts. Indeed, this is one compelling way to understand the current insurance marketplace, with some individual insurers appealing to informed consumers who desire enhanced coverage but with a separate tranche of insurers free to substantially reduce coverage without meaningful scrutiny from their policyholders.

Second, the Article provides some modest evidence in support of the behavioral claim that standard form contracts may tend to be less efficient with respect to non-salient terms. One striking feature of the results

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311 See McDonnell & Schwarcz, Regulatory Contrarians, supra note 12.
312 See Schwartz, Consumer Dispute Resolution, supra note 152, at 753.
313 See McDonnell & Schwarcz, Regulatory Contrarians, supra note 12 (discussing the various reasons why financial regulators have difficulty evolving along with the markets they regulate).
314 See Schwartz & Wilde, supra note 184, at 662-65 (rejecting the notion that firms may discriminate among consumers on a mass basis because price would ultimately reflect quality). To be sure, the risk of mass segmentation may be elevated in the insurance context, where price is not necessarily a good proxy for quality. See Part II.B.3. supra.
315 See Part II. supra.
316 See Korobkin, supra note 172, at 1234 (“non-salient attributes are subject to inefficiencies driven by the strategic behavior of sellers attempting to increase their profits at the expense of unknowing buyers”). One interesting distinction between insurance policies and other standard form contracts is
reviewed in Part II is that insurers’ downward deviations in coverage are typically complicated and difficult to explain, in many cases requiring deep familiarity with insurance law.\textsuperscript{317} By contrast, the marketplace seems to continue to embrace uniformity with respect to many other more salient terms. For instance, every policy examined included every single covered peril for personal property listed in the ISO policy. The reason, one suspects, is that these terms are easy to understand – if one policy covered loss due to lightning or theft, but another did not, consumers would eventually learn about this fact.\textsuperscript{318} Indeed, many of the insurer websites samples above specifically listed each of the covered perils for personal property.\textsuperscript{319}

A final implication of this study is that, with respect to standard form contracts, context matters.\textsuperscript{320} Some markets may work well in protecting consumers from exploitation through standard form contracts.\textsuperscript{321} But others do not. Indeed, this fact has started making important inroads in modern contract law scholarship, with some of the best scholarship focusing on specific contract markets, such as warranties, software licenses, and credit cards.\textsuperscript{322} For this reason, the frontier in standard form contract law scholarship is likely best understood not in terms of further argumentation about general theory, but instead in terms of careful study of individual markets.

**Conclusion**

The current personal lines insurance marketplace is largely organized around a myth. That myth is that personal lines insurance policies are completely uniform. This myth explains regulatory rules that do nothing to promote insurance contract transparency. It explains the ignorance of most information intermediaries about the details of contract terms. And, to a substantial degree, it explains the willingness of courts to treat insurance policies as ordinary contracts. As this Article has shown, this myth is false. Not only does there exist substantial heterogeneity in insurance policy terms, but most of this heterogeneity reflects the efforts of carriers to limit coverage relative to the presumptive industry baseline.

\textsuperscript{317} See Part II.A, supra.

\textsuperscript{318} See Part III, supra.

\textsuperscript{319} See Bar-Gill, supra note 172.


These insurers have actively hidden and obscured this trend, in notable contrast to the comparatively transparent marketing of the few carriers who have departed from standardized policies to improve coverage. If regulators do not act to substantially improve consumer protection in this domain, then it can be expected that coverage will continue to degrade for most carriers, in a modern-day reenactment of the race to the bottom in fire insurance that triggered the first-wave of standardized insurance policies.