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An Economic Analysis of the First Manifest Doctrine: *Paul Revere Life Insurance Co. v. Haas*, 644 A.2d 1098 (N.J. 1994)

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An Economic Analysis of the First Manifest Doctrine: *Paul Revere Life Insurance Co. v. Haas*, 644 A.2d 1098 (N.J. 1994)

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I. INTRODUCTION

It is unchanging black letter law that a contract of insurance is a transfer of risk. This system, which funds the transfer of risk, operates through an application of the law of large numbers. The transferred risk, or "peril," will produce a loss to some individuals in a large group. While each individual cannot predict if he will suffer the peril, it can be stated statistically that the peril will strike some individuals in the group. The insurer collects premiums from the group and pools them to cover these losses and the operating costs of the insurer. The risk-neutral individual, who does not know whether or not the risk will materialize, pays a small amount for protection against the small chance that it will materialize. These individuals fund the operation of a system that achieves a social good in an effective and efficient manner.¹

The perfect operation of the system can be thwarted by free riders in two ways. First, when individuals who have chosen not to participate in the group attempt to transfer risk for a loss that already has occurred, the prevalence of the risk is altered in the group. In an insurance context, this can occur when a proposed insured conceals a condition and then claims benefits for that condition. The risk-neutral individuals who "play by the rules" end up participating in a system with an artificially high concentration of the risk and facing higher than necessary payments to fund the losses of free riders, who do not participate in the cost of the system, but reap the benefit of the system.² Second, the system also is defeated to the extent that legitimate losses are not indemnified.

Historically, courts and legislatures have focused on the second concern more than the first. Through "incontestability" clauses, the insurer's ability to challenge the validity of the contract has been legislatively limited in time or scope. As insurance fraud has become more prevalent, however, these clauses have been increasingly used by opportunists as a safe harbor for fraud. Judicial doctrines have attempted to find solutions that balance the desire to protect innocent insureds with the desire to avoid encouraging insurance fraud.

One of those doctrines is the so-called "first manifest" doctrine. This doctrine uses policy language to avoid incontestability facilitated fraud by allowing coverage, but limits the risks transferred to those

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1. "Insurance law promotes efficiency whenever it is structured to help reduce the sum of the costs of insurance and loss prevention." KENNETH S. ABRAHAM, *DISTRIBUTING RISK* 11 (1986).
 2. The system becomes economically inefficient in that the cost of insurance is increased by the artificially high incidence of risk in the group. Further, to the extent that loss prevention reduces the occurrence of the risk in the group, individuals who introduce a loss that already has occurred frustrate the ability of loss prevention to reduce the frequency of occurrence.

intended by the contract. The doctrine allows the insurer to deny a specific claim for a concealed condition while allowing the insured to keep coverage under the policy in effect for any condition that was unknown to the applicant.

This Article discusses a recent leading case in the area, *Paul Revere Life Insurance Co. v. Haas*.³ *Haas* represents an example of a state supreme court making new law to achieve policy objectives. Analysis of *Haas* and similar cases in other jurisdictions suggests that the relevant policy factors behind both incontestability and exceptions to incontestability can be described in equation form. A review of historical trends suggests that those variables leading to legislative recognition of incontestability have been supplanted by other factors. In contrast, those variables leading to judicial exceptions to incontestability, including insurance fraud, have become more prominent. This perspective suggests that recent first manifest cases represent a judicial balancing of an equation thrown out of balance by rising insurance fraud. Finally, the economic perspective suggests that the doctrine is a more efficient way to achieve multiple policy goals than the legislative alternative available in some states.

II. THE HAAS DECISION

Paul Revere Life Insurance Co. v. Haas dealt with several themes that will be common in first manifest cases:

- historical policy concerns, which led to the incontestability clause, namely a belief that insurers used unequal power to overreach as against innocent insureds;
- modern policy concerns recognizing the ease and prevalence of fraud;
- the effect of any election between alternate clauses allowed by the relevant incontestability statute; and
- the interaction between incontestability clauses and contract provisions dealing with preexisting conditions.

In *Haas*, the insurer sought a declaration that a policy issued to an insured was void or in the alternative that the policy provided no coverage for a condition concealed on the application. A trial court granted the insured's motion for summary judgment, holding that the insured's policy was incontestable. The insurer appealed.⁴

In this procedural posture, the appeals court therefore viewed all disputed facts in a light most favorable to the insurer. Under this standard, the court assumed that Haas knew he had suffered from a

3. 644 A.2d 1098 (N.J. 1994), *rev'g in part*, 628 A.2d 772 (N.J. Super. Ct. App. Div. 1993).

4. 628 A.2d 772, 773 (N.J. Super. Ct. App. Div. 1993).

four-year history of retinitis pigmentosa, a degenerative condition that can lead to blindness. He neither disclosed this fact nor revealed treatment received for the condition when he applied for disability coverage with the insurer. Two years and nine months after issuance of the policy, Haas claimed that he had become totally disabled from retinitis pigmentosa and therefore was entitled to be paid under the policy.⁵

The policy issued to Haas had statutorily mandated incontestability language, which stated as follows:

10.2 INCONTESTABLE

a. After Your Policy has been in force for two years, excluding any time You are disabled, We cannot contest the statements in the application. b. No claim for loss incurred or disability beginning after two years from the Date of Issue will be reduced or denied because a disease or physical condition existed before the Date of Issue unless it is excluded by name or specific description.⁶

This version of the incontestability clause was one of two alternate versions required by section 17B:26-5 of the New Jersey statutes. The second alternative would have provided that

[a]fter 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.⁷

The appeals court found that the election to use the first version of the clause was fatal to the attempt to void the policy, even if Haas acted with fraudulent intent. "We would contravene the clear meaning of the policy, and indeed the statute, were we to graft the 'except fraudulent misrepresentations' phrase upon the clause pertinent here."⁸

The policy, however, also contained language that required the disability to be caused by a sickness that "first manifests itself after the Date of Issue and while Your Policy is in force."⁹ The policy also indicated that it would not pay benefits for "a Pre-existing Condition if it was not disclosed on Your application."¹⁰ This led to an argument that even if the policy was valid, the condition was not covered. Under this argument, the incontestability clause did not bar diseases that had not only existed, but had manifested in illness known to the insured. Alternately, the exclusion for preexisting conditions could be

5. *Id.* at 773-74.

6. *Id.* at 773.

7. N.J. REV. STAT. § 17B:26-5(a) (1985).

8. Paul Revere Life Ins. Co. v. Haas, 628 A.2d 772, 775 (N.J. Super. Ct. App. Div. 1993).

9. *Id.*

10. *Id.*

viewed as meaning that the disease was "excluded by . . . specific description."¹¹

The appeals court rejected these arguments on several grounds. First, the court held that the insurer's position would frustrate the "reasonable expectations of the average member of the public who buys it."¹² Second, the court viewed the contract as a contract of adhesion and resolved any ambiguity as to whether the condition was excluded by specific description against the insurer.¹³ Third, the court felt that the proposed rule "frustrates the underlying purpose of the incontestability clause," namely to limit litigation and to allow the insured a sense of security after the contestability period.¹⁴

The New Jersey Supreme Court reversed the appeals court decision and overruled prior New Jersey law in doing so.¹⁵ Although the court evaluated the case based on contract language, it recognized that policy concerns were involved as well. "Ultimately . . . it involves a policy choice concerning the effect of an insured's concealment of a disability in an application for insurance on a subsequent claim for the concealed disability."¹⁶

The court initially discussed the historical policy justification for the clause. Unlike the historical conclusion that insurance fraud was only a "minuscule"¹⁷ problem, however, the court also noted that "[i]nsurance fraud is a problem of massive proportions that currently results in substantial and unnecessary costs to the general public in the form of increased rates."¹⁸ Further, the court noted that the legis-

11. *Id.*

12. *Id.* at 776 (quoting *Kievit v. Loyal Protective Life Ins. Co.*, 170 A.2d 22, 30 (N.J. 1961)). Logically, this argument is valid only to the extent that the "average member of the public" expects that he may conceal an existing illness and obtain coverage for that illness.

13. *Id.* at 775. The appeals court also relied on a prior New Jersey appeals court case that had rejected this very argument. See *Lindsay v. United States Life Ins. Co.*, 194 A.2d 31 (N.J. Super. Ct. Law Div. 1963).

14. *Paul Revere Life Ins. Co. v. Haas*, 628 A.2d 772, 777 (N.J. Super. Ct. App. Div. 1993). The appeals court decision was remarkably similar to a decision by a Pennsylvania federal district court applying New Jersey law in January 1993. In *Manzella v. Indianapolis Life Insurance Co.*, 814 F. Supp. 428 (E.D. Penn. 1993), the court rejected a first manifest argument on the grounds that the insurer had elected not to use the version of the clause allowing a challenge for fraudulent misrepresentations. *Id.* at 432. The court also rejected the argument that the exclusion of preexisting conditions operated as an exclusion by specific description. *Id.* at 433-34.

15. *Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098 (N.J. 1994).

16. *Id.* at 1101.

17. *Id.* at 1102 (quoting 1A JOHN ALAN APPLEMAN & JEAN APPLEMAN, *INSURANCE LAW AND PRACTICE WITH FORMS* 305 (1981)).

18. *Id.* at 1107 (quoting *Merin v. Maglaki*, 599 A.2d 1256, 1259 (N.J. 1992)). *Merin v. Maglaki* acknowledged that "approximately 10 to 15 percent of all insurance claims involve fraud." 599 A.2d 1256, 1259 (N.J. 1992).

lature recently had passed new insurance fraud legislation designed to "confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud . . . and reducing the amount of premium dollars used to pay fraudulent claims."¹⁹ With these concerns, the court harmonized the various policy provisions by allowing the policy to remain in force, but limiting its coverage so as to exclude known conditions concealed on the application.

To do so, the New Jersey Supreme Court focused again on the incontestability clause in the contract. First, the court rejected the argument that the clause must be construed against the insurer.

Provision 10.2b . . . is not the result of the insurer's dominant bargaining power. Rather, it results from the statutory mandate of N.J.S.A. 17B:26-5b, which requires the inclusion of the provision in a disability policy.

"A specific provision integrated into the contract by the force of a statute, as a matter of public policy, 'must be interpreted and given effect in accordance with the intention of the legislature . . .'"

. . . We doubt that the Legislature, when enacting N.J.S.A. 17B:26-5b, contemplated that it was authorizing insureds to conceal a known disability and then reap the benefit of their deception by recovering for the disability that was so concealed.²⁰

Turning to the language of the clause, the court noted that the contract provided no coverage for conditions "excluded by name or specific description."²¹ Since the definition of sickness included only conditions that had manifested after the date of issue, the court held conditions known to, but concealed by, the insured were "exclu[ded] by specific description" as described in the incontestable clause.²² "Because Haas concealed that he suffered from retinitis pigmentosa, Paul Revere could hardly be expected to exclude 'that disease or physical condition' by a more specific description."²³

The court distinguished between conditions that existed but were unknown to the insured and conditions that both had existed and manifested themselves to the insured. Balancing the concern that an innocent insured could be pulled within the ambit of the court's decision, the court held that the defense could be used only when the insured was aware of a condition. "[W]hen a condition existed, but was not manifest, the insurer may not use it as a defense; but when the

19. *Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098, 1107-08 (N.J. 1994)(quoting N.J. REV. STAT. § 17:33A-2 (1985)).

20. *Id.* at 1106-07 (quoting *Saffore v. Atlantic Cas. Ins. Co.*, 121 A.2d 543, 548 (N.J. 1956)(quoting 3 CORBIN, CORBIN ON CONTRACTS § 551, at 200-01 (1960))). Using common sense, the *Haas* court also recognized that "[t]he premium would be vastly different if the insured could deceive the insurer into insuring against risks that had already arisen." *Id.* at 1107.

21. *Id.*

22. *Id.* at 1105. The decision overruled *Lindsay v. United States Life Insurance Co.*, 194 A.2d 31 (N.J. Super. Ct. Law Div. 1968), as wrongly decided on this point. *Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098, 1106 (N.J. 1994).

23. *Paul Revere Life Ins. Co. v. Haas*, 644 A.2d 1098, 1105 (N.J. 1994).

condition was known to the insured, the insurer may deny coverage."²⁴

The court reinforced the explicit policy considerations behind this interpretation by stating that "[w]e believe that insurers should compensate victims to the extent 'that compensation will not condone and encourage intentionally wrongful conduct.'"²⁵

Two dissenters harkened back to the historical policy considerations behind incontestability and would have rejected the first manifest defense.

[W]hat of the next policyholder who, not having known that she had cancer at the time she purchased her health insurance despite having felt a lump in her breast, must face costly and lengthy litigation brought by her insurance company, which claims she concealed her cancer? . . . The only reason we have incontestability clauses in insurance policies is because of widespread "charges of corruption, fraud and dishonesty" in the insurance industry.²⁶

The dissenters also felt that the insurer had made a "marketing" decision not to use the alternate clause, which would have allowed the policy to be contested on the basis of fraud.²⁷ This argument ignores that the insured's policy was not being contested and remained in force for any other conditions that had not manifested prior to issuance.

The rule in *Haas* prevents either party to the transaction from taking undue advantage of the other. The insurer is not required to indemnify for illnesses that were concealed by the insured. The policy remains in force, however, for other conditions unknown to the insured. Thus, the insured who conceals a back condition, but becomes disabled from a heart attack, retains coverage. The risk of these unforeseen losses is spread through the insurance system. Risk of a loss that has already transpired, however, remains with the insured.

Understanding the rule in *Haas* requires an understanding of the historical roots of incontestability, as well as the current massive increase in insurance fraud. The next section addresses the historical aspects of incontestability.

A. The Roots of Incontestability

The first known incontestability clause was introduced as a marketing technique in 1848 by an insurer with the unlikely name of Indisputable Life Insurance Company.²⁸ The clause is believed to have

24. *Id.* at 1107.

25. *Id.* (quoting *Voorhees v. Preferred Mut. Ins. Co.*, 607 A.2d 1255, 1263 (N.J. 1992)).

26. *Id.* at 1109 (O'Hern, J., dissenting)(quoting Eric K. Fosaaen, Note, *AIDS and the Incontestability Clause*, 66 N.D. L. REV. 267, 269 (1990)).

27. *Id.* at 1110.

28. 1 BERTRAM HARNETT & IRVING L. LESSNICK, *THE LAW OF LIFE AND HEALTH INSURANCE* § 507[3], at 5-207 (1997).

been introduced to reduce buyer resistance after a series of cases relying on breach of warranty as a defense.²⁹ Notably, the early policies excepted fraud from the operation of the clause.³⁰

Early American experience essentially mirrored the English experience, with claims resisted on the basis of breach of warranty. "Many resisted claims with such intensity that public receptivity to life insurance was further abated."³¹ By the turn of the century, the clause was relatively well established in American life insurance policies.

The voluntary introduction of the clause did not end complaints regarding insurance practices. "Common abuses by life insurance companies included the refusal to pay death benefits or offers of settlement of substantially less than the policy value because of often minor misrepresentations in the application."³² These issues led to reform commissions and hearings in several states, the most notable being the Armstrong Commission in New York and the "Committee of Fifteen" in Chicago. Both groups developed standard policy language, including a standard incontestability clause, which was rapidly adopted by a number of states.³³

Most sources relate the policy behind incontestability statutes to these early complaints.

The explanation lies in the early greed and ruthlessness of the insurers. All too often, instead of paying the beneficiary, they resisted liability stubbornly on the basis of some misstatement made by the insured at the time of applying for the policy, as to which they carefully refrained from comment until the insured had died and was unable to testify in his own behalf. . . . [S]uch cases . . . create[d] the impression on the public mind that a contract of life insurance was a one-sided affair, and was simply a scheme on the part of designing individuals and corporations to secure to themselves to the earnings of others.³⁴

Early decisions construed the statutorily mandated clause quite strictly, holding that an incontestability clause cut off all defenses except for those specifically mentioned in the clause.³⁵ Other cases held that the clause functioned as a statute of repose without exceptions.³⁶

29. *Id.*

30. *Id.* The earliest American legislation regarding incontestability also excepted fraud. Section 5779 of the Ohio statutes estopped insurers from "defending, upon any ground other than fraud . . . errors, omissions, or misstatements of the assured, in any application." See Eric K. Fosaaen, Note, *AIDS and the Incontestability Clause*, 66 N.D. L. REV. 267, 268 n.13 (1990)(citing OHIO REV. STAT. OF 1880, § 5779 (Laning 1907)).

31. Fosaaen, *supra* note 30, at 269.

32. *Id.* at 268 n.10.

33. *Id.* at 269.

34. 7 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS 394-95 (Walter H.E. Jaeger ed., 3d ed. 1963).

35. See, e.g., Plotner v. Northwestern Nat'l Life Ins. Co., 183 N.W. 1000 (N.D. 1921).

36. See, e.g., Wright v. Mutual Ben. Life Ass'n of Am., 23 N.E. 186, 187 (N.Y. 1890).

In response to the strict construction of the statute, a widely cited 1930 New York decision by Justice Cardozo began to open the interpretation of the incontestability clause. In *Metropolitan Life Insurance Co. v. Conway*,³⁷ the insurer sought to place a rider in all of the life insurance policies it issued excluding loss due to air travel other than as a paying passenger. The Superintendent of the New York Department of Insurance refused to allow the rider because in his opinion it was inconsistent with the incontestability clause of New York's insurance law.³⁸ Justice Cardozo disagreed.

The provision that a policy shall be incontestable after it has been in force during the lifetime of the insured for a period of two years is not a . . . definition of the hazards to be borne by the insurer. It means only this, that within the limits of the coverage the policy shall stand, unaffected by any defense that it was invalid in its inception, or thereafter became invalid by reason of a condition broken. . . . The kind of insurance one has at the beginning, that, but no more, one retains until the end.³⁹

In 1947, the life insurance industry drafted model legislation codifying the *Conway* decision. The model statute, drafted by a group known as the Holland Committee, stated that

[a] clause in any policy of life insurance providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such clause.⁴⁰

In spite of this trend, cases in some jurisdictions continued to enforce the clause strictly.⁴¹ From this brief history, cycles can be seen in which the incontestability has been absent, then strictly applied, then more narrowly applied, then strictly applied in some jurisdictions, and liberalized in others.

The *Haas* court explicitly discussed the rise in insurance fraud as a policy concern supporting a departure from earlier law in New Jersey. An economic perspective would predict that variations in the cycle are due to courts adjusting the rule of law to seek economic efficiency. The next section turns to that analysis.

B. An Economic Analysis of the Rule in *Haas*

The perfect function of the insurance system assumes two basic rules—that only risks within the contemplation of the parties are transferred, and that when these risks are transferred, individuals

37. 169 N.E. 642 (N.Y. 1930).

38. *Id.* at 642 (stating that the superintendent of insurance referred to N.Y. Ins. Law § 101, subd. 2.)

39. *Id.* at 642-43.

40. Fosaaen, *supra* note 30, at 276. The footnote collects citations to 27 states that have enacted some form of the Holland Committee statute. *Id.* at 276 n.67.

41. *See, e.g.,* Strawbridge v. New York Life Ins. Co., 504 F. Supp. 824 (D.N.J. 1980).

who incur the covered peril are compensated. In theory, this is a zero-sum system. Comparing only investment and payoff, an individual who transfers a risk but who does not suffer the peril has a small negative payoff. An individual who transfers the risk and suffers the peril has a large gain. On the other side of the balance sheet, the individual who incurs the peril has his large gain nullified by the economic impact of the peril. The individual who does not incur the peril has this cost offset by the benefit of knowing that the peril will have no impact. The insurer acts merely to administer the transfer of risk by setting the cost of participating in the system and delivering indemnity to those who suffer the peril. The advantage of this system is that the negative consequences of the peril are eliminated at an overall cost of zero to society.

Yet, any zero-sum system is vulnerable to manipulation by individual participants. Our "hypothetical" system assumes that risk-neutral individuals have transferred a risk of a future contingency. Free riders, in this case those who transfer the risk of a loss that already has happened or is substantially certain to happen, do not participate in the system unless and until it is to their advantage. Similarly, a hypothetical insurer who fails to indemnify for valid losses receives a free ride by artificially decreasing the incidence of risk in the pool and externalizing the cost of maintaining the insurance system to others.

From a law and economics perspective, theory would predict that concerns of economic efficiency and pareto-optimality⁴² are either implicit or explicit in formulating the rule of law applied to specific cases before a court. This theory can be demonstrated by an analysis of policy factors in incontestability, and how the doctrine has changed over time in response to changes in the strength of individual variables to the equation.

One commonly quoted source lists the main historical policy reasons favoring incontestability:

[A]n applicant . . . may be guilty of outrageous fraud. . . . On the other hand, only a minuscule percentage of the population ever resorts to such devious conduct, and it is considered desirable to have a cutoff time as to ordinary misrepresentations for two reasons: first, to lighten the burden upon the courts, since litigation could otherwise be increased manyfold; second, since most contests would arise after an insured's death, a beneficiary is in a deplorable condition to wage battle with a large insurer over statements which may have been made years earlier. For these reasons, it is better to countenance an occasional fraud in order to bring an end to controversy.⁴³

42. Pareto optimality is a definition of efficiency in which "an allocation of resources is efficient if no one could be made better off by a reallocation without someone else's being made worse off." ABRAHAM, *supra* note 1, at 10.

43. 1A JOHN ALAN APPLEMAN & JEAN APPLEMAN, *INSURANCE LAW AND PRACTICE WITH FORMS* § 311, at 305-06 (1981).

Professor Appleman's analysis can be viewed as the framework for an equation. We can describe the analysis as $TC_{(L)} + (C_{(A)} \times A_{(I)}) > (C_{(F)} \times F_{(F)}) TC$, where

$TC_{(L)}$ (Transactional Cost of litigation) + $C_{(A)}$ (Evidentiary Cost of Absence of Insured and/or passage of time) $\times A_{(I)}$ (relatively lower ability of beneficiary to successfully present evidence of true state of affairs to court) $> C_{(F)}$ (Cost of Fraud) $\times F_{(F)}$ (Frequency of Fraud).

Under Appleman's analysis, the cost of $T_{(L)} + (C_{(A)} \times A_{(I)})$ is greater than the cost $(C_{(F)} \times F_{(F)})$. Therefore, the judicial system, seeking economic efficiency, takes steps to define a rule of law that tolerates $(C_{(F)} \times F_{(F)})$ in order to reduce $TC_{(L)} + (C_{(A)} \times A_{(I)})$. A strict interpretation of incontestability reduces $C_{(A)}$ by setting a limit of two to three years in which any misrepresentation can be challenged. This also reduces $C_{(A)}$ and moots $A_{(I)}$ by cutting off the insurer's ability to present evidence as to the true state of affairs in some circumstances. Where proof of fraudulent misrepresentation after the contestable period is allowed, $C_{(A)}$ is still decreased. This is because the bar is raised for the insurer, who has the higher burden of proof of demonstrating fraud, as opposed to material misrepresentation. Systemically, $TC_{(L)}$ is lowered through a reduction in the number of cases litigated.

Other authorities state policy concerns in even more detail. The reasons that have been given for the use and mandate of incontestability clauses include the following:

- to provide insureds with a sense of security or assurance of payment;
- to prevent excessive litigation;
- to protect the consumer from the "power discrepancy" between large insurers and individual insureds;
- to provide for an investigation period followed by a period of repose;
- to prompt insurers to investigate (and discover fraud) sooner rather than later;
- to encourage consumer confidence and create a climate that encourages people to provide for their own financial security;
- to gain a competitive marketing advantage; and
- to protect insureds from the consequences of an unintentional misrepresentation.⁴⁴

This comprehensive list of policy concerns can be used to refine the Appleman analysis even further, to $TC_{(L)} + C_{(O)} + C_{(LS)} + (C_{(A)} \times A_{(I)}) > (C_{(F)} \times (F_{(F)} - ED_{(F)}))$, where

$TC_{(L)}$ (Transactional Cost of litigation) + $C_{(O)}$ (Cost of Insurer Overreaching) + $C_{(LS)}$ (Cost of Loss of Security Felt by Insured) + $C_{(A)}$ (Evidentiary Cost of Absence of Insured and/or passage of time) $\times A_{(I)}$ (relatively lower ability of beneficiary to successfully present evidence of true state of affairs to court) $> C_{(F)}$

44. Robert R. Googins, *Fraud and the Incontestable Clause: A Modest Proposal for Change*, 2 CONN. INS. L.J. 51, 68 (1996).

(Cost of Fraud) \times ($F_{(F)}$ (Frequency of Fraud) - $ED_{(F)}$ (Insurer's Ability to Detect Fraud at an early date)).

Historically, $C_{(O)}$ was viewed as having a high value. Similarly, in the historical analysis, $ED_{(F)}$ was viewed to be high because application fraud was thought to be relatively easy to detect. These variables act only to strengthen the degree to which the equation was historically viewed as tipping to the first side.

The current empirical validity of this analysis can be tested by assessing both historical and current values of each variable.

1. $C_{(F)}$ (Cost of Fraud) \times $F_{(F)}$ (Frequency of Fraud)

It is clear that both $C_{(F)}$ and $F_{(F)}$ have increased. Insurance fraud is an enormous societal cost, with an estimated \$163 billion paid in fraudulent property and casualty claims alone from 1985 to 1994.⁴⁵ Fraud in health care may be higher, with estimates running as high as \$100 billion per year.⁴⁶ One study found that between 35% and 42% of auto injury medical costs were fraudulent or exaggerated.⁴⁷ Twenty percent of every claims-dollar may be attributable to fraud.⁴⁸ In disability cases, 12% of fraud may be attributable to concealing a previous condition, with an additional 16.2% involving misstated income at the time of application, and an additional 6.5% involving misstated occupations.⁴⁹

Arrests for insurance fraud have risen from 251,000 in 1985, to 331,000 in 1994, a 31.8% increase in nine years.⁵⁰ This statistic should be viewed in light of the low conviction rate and the minor penalties imposed.⁵¹ The problem is so massive that in spite of the large number of arrests, "the track record of insurance fraud detection and prosecution in the states has been unremarkable. Police and prosecutors have not always followed their legislative mandates. State insur-

45. INSURANCE FRAUD: THE QUIET CATASTROPHE 51 (Conning & Co. 1996).

46. Googins, *supra* note 44, at 76 n.118.

47. INSURANCE FRAUD, *supra* note 45, at 55 (quoting RAND INST. FOR CIVIL JUSTICE, THE COSTS OF EXCESS MEDICAL CLAIMS FOR AUTOMOBILE PERSONAL INJURIES (1995)).

48. Googins, *supra* note 44, at 76 (quoting CAL. INS. CODE § 1871(b) (West 1993)).

49. KATHLEEN FYFFE ET AL., HEALTH INSURANCE ASSOCIATION OF AMERICA, DISABILITY INCOME INSURERS' ANTI-FRAUD PROGRAMS 4-5 (1994).

50. INSURANCE FRAUD, *supra* note 45, at 8.

51. *Id.* at 57. For example, while 15% of arson cases lead to arrest, only 2% of arson cases result in a conviction. One-third of those convicted receive no prison time, and the remainder generally receive fewer than two years. *Id.* "Most criminal law enforcers are interested in highly visible, organized fraud cases and are not particularly suited or eager to pursue the single policy fraud case." Googins, *supra* note 44, at 75. Professor Googins notes that during his term as insurance commissioner, "a member of the FBI team fighting insurance fraud stressed that the Bureau was interested in large, high visibility cases because of their newsworthiness and educational value." *Id.* at 75 n.110.

ance departments often are underfunded and understaffed. Prosecutors often refuse cases unless they involve major organized fraud."⁵²

Numerous egregious examples of fraud have received attention in the media:

- New Jersey fraud investigators staged a series of bus accidents in which the only passengers were fraud investigators. More than 100 individuals either jumped on the bus immediately after the staged accident or filed claims stating that they were on the bus.⁵³
- Fraud rings involving attorneys, physicians, and fraudulent claimants have spread from automobile injury claims, to workers compensation, to "disability mills . . . buying lists of workers that had been laid off to create false medical reports and bills."⁵⁴
- A Florida dentist allowed his brothers to chop off a finger to facilitate a \$1.3 million homeowners claim and a simultaneous disability claim. A portion of the money was used to purchase a yacht named the "Minus One."⁵⁵
- A worker collected \$3 million from a worker's compensation claim and an allegedly botched corrective surgery, claiming that he was totally dependent on his wife for his needs. Video surveillance captured the insured dancing.⁵⁶
- A Colombian insured supported his own \$500,000 death claim with a faked death certificate, a rented burial vault, and a fabricated automobile accident.⁵⁷

Societal attitudes toward insurance fraud have also changed. Twenty-five percent of respondents in a recent survey indicated that they knew an individual who was collecting worker's compensation even though capable of working.⁵⁸ "An estimated 17 percent of the public would stay out of work and collect income replacement benefits even after they had fully recovered from their disabling sickness or injury."⁵⁹

Acceptability of claim padding, application fraud, and similar practices is rising:

52. Edward J. Schrenk & Jonathon B. Palmquist, *Fraud and Its Effects on the Insurance Industry*, 64 DEF. COUNS. J. 23, 34 (1997).

53. INSURANCE FRAUD, *supra* note 45, at 23.

54. *Id.* at 26.

55. *2 Brothers Held in Amputated Finger Scam*, ORLANDO SENTINEL, Aug. 13, 1994, at D8A.

56. *Horse Slayings & Digitless Dentist Among Top Ten Frauds*, 9 FED & ST. INS. WK., Jan. 23, 1995.

57. Joseph B. Treaster, *Faked Deaths Plague Insurance Industry—Number of Cases Growing at an Alarming Rate*, MINN.-ST. PAUL STAR-TRIB., July 5, 1997, at 1D.

58. INSURANCE FRAUD, *supra* note 45, at 51.

59. Andrew S. Bernstein, *Tackling Disability Insurance Fraud*, NAT'L UNDERWRITER, Apr. 28, 1997, at 40 (Life & Health/Fin. Serv. ed.).

Compared to five years ago, more people today believe that padding and stretching are acceptable when it comes to insurance claims. According to a 1995 survey conducted by the Insurance Research Council (IRC), 28% believe that claim-padding is appropriate in order to recover their deductible, and 24% think they can do the same thing to make up for premiums paid in earlier years.⁶⁰

Beyond this, 14% of the public felt it was acceptable to omit accidents or tickets from an insurance application. Eleven percent felt that it was okay to go back to a doctor for treatment after an injury had healed. A shocking 5% rated as acceptable "[b]eing involved with an organized ring of doctors, lawyers and body shops that file false claims to get money from insurance companies."⁶¹

2. *ED*(*F*) (Insurer's Ability to Detect Fraud at an Early Date)

Traditionally, the medical history of a proposed insured is evaluated through medical records, a medical examination, and contact with the insured's physician, which is merely optional. The insurer cannot uniformly rely on the insured's physician, however. One study found that only 20.7% of physicians in a sample believed that each of three examples of insurance fraud should be reported. In the remaining cases, criteria such as the patient's overall health and the wealth of the patient impacted their decision.⁶² Provider fraud in the health area has increased 75.5% from 1990 to 1992.⁶³ The failure of providers to respond to requests for records, along with a refusal to release psychiatric records and refusal to provide information on physical or mental capacity, is a recognized problem in the disability insurance industry.⁶⁴

The insurer's ability to detect fraud also has been hampered by statute or case law on several fronts. For example, some states initially placed restrictions on an insurer's ability to use HIV testing in the application process or to ask questions concerning prior testing.⁶⁵

60. INSURANCE FRAUD, *supra* note 45, at 25.

61. *Id.* at 27.

62. Neil J. Farber et al., *Confidentiality and Health Insurance Fraud*, 157 ARCH. INT. MED. 501, 501-02 (1997). The insurer's ability to discover fraud is "pivotal to the philosophical underpinning of the clause." 1 HARNETT & LESSNICK, *supra* note 28, § 507[2], at 5-224. When that ability to investigate is compromised, other policy assumptions behind strict incontestability are open to question as well.

63. INSURANCE FRAUD, *supra* note 45, at 67. Provider fraud included fraudulent diagnosis, fraudulent dates of treatment, and billing for services not rendered. *Id.* It is difficult to imagine providers involved in health fraud cooperating in application fraud detection efforts.

64. FYFFE ET AL., *supra* note 49, at 9-10.

65. See, e.g., CAL. HEALTH & SAFETY CODE § 120980(f) (West. Supp. 1996)(stating that insurers may not use results of HIV blood tests to determine insurability)(limited to policies prior to September 26, 1989, see by CAL. INS. CODE art. 6.9, § 799.02 (West. Supp. 1996)); WIS. STAT. ANN. § 631.90 (West 1995 & Supp. 1997)(insurers may not inquire into whether an applicant has taken an HIV test).

In some states, a provider may refuse to release psychiatric or psychological records if, in the judgment of the provider, access would have a negative impact on the health of the patient.⁶⁶ Under one judicial decision, a hospital may decline to release records despite an authorization if releasing the record would be harmful to "an important program of the custodian of the records."⁶⁷ Access to records of substance abuse require special authorizations and may meet with partial or limited disclosure due to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970.⁶⁸

Medical examination also is less valuable than previously. Improving medical technology has increased the latency time between diagnosis of a disease and disability or death from the disease.⁶⁹ This makes the disease more difficult to detect, even if a medical examination accompanies the policy. It also means that "waiting out" the contestability provision may be easier for the insured. As a result, other commentary has suggested that the period of incontestability should be extended from two years to five years. The reasoning behind this argument is that the two year period, fixed before 1950, was chosen in the context of life insurance. The period may have been chosen due to a belief that "if an applicant with a terminal illness misrepresented his health condition, death would result in two years."⁷⁰ In contrast, when improved medical treatment extends life spans, "there may be a greater incentive for the applicant to withhold material information and gamble on the likelihood that they will live longer than two years."⁷¹

Judicial decisions also have impacted this area. At least some decisions have allowed incontestability to be enforced when it is proven that the insured sent an imposter to the medical exam.⁷² Medical records and other documents also can be falsified. Technology, includ-

These statutes create a "catch-22" in that one of the policies behind incontestability is to encourage investigation into the insured's medical condition. Thus, incontestability is mandated because the insurer "failed to investigate." At the same time, the investigation is elsewhere prohibited by statute.

66. See, e.g., COLO. REV. STAT. § 25-1-801 (1994).

67. Cynthia B. v. New Rochelle Hosp. Med. Ctr., 458 N.E.2d 363, 365 (N.Y. 1983).

68. 42 U.S.C. § 290dd-3 (1995).

69. Googins, *supra* note 44, at 76. Googins notes a telling comment from Karen A. Clifford & Russell P. Iuculano, *Aids and Insurance: The Rationale for AIDS-Related Testing*, 100 HARV. L. REV. 1806 (1987). "[I]t becomes relatively simple for an individual with knowledge of his or her infected status to make misrepresentation regarding such knowledge with reasonable assurance that the incontestability period will expire before 'suspicious' symptoms appear." *Id.* at 1819.

70. Greg C. Oberland, *Fraudulent Misrepresentations Discovered After the Contestable Period—Is There a Defense?*, 1995 INT'L CLAIMS ASS'N LIFE INS. WORKSHOP REP. 60, 60-61.

71. *Id.* at 64-65.

72. See *Amex Life Ins. Co. v. Superior Court*, 930 P.2d 1264 (Cal. 1997).

ing optical scanners, makes it increasingly easy to forge documents submitted with an application or claim.⁷³ Another sophisticated use allows fraudulent claimants to alter photographs submitted to insurers as documentation of loss.

Finally, it should be remembered that the insurer's access to information regarding the insured is to some extent controlled by the insured. If an applicant fails to disclose a source of medical treatment on an application, the insurer's devices to locate the truth are limited. Most insurers use the Medical Information Bureau, a clearing house of insurance reports on medical information. But, the system is contingent on the information contained in it. Most adverse information comes from declined applications from other insurers. When adverse information is unreported or undiscovered by other insurers, the value of this tool is limited.⁷⁴ Interviews of the applicant's associates are expensive, intrusive, and vulnerable to manipulation by persons sympathetic to the insured. Of course the availability of anonymous testing for disorders such as HIV opens yet another possible means of manipulating the system.

3. C_(A) (Evidentiary Cost of Absence of Insured and/or Passage of Time)

Most cases applying the first manifest doctrine involve the accident and sickness line, and, in particular, disability policies. Policy considerations behind incontestability are weaker in these cases. As one court notes,

(1) in a contest of an accident and sickness policy, the insured is generally alive and can testify to protect his rights while in the case of life insurance he is no longer available to rebut adverse claims of the insurer and the broader incontestable clause is needed to safeguard the rights of the beneficiary; (2) although a physical examination is required before a substantial life insurance policy is issued, most accident and sickness policies are written without such an examination and the benefit of the information it reveals; (3) in most life insurance contracts there can be only one claim on each policy and in a

73. Schrenk & Palmquist, *supra* note 52, at 26 (quoting Gene Rappe, *High-Tech Criminals Dupe Claims Professionals*, NAT'L UNDERWRITER, May 22, 1995, at 13 (Prop. & Cas./Risk & Benefits Mgmt. ed.). Document fraud can be low-tech as well. For example, a Massachusetts man forged forms from both his physician and employer to support a disability claim. When discovered, the insured "stated that the insurance proceeds were used for her car payments." Insurance Fraud Bureau of Mass., "*Disability Benefits Used for Car Payments*" Case Update (visited Feb. 19, 1996) <<http://www.ifb.org/129522.htm>> (on file with Author).

74. After one policy was declined, the insured in the one case altered the spelling of his name (from C. Tony to Anthony C.) and his birthdate on an application to a second insurer. *Fioretti v. Massachusetts Gen. Life Ins. Co.*, 53 F.3d 1228 (11th Cir. 1995). Efforts such as this appear to be designed to create confusion and defeat any use of pooled information.

fixed amount while accident and health insurance subjects the insurer to many claims in varying amounts which can be potentially large.⁷⁵

Courts and legislatures quickly recognized that much of the policy behind incontestability was not a good fit with lines of law other than life insurance laws. In 1922, the National Association of Insurance Commissioners recognized this concern and suggested that insurers should be allowed to exempt from the operation of the statute disability and accidental death benefits appended to a life insurance contract.⁷⁶ Approximately one-half of the states have followed the recommendation,⁷⁷ and these statutes were well received by the courts.⁷⁸

75. *Taylor v. Metropolitan Life Ins. Co.*, 214 A.2d 109, 115-16 (N.H. 1965).

Another differing rationale is that for life insurance claims, the clause functions to protect innocent beneficiaries who had no part in the original fraud. This is untrue in disability cases. In a parallel context, one court dealt with the issue of whether the risk of misrepresentation should be allocated to an insured or insurer under a compulsory no-fault. In a case in which the insured misrepresented information, and filed a claim one hour after the binder was issued, the court stated that there was no reason in law or policy for the burden of such a risk to be placed on the insurer in preference to the insured who made the intentional material misrepresentations. . . . [N]o question of reliance on the binder by the public is presented, because the claim for personal protection benefits is made by an insured who made intentional material misrepresentations, rather than an innocent third party.

United Sec. Ins. Co. v. Commissioner, 348 N.W.2d 34, 36 (Mich. Ct. App. 1984).

76. MURIEL L. CRAWFORD & WILLIAM T. BEADLES, *LAW AND THE LIFE INSURANCE CONTRACT* 432 (6th ed. 1989).

77. *Id.* Actually, the recommendation has been incompletely followed. The amendment may be made to statutes governing life insurance policies, but not to parallel incontestability statutes governing accident and health policies. As a result, disability benefits appended to a life insurance contract may be contestable for material misrepresentation, while a stand-alone disability policy purchased at the same time, from the same company, could be incontestable or contestable only on the basis of fraud. Compare MINN. STAT. § 61A.03(1)(c) (Supp. 1996) (stating that disability benefit provisions of a life insurance policy may be exempted from incontestability), with MINN. STAT. § 62A.04(2)(a) (Supp. 1996) (stating that in accident and health insurance policies, statements are contestable after two years only for a fraudulent misstatement). The result is a strong argument for the first manifest doctrine in some jurisdictions. A legislative intent to exempt disability benefits from the operation of life incontestability statutes altogether should at least translate into a narrow reading of parallel incontestability statutes pertaining to an accident and health disability contract. The same policy concerns support an identical interpretation of the same kind of benefit in both lines.

78. See, e.g., *Equitable Life Assurance Soc'y v. Deem*, 91 F.2d 569 (4th Cir. 1937). The *Deem* court stated that "[t]o make a contract incontestable after the lapse of a brief time is to confer upon its holder extraordinary privileges. We must be on our guard against turning them into weapons of oppression." *Id.* at 575 (quoting *American Life Ins. Co. v. Stewart*, 300 U.S. 203, 215 (1937)).

4. *A₀* (Relatively Lower Ability of Beneficiary to Successfully Present Evidence of True State of Affairs to Court)

This variable addresses a presumed difference in resources between the "large insurer" and the lone beneficiary. While this picture may have had validity in the early 1900s, several factors have changed. First, it is easier for the modern consumer to find and fund counsel to pursue a case. The willingness of plaintiffs' counsel to accept cases on a contingent fee has increased.⁷⁹ Televised advertising has made it easier for an insured to locate counsel ready, willing, and eager to take on an insurer.

Second, beginning in the 1980s, precedent in a number of jurisdictions has allowed an insured to recover attorney's fees when it is "reasonably compels the insured to retain an attorney to obtain the benefits due under a policy."⁸⁰

Third, the rules of civil procedure have changed to make class actions easier to certify and available to correct any abusive practice that affects a group of individuals. In the days when warranty was used abusively by some insurers, each insured faced an individual battle. Equity courts were more comfortable with class actions than law courts. The original federal rules provided a difficult-to-apply rule defining "true," "hybrid," and "spurious" class actions.⁸¹ The rule was rewritten in 1966 and became more frequently used.

[U]nder the 1966 revision of the federal rules the class action seemed to be a vehicle ideally adapted to the task of redressing wrongs that the general public had traditionally been forced to suffer in silence It would be an exaggeration to say that people flocked to the courts in swarms and clogged the dockets with class actions. However, newspapers abounded in stories of class actions, and the federal advance sheets were full of them.⁸²

Fourth, the power difference has been altered by the ability of the insured to conduct broad discovery. In an individual case in which the insured believes that a pattern or practice has occurred, the insured

79. Indeed, contingent fees were not available at the time the incontestability debate began.

The American Bar Association, reflecting the history of the development of the contingent fee as one of grudging acceptance, gave its reluctant approval in 1908. Subsequent developments have accelerated the acceptance and use of contingent fees. Extensions of tort liability have increased plaintiffs' likelihood of prevailing. . . . [I]n turn, this has increased the number of lawyers willing to accept contingency fee arrangements.

Lester Brickman, *Contingent Fees Without Contingencies: Hamlet Without the Prince of Denmark?*, 37 UCLA L. REV. 29, 37-38 (1989).

80. *Brandt v. Superior Court*, 693 P.2d 796, 798 (Cal. 1985).

81. MILTON D. GREEN, *BASIC CIVIL PROCEDURE* 98-99 (1979).

82. *Id.* at 96. "[C]lass actions filings have increased dramatically, to a point where it is argued that they have become strike suits, filed by attorneys seeking fat fees but producing few other real benefits." MARY KAY KANE, *CIVIL PROCEDURE IN A NUTSHELL* § 8.1, at 226-27 (1979).

may be allowed to conduct wide ranging discovery of other litigation, claim denials, or complaints involving the insurer.⁸³ In practice, this type of discovery probably creates more abuse than it prevents. Nevertheless, it again is an indication that the power balance between insured and insurer has changed.

Finally, the modern insured has an increased ability to preemptively sue or countersue under changing legal theories. This can allow the insured to abort the investigative process if a claim is filed. In spite of qualified immunity in many states, insurers may face defamation suits for reporting suspected fraud.⁸⁴ One attorney discussing the problem notes that "[y]our field report on a \$10,000 claim can cost you \$100,000 even if you win on summary judgment."⁸⁵ The use of independent medical examinations is also under attack, with independent medical examiners facing the possibility of being named individually in a suit.⁸⁶ The "power difference" in these figures is the reverse of the classic assumptions.

5. *C*_(O) (Cost of Insurer Overreaching)

This concern essentially is a stereotypical fear that insurers will use any opportunity to overreach and take advantage of insureds. Much of the historical concern with insurer overreaching grew from the characterization of statements in the application as warranties in the late 1800s and early 1900s. Warranty is a concept from marine insurance, which was grafted onto the fledgling life insurance industry.

[A] warranty must be absolutely and literally true, and a forfeiture will result if merely the falsehood of the statement can be shown, irrespective of its materiality. A company need prove only that a warranted statement is incorrect. The courts assume that the materiality of the thing warranted has been established and that all inquiry on the subject is precluded.⁸⁷

In maritime law, no hardship flowed from the use of warranties because of the short time between the making of the contract and any dispute over the validity of the contract.⁸⁸ Applied to life insurance, a warranty could have harsh application, allowing the contract to be de-

83. See, e.g., *Colonial Life & Accident Ins. Co. v. Superior Court*, 647 P.2d 86 (Cal. 1982)(allowing discovery of the identity of other policyholders potentially subject to an alleged improper business practice of the insurer).

84. Douglas McLeod, *As If Fraud Weren't Expensive Enough: Suspects May Sue Insurers for Defamation*, *Bus. Ins.*, June 16, 1997, at 10.

85. *Id.*

86. See, e.g., *Pettus v. Cole*, 57 Cal. Rptr. 2d 46 (Cal. Ct. App. 1996)(involving an employee who sued his employer and two psychiatrists used to examine the employee in connection with a request for disability leave under the California Confidentiality of Medical Information Act and various tort theories).

87. KENNETH BLACK, JR. & HAROLD SKIPPER, JR., *LIFE INSURANCE* 126 (11th ed. 1987).

88. CRAWFORD & BEADLES, *supra* note 76, at 423-24. Maritime law disputes generally involve commercially sophisticated parties as well.

feated for statements that were not material to the assumption of the risk. The use of warranties in applications subsequently has been prevented by statute in most states⁸⁹ and rarely is used by the industry in life and health insurance.

The second major change between the early 1900s and present day has been the rise of first-party bad faith actions. If insurers were motivated to overreach, this doctrine controls the tendency. A first-party bad faith action allows the insured to recover tort damages, including punitive damages and attorneys fees, in a dispute over the administration of an insurance contract. Without first-party bad faith, the insured is limited to contract remedies and damages. The leading precedent in these cases arose in 1973, in *Gruenberg v. Aetna Insurance Co.*⁹⁰ Since then, the doctrine has continued to evolve. A recent study by the RAND corporation found that 12.8% of insurance verdicts in a multijurisdiction sample awarded punitive damages.⁹¹ In California, the figure was 19.1%.⁹² The median punitive award nationwide in insurance cases was \$652,000, with 10% of the awards exceeding \$13.5 million.⁹³ The study concluded by noting that

because punitive damages can be many times the compensatory award . . . their size is less predictable. Individuals and organizations may find it more difficult to develop expectations as to both the kinds of behavior that will result in a punitive award and the amount of any such award. . . . Critics of the current system, for example, argue that the risk of a very large punitive award sometimes drives defendants to settle cases in which they believe the claim is not meritorious, or to settle meritorious claims for far too much. . . . The literature on risk perception and management in decisionmaking suggests that in assessing risks, most business decisionmakers focus on worst case scenarios and will go to great lengths to avoid exposing their companies to very large financial losses.⁹⁴

In short, the "power differential" that concerned the formulators of incontestability may well have not only been closed, but actually reversed.

Third, regulation of insurers has increased in the decades since the early 1900s.

In the last several decades we have seen the elaborate development of state insurance codes dictating the construction of contracts and requiring their filing, the increased use of mandated coverages, and the enactment of entire contract laws. More importantly still is the development and strengthening of consumer affairs (complaint) staffs within the Insurance Departments and

89. BLACK & SKIPPER, *supra* note 87, at 126-27.

90. 510 P.2d 1032 (Cal. 1973).

91. ERIK MOLLER ET AL., RAND INSTITUTE FOR CIVIL JUSTICE, PUNITIVE DAMAGES IN FINANCIAL INJURY JURY VERDICTS 22 (1997).

92. *Id.* at 35. Punitive damage awards were "considerably higher in California relative to the other states in the database." *Id.* at 34. The mean punitive award in the sample was \$2.9 million. *Id.*

93. *Id.* at 29.

94. *Id.* at xi.

Market Conduct Divisions specifically designed to examine the sales and claims practices of insurers. . . . This development has been coupled with the growth of organized consumer groups that assist identification of questionable trade practices. Multistate market conduct exams have been initiated.⁹⁵

In summary, the use of strict incontestability to control any perceived tendency of insurers to overreach⁹⁶ is at best an elaborate redundant backup system to antiwarranty statutes, tort doctrines, and state regulation. The cost of this fourth backup system is high in that fraud is tolerated.

6. $C_{(LS)}$ (Cost of Loss of Security Felt by Insured)

This variable arose again in the life insurance context and contains an implicit assumption that the insured is entitled to security. It is unquestionable that an applicant who has been honest is entitled to the security of the contract he obtains. There are limits to this principle when fraud is involved, however.

It does not necessarily follow . . . that frauds and cheats are entitled to the same comfort. Why should frauds—criminals, to be blunt about it—be entitled to the warm and fuzzy feeling of repose? Certainly, no public policy reason exist to protect frauds unless their protection is an unavoidable evil as the only way innocent insureds are provided the comfort to which they are entitled.⁹⁷

The remedy that a court can grant under the first manifest doctrine also acts to reduce the value of $C_{(LS)}$, as will be discussed.⁹⁸

Finally, changes in the social safety net since the early 1900s also have somewhat reduced the value of this variable. The loss of benefits to a beneficiary of a life policy in a single-income family in the early 1900s (or worse, in the Depression years) was devastating. In the 1990s, social devices such as social security disability, welfare, Medicaid, and state cash sickness programs provide alternate, albeit less complete, methods of mitigating a loss of income.

7. $TC_{(L)}$ (Transactional Cost of Litigation)

This variable revolves around the concern that incontestability discourages litigation and thereby reduces the transactional costs associated with the insurance system. Appleman states the issue as one in

95. Googins, *supra* note 44, at 70.

96. In the Author's practice and belief, the industry is filled with claims personnel whose primary concern is paying legitimate claims. The good faith belief that an individual claim may be improper or even fraudulent is far from the type of overreaching on warranty issues described as occurring in the late 1800s and early 1900s.

97. Googins, *supra* note 44, at 69.

98. See *infra* note 106 and accompanying text.

which without incontestability, "litigation could otherwise be increased manyfold."⁹⁹

This concern probably is mitigated by developments discussed above in the areas of bad faith and increased insurer regulation.¹⁰⁰ With respect to fraud, the concern may be philosophically flawed as well. "Additional litigation which helps identify and eliminate the effects of fraud cannot appropriately be described as 'excessive litigation.'"¹⁰¹ Finally, as discussed below, the first manifest doctrine actually may simplify any litigation by reducing the issues for trial and avoiding speculation on state of mind.¹⁰²

C. Incentives from the Insured's Perspective

It should be remembered that the individuals considering fraud also base their behavior on a cost/benefit analysis. That analysis involves some of the same factors described for the policy analysis and can be roughly stated as $B_{(F)} / (C_{(D)} \times P_{(D)}) + (C_{(P)} \times P_{(P)}) + C_{(M)}$, where $B_{(F)}$ is the benefit of fraud; $(C_{(D)} \times P_{(D)})$ is the cost of detection times the probability of detection; $(C_{(P)} \times P_{(P)})$ is the cost of prosecution times the probability of prosecution; and $C_{(M)}$ is the perceived moral cost of fraud to the individual. If $B_{(F)} > (C_{(D)} \times P_{(D)}) + (C_{(P)} \times P_{(P)}) + C_{(M)}$, the individual will commit fraud.

In individual cases, $B_{(F)}$ can be quite high. In one case discussed later in this Article, the insured secured \$560,000 per year in disability income and business overhead expense coverage, an amount well in excess of his income.¹⁰³ In contrast, $C_{(D)}$ is low in that the individual simply has premiums returned to him for the policy. $P_{(D)}$ is relatively low due to the decreases discussed in $ED_{(F)}$ —the insurer's ability for early detection of fraud.¹⁰⁴ $P_{(P)}$ is low due to the disinterest of authorities in prosecuting individual fraud cases, and $C_{(P)}$ is low as compared to other crimes.¹⁰⁵ Historically, $C_{(M)}$ has been high. Increases in the public's acceptance of fraud, however, suggest that this variable is dropping.¹⁰⁶

99. 1A APPLEMAN & APPLEMAN, *supra* note 43, § 311, at 305.

100. See *supra* notes 86-88 and accompanying text.

101. Googins, *supra* note 44, at 69.

102. See *infra* note 106 and accompanying text.

103. For a discussion of *Scalia v. Lafayette Life Insurance Co.*, see *infra* notes 113-20 and accompanying text.

104. See *supra* notes 62-73 and accompanying text.

105. See *supra* notes 51-52 and accompanying text.

106. See *supra* notes 58-61 and accompanying text.

D. A Comparative Analysis: First Manifest and Fraudulent Misstatement

One issue that arose in *Haas*, and which is discussed in other first manifest cases, is that statutes in some states allow for an alternative formulation of incontestability when an exception is made for fraudulent misstatements. One argument against the adoption of a first manifest doctrine is that with the option to insert this clause, insurers may adequately fight fraud. The argument continues that by their election not to use the alternate clause, insurers voluntarily have provided a higher level of protection, which countenances fraud.

One answer to this argument simply notes that the deceptive transfer of known losses is contrary to the basic principles of insurance and should be contrary to public policy. The contracts, with either version of the clause, attempt to exclude known losses. The law simply should not tolerate fraud, rather than bend contract language to protect and nurture it. This argument essentially is that since the insurer could have made its contract even stronger, it has failed to prevent fraud, and the system must tolerate the cost. Economic analysis, however, suggests that the insured who conceals a known loss is in fact the least-cost risk avoider.

An even more detailed analysis suggests that the use of first manifest jurisprudence is a more economically efficient solution to several issues than is the use of fraudulent misrepresentation clauses. Consider initially the transactional cost of litigation, the $T_{(L)}$ variable discussed above. One rationale for incontestability is that the clause reduces litigation. As between a first manifest question and a fraudulent misrepresentation question, the former is a less judicially burdensome litigation. The issues are largely objective ones, possibly even subject to resolution in a summary judgment context:

- Did the condition manifest prior to the issuance of the policy?
- Was the condition disclosed on the application?
- Does the claim involve the same condition?

In contrast, fraudulent misrepresentation necessarily involves subjective questions regarding the insured's intentions and state of mind.¹⁰⁷ It will involve issues such as insurer reliance and may veer into insurer underwriting guidelines and their interpretation of select cases. These issues tend to produce factual questions that, depending on the case, can be more difficult to resolve without a full jury trial.

In a related effect, the first manifest doctrine levels the playing field with respect to the $A_{(A)}$ variable. The concern here is that given

107. Depending on the jurisdiction, proof of fraud may require a heightened showing, variously stated as "clear, cogent and convincing" or "clear, precise and indubitable." 37 AM. JUR. 2D, *Fraud and Deceit* § 468 (1968).

the presumed greater resources of the insurer, the ability of the insured to present its case is far lower than the insurer. By reducing the issues and their complexity, this perceived "power differential" is lessened.

Finally, remember the $C_{(LS)}$ variable. This is the cost of the loss of security argument used to support incontestability. Assume that fraud is committed. Use of a fraudulent misrepresentation statute involves a contest of the policy and is therefore an all or nothing scenario. If fraud is demonstrated, the risk of the known loss is shifted back to the insured—along with the risk of every unknown loss.

In contrast, the first manifest doctrine allows the policy to remain in effect, with certain conditions excluded. Under the $C_{(LS)}$ rationale, the first manifest doctrine produces a lower cost. Beyond this, the risk-sharing function is enhanced in that the risk of unknown loss is still spread among the various parties involved.

E. Summary

A review of the historical concerns that led to incontestability shows that these concerns have changed over the last several decades:

VARIABLE	HISTORIC ANALYSIS	MODERN TRENDS
$F_{(F)}$	Fraud is Infrequent	Increased public acceptance; Increased incidence of fraud
$C_{(F)}$	Fraud has a low cost	Cost is \$100 billion or more per year
$ED_{(F)}$	Insurers can detect fraud early in the underwriting process	Privacy statutes; Anonymous testing; Increased disease latency; Less physician cooperation; Imposter cases
$TC_{(L)}$	Insurers will unleash a flood of litigation without incontestability	Rise of bad faith jurisprudence; Increased state regulation
$C_{(F)}$	Insurers will use absence of incontestability to take advantage of insureds	Antiwarranty statutes; Rise of bad faith jurisprudence; Increased state regulation
$C_{(LS)}$	Insureds will lose the security of their contract	Frauds should not be entitled to profit from fraud
$C_{(A)}$	Insured will be unavailable to testify if policy is contested	Only applicable to life insurance
$A_{(A)}$	Insured is less able to litigate	Contingent Fees; Recovery of Attorneys Fees; Class Actions; Broad Discovery

In the historical analysis, the costs from policy concerns supporting incontestability were high, while those from fraud were low. As a result, judges sought a rule of law that minimized the costs of factors supporting incontestability. Since that time, however, other areas of law have developed to minimize these factors. At the same time, the

cost of fraud and the frequency of fraud have increased. The *Haas* court, noting the increase in fraud, crafted a rule of law that sought to minimize that cost. This swing in judicial precedent can be predicted on a law and economics perspective and can be expected to continue.

Some jurisdictions have reached conclusions similar to *Haas*, while others have reached entirely different results. The next section turns to that analysis.

III. THE FIRST MANIFEST DOCTRINE IN OTHER JURISDICTIONS

Two courts have followed the *Haas* decision. *Krakowiak v. Paul Revere Life Insurance Co.*¹⁰⁸ applied the rule in Tennessee. In *Krakowiak*, the insured concealed that he had been diagnosed as HIV-positive when applying for a disability policy.¹⁰⁹ The policy contained a statutorily required incontestable clause almost identical to the clause in *Haas* and defined sickness as "sickness or disease which first manifests after the Date of Issue."¹¹⁰ It also contained a strong limitation for preexisting conditions: "We will not pay benefits for a pre-existing condition if it was not disclosed on your application. You are responsible for verifying the accuracy of each and every statement on your application. Also, We will not pay benefits for any loss We have excluded by name or specific description."¹¹¹

Four years after the issuance of the policy, the insured claimed disability due to AIDS. The insurer defended on the basis that the condition had first manifested prior to issuance of the policy. The decision again revolved around explicit policy considerations: the plaintiff proposed a system whereby the incontestability clause would grant the same degree of protection to insureds who fraudulently misrepresent their medical status to those who are unknowingly afflicted by an illness that does not manifest itself prior to the issuance of the policy. To adopt such a system would encourage dishonesty and reward deception contrary to clear public policy. Consumers should neither be encouraged nor allowed to purchase insurance for a risk that is known to have already occurred.¹¹² With these concerns, the court held that a limitation of coverage to conditions that manifest after the issuance of the policy was not a contest of the policy.

Paul Revere does not contest the validity of the policy due to fraudulent misrepresentations made by plaintiff in his application for insurance. Paul Revere contends that the policy's limiting definition of covered sickness excludes plaintiff's claim from coverage under the policy. . . .

108. No. 95-249-I, 1996 WL 303661, at *1 (Tenn. Ct. App. June 7, 1996).

109. *Id.* at *1.

110. *Id.*

111. *Id.*

112. *Id.* at *6.

. . . [T]he incontestability clause relates only to the validity of the contract and should not affect in any way whatsoever the construction of the terms of the policy. . . .

. . . Plaintiff was diagnosed and treated as HIV-positive before the policy was issued. Therefore, plaintiff is not covered under Paul Revere's policy which limits covered sicknesses to those which first manifest themselves after the policy was issued.¹¹³

*Scalia v. Lafayette Life Insurance Co.*¹¹⁴ provided an example of the potentially high rewards of application fraud. The case is an example of the increase in $C_{(P)}$. Scalia had suffered injuries in an automobile accident in 1985, which led to a permanent ulnar neuropathy in his right arm. Dr. Scalia also suffered leg injuries that made it difficult for him to stand for extended periods of time, other injuries requiring more than 300 stitches, a skull fracture, and a bone graft.¹¹⁵ The injuries prevented him from performing his occupation as a dentist, and he collected on various disability policies through September 1988, at which time his claim ended through an agreed lump sum settlement.¹¹⁶

After the settlement, Scalia began to amass additional disability policies, securing coverage of \$560,000 per year on eleven policies.¹¹⁷ At the time, his annual income was approximately \$169,000,¹¹⁸ meaning that Scalia stood to recover \$391,000 more per year on a tax-free basis than he had previously made on a taxable basis. Although the representations to each carrier varied, he generally disclosed that he was in a car accident in 1985, but represented that he had made a full recovery. He failed to disclose the severity of the injuries, that he was under continuing care for these injuries, or that he had received disability benefits for three years as a result of the injuries.¹¹⁹ In February 1991, Scalia filed a claim on all of the policies, alleging that ulnar

113. *Id.* at *5 (citations omitted). Some older Tennessee authority would have supported this holding. In *Childress v. Fraternal Union*, 82 S.W. 832 (Tenn. 1904), the court dealt with an argument that an incontestability clause barred use of another clause in a fraternal benefit policy, which reduced the indemnity to one third in the event of suicide. The court rejected the argument, noting that "the suicide clause is not one which enters into the original validity of the contract, but one which defeats the right of recovery after the full existence of the contract is established." *Id.* at 833. The same is true of the limitation in *Krakowiak v. Paul Revere Life Insurance Co.*, No. 95-249-I, 1996 WL 303661, at *1 (Tenn. Ct. App. June 7, 1996).

114. No. Civ.A.92-3714, 1995 WL 631841, at *1 (D.N.J. Oct. 23, 1995), *aff'd*, 114 F.3d 1173 (3d Cir. 1997)(Table No. 96-5341).

115. *Id.* at *1-2.

116. *Id.* at *3.

117. *Id.*

118. *Id.* at *6.

119. *Id.* at *6-7 (reviewing misrepresentations on Revere coverage); *id.* at *11 (reviewing Lloyds coverage); *id.* at *15 (reviewing Lafayette coverage).

neuropathy resulting from a fall at home, which disabled him from performing dentistry.¹²⁰

Citing *Haas*, the court granted summary judgment to the insurers involved in the suit. The summary judgment was affirmed by the Third Circuit, which stated that "Dr. Scalia may not reap the benefit of deception by recovering for a disability that he concealed on his application solely because of the incontestability clause."¹²¹

Other courts have reached the same result outside of the *Haas* line of cases. *Massachusetts Casualty Insurance Co. v. Forman*¹²² allows a first manifest defense based on the Fifth Circuit's interpretation of language in a Florida contract. In *Forman*, the insured concealed both a two and four week hospitalization for diabetes less than a year prior to the issuance of his policy.¹²³ Nineteen months after the issuance of the policy, he filed a claim for disability due to diabetes. The insurer learned of the diabetes in May 1972, thirty months after the policy was issued.¹²⁴

Forman's policy contained both a statutory incontestability clause and an insuring clause providing coverage against "[s]ickness which first manifests itself during the term of the policy."¹²⁵ The court framed the issue as whether the incontestability clause expanded the insuring clause:

In this case the condition for which Forman claimed benefits had "first manifested" itself almost a year before the policy became effective. Thus disability resulting from diabetes was never within the scope of policy coverage, and Forman cannot now claim diabetes-related disability benefits unless the incontestability provisions of the policy caused this prior-existing illness to become covered.¹²⁶

The court had little difficulty in concluding that the incontestable clause did not expand coverage. "This statutory clause only prohibits denials of claims based on the prior existence of a disease. Such denials are irrelevant here because a disease is covered no matter when it existed, so long as it was not first manifested prior to the policy

120. *Id.* at *3.

121. *Scalia v. Lafayette Life Ins. Co.*, No. 96-5341, slip op. at 17 (3d Cir. Apr. 24, 1997). *Haas* also was applied in a recent case in which the Eleventh Circuit applied New Jersey law under a choice of law question. See *Fioretti v. Massachusetts Gen. Life Ins. Co.*, 53 F.3d 1128 (11th Cir. 1995). In addition to altering his name, birthdate, and social security number, the insured sent an impostor to a required blood test so that the insured could obtain life coverage despite his HIV-positive status. *Id.* at 1230-31. Citing *Haas* as authority that fraud could be a basis for denying a claim after contestability, the court recognized an "impostor exception" to an incontestability clause and allowed the claim to be denied despite the passage of more than two years. *Id.* at 1237.

122. 516 F.2d 425 (5th Cir. 1975).

123. *Id.* at 427.

124. *Id.*

125. *Id.*

126. *Id.* at 428.

date.”¹²⁷ The court also noted that the concealment altered any policy concerns in favor of contestability:

[W]here coverage is framed in terms of first manifestation and the misrepresentation of no prior history of diabetes goes to the heart of the definition of coverage, the principle of not permitting incontestability to broaden the scope of coverage attains especially strong force. There is little reason to decline to give it full effect. The policy of protecting the insured from belated discovery that he has no coverage loses much of its vitality.¹²⁸

In terms of the previous economic analysis, this is an explicit statement that $C_{(LS)}$ is a less valid concern in cases of fraud. The *Forman* court ultimately struck the same balance as the *Haas* court, concluding that “[t]hrough the policy continues in effect it, of course, does not cover diabetes.”¹²⁹

The Ninth Circuit, applying California law, recognized the defense in *Paul Revere Life Insurance Co. v. Sapp*.¹³⁰ In *Sapp*, the insured concealed a diagnosis of HIV and later claimed disability due to AIDS. Paul Revere denied the claim, and the insured sued, claiming that any misrepresentations as to his condition were incontestable. Citing California law defining the purpose of insurance, the court disagreed.

It is axiomatic that insurance does not cover known losses. Insurance covers the risk of loss. California Insurance Code § 22 provides that “[i]nsurance is a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.” Section 22 forms part of every contract of insurance. If uncertainty exists in statutory interpretation, we presume the legislature intended a reasonable result consistent with the statute’s purpose, not absurd consequences. We consider the interpretation urged by *Sapp* that section 10350.2 was intended to cover losses

127. *Id.* at 429. A review of *Forman* makes it is clear that the rise in insurance fraud was the driving force behind the decision. As one commentator has noted,

[s]ome might view *Haas*, in isolation, as a case that simply puts New Jersey in the *Forman* defense camp which rejects the *Wischmeyer* and *Bell* line of decisions. However, such a reading does not properly account for the substantial discussion of fraud and the breadth of the court’s language. Had the court simply wished to embrace *Forman*, it could have done so by resting upon the recognition of the “exist-manifest” distinction—one the court found to be “valid.”

Googins, *supra* note 44, at 62.

128. Massachusetts Cas. Ins. Co. v. *Forman*, 516 F.2d 425, 429 (5th Cir. 1975).

129. *Id.* at 431. In a case in which the incontestability issue arose in another context, the Fifth Circuit, applying Florida law, held that the clause did not bar a showing that a preexisting illness had contributed to a death in an accidental death only policy. *Allen v. Aetna Life Ins. Co.*, 563 F.2d 1240, 1241-42 (5th Cir. 1977). The Fifth Circuit allowed a first manifest defense applying Georgia law in *Keaten v. Paul Revere Life Ins. Co.*, 648 F.2d 299 (5th Cir. 1981). *Keaten* involved a concealed heart condition. The court enforced the first manifest language in the policy as against a claim of incontestability. “To hold otherwise, would be to expand coverage thereby forcing liability upon the insurer for risks it never intended to assume.” *Id.* at 301.

130. No. 93-56290, 1994 WL 259328, at *2 (9th Cir. June 13, 1994).

known to the insured to be an absurd consequence, contrary to the basic principles of insurance and section 22 of the California Insurance Code.¹³¹

Sapp is an explicit statement of the free rider problem that occurs when known losses are introduced into the risk pool.

In *Button v. Connecticut General Life Insurance Co.*,¹³² the Ninth Circuit foreshadowed the result in *Sapp* under Arizona law. In *Button*, the insured's policy provided for a limited term of benefits for sickness. The policy defined the cause as sickness if the loss "(a) results from injuries caused or contributed to by disease, or (b) results from disease or infection, or medical or surgical treatment therefor . . . whether the disease or infection is the proximate or a contributing cause of the loss."¹³³ In contrast, the policy provided lifetime benefits if the disability was the result of an accident independent of all other causes.¹³⁴

Button suffered a lower back injury after a fall in 1979. But, Button had had lower back problems dating back to the 1960s, and his treating physician testified that the injury and the preexisting back condition were not independent of each other.¹³⁵ Button argued that any reference to the prior problems was barred by the incontestability clause. The court ruled that the clause was irrelevant as the clause "relates to the validity of the contract and not to the construction of policy provisions."¹³⁶

131. *Id.* (citations omitted). The court relied in part on two older California cases. In *Cohen v. Metropolitan Life Insurance Co.*, 89 P.2d 732 (Cal. Ct. App. 1939), the court upheld a denial of coverage for preexisting tuberculosis, stating that [a]n incontestable clause in an insurance policy does not extend the coverage beyond the terms of the policy. Therefore, it does not relieve the insured (appellant) from the burden of proving that the disease from which he is suffering originated and occurred after the issuance of the policies nor prevent the insurer (respondent) from proving that the disease originated before the date of the issuance of the policies.

Id. at 738. See also *New York Life Ins. Co. v. Hollender*, 237 P.2d 510, 515 (Cal. 1951) (stating that the incontestability clause does not bar reformation of a policy due to misrepresented age in accordance with age adjustment provisions in the policy). There is older, possibly inconsistent authority in dicta in *McMackin v. Great American Reserve Insurance Co.*, 99 Cal. Rptr. 227 (Cal. Ct. App. 1971). The majority in *McMackin* dealt with interpretation of a recurrent disability provision. The insurer also urged that the insured had concealed conditions. It is unclear if these conditions were related to the cause of disability. The final sentence of the opinion, however, states that the insurer "cannot now urge that plaintiff's disability resulted from a pre-existing disease, illness or injury not covered by the policy." *Id.* at 234-35.

132. 847 F.2d 584 (9th Cir. 1987).

133. *Id.* at 586.

134. *Id.*

135. *Id.* at 585-86.

136. The *Button* court was not required to reach the first manifest question for its holding, noting that "[t]he determining factor here is causation, not the insured's physical condition on the date of the policy." *Id.* at 589. Nevertheless, the court cited older first manifest law with approval, discussing *Posner v. New York Life*

Mississippi recognized the first manifest doctrine in *Prudence Life Insurance Co. v. Cochran*.¹³⁷ This case involved an older version of the first manifest language, which provided that “[s]ickness’ as used in this policy means sickness or disease contracted and commencing after the policy has been maintained in force for not less than thirty days from its date and causing loss of time commencing while the policy is in force.”¹³⁸ The insured admitted to suffering rheumatoid arthritis, but failed to disclose treatment immediately prior to the issuance of the policy.¹³⁹

The court held that the issue was not whether the partial disclosure was a misstatement that implicated the incontestability clause. Rather, “[u]nder the facts established by plaintiff’s testimony his disabling sickness resulted from rheumatoid arthritis which ‘commenced’ before the policy had been in force for thirty days. Plaintiff’s right to recover is therefore excluded by the express terms of the policy.”¹⁴⁰

Alabama allowed use of the incontestability clause after a review of numerous older cases from other jurisdictions and treatises. The policy at issue in *National Life & Accident Insurance Co. v. Mixon*¹⁴¹ was a critical illness policy with blindness as one of the covered conditions. But, the policy contained a requirement that the loss be “caused solely by disease or injuries contracted or sustained after the Date of Issue.”¹⁴² The court noted that there was a “valid distinction between a pre-existing disease or suicide clause . . . and a clause . . . to preclude

Insurance Co., 106 P.2d 488 (Ariz. 1940). In *Posner*, the insured concealed a pre-existing condition of diabetes. The *Posner* court held that the incontestability clause in the policy did not bar the insurer from denying a claim on the basis of a preexisting condition.

It must be observed that the defense was not that the policy was invalid because of previous existing disease, but that the disability claimed by plaintiff was not covered by the terms of the policy. This court has held that policies of this nature do not extend to and cover disabilities which have their origin in injury or disease commencing before the issuance of the policy.

Id. at 492. *Posner* predated the standard promulgated by the National Association of Insurance Commissioners (NAIC) for the incontestability statute in Arizona, but was found significant by the court. *Button v. Connecticut Gen. Life Ins. Co.*, 847 F.2d 584, 588 (9th Cir. 1987), *cert. denied*, 488 U.S. 909 (1988). Despite the intervening passage of the statute, precedent such as *Posner* is relevant as to how the statute should be interpreted.

137. 183 So. 2d 830 (Miss. 1966).

138. *Id.* at 831.

139. *Id.* at 832.

140. *Id.* The Fifth Circuit determined that the first manifest doctrine was so well established in Mississippi that a recent first manifest case was dismissed as insufficient on its face pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. *Neville v. American Republic Ins. Co.*, 912 F.2d 813, 815 (5th Cir. 1990)(applying Mississippi law).

141. 282 So. 2d 308 (Ala. 1973).

142. *Id.* at 310.

the contract from ever coming into existence."¹⁴³ With this distinction, "the policy is a perfectly good policy and completely incontestable . . . [b]ut it does not and never did cover the particular casualty on which the plaintiff is suing."¹⁴⁴

Other states have limited the use of a first manifest type of defense based solely on the language of the incontestable clause. In *Taylor v. Metropolitan Life Insurance Co.*,¹⁴⁵ a trial court dismissed an insured's suit as a matter of law after an agreed statement of facts disclosed misrepresentations. On appeal to the New Hampshire Supreme Court, the primary issue before the court was whether the insurer was required to show an intent to deceive.

The statutorily phrased incontestable clause in the policy provided that

(a) After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability . . . commencing after the expiration of such two year period. (b) No claim for loss incurred or disability . . . commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition had existed prior to the effective date of coverage under this policy unless, effective on the date of loss, such disease or physical condition was excluded from coverage by name or specific description.¹⁴⁶

Interpreting clause (a), the court held that for any disability commencing after two years, proof of intent to deceive was required, but only for disability or loss that commenced after two years. The court reached that conclusion by applying the portion of the clause stating that it applied to loss "commencing after the expiration of 'two years from the date of issue of this policy.'"¹⁴⁷ For loss or disability commencing within two years, however, the court held that the clause had no application. "Hence the defendant may raise after that period the defense of a non-fraudulent misstatement in the application against a

143. *Id.* at 313.

144. *Id.* at 315 (quoting 7 SAMUEL WILLISTON & WALTER H.E. JAEGER, A TREATISE ON THE LAW OF CONTRACTS § 912 (3d ed. 1963)). The case also relied on older first manifest law from a number of jurisdictions, as well as treatises, in concluding that the first manifest argument was not barred by disability. *See, e.g.*, *Pekras v. Prudential Ins. Co.*, 10 N.E.2d 704, 706 (Ill. App. Ct. 1937); *Palumbo v. Metropolitan Life Ins. Co.*, 199 N.E. 335, 336 (Mass. 1935); *John Hancock Mut. Life Ins. Co. v. Hicks*, 183 N.E. 93, 95 (Ohio Ct. App. 1931); *Prudential Ins. Co. v. Elias*, 109 P.2d 815 (Okla. 1941); *Guise v. New York Life Ins. Co.*, 191 A. 626 (Pa. Super. Ct. 1937); 18 G. COUCH, COUCH ON INSURANCE § 72:101 (2d ed. 1968). *See generally* V.G. Lewter, Annotation, *Construction of Incontestable Clause Applicable to Disability Insurance*, 13 A.L.R.3d 1383 (1968). The majority of incontestability statutes are patterned on a model NAIC statute drafted in 1946. *See Fosaaen, supra* note 30, at 270. Cases predating 1946 will arise under a differing version of the statute, but will remain authority for interpretation of a newer version.

145. 214 A.2d 109, 115-16 (N.H. 1965).

146. *Id.* at 114.

147. *Id.* at 115.

claim for loss incurred or a disability commencing before such two year period of limitation has arrived."¹⁴⁸ Similarly, the court held that "paragraph (b) would not bar the insurer from raising, after two years from the date of issue, the defense of pre-existing disease or physical condition as to a loss incurred or a disability commencing within two years from the date of issue of the policy."¹⁴⁹

Still other courts have rejected the doctrine based on policy considerations. *Oglesby v. Penn Mutual Life Insurance Co.*¹⁵⁰ involved an insurer who raised the defense in a less than ideal situation. In *Oglesby*, Delaware law allowed an alternate version of the statute, which stated that "[a]fter this policy has been in force for a period of 2 years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to any statements, other than fraudulent statements, contained in the application."¹⁵¹ The statute also allowed the insurer to deviate in a fashion more favorable to the insured.¹⁵² In this case, Penn Mutual deviated from the statute by deleting the portion of the clause dealing with fraudulent misrepresentations. The policy also contained language excluding preexisting conditions and defining sickness as sickness that "first makes itself known while this policy is in force."¹⁵³

Oglesby concealed a degenerative cervical arthritis. Five years after the issuance of the policy, he filed a claim for disability due to cervical arthritis.¹⁵⁴ Penn Mutual attempted to rescind the policy and subsequent upgrades.

At a final pretrial conference, Penn Mutual asserted for the first time a first manifest defense. The plaintiff moved for a summary judgment excluding the defense, and the court granted the motion. "Despite its lachrymose cries . . . Penn Mutual took a calculated risk by . . . opting for a more lenient, and thus more marketable version of the incontestability clause. Courts are not in the habit of relieving parties, especially sophisticated insurance companies, of their improvident decisions."¹⁵⁵

Oglesby may be an interesting example of a court placing a higher value on $C_{(0)}$. The combination of the late assertion of the defense and

148. *Id.*

149. *Id.* at 116.

150. 889 F. Supp. 770 (D. Del. 1995), *aff'd*, 127 F.3d 1096 (3d Cir. 1997)(Table No. 95-7596).

151. DEL. CODE ANN. tit. 18, § 3306(c) (1996).

152. *Id.* § 3304(a).

153. *Oglesby v. Penn Mut. Life Ins. Co.*, 899 F. Supp. 770, 775 (D. Del. 1995).

154. *Id.* at 772.

155. *Id.* at 778-79. The court also relied heavily on giving the language in the policy its "ordinary and usual meaning." *Id.* at 777. The holding in *Oglesby* was confirmed by the Delaware Supreme Court in a certified question. *Penn Mut. Life Ins. Co. v. Oglesby*, 695 A.2d 1146 (Del. 1997).

the voluntary deviation from the statute tipped the equities away from the insurer and may have appeared as overreaching.

Several cases interpreting Indiana law have also reached the same response. In *Wischemeyer v. Paul Revere Life Insurance Co.*,¹⁵⁶ the insured concealed his medical history and misrepresented his financial condition. The clause contained language identical to the *Haas* clause,¹⁵⁷ except for a plain language beginning, which stated that "[a]fter Your Policy has been in force for two years, excluding any time You are Disabled, We cannot contest the statements in the application."¹⁵⁸

The court cited three policy reasons in favor of the clause, first noting that the clauses were enacted to "promote certainty and reduce litigation."¹⁵⁹ In addition, the clauses prevent "an insurer from lulling the insured, by inaction, into fancied security during the time when the facts could best be ascertained and proved, only to litigate them belatedly, possibly after the death of the insured."¹⁶⁰

After noting policy reasons behind the passage of the clause, the court rejected the first manifest defense.

By use of this precise language, the legislature struck a balance. The clause protects an insured who is healthy enough to work throughout the two-year period from losing the security of disability insurance because of some prior condition that might eventually disable him. On the other hand, the insurer is protected in that it is not precluded from denying benefits to an applicant whose pre-existing condition is so bad that he becomes disabled during the two-year period.¹⁶¹

156. 725 F. Supp. 995 (S.D. Ind. 1989).

157. See *supra* note 4 and accompanying text.

158. *Wischemeyer v. Paul Revere Life Ins. Co.*, 725 F. Supp. 995, 998 (S.D. Ind. 1989).

159. *Id.* at 1000.

160. *Id.* This policy concern was a factor in New York cases that reject the doctrine. In *White v. Massachusetts Casualty Insurance Co.*, 465 N.Y.S.2d 345 (N.Y. App. Div. 1983), the court rejected the doctrine, stating that "the legislative intent behind the clause is to safeguard an insured from excessive litigation many years after a policy has already been in force and to assure him security in financial planning for his family, while providing the insurer a reasonable opportunity to investigate." *Id.* at 346. See also *Fischer v. Massachusetts Cas. Ins. Co.*, 458 F. Supp. 939, 944 (S.D.N.Y. 1978)(stating that the purpose of the incontestability clause is to "encourage insurance buyers to purchase insurance with confidence that after the contestable period has passed they are assured of receiving benefits"); *Monarch Life Ins. Co. v. Brown*, 512 N.Y.S.2d 99 (N.Y. App. Div. 1987)(following *White v. Massachusetts*, 465 N.Y.S.2d 345 (N.Y. App. Div. 1983), and specifically rejecting *Massachusetts Casualty Insurance Co. v. Forman*, 516 F.2d 425 (5th Cir. 1975)). But see *Mutual Life Ins. Co. v. Hayden*, 386 N.Y.S.2d 978, 981-82 (N.Y. Sup. Ct. 1976), *aff'd*, 401 N.Y.S.2d 992 (N.Y. App. Div. 1978)(following *Massachusetts Casualty Insurance Co. v. Forman*, 516 F.2d 425 (5th Cir. 1975), and recognizing the exist/manifest distinction).

161. *Wischemeyer v. Paul Revere Life Ins. Co.*, 725 F. Supp. 995, 1001-02 (S.D. Ind. 1989).

The court also rejected the reasoning later used by the *Haas* court that the limitation as to preexisting conditions was an exclusion by specific description. "[S]uch a provision would be absurd, for all insurers would instantly place such a statement in their form policies, and thereafter no insurer would be precluded from denying claims based on pre-existing conditions."¹⁶²

The Northern District of Indiana reached a similar result in 1983, in *Equitable Life Assurance Society v. Bell*.¹⁶³ In *Bell*, the insured was diagnosed with multiple sclerosis in 1978, missing four months of work. In 1980, Bell took out an occupational disability policy, failing to mention either his conditions or several hospitalizations.¹⁶⁴ The policy contained both a standard incontestability clause and an exclusion for preexisting conditions.¹⁶⁵

Initially, the court simplified the clause by impliedly rejecting the argument later used in *Haas* that the preexisting clause operated as an exclusion by specific description. "[M]ultiple sclerosis was not a condition excluded from coverage by name or specific description."¹⁶⁶ The court also rejected construction of the clause to protect only conditions that had not manifested. "Such an interpretation would controvert the statutorily imposed incontestability clause, and reduce its protection below that which was mandated by the legislature."¹⁶⁷

The Seventh Circuit affirmed. Focusing on the language of the clause, the court held that

the term "exist" in its ordinary sense refers broadly to a state of being, without reservation as to other qualities, including manifestation. . . . To insert into

162. *Id.* at 1005. The reasoning is flawed. First, the reasoning ignores that insurers would be allowed to deny claims only for those conditions that have manifested, allowing the innocent insured to be protected. An early Oklahoma court described the absurdity inherent in the *Wischmeyer* holding.

It seems to us illogical to say that a company will issue a policy of insurance wherein it is expressly stated that it will give certain benefits upon the happening of a clearly defined future event, and to further say . . . it thereby agrees to deny itself the right to ask whether the clearly defined future event has happened. We are asked to hold that the incontestability clause has the effect of making the company say: we assume certain stated coverages for a period of two years, and coverages without limit thereafter.

Prudential Ins. Co. v. Elias, 109 P.2d 815, 817 (Okla. 1941). Second, insurers themselves advocate use of the doctrine only in narrow circumstances, as is evidenced by commentary at the International Claims Association. "It is important that the Forman defense be used correctly, appropriately and when warranted by the facts." Ralph Olsen, *First Manifest*, 1991 INT'L CLAIMS ASS'N INDIVIDUAL HEALTH INS. WORKSHOP REP. 120, 123. The industry recognizes that if the doctrine is not used appropriately, courts will restrict its use. *Id.*

163. 818 F. Supp. 245 (N.D. Ind. 1993), *aff'd*, 27 F.3d 1274 (7th Cir. 1994).

164. *Id.* at 246.

165. *Id.* at 247.

166. *Id.* at 250.

167. *Id.* at 251.

the clause a limitation to a disease or condition which existed but did not manifest prior to the effective date of the policy would be to evade the mandate of the legislature, and that we cannot sustain.¹⁶⁸

Additionally, the court noted that Equitable Life could have worded the clause so as to exclude fraudulent misstatements. The court recognized that "[t]here may be a price for such a rule, in the form of higher premiums and more extensive intrusions on the privacy of applicants as insurers go to greater lengths to expose any ailments that might have been concealed. But that is a balance that the legislature has struck."¹⁶⁹

The doctrine also was rejected in *Insurance Commissioner v. Mutual Life Insurance Co.*¹⁷⁰ The *Mutual Life* case arose in an unusual procedural context. Holland, a Mutual Life (MONY) insured, applied for a disability policy in November 1985. She disclosed an ulcer, and a rider for gastrointestinal disorders was added to her policy.¹⁷¹ Four years later, Holland filed a claim for disability due to anxiety and panic attacks. Investigation disclosed a history of panic attacks and anxiety beginning in 1984.¹⁷² MONY denied the claim based on the language defining sickness as "sickness or disease which first manifests itself while the Policy is in force."¹⁷³ Holland complained to the Maryland Insurance Administration (MIA), which found that the claim denial was in contravention of state law.¹⁷⁴ MONY appealed first to the Insurance Commissioner, who upheld MIA's determination, and then to the Maryland Court of Special Appeals.

The Court of Special Appeals reviewed the determination on what is essentially an arbitrary and capricious standard.¹⁷⁵ Even under this standard, however, it is clear that the court felt legislatively bound to reject the first manifest doctrine. After reviewing a number of cases, including *Wischmeyer*, *Ogelsby*, *Haas*, and *Forman*, the court adopted the minority rule.¹⁷⁶

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168. *Equitable Life Assurance Soc'y v. Bell*, 27 F.3d 1274, 1281-82 (7th Cir. 1994).
169. *Id.* at 1283. For student commentary supporting the holding in *Bell*, see Alexander B. Temel, Comment, *Incontestability Statute Nullifies Contract Language: Equitable Life Assurance Society v. Bell*, 27 F.3d 1274 (7th Cir. 1994), 47 WASH. U. J. URB. & CONTEMP. L. 271 (1995).
170. 680 A.2d 584 (Md. Ct. Spec. App. 1996), cert. granted, 685 A.2d 450 (Md. 1996).
171. *Id.* at 586-87.
172. *Id.* at 588 n.9.
173. *Id.* at 587.
174. *Id.* at 588.
175. *Id.* at 590. The reviewing court can modify a determination of the Commissioner when the determination is (1) in violation of constitutional provisions; (2) in excess of the Commissioner's statutory authority or jurisdiction; (3) made on unlawful procedure; (4) affected by error of law; (5) unsupported by substantial evidence; or (6) is arbitrary and capricious. *Id.*
176. The *Mutual Life* court described it as a "substantial minority." *Id.* at 596. The *Ogelsby* court described it as a "growing minority." *Penn Mut. Life Ins. Co. v.*

[W]e feel that a reasonable person reading this clause, or its equivalent in § 441(2), and giving the terms their ordinary meanings would conclude that, after the expiration of the incontestability period, no disability claim that was not specifically excluded by name or specific description, commencing two years after the policy's inception could be denied on the ground that the underlying disease or condition existed before the policy became effective, regardless of whether it manifested itself prior to the policy date.¹⁷⁷

Two Michigan cases reached an opposite result on the doctrine. The differing results show that courts have applied the doctrine in a fact-specific manner with concern for the equities involved. In *Weiner v. Paul Revere Life Insurance Co.*,¹⁷⁸ the insured was told in 1985 that she might have optical neuritis, which was likely, but not definitely the result of multiple sclerosis (MS). Her policy of disability insurance became effective one month later.¹⁷⁹ The policy contained a standard incontestability clause and an exclusion for preexisting conditions. The insured filed a claim for disability from MS in 1988.

In opposition to the result reached in *Bell*, the court held that it would be rewriting the clause if it did not follow the *Revere* interpretation.

[T]here is nothing ambiguous as to the language of M.C.L.A. § 500.3408(b), the statutorily mandated incontestability clause. It only estops an insurer from denying coverage on the ground that a disease existed prior to the issuance of the policy. M.C.L.A. § 500.3408(b) contains no language implying that an insurer may not deny coverage if a disease manifested itself, as well as existed, prior to the policy's issuance. . . . [T]he Court under Michigan law does not have the power to add new meaning to the incontestability clause.¹⁸⁰

A different judge on the same court reached a different conclusion in *Provident Life & Accident Insurance Co. v. Altman*.¹⁸¹ In *Altman*, the insured was told in 1986 that a chronic uveitis could lead to loss of vision. He was issued a disability policy after failing to disclose the condition.¹⁸² In 1991, the insured suffered a vitreous hemorrhage and filed a claim for disability benefits. Medical testimony conflicted as to whether the chronic uveitis caused the hemorrhage.¹⁸³

Altman's policy contained a nonstandard incontestability clause that had been modified by deleting a fraudulent misstatement exception. At oral argument, the insurer admitted that the policy had been

Oglesby, 889 F. Supp. 770, 776 (D. Del. 1995), *aff'd*, 127 F.3d 1096 (3d Cir. 1997)(Table No. 95-7596).

177. *Insurance Comm'r v. Mutual Life Ins. Co.*, 680 A.2d 584, 599 (Md. Ct. Spec. App. 1995).

178. No. 90-72772, 1991 WL 353370 (E.D. Mich. July 31, 1991).

179. *Id.* at *1.

180. *Id.* at *2. The court, while agreeing with *Revere's* interpretation of the clause, denied summary judgment due to the factual issue of whether the disease had manifested prior to the issuance of the policy. *Id.* at *3.

181. 795 F. Supp. 216 (E.D. Mich. 1992).

182. *Id.* at 217-18.

183. *Id.* at 220.

modified to make it "more marketable."¹⁸⁴ Based on this, the court concluded that the insurer had "contracted not to contest statements in the application, even if those statements were fraudulently made. . . . [I]t cannot have this court now include in the policy either the specific language or the public policy behind the language."¹⁸⁵

The differing results can be explained in terms of two factors—the more attenuated link between the concealed condition and cause of loss, and the modification of policy language for marketing reasons in *Altman*. Again, this may have impliedly raised the value of $C_{(o)}$ by creating the impression of overreaching.

IV. CONCLUSION

In the area of first manifest, courts grapple with a difficult issue overlaid with significant policy concerns. This Article suggests that the policy concerns that favored incontestability have now been controlled by other developments in the law, while those favoring limited exceptions to incontestability have become far more prominent.

This theoretical analysis does not exist in a vacuum. The potential impact of fraud in the disability area is enormous. An estimated 48.8 million Americans meet one broad, nonoccupational definition of disability.¹⁸⁶ Disability costs account for as much as 10% of employer's payrolls.¹⁸⁷ "[D]isability claims, in pure numbers, have risen dramatically over the past few years."¹⁸⁸ Diagnoses that are difficult to test objectively, or for which severity is difficult to measure, account for a large component of the increase. Disability claims for chronic fatigue syndrome increased 800% industrywide from 1988 to 1994, while claims for carpal tunnel syndrome increased 520%.¹⁸⁹

In *Haas*, the court implicitly used economic analysis to alter the rule of law and promote economic efficiency. Beyond this, the rule promotes justice between the parties.

184. *Id.* at 222.

185. *Id.* The court went on to indicate that it would have reached a different result even had it agreed with the interpretation advanced by the insurer. "[S]uch a reading would render the contract ambiguous. . . . [T]hus, the court will construe such ambiguity in favor of the insured." *Id.* at 223.

186. *Background Check: Americans With Disabilities Act*, PORTLAND OREGONIAN, July 26, 1995, at A12.

187. John Wiggin, *Managing Disability To the Client's Benefit*, *BEST'S REV.*, Nov. 1993, at 73.

188. Bernstein, *supra* note 59, at 40.

189. Jacalyn Reinberg & Nora K. Lewis, *Subjective Claim Templates: Dynamics of Disability: Marketing, Risk & Financial Management Seminar*, Presentation at JHA Seminar 4 (Feb. 16, 1994)(on file with Author).