

COMMENT SUBMISSION

TITLE

Half-Truths, Whole Lies, & the Duty of Disclosure in Insurance Law

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ABSTRACT

A half-truth need not be a whole lie for insurance purposes; insurance law must distinguish between concealment and misrepresentation for equity and efficiency reasons. Reasonable disclosure should be the goal of underwriting, though what is “reasonable” should depend upon the insured’s degree of sophistication. This Comment argues that, whereas it may be equitable and efficient to relax the disclosure duty for the average person, it makes sense to raise this duty for the commercial insured. This argument is normative—asking what the duty *ought to be*, rather than what it *is*—though it finds empirical support in the case law.

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Introduction

In high school, I had the pleasure of meeting U.S. Senator John Ensign at a private gathering, where he shared his views with a small group of students. The details of his talk escape me, but one statement in particular stood out: “A half-truth is a whole lie.” Although this statement resonated with me on some level, I found it inadequate and simplistic—a sound bite of sorts, perhaps a bit quaint. Generally speaking, a half-truth is not a whole lie because the exclusion of a fact from an otherwise accurate statement does not render the statement false, *per se*. In an ethical sense, and even more so in a legal sense, a duty to speak truth may not be expansive, as one may be obliged to disclose only important, relevant facts per some established criteria.

The distinction between a half-truth and a whole lie is of particular importance in insurance law. In this context, a whole lie does not necessarily follow from a half-truth because the two are, by definition, largely discrete. I define a “half-truth” as incomplete disclosure.¹ It is a misrepresentation only in the loose sense that the omission of certain facts may be somewhat misleading. If a truth T encompasses a set of n facts, then a half-truth is the omission of not more than $n-1$ (but not less than 1) of these facts. At least one fact must be disclosed, otherwise there is no disclosure; however, at least one fact must be withheld, otherwise there is full disclosure. A half-truth may take the form of oversight, nonresponsiveness, or outright concealment.

By contrast, a “whole lie” is defined as an affirmative misstatement of the facts.² It amounts to misrepresentation in the strong sense because its content, taken as a whole,

¹ The American Heritage Dictionary defines a half-truth as “[a] statement, especially one intended to deceive, that omits some of the facts necessary for a full description or account.” THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed., 2000).

² A formal definition of a (whole) lie is “[a] false statement deliberately presented as being true.” *Id.*

communicates false information. If *T* encompasses a set of facts *X*, *Y*, and *Z*, then a whole lie is a statement about *T* that includes the opposite of any or all of these facts. For example, a whole lie occurs with the assertion of *X*, *Y*, and the opposite of *Z* (or a fact different from *Z* that one falsely presents as *Z*). This example underscores the broad conception of a whole lie taken herein. Although only one fact was misstated, its inclusion in an otherwise true statement constitutes a false disclosure about *T*. Whereas the omission of a fact would result in a half-truth, the perversion of a fact renders the set a whole lie. Thus, a breach of warranty would qualify as a whole lie, as would a material misrepresentation, although an immaterial misrepresentation may fall in the nebulous region between half-truth and whole lie.

Such a distinction in terminology, however conceptualized, is critical to the issue of disclosure in insurance law. As a general matter, an insurance applicant is required to complete a questionnaire as part of his application for coverage. The applicant must answer each question truthfully and provide reasonable disclosure. Despite ambiguity over the term “reasonable disclosure,” the need for disclosure in insurance is beyond question. And this need has less to do with intruding on the applicant’s privacy than with providing the potential insurer with information necessary to perform the economic functions of insurance. Not surprisingly, the legal need to differentiate between half-truths and whole lies is approximated by the insurance concepts of concealment and misrepresentation, respectively.

In this Comment, I seek to address the issue of reasonable disclosure within the context of insurance and, in light of the economic functions of insurance, make sense of what the legal implications of half-truths should be for the insured. Less attention is given

to whole lies, for which the general rule is rather straightforward: when material, or as warranty, they void the policy. My central query is whether the insurance applicant should owe a duty of full disclosure to the insurer. Should a half-truth on an issue preclude relevant coverage? That is, should less than full disclosure on an insurance application void the policy (or applicable provisions) and, if so, under what circumstances?

These questions are normative, not empirical. They ask what the disclosure duty *ought to be*, rather than what that duty *is* under current law. However, I still rely on case law to back up my claims, highlighting favorable judicial reasoning and debunking unfavorable treatment whenever possible. Against this backdrop, Part I provides a rough sketch of the nature of insurance, in addition to briefly summarizing the general role of the insurance questionnaire. Part II argues that, in the interest of public policy, an unsophisticated insured should owe less than a duty of full disclosure. Thus, in the absence of full disclosure by the average person, an insurer should internalize the resulting costs as an equitable and efficient solution. Alternatively, in the case of a sophisticated insured, Part III endorses a duty of full disclosure because fairness and efficiency dictate that an insured should internalize the costs of incomplete disclosure if that insured can better appreciate its consequences.

I. The Nature of Insurance and the Role of the Insurance Questionnaire

Ultimately, insurance is about risk. All events involve at least some degree of uncertainty—driving a car, riding an elevator, boarding a plane, even crossing the street—and this uncertainty implies risk, or the probability of loss. Since the members of

a society cannot know in advance which of them will lose from risk, it makes sense for them to chip into a pool that provides at least some protection (i.e., indemnification) against loss. Thus, the purpose of insurance is to manage risk, which can be achieved by segregating different risks on the basis of magnitude, collecting appropriate premiums for each degree of risk, and aggregating these risks so as to spread loss (thereby minimizing individual loss) and reduce risk (through incentives to avoid risky behavior).

Broadly speaking, insurance involves “[a] contract by which one party (the *insurer*) undertakes to indemnify another party (the *insured*) against risk of loss, damage, or liability arising from the occurrence of some specified contingency,” where the “insured . . . pays a premium to the insurer in exchange for the insurer’s assumption of the insured’s risk.”³ In so doing, insurance protects policyholders in the event of future loss. There are many different types of insurance, e.g., fire and property insurance; life, health, and disability insurance; liability insurance; and automobile insurance. However, most insurance can be grouped into two main categories: (1) property/casualty insurance, which protects against the loss of property and against legal liability; and (2) life/health insurance, which guards against the loss of life, ill health, and disability. Alternatively, insurance can be divided along the lines of first- and third-party insurance.⁴

Kenneth Abraham identifies three primary insurance functions: (1) risk-transfer, which shifts risk from more risk-averse to more risk-neutral parties; (2) risk-pooling,

³ BLACK’S LAW DICTIONARY (8th ed., 2004) (emphasis in original). One scholar defines insurance as “a risk-distribution arrangement for the compensation of damages or loss that is entered into by one party as its business, rather than as an incident of another business transaction.” KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 2 (4th ed., 2005) [*hereinafter* INSURANCE]. Note that indemnification is an integral component in both these definitions. *See also* NationsBank of North Carolina v. Variable Annuity Life Ins. Co., 513 U.S. 251, 264 (1995) (“A key feature of insurance is that it indemnifies loss.”).

⁴ The former is “victim’s insurance” because it insures against loss that insureds themselves suffer, e.g., fire, property, life, health and disability insurance. The latter is “liability insurance” because it insures against legal liability to a third-party resulting from the insured’s actions. ABRAHAM, INSURANCE, *supra* note 3, at 72.

whereby risk-averse parties combine risks and, in turn, reduce collective risk through diversification; and (3) risk-allocation, which assigns a proportional price to the degree of risk posed by each insured.⁵ Insurance also serves a social function, particularly as an equalizer, in effect taking money from the fortunate and giving it to the unfortunate.⁶ In so doing, it smoothes out at least some differences between parties that are attributable to dumb luck. Of course, insurance is far from perfect—only some but not all risk can be transferred, diversification through pooling is imperfect, and the administrative costs of obtaining information to set premiums is always subject to cost-benefit analysis. This last point in particular is worth noting. After all, obtaining information about the risk posed by an applicant is the purpose of disclosure.

The takeaway here is that insurance is an economic (and social) good precisely because it aggregates and segregates risk. Indeed, aggregation and segregation are integral to the proper functioning of insurance. Aggregation is the diversification of risk, which lowers the variance of risk per the law of large numbers, provided that risks are independent (i.e., uncorrelated) and, in fact, “risks.” By definition, a risk must be subject to uncertainty; a loss that is certain to occur is not a risk, although the timing of loss may be probabilistic, e.g., the certainty of death is still subject to life insurance because of the uncertainty of its occurrence. Statically, a greater number of data points increases the likelihood that a given outcome will occur around the mean. This is the law of large numbers. The basic function of an insurer is to collect premiums and maintain economic reserves to compensate for loss. Insurers keep small reserves for low-probability, low-magnitude risk, and somewhat larger reserves for low-probability, high-magnitude risk.

⁵ *Id.* at 3-4.

⁶ *Id.* at 4.

However, since most reserves are kept for high-probability, medium-magnitude risk, the cost of maintaining reserves declines with aggregation as the distribution of risk narrows (around the mean). Thus, the benefit of aggregation arises not just from the diminishing marginal utility of money, but also from economic feasibility—that is, insurers who aggregate risks can provide insurance at a lower cost to society by, on balance, charging lower premiums (because they can extract greater profits).

Beyond spreading risk through aggregation, insurance also reduces risk through segregation, which assigns risk into different categories, e.g., high and low risk.⁷ This process is known in the trade as “underwriting.” While in theory there is a problem of infinite segregation—segregating to the point where there is no individual benefit to insurance—in practice, this problem almost never plays out, as variation typically proves sufficient to achieve diversification. Thus, insurers can apply the law of large numbers within each risk pool. One benefit of segregation is that it enhances the availability of insurance by allowing insurers to charge differential rates and, in turn, attract diverse applicants (willing to pay premiums that correspond to their respective levels of risk).

Another benefit is that it cuts against the phenomenon of adverse selection, i.e., “a party facing a high risk of loss is more likely to seek insurance than a party facing a lower risk,” *ceteris paribus*.⁸ On the one hand, high-risk parties seek to buy insurance when they can pay lower premiums than justified; on the other hand, low-risk parties would drop out of the pool (or refuse to join), thereby raising the average risk and driving up premiums.⁹ Segregation reduces (but does not eliminate) adverse selection. This point also relates to

⁷ Whereas with aggregation, it is helpful to visualize a bell curve, a Venn diagrams is the best way to think about segregation, where each circle in the diagram would represent a discrete risk pool.

⁸ ABRAHAM, INSURANCE, *supra* note 3, at 6.

⁹ See Michael D. Rothschild & Joseph E. Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. Econ. 629 (1976).

the problem of moral hazard, i.e., “the tendency of any insured party to exercise less care to avoid an insured loss than would be exercised if the loss were not insured.”¹⁰ Moral hazard implies that insured parties are more likely to participate in high-risk activities than non-insured (i.e., self-insured) parties. Because segregation allows insurers to charge high-risk parties (higher) differentiated premiums, it encourages these parties to refrain from high-risk behavior (i.e., moral hazard), thereby reducing the overall level of societal risk.¹¹

Both adverse selection and moral hazard relate back to the problem of imperfect information—most of the costs incurred by the insurer are unknown at the time a policy is sold to the insured. The problem with informational deficiencies is that they thwart the insurer’s ability to accurately match premium rates with actual risk.¹² That is, if the insurer perceives less risk because of missing information, it is more likely to charge a lower premium than justified by actual risk. For this reason, reasonable disclosure is of central importance in insurance law, and insurers expend a good deal of administrative resources drafting, executing, evaluating, and following up on insurance questionnaires. These questionnaires are typically included in the application itself, and their purpose is to collect enough important, relevant information to reasonably estimate the applicant’s risk and, in turn, set an appropriate premium. In the case of life insurance, an insurer might ask if the applicant has suffered from any number of health-related issues, e.g., a

¹⁰ ABRAHAM, INSURANCE, *supra* note 3, at 7.

¹¹ In the absence of segregation, aggregation does not affect the overall level of risk. But it does reduce the impact of risk by lowering the cost of risk.

¹² For precisely this reason, insurers screen and evaluate applications to determine the degree of risk posed by prospective insureds; they classify insureds based on the degree of risk posed and set premium levels accordingly; [and] they experience-rate, or charge premiums for coverage renewals based in part on the insured’s loss experience during the previous policy period

ABRAHAM, INSURANCE, *supra* note 3, at 7.

heart condition or physical disability. An automobile insurer, by contrast, might inquire about an applicant's driving record or variables that correlate with responsible driving, e.g., (older) age and (female) gender.

Thus, especially when answering an insurance questionnaire, an applicant should owe the insurer a duty of reasonable disclosure so that the latter can properly collect premiums and maintain adequate reserves. While insurers have multiple strategies to alleviate moral hazard,¹³ their primary weapon against adverse selection is the insurance questionnaire (and the subsequent, related monitoring of risk). As such, the issue of disclosure in insurance law should be taken seriously. The central point of reference should be the extent to which information from an insurance questionnaire (or the like) helps or hinders the insurer's ability to fulfill the functions of insurance. From this perspective, it becomes apparent that disclosure aids insurers in assigning applicants to their proper risk pools, thereby reducing adverse selection.¹⁴

It seems clear that "whole lies" defeat the purpose of disclosure and, therefore, should void coverage. A more difficult case is presented by "half-truths" on the insurance questionnaire. Clearly, half-truths undermine the underwriting process, sometimes materially. However, "incomplete answers to open-ended questions may be more easily forgiven than false answers to detailed questions,"¹⁵ as their adverse effects can be abated through more rigorous insurance questionnaires. Indeed, the modern practice is to ask relatively detailed questions on insurance applications, rendering a half-truth more

¹³ Insurers may effectively combat moral hazard through aggregate limits, deductibles, and coinsurance. Aggregate limits are caps on insurance, such that risks that involve losses greater than the limit are self-insured. In the case of deductibles, the insured must pay a fee before coverage kicks in. In effect, deductibles raise premiums against careless insureds. Coinsurance involves a similar additional cost of coverage. *See id.*

¹⁴ Disclosure may even help shield insurers against moral hazard by allowing them to better appreciate the ways in which an insured might be careless or otherwise engage in sabotage.

¹⁵ ABRAHAM, INSURANCE, *supra* note 3, at 18.

amenable to scrutiny and, therefore, less likely to pass unnoticed. The problem, of course, is that there are always gaps between the questions asked, and “material facts may fall into these cracks.”¹⁶ Notwithstanding this limitation, many jurisdictions have settled upon the “inquiry notice” rule, such that misrepresentation and concealment do not lie in the event that “the insured furnishe[d] reasonable complete answers that could lead an insurer to the information it seeks through diligent follow-up search.”¹⁷ However, this rule ought to be circumscribed to the extent that the insured is sophisticated. That is, the more sophisticated the insured, the less the insured should be afforded the benefit of an inquiry notice rule. The disclosure duty should be context-dependent. Parts II and III pick up on this point, arguing that unsophisticated and sophisticated insureds should face a lower and higher duty of disclosure, respectively.

II. The Unsophisticated Insured: A Lower Disclosure Duty

As a rule of thumb, an applicant must furnish full and truthful answers in an insurance questionnaire to consummate a valid, enforceable policy (i.e., contract).¹⁸ The importance of complete and accurate disclosure is often enshrined in the resulting insurance policy itself.¹⁹ Ideally, such a duty could only be met in the absence of half-

¹⁶ *Id.*

¹⁷ *Id.* (citing *Cullen v. Valley Forge Life Ins. Co.*, 589 S.E.2d 423 (N.C. App. Ct. 2003) and *Gomogda v. Prudential Ins. Co.*, 501 P.2d 756 (Colo. App. Ct. 1972) as examples).

¹⁸ For example, see the Sample Commercial General Liability (CGL) Policy in Abraham’s book. When the applicant accepts the policy, he agrees per section IV that “[t]he statements in the Declarations are *accurate and complete*,” “[t]hose statements are based upon representations [he] made to [the insurer],” and “[the insurer has] issued this policy in reliance upon [his] representations.” *Id.* at 455 (emphasis added).

¹⁹ Consider the following examples from Abraham’s book. Under the first “Conditions” section of the Sample Homeowners Policy, there is a provision on “Concealment or Fraud,” which precludes coverage for an insured who, insofar as it relates to this insurance, has: (1) “[i]ntentionally concealed or misrepresented any material fact or circumstance”; (2) “[e]ngaged in fraudulent conduct”; or (3) “[m]ade false statements.” *Id.* at 189-90. A similar provision is included in the second “Conditions” section. *Id.* at 195. On a related note, the first section of the Sample Term Life Insurance Policy provides that “If the age or sex of the Insured has been misstated, the amount payable will be the amount which the premiums paid would have

truths and whole lies. But that duty is circumscribed by the following qualification: an applicant should only answer questions to the best of his ability and knowledge. This opens up the possibility that a half-truth might still be consistent with reasonable disclosure as a practical matter.²⁰ Commonsense morality dictates that a whole lie, i.e., affirmative misrepresentation, is more blameworthy than a half-truth in the form of failure to fully answer a question that the insurer could have phrased to exact a more complete response. And whereas oversight seems excusable, the half-truths of deceptive nonresponsiveness or outright concealment may carry greater moral culpability.

However, the emphasis here is on law more than morality. While even an unsophisticated insured may have an *ethical* duty to disclose more fully when tempted to tell a half-truth that will lower his premium, he may not have a *legal* duty to do so. Already adopted in many jurisdictions, the inquiry notice rule is a case in point.²¹ But my concern here is not what the law on half-truths for unsophisticated insureds *is*, but rather what that law *ought to be*. In this Part, I argue that insurance jurisprudence along the lines of the inquiry notice rule and related doctrines is both equitable and efficient for the treatment of an unsophisticated insured's half-truths. That is, unsophisticated insureds should face a lower disclosure duty for two primary reasons. First, because unsophisticated insureds typically lack a full grasp of the importance and relevance of the facts to the proper functioning of insurance, it is only fair to give them at least some

purchased at the correct age and sex.” *Id.* at 282. And the Sample Personal Automobile Insurance Policy contains a provision against fraud: “[the insurer does] not provide coverage for any ‘insured’ who has made fraudulent statements . . .” *Id.* at 655.

²⁰ By definition, a whole lie implies intent to deceive, and scienter contravenes the knowledge requirement in the preceding qualification.

²¹ *See, e.g., Cullen*, 589 S.E.2d at 428 (“[P]laintiff did not disclose the existence of the blood blister in the subject policy application, but the medical records, obtained as part of the application, revealed its existence.”); *Gomogda*, 501 P.2d 756 (“[I]t is clear that the insurer, at any time, could have ascertained the information it now claims would have caused it to deny insurance to the deceased.”).

leeway. Second, because the threat of adverse selection is lower for unsophisticated insureds, and because insurance largely depends upon the public confidence that insurers command, it makes efficiency sense to lower the disclosure duty, thereby encouraging insurers to better perform their underwriting function.

An “unsophisticated insured” is generally defined as a noncommercial party to insurance. More specifically, I have in mind the average person who seeks insurance but has only a cursory knowledge of its nature and function. Compared to the “sophisticated” (i.e., commercial) insured, this person lacks the ability to precisely and consistently distinguish between facts based upon their importance and relevance to the insurer. This point is not meant to suggest that the unsophisticated insured is inept and otherwise incapable of recognizing important, relevant facts when they arise. Surely, a man with a heart condition should have the good sense to disclose this fact when applying for life insurance. Rather, my point is that the general capacity for complete and accurate disclosure is lower for the average person relative to a commercial party. And this differential level of sophistication justifies a lower disclosure duty for the former.

My first argument is that a lower disclosure duty for unsophisticated insureds is fair. Consider the following example: an unsophisticated life insurance applicant *A* may disclose any one of a set of facts *X*, *Y*, and *Z*. Assume that *X* represents a heart problem, *Y* a mild asthmatic condition, and *Z* two HIV antibody tests (both negative). While *A* should have a legal duty to disclose *X*, which is both important and relevant in life insurance, *A* should not have a legal duty to disclose *Y* and *Z* unless, perhaps, the insurer specifically requests such information. In its application, the insurer may include questions like “Do

you have an asthmatic condition?” or “Have you ever taken an HIV-related test?”²² But even if insurers ask pointed questions, which they now often do, they should bear the burden of following up with the unsophisticated insured if there is suspicion of half-truth. An insurer may reasonably suspect a half-truth whenever answers appear nonresponsive or questions are left blank.

If A provides an answer that evades the substance of the question, he is guilty of nonresponsiveness. For example, A might answer “I sometimes wheeze” or “I had an MRI once” to the hypothetical questions above, respectively. But nonresponsiveness need not preclude coverage because, per the inquiry notice rule,²³ it should be the insurer’s duty to follow up on these questions and thereby smoke out the truth.²⁴ On a related note, if A leaves a question blank, he may still be guilty of incomplete disclosure within the meaning of a half-truth. By itself, a blank answer would not be a half-truth because it lacks content and, therefore, the possibility of truth. However, given the insurance application as a whole, the blank answer constitutes a half-truth, assuming that true facts were provided elsewhere and no affirmative misrepresentations were made. Thus, if A declines to answer the above questions, he commits half-truth and should receive the benefit of a lower disclosure duty, whereby he retains coverage. After all, A’s half-truth may not be insidious. He may have left a question blank for any number of reasons—refusing to answer, overlooking the question, or temporarily skipping the

²² If A answers “no” to either question, the result would be not a half-truth but a whole lie, which should preclude coverage. But in all fairness, preclusion should apply only to the relevant provision rather than void the policy as a whole. That is, more material misrepresentations should be more far-reaching than less material ones, which should only preclude coverage under certain circumstances, e.g., A dies because of a severe and unexpected asthmatic episode, or because of the surprising onset of AIDS.

²³ ABRAHAM, *INSURANCE*, *supra* note 3, at 18.

²⁴ *Cf.* *Bronston v. United States*, 409 U.S. 352, 358-359 (1973) (“If a witness evades, it is the lawyer’s responsibility to recognize the evasion and to bring the witness back to the mark, to flush out the whole truth with the tools of adversary examination.”).

question and later forgetting to return. His scienter is not clear, and in this example *A* may well have been unsure how to answer the questions because his asthma is mild and his HIV tests both came out negative (or may be otherwise embarrassing to discuss).

In these cases, the insurer should internalize the cost of incomplete disclosure because it has the wherewithal to investigate further. And, as the party that drafts the insurance questionnaire, the insurer is also better positioned to guard against ambiguity in disclosure. The insurer has the resources (albeit at a cost) to generate applications that are more precise, rigorous, and exacting. This point weighs heavily in favor of retaining insurance coverage when an insured tells a half-truth. The point is only strengthened when the insured is unsophisticated. And this general line of reasoning is closely related to the doctrine of *contra proferentem*, i.e., ambiguous provisions in an insurance policy are to be interpreted against the insurer.²⁵ The rationale is that, “as the drafter of the policy, the insurer has control of its language and therefore the capacity to make it clear.”²⁶ Fairness appears to be the guiding principle here (although there are also important efficiency implications).²⁷ For this reason, in *Vargas v. Insurance Company of North America*, the Second Circuit interpreted an ambiguity about the coverage range of

²⁵ ABRAHAM, INSURANCE, *supra* note 3, at 36; *see also* Imperial Fire Ins. Co. v. Coos County, 151 U.S. 452, 462-63 (1894) (“[W]hen an insurance contract is so drawn as to be ambiguous, or to require interpretation, or to be fairly susceptible of two different constructions, so that reasonably intelligent men on reading the contract would honestly differ as to the meaning thereof, that construction will be adopted which is most favorable to the insured.”) (citing Thompson v. Phoenix Ins. Co., 136 U.S. 287 (1890)).

²⁶ ABRAHAM, INSURANCE, *supra* note 3, at 41.

²⁷ *Cf.* Atwater Creamery Co. v. W. Nat’l Mut. Ins. Co., 366 N.W.2d 271 (Minn. 1985) (holding that a forcible entry-exit requirement for burglary insurance violated the “reasonable expectations” of the insured); Atwood v. Hartford Accident & Indemnity Co., 365 A.2d 744 (N.H.1976) (enforcing a policy on the expectations principle even though it excluded “completed operations” coverage). Most jurisdictions have adopted this expectations principle, which is also justified on fairness. ABRAHAM, INSURANCE, *supra* note 3, at 50. Abraham suggests that this principle may simply make *contra proferentem* operational—“an ambiguity was to be construed in accord with the reasonable expectations of the insured.” *Id.* For more on “honoring the reasonable expectations of the insured,” *see* ROBERT E. KEETON, INSURANCE LAW: BASIC TEXT 351 (1971). Similarly, the substantial compliance doctrine is also justified as fair to the unsophisticated insured. *See, e.g.,* Engelman v. Connecticut Gen. Life Ins., 690 A.2d 882 (Conn. 1997).

aviation insurance against the insurer, whose policy terms created the uncertainty at issue.²⁸

A lower disclosure duty for unsophisticated insureds is not only equitable, but it is also efficient. Indeed, efficiency provides another justification for a lower duty in these cases. From this efficiency perspective, a duty is justified insofar as it spreads risk to the greatest extent possible and at the lowest possible cost, and reduces overall risk by forcing high-risk parties to either pay higher premiums or, after some threshold, internalize the costs of their own high-risk behavior. Both higher premiums and self-insurance act as disincentives to engage in high-risk activities, thereby reducing risk in the aggregate. This reduction in aggregate risk is a net benefit to society, as it tends to decrease the actual frequency and severity of accidents. This understanding of insurance is the framework by which its economic efficiency should be measured.

Based on this understanding, a lower disclosure duty for unsophisticated insureds seems reasonable. There are two main arguments here. First, the threat of adverse selection is less pronounced for the unsophisticated relative to the sophisticated, for the average person versus the commercial enterprise. In the case of an unsophisticated insured, the insurer may know more about the applicant (in some areas) than he knows about himself. That is, A may perceive his risk as higher or lower than its actual value, or he may have no intuition on the matter at all. Adverse selection is likely to be weak or nonexistent in these cases.²⁹ Since adverse selection is a key concern behind the disclosure duty, which preserves the ability of insurer's to segregate insureds into

²⁸ 651 F.2d 838, 839-40 (2d Cir. 1981) (“[A]n ambiguous provision in an insurance policy is construed ‘most favorably to the insured and most strictly against the insurer.’”) (quoting *Index Fund, Inc. v. Ins. Co. of N. Am.*, 580 F.2d 1158, 1162 (2d Cir. 1978), *cert. denied*, 440 U.S. 912 (1979)).

²⁹ ABRAHAM, INSURANCE, *supra* note 3, at 6.

differential risk pools, the reduced threat of adverse selection from unsophisticated insureds should imply a corresponding decrease in their duty to disclose.

The prevalence of risk aversion reinforces this point. Risk-averse insureds tend to buy and retain insurance even when they are charged somewhat more for coverage than justified by their degree of risk. The result is a reasonable extent of cross-subsidization within the insurance pool. As a general matter, because they have neither the know-how nor the information to accurately estimate their risk, unsophisticated insureds may be more risk-averse than sophisticated insureds and, therefore, more likely to contribute to cross-subsidization. This likelihood provides yet another reason why it might be efficient (or at least not inefficient) to lower the disclosure duty for the average person.

Second, such a duty encourages insurers to better perform their underwriting function by asking more detailed questions on insurance applications, and doing a more thorough follow-up on the answers. Generally speaking, people are suspicious of insurance companies. Reasonable or not, the general opinion seems to be that insurers try to avoid insurance claims by identifying technicalities. As it relates to disclosure, the storyline here is that an insurer will always try to dig up half-truths (or trivial whole lies) by which they can deny coverage to an unsophisticated insured—one who could not be expected to fully understand the implications of his half-truths, and who should otherwise be entitled to recover. Waning public trust is problematic from an efficiency standpoint, as this trust is essential to the proper functioning of insurance. If insureds do not trust that their insurers will compensate them for losses—that is, if they believe that insurers will find technicalities to deny coverage—then they are less likely to buy insurance. At some

level, this possibility undermines the aggregation function of insurance, as unsophisticated parties increasingly opt out of insurance, i.e., choose to self-insure.

By forcing insurers to be more rigorous in their insurance questionnaires, a lower disclosure duty for unsophisticated insureds that is well-established and widely recognized may restore greater public confidence in insurance, thereby shoring up any erosion (however small) in the aggregation benefits of insurance. As an additional benefit, more rigorous insurance applications would exact more precise information from applicants and thereby better serve the segregation function of insurance. These points speak to hard, concrete efficiency gains. And jurisdictions that provide insureds with more leeway are already reaping these gains.³⁰ While I do not mean to overstate the aggregation and segregation benefits of a lower disclosure duty for these insureds, neither do I intend to understate potential losses from insurance inefficiencies like “post-claim underwriting,” whereby insurers strain to find inaccuracies on an application so as to build a misrepresentation defense.³¹ In *American Income Life Insurance Co. v. Hollins*, the Mississippi Supreme Court “condemned this practice of post-claim underwriting and cautioned insurers to abstain from such practices in the future.”³² This issue of public confidence in insurers is also generally at stake in *Mighty Midgets, Inc. v. Centennial Insurance*³³ and *West Bay Exploration v. AIG Specialty Agencies*.³⁴ A relaxed disclosure

³⁰ For example, courts in North Carolina and Colorado have adopted the inquiry notice rule and other doctrines that allow for greater flexibility in the disclosure duty of insureds. *Id.* at 18.

³¹ See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809 (2000); see also *Am. Income Life Ins. Co. v. Hollins*, 830 So.2d 1230, 1236 (Miss. 2002) (condemning what the court calls “post-claim underwriting”). Indeed, the existence of post-claim underwriting is seen throughout the case law. See, e.g., *In re Adelpia Comm’ns Corp.*, 307 B.R. 404 (Bankr. S.D.N.Y. 2004); *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F.Supp.2d 988 (W.D. Wash. 2004).

³² 830 So.2d at 1236. To substantiate its position, the court cited *Lewis v. Equity National Life Insurance Co.*: “An insurer has an obligation to its insureds to do its underwriting at the time a policy application is made, not after a claim is filed.” 637 So. 2d 183, 188-89 (Miss. 1994).

³³ 47 N.Y.2d 12 (1979) (finding for the insured).

duty for unsophisticated insureds puts pressure on insurers to probe more deeply and obtain more complete and accurate information. Such information, in turn, undercuts the temptation to engage in post-claim underwriting; and, as I have made abundantly clear, more refined information allows insurers to charge more accurate premiums.

Not surprisingly, many jurisdictions have already embraced parts of the reasoning here, and have adopted judicial doctrines that grant unsophisticated insureds more leeway and approximate the distinction that I draw between half-truths and whole lies.³⁵ Whereas the preceding discussion has concerned itself more with the normative implications of a lower disclosure duty for unsophisticated insureds, this Part now turns to the empirical aspects of this duty. Indeed, a relaxed disclosure duty for unsophisticated insureds finds substantial support in insurance law. Abraham explains that courts often differentiate between concealment and misrepresentation, approximating the distinction I draw between half-truths and whole lies.³⁶ He explains that “courts typically do not require complete accuracy of representations made by the insurance applicant; if a statement is substantially true, there has been no misrepresentation.”³⁷ And in some cases, even an insured’s misrepresentation (as whole lies) may be excused.³⁸

First, consider the case of concealment, which approximates my conception of half-truth. When concealed facts are material, an insurer must prove that the applicant

³⁴ 915 F.2d 1030 (1990) (ultimately finding for the insurer on other grounds).

³⁵ *See supra* note 30.

³⁶ ABRAHAM, INSURANCE, *supra* note 3, at 16.

³⁷ *Id.*

³⁸ A misrepresentation may be material and induce justifiable reliance. The test for materiality and justifiable reliance is an objective one. *See, e.g.,* Palisads Safety & Ins. Ass’n v. Bastien, 814 A.2d 619, 622 (N.J. 2003) (adopting a “reasonable insurer” standard for determining misrepresentation). There is disagreement in the case law over the extent of reliance required to preclude coverage in these cases; however, many jurisdictions now hold that where an insured has misrepresented his age in a life insurance application, the policy is not voided, but the beneficiary is entitled to recover only the amount that would have been payable if the decedent’s age had been accurately stated. *See, e.g.,* VA. CODE ANN. § 38.2-3306.

knew these facts were material before the policy can be voided on the basis of concealment.³⁹ That is, by law, a scienter element must attach to a half-truth before it can preclude coverage. By negative implication, the innocent failure to disclose a fact does not by itself render the policy voidable. Concealment was at issue in *Neill v. Nationwide Mutual Fire Insurance Co.*⁴⁰ Neill applied for fire insurance on his mobile home but neglected to report three earlier fires. He claimed that he was never asked by the insurance agent about previous instances of fire. Because the scienter element of concealment was in doubt, the court reversed the insurer's grant of summary judgment and remanded the case to allow for testimony from the insurance agent.⁴¹

One might criticize *Neill* for relaxing the duty of disclosure, which facially appears to increase the difficulty of distinguishing between low- and high-risk applicants. Neill is high risk, the argument goes, and incomplete disclosure prevented the insurer from accurately gauging his risk. I am sympathetic to this objection and, in fact, endorse a relaxed disclosure duty for precisely this reason. In *Neill*, concern over the segregation function weighs in favor of a lower, not higher, duty. By ruling in favor of Neill, the court holds the insurer responsible for inadequate underwriting. To rule otherwise would provide the insurer with a perverse incentive, leaving intact a system that invites doubts that could later be used to preclude coverage.⁴² Here, the insurer collected information through an insurance agent who manually inputted the applicant's oral answers into a computer.⁴³ Doubt arises not only when there is a problem with disclosure, but also when

³⁹ ABRAHAM, INSURANCE, *supra* note 3, at 18.

⁴⁰ 98 S.W.3d 448 (Ark. App. Ct. 2003).

⁴¹ *Id.* at 451. For similar reasons, the court in *Time Insurance Co. v. Graves* gave the insured added leeway. 734 S.W.2d 213 (Ark. App. 1987).

⁴² The point is related to a previous discussion on post-claims underwriting.

⁴³ 98 S.W.3d at 452.

there is dispute over whether such a disclosure actually took place. Clearly, this method of underwriting leaves a lot to be desired. Instead, the insurer in *Neill* should have required applicants to submit information about past losses in writing. A lower duty of disclosure would encourage the insurer to do so. As a final point, Neill is the archetypal unsophisticated insured,⁴⁴ providing yet another reason to put the cost of problematic disclosure on the insurer.

However, if Neill had in fact answered “none” when asked about past losses, then he may be guilty of material misrepresentation—both because the answer was false, and because the question was central to the insurance sought. Neill’s half-truth (i.e., not disclosing his previous fires because he purportedly was not asked) would become a whole lie (i.e., lying about his previous fires when asked), which should preclude coverage. The outcome of these cases tends to turn on the nature of the question asked and answered on the insurance application. For example, an insurer is much more likely to prevail if an HIV-positive insured answered “no” to the question “Do you suffer from an immune system deficiency?” rather than “Are you in good health?”⁴⁵ This general principle preserves the insurer’s incentive to make insurance questionnaires detailed and precise. Assuming materiality, a false answer to a question whether an applicant has tested positive for HIV would almost certainly void the policy.⁴⁶ The reason has to do with the specificity of the question “Have you ever tested HIV positive?” It also relates to the material importance of the answer in life and health insurance.⁴⁷

⁴⁴ Neill testified that the insurance agent, Anderson, did not ask him about any previous losses and that he signed the application without reading it. *Id.*

⁴⁵ ABRAHAM, INSURANCE, *supra* note 3, at 24.

⁴⁶ See, e.g., *Golden Rule Ins. Co. v. Hopkins*, 788 F.Supp. 295 (S.D. Miss. 1991).

⁴⁷ AIDS poses the threat of adverse selection in life and health insurance. Thus, insurers take steps to screen out HIV-positive applicants, sometimes by requiring blood testing. While blood testing should not be prohibited altogether, I do believe that HIV-related screening should be regulated. For example, while it

Materiality is irrelevant in the case of outright fraud: even immaterial fraud renders a policy voidable.⁴⁸ But materiality is important in determining whether misrepresentation voids coverage. If material,⁴⁹ an affirmative misrepresentation makes the policy voidable in most jurisdictions. *MacKenzie v. Prudential Insurance Co.* is a representative case.⁵⁰ When asked on an insurance application if he had “heart trouble or murmur, high blood pressure, or abnormal pulse,” MacKenzie answered “no.”⁵¹ The representation was true when he signed the application; however, before the policy was delivered, MacKenzie suffered a chest bruise and was forced to take medication for high blood pressure. Because MacKenzie did not disclose this fact to the insurer, as mandated in his application, the Sixth Circuit denied coverage.⁵² By accepting insurance, MacKenzie effectively denied his change in health condition, which amounted to a material misrepresentation sufficient to void the policy. This empirical point from *MacKenzie* is in line with my normative point on whole lies.

allows for blood testing, Vermont does not permit insurers to inquire about HIV-related tests taken in the past. VT. STAT. ANN. tit. 8, § 4724(20)(A). Texas provides only one more degree of flexibility, authorizing insurers to ask if the applicant has ever tested positive on such a test. TEX. INS. CODE ANN. 21.21-4(d).

⁴⁸ ABRAHAM, INSURANCE, *supra* note 3, at 17.

⁴⁹ But what makes a false representation material? Consider *Mutual Benefit Life Insurance Co. v. JMR Electronics Corp.*, where the decedent stated that she did not smoke when, in fact, she smoked two packs a day. 848 F.2d 30 (2d Cir. 1988). The court denied recovery because a misrepresentation that would have resulted in the same policy for a higher premium is material. *Id.* at 34. The impact of misrepresentation on segregation seems to be the primary concern here. Thus, misrepresenting one’s net worth on a life insurance application was held material in *Sovereign Life Insurance Co. v. Rewald*, 601 F. Supp. 1489 (D. Hawaii 1985); and *Swihart v. Universal Underwriters Life Insurance Co.* found a material misrepresentation where the insured signed an application falsely stating that he was not under the care of a physician, 669 N.W.2d 260 (Iowa App. 2003).

⁵⁰ 411 F.2d 781 (6th Cir. 1969).

⁵¹ *Id.* at 782.

⁵² *Id.* at 783. In reaching this holding, the *MacKenzie* court relies heavily on *Stipcich v. Metropolitan Life Insurance Co.*: “If, while the company deliberates, he discovers facts which make portions of his application no longer true, the most elementary spirit of fair dealing would seem to require him to make a full disclosure.” 277 U.S. 311 (1928), 316-317.

In the alternative, the facts of this case might be construed as a half-truth rather than a whole lie. And, empirically, a failure to disclose is not dispositive.⁵³ But the reasoning in *MacKenzie* is still consistent with the logic herein. MacKenzie's half-truth has the effect of a whole lie because the insurer could not discover it *ex ante* (i.e., in the insurance application), as the change occurred later, and it may be unreasonable to expect the insurer to ferret out this fact *ex post* (but before the policy was delivered). That is, the special circumstances of this case may well reverse the fairness and efficiency reasoning presented above. However, given more time for the insurer to ferret out the (whole) truth, this reasoning may be reversed back in favor of the insured. For example, fairness is a key justification given for the incontestability clause, which "creates a kind of contractual statute of limitations on certain defenses of the insurer—primarily those involving misstatements by insured that eventuate in defense of fraud, misrepresentation, concealment, or breach of warranty."⁵⁴ And, when incontestability is at issue, many courts apply a discoverability test which itself is grounded in fairness.⁵⁵

As a final note, it is worth mentioning that a warranty is another special case in which my fairness and efficiency reasoning may reverse itself. Even an unsophisticated insured should face a high disclosure duty when he makes a warranty. Unlike a mere representation, a warranty is not simply a promise that information is accurate but is also a guarantee that such information is complete. A warranty is meant to be an inclusive

⁵³ See *Seidler v. Georgetown Life Ins. Co.*, 402 N.E.2d 666 (Ill. App. 1980).

⁵⁴ ABRAHAM, *INSURANCE*, *supra* note 3, at 337. Section 1.4 of the Sample Term Life Insurance Policy in Abraham's book is an example. *Id.* at 282.

⁵⁵ For example, in *Amex Life Assurance Co. v. Superior Court*, the California Supreme Court rejected the insurer's impostor defense in a case involving HIV-related fraud. 930 P.2d 1264 (Cal. 1997). The court reasoned that the fraud did not void the policy *ab initio*, and found that "Amex could have discovered the fraud at the outset," before the incontestability clause took effect. *Id.* at 1271. The court held the policy enforceable on fairness grounds: "Amex, which did nothing to protect its interests but collect premiums until [the insured] died after the contestability period, may no longer challenge coverage on the basis that an impostor took the medical examination." *Id.* at 1266.

statement of the facts—that is, a strong presentation of all important, relevant facts. If any fact is missing or false, the party who issued the warranty should bear full responsibility. This principle has long existed in insurance law.⁵⁶ As a result, in the warranty context, it is easy to see how a half-truth becomes a whole lie. And the distinction between warranty and representation has economic value, as it reduces transaction costs. Strictly speaking, the party who receives a warranty may reasonably accept it without further investigation. Thus, this distinction should be airtight—free of any doubt, rid of as much uncertainty as possible. And even an unsophisticated insured should not be allowed to escape responsibility by claiming ignorance in this matter.

Vlastos v. Sumitomo Marine & Fire Insurance Co. is poorly decided precisely because the court obfuscated this distinction, interpreting the insured’s statement on the application “Warranted that the 3rd floor is occupied as Janitor’s residence” as a representation, rather than a warranty.⁵⁷ Notwithstanding the fact that “warranted” typically implies warranty, the Third Circuit held that it was reasonable to hold otherwise in this case. While the insurer could have eliminated ambiguity by placing the term “solely” in the insured’s statement, such a duty may be unreasonable in light of the fact that it was the insured, and not the insurer, who included this statement. Why else would the insured use the term “warranted” unless she meant to guarantee the fact that her massage parlor did not extend onto the third floor? The only reason why Vlastos would insert this phrase into her insurance application is to obtain a lower premium. The point

⁵⁶ See, e.g., *De Hahn v. Hartley*, 1 T.R. 323 (1786) (“A representation may be equitable and substantially answered; but a warranty must be strictly complied with.”). However, many states have enacted statutes to collapse the distinction between insurance warranties and representations, such that a breach of warranty voids a policy only if the breach is material. Some states provide that a breach is material if it increases the risk of loss, see, e.g., MICH. COMP. LAWS ANN. § 500.2218; others require that the breach contribute to loss, see, e.g., KAN. STAT. ANN. § 40-418.

⁵⁷ 707 F.2d 775, 776, 780 (3d Cir. 1983).

here is that both half-truths and whole lies should render a policy voidable in insurance warranties, but should otherwise be subject to differential treatment, as argued above.

III. The Sophisticated Insured: A Higher Disclosure Duty

While considerably shorter than its predecessor, this Part argues that a sophisticated insured should bear a higher duty of disclosure. Here, a “sophisticated” insured is conceptualized broadly to include both commercial non-insurers (i.e., business enterprises specializing in the sale and trade of something other than insurance) and insurance companies themselves; government entities would also qualify as “sophisticated,” although they are not explicitly considered here. Insurers become the subjects of insurance when they procure policy coverage on their own liabilities (and potential liabilities) through a process called reinsurance, which is discussed in detail below. In reference to these insureds, I again justify my position on the grounds of equity and efficiency; however, by applying these criteria to commercial parties, I arrive at a different conclusion: whereas it makes sense to relax the disclosure requirement for unsophisticated insureds, it is both fair and efficient to hold sophisticated insureds to a higher duty of disclosure. Again, this position is a normative one, asking what the disclosure duty *ought to be* in theory, although it finds traces of empirical support in the case law.⁵⁸

⁵⁸ On this point, judicial treatment of *contra proferentem* might serve as a comparable example. When applied to sophisticated insureds, *contra proferentem* has been called into question. Compare *Owens-Illinois, Inc. v. United Ins. Co.*, 625 A.2d 1, 15 (N.J. Super. App. Div. 1993) (“The principles favoring the interests of the insured are less persuasive in the context of a large skilled corporation.”), *rev’d on other grounds*, 650 A.2d 974 (N.J. 1994), with *CPS Chemical Co. v. Continental Ins. Co.*, 536 A.2d 311, 318 (N.J. Super. App. Div. 1988) (“These principles [of interpretation] are no less applicable merely because the insured is itself a corporate giant.”).

First, a higher disclosure duty for sophisticated insureds is fair. Let us start with the premise that the disclosure duty for a commercial party should be at least that of the average person. Thus, a sophisticated insured's whole lies would make the policy voidable. But my argument is that, under certain circumstances, its half-truths should also preclude coverage. The reasoning here is rather straightforward: given its economic and administrative resources, a sophisticated insured is better positioned to identify the important, relevant facts that should be disclosed.⁵⁹ And, in the case of reinsurance, the reinsured has the capacity to fully comprehend the cost of any incomplete disclosure. In fact, the reinsured even possess the know-how to estimate that cost (in actuarial terms), and it can do so before it submits its insurance application. Another equitable justification for holding them to a higher duty of disclosure is that most sophisticated insureds are giant corporations, meaning they have the wherewithal to share in the costs that arise from incomplete disclosure.

This point on fairness, however, is not with qualification. That is, a higher disclosure duty should not operate to deny coverage to a sophisticated insured in all cases. In cases where the insured's sophistication—its institutional knowledge, its economic resources, its administrative manpower, and so on—confer no advantage on that insured in the underwriting process, a half-truth should not necessarily serve to void the policy. Although it might be difficult to imagine such a case, one may gain understanding by noting the ways in which other insurance principles have been applied to sophisticated insureds.

⁵⁹ *Cf.* *Atwood v. International Ins. Co.*, 1991 Ohio App. LEXIS 6030, *13 (Ohio Ct. App. 1991) (“[C]onsumer-oriented technical offer or notice requirements do not make sense when the insured is a well-informed commercial or government entity.”); *Piro v. Bell*, 25 Pa. D. & C.3d 668, 672 (Pa. C.P. 1981) (“[A] sophisticated insured would be aware of the potential adverse relationship with his or her insurance company and consequently would not necessarily provide the same information . . .”).

Consider the doctrine of *contra proferentem*. In *New Castle County v. Hartford Accident & Indemnity Co.*, the Third Circuit applied that doctrine to a sophisticated insured: “[w]e can conceive of no compelling reason why even a sophisticated insured should not be entitled to a pro-coverage interpretation of a standardized ISO policy drafted by the insurance industry.”⁶⁰ The court’s rationale was driven by an understanding that *contra proferentem* applies whenever the policy in question is drafted by the insurer, regardless of whether the insured is sophisticated or not. However, the California Supreme Court took a different position in *AIU Ins. Co. v. Superior Court*: “where the policyholder does not suffer from lack of legal sophistication or a relative lack of bargaining power, and where it is clear that an insurance policy was actually negotiated and jointly drafted, we need not go so far in protecting the insured from ambiguous or highly technical drafting.”⁶¹ But this opinion suggests that if one of the elements were missing, e.g., the policy was not “jointly drafted” or there was a “lack of bargaining power,” even a sophisticated insured could receive the benefit of *contra proferentem*. So perhaps the sophisticated insured’s duty of disclosure could approximate that of the unsophisticated insured when similar elements are missing from the underwriting process. At any rate, save for these rare cases, a commercial party should be subject to a higher disclosure duty.

This higher duty is also generally efficient. This point is true by negative implication, because it would be inefficient to give sophisticated insureds the benefit of the doubt when half-truths arise. After all, the insureds possess the know-how to take

⁶⁰ 933 F.2d 1162, 1189 (3d Cir. 1991). *But see Owens-Illinois, Inc.*, 650 A.2d at 991 (N.J. 1994) (holding that “a sophisticated insured . . . cannot seek refuge in the doctrine of strict construction by pretending it is the corporate equivalent of the unschooled, average consumer”) (quoting *Owens-Illinois, Inc.*, 625 A.2d at 15). This inconsistent treatment was noted in *supra* note 58.

⁶¹ 799 P.2d 1253, 1265 (Cal. 1990).

advantage and otherwise abuse a lower duty of disclosure. It would be a fool's errand to ask an insurer to design a detailed insurance questionnaire for a sophisticated insured if the burden of half-truths (i.e., adverse selection and, perhaps, moral hazard) consistently fell on the former, and their benefit (i.e., lower premiums) consistently flowed to the latter. That is, the sophisticated insured could "game" this arrangement—first, by being as strategically nonresponsive as possible on its insurance application; and, second, by being skillful enough to legally avoid a loss of coverage. Because the risk of voiding the policy is lower under a relaxed disclosure duty, the sophisticated insured would have the incentive to play this game. And it would be administratively burdensome for an insurer to play this game against one who has the expertise and information to make the game competitive. The expense of administration, not to mention the loss from adverse selection, thwart the benefits of insurance and are otherwise costly to society. Admittedly, this risk is also present for unsophisticated insureds, but that risk is minimized given their relative inability to effectively play this game.

These fairness and efficiency points are only strengthened within the context of reinsurance. Abraham defines reinsurance as "an agreement between two or more insurers, whereby all or part of the risk of loss under an insurance policy or policies sold by one is transferred to the other."⁶² It seems less fair to give a reinsured the benefit of a lower disclosure duty when it is evenly matched against the reinsurer; the reinsured is also the ideally positioned party to play the inefficiency game described above. For this reason perhaps, the reinsured owes the reinsurer a duty of utmost good faith, known as

⁶² ABRAHAM, INSURANCE, *supra* note 3, at 739. Reinsurance allows insurer to diversity their risk as a "protection against unexpected frequency of losses, unexpected severity, or both." *Id.* Similarly, reinsurers themselves may diversify their risks through a process called retrocession, whereby they procure insurance on reinsurance. *Id.*

uberrimae fidei.⁶³ At least historically, this duty has discouraged litigation; without it, the threat of litigation is strong, as reinsurance tends to be custom-made and subject to less regulation because the parties are thought to be sophisticated.⁶⁴ Since a reinsured is the archetypal sophisticated insured, these points drive home my central argument: a sophisticated insured should be held to a higher duty of disclosure.

Conclusion

Based on the preceding discussion, it has become abundantly clear that a half-truth need not be a whole lie. In fact, it would be foolish (and costly) not to distinguish between them in insurance law. Half-truths are of particular interest, as they may be subject to differential treatment depending upon the insured's degree of sophistication. And this point speaks to a key topic in insurance law: the issue of disclosure. Whereas it may be equitable and efficient to relax the disclosure duty for the average person, it makes more sense to raise this duty for the sophisticated, commercial insured. Thus, while the distinction between half-truths and whole lies should not be overstated—as there are important intersections, e.g., in the case of insurance warranties—neither should it be understated. This Comment has endeavored to demonstrate this point, not just in normative terms, but also through empirical references.

⁶³ See, e.g., *Allendale Mut. Ins. v. Excess Ins.*, 992 F.Supp. 278 (1998) (citing *In re Liquidation of Union Indemnity Ins. Co.*, 674 N.E.2d 313 (N.Y. 1996)). This duty entails, inter alia, a duty to disclose insolvency. See *Nichols v. Am. Risk Mgmt., Inc.*, 2002 U.S. Dist. LEXIS 22221 (S.D.N.Y. 2002). Although this duty has been challenged with the entry of non-traditional companies into the reinsurance market, *uberrimae fidei* continues to survive in most jurisdictions. See, e.g., *Unigard Security Ins. Co. v. N. River Ins. Co.*, 4 F.3d 1049 (2d Cir. 1993).

⁶⁴ ABRAHAM, INSURANCE, *supra* note 3, at 740 (discussing facultative reinsurance).