The Antitrust Suits and the Public Understanding of Insurance

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THE ANTITRUST SUITS AND THE PUBLIC UNDERSTANDING OF INSURANCE

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The social significance of the insurance antitrust suits extends beyond the specific legal issues of McCarran-Ferguson Act interpretation and the economics of boycotts. Few people have forgotten the extraordinary insurance disruptions of 1985-1986. For liability insurance reasons, jails, day care centers, and ski lifts were closed; police patrols were suspended; and playground equipment and diving boards were removed from public schools and parks. For similar reasons, nurse-midwives could not obtain insurance and doctors fled from obstetric specialties. Though perhaps more quietly, producers removed scores of products from markets and product innovation declined. 1

The insurance antitrust suits represent a national trial of the source of these disruptions. Narrowly, the suits claim that one principal phenomenon of the crisis, the withdrawal of occurrence, pollution, and defense cost insurance coverage, was generated by collusive practices of insurers, rather than by the expansion of tort liability. But the suits' broader social import stems from their implied allegation that the insurance industry possesses a combination of unbridled power and a voracious desire for profits that give it the ability and impetus to engage in massive manipulation of product and service markets, even of such central, yet vulnerable, services as municipal parks, day care, and obstetrics. In this respect, the suits represent the delegation to a jury, not merely of legal issues involving standard insurance forms, but of the broader charges of power, manipulation, and excessive profit making and of issues regarding the role

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1. For a further description of these phenomena, see Priest, The Current Insurance Crisis and Modern Tort Law, 96 YALE L.J. 1521, 1521-22, 1585 (1987), and sources cited therein [hereinafter Priest, Insurance Crisis].
and impact of state insurance regulation. The resolution of the
suits may signal the direction of statutory and regulatory poli­
cies toward the insurance industry for the decade to come.

The insurance antitrust suits are currently only one of many
manifestations of deep social suspicion of the insurance industry.
Support continues to grow for repeal of the McCarran-Ferguson
Act’s3 limited exemption of insurance practices from the federal
antitrust laws.4 The recent enactment by referendum of Propo­
sition 103 in California,5 which mandated a twenty percent roll­
back in insurance premiums, is the most extreme example of
popular distrust of insurer pricing and profits. Indeed, such dis­
trust has expanded to become counterproductive. The Califor­
nia premium roll-back, if constitutionally upheld, cannot help
the consumer population and will surely reduce insurance avail­
ability. But the popular distrust of the insurance industry is so
severe that it seems certain to intensify if the courts strike down
the roll-back, yet it is likely to increase even more if courts
uphold the roll-back and insurers leave the state.

Few people would contest the importance of insurance in
modern life. Indeed, few would dispute that a central ambition
of a civilized society is to maximize the availability of insurance
against all forms of prospective loss.6 The broader significance
of insurance in modern society thus suggests the importance of
formulating policies toward the insurance industry with a clear
view of how insurance operates and how to enhance insurance
availability. In the context of the antitrust suits, it is especially
important to evaluate the Attorneys’ General claims, along with
other theories of insurer antitrust violations, in the broader con­
text of the overall structure of the commercial casualty industry
and the longer-term changes in industry structure and practice
since the early 1970s.

Regrettably, both the claims of the Attorneys General and

4. See American Bar Ass’n, Report of the Commission to Improve the Liability
Insurance System 64-65 (Feb. 6-7, 1989) (1989 Midyear Meeting) (recommending repeal
subject to defenses for collectively efficient industry practices) [hereinafter Insurance
Comm’n Report]. I was a member of this Commission and concurred in recommending
McCarran-Ferguson Act repeal.
5. CALIF. INS. CODE § 1861.01(a) (West Gen’l Election Supp. 1989).
6. I believe this conclusion is the heart of the most influential philosophical
For an elaboration of this view, see G. Priest, The Role of the State in Risk-Spreading
other anticompetitive theories of the insurance coverage withdrawals, such as that of Professor Ayres and Mr. Siegelman,\(^7\) ignore the broader context of the industry structure and its evolution. Though there are differences between them,\(^8\) both the claims of the Attorneys General and those of Ayres and Siegelman neglect crucially relevant characteristics of the commercial casualty insurance industry. The Attorneys’ General complaints (as well as their broader statements explaining the suits)\(^9\) are built upon a very limited set of facts concerning the circumstances of the coverage withdrawals. Ayres and Siegelman, more oddly yet, constrain their analysis to nothing beyond the facts alleged in the Attorneys’ General complaints.\(^{10}\) Both theories ignore easily available information concerning structural conditions of the industry and other data concerning industry developments in the preceding decades.

As we shall see, this limited vision substantially clouds both conclusions that the coverage withdrawals restrained trade. The broader context of developments in the commercial casualty industry since the 1970s powerfully demonstrates how the expansion of tort liability undermines insurance pools and leads to the selective withdrawal of insurance coverage. This demonstration,\(^{11}\) along with evidence of industry structure, uncovers the weakness of the Attorneys’ General complaints. Moreover, the particular cost structure of insurance services and the ease of entry into the commercial liability insurance industry make the Ayres-Siegelman exclusionary theory particularly unrealistic.

Part I of this Article describes the structure of the commercial casualty insurance industry. It discusses evidence of general competitiveness within the industry, and it documents the dramatic shift toward self-insurance that appears to have begun in the early 1970s. Part II applies this understanding of industry


\(^8\) The most significant difference is the Ayres-Siegelman criticism that the Attorneys General have no coherent explanation of how coverage withdrawals could increase insurance profits. \textit{Id.} at 980-81. For a further discussion of this point, see infra notes 29-31 and accompanying text.


\(^{10}\) Ayres & Siegelman, \textit{ supra} note 7, at 973 ("This Article will . . . analyze, under a demurrer standard, whether a coherent economic theory underlies the plaintiffs' Sherman Act claims.").

\(^{11}\) See generally Priest, \textit{Insurance Crisis}, \textit{ supra} note 1, criticized in Ayres & Siegelman, \textit{ supra} note 7, at 982-85.
structure to an analysis of the specific antitrust claims of the Attorneys General. Part II shows the link between the withdrawal of pollution, defense cost, and occurrence coverage and the broader changes in industry structure since the 1970s. It also explains why the withdrawal of these forms of coverage, although limited in impact, more likely expanded, rather than contracted, insurance availability. This discussion strongly implies that the Attorneys’ General complaints about insurer practices, besides lacking antitrust merit, are particularly adverse to the broad social desire to expand the availability of insurance and to lower insurance prices. Next, Part III considers the Ayres-Siegelman exclusionary hypothesis of the coverage withdrawals. This Part shows why structural conditions of the industry make any effort to raise rivals’ costs impractical. Finally, Part IV describes how future policies toward the industry must be defined more broadly to facilitate the provision of insurance and increase insurance availability, especially to low-risk insureds (such as those persons with low income) to whom insurance might otherwise be denied.


Insurance offerings are divided between personal lines—life insurance, health insurance, annuities, consumer automobile insurance, and homeowners’ liability insurance—and commercial lines, the largest of which is commercial property/casualty insurance. The distinction between personal and commercial lines derives, most importantly, from the nature of the parties purchasing insurance: personal lines are purchased by consumers, whom regulators seek to protect because consumers are generally regarded as uninformed about insurance, and commercial lines are purchased by business firms which, because of greater commercial ability, compel less regulatory protection.

The insurance crisis of 1985-1986 affected only commercial casualty insurance lines, in particular the “Other Liability” and “Medical Malpractice” insurance lines, as they are classified in industry reports. Other Liability includes products liability, professional liability, and, more generally, commercial coverage of personal injury claims against insured corporations. The Attorneys’ General antitrust suits are directed solely at practices
in the Other Liability and Medical Malpractice lines.\textsuperscript{12} To understand the antitrust suits as well as the 1985-1986 crisis, it is important to appreciate the structural conditions of the commercial casualty industry that offers these lines of coverage.

By all accounts, the commercial casualty industry has always been highly competitive. Both for the industry as a whole and for specific insurance lines, individual firm market shares are low.\textsuperscript{13} As a result, industry concentration levels are low. For example, in 1986, the four-firm concentration ratio for Other Liability was less than twenty-nine percent.\textsuperscript{14} Market shares and concentration ratios were low even within individual states. Justice Department Merger Guidelines regard an industry as unconcentrated if it possesses a Herfindahl index of less than 1000 when the market shares of all potential industry entrants are included in the index calculation.\textsuperscript{15} Table 1 displays 1986 Herfindahl indices by state for the Other Liability line in declining order of concentration. The figures in Table 1, however, were calculated from the market shares solely of existing insurers, ignoring potential entrants and thus substantially overstating concentration as measured by the Justice Department. Yet, even overstated, Table 1 shows that the Other Liability index exceeds 1000 in only one state.

Table 1 also shows, by state, the number of insurers offering Other Liability coverage. Obviously, the more populous states, such as Pennsylvania (235 firms), Illinois (225 firms), New York (219 firms), and California (204 firms) contain the largest number of insurers. But even in the least populous states, Other Liability coverage is offered by a large number of firms, such as in Hawaii (by 101 firms), Alaska (by 121 firms), and Wyoming (by 130 firms).

The low concentration ratios and large number of existing carriers result from the very low costs of entry into the commercial casualty industry. Insurance, in essence, is a financial service. Aside from regulatory requirements, entry into the

\textsuperscript{12} Actually, the suits may be only directed at practices in the Other Liability line. I have included reference to Medical Malpractice because of the use of claims-made policies in this line, one of the subject matter concerns of the lawsuits. \textit{See infra} note 47 and accompanying text.

\textsuperscript{13} Insurance Comm'n Report, \textit{supra} note 4, at 14.

\textsuperscript{14} \textit{Id}.

### TABLE 1
Market Structure of Other Liability Line
Number of Firms, Herfindahl Index, by State

<table>
<thead>
<tr>
<th>State</th>
<th>No. of Firms</th>
<th>Herfindahl Index</th>
<th>State</th>
<th>No. of Firms</th>
<th>Herfindahl Index</th>
</tr>
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<tbody>
<tr>
<td>MI</td>
<td>184</td>
<td>1,780</td>
<td>TN</td>
<td>203</td>
<td>390</td>
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<tr>
<td>RI</td>
<td>130</td>
<td>967</td>
<td>NC</td>
<td>179</td>
<td>388</td>
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<tr>
<td>VT</td>
<td>134</td>
<td>958</td>
<td>AR</td>
<td>173</td>
<td>383</td>
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<tr>
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<td>888</td>
<td>KS</td>
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<td>610</td>
<td>MD</td>
<td>198</td>
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<td>362</td>
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<td>163</td>
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<td>558</td>
<td>GA</td>
<td>209</td>
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<tr>
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<tr>
<td>PA</td>
<td>235</td>
<td>396</td>
<td>IN</td>
<td>229</td>
<td>266</td>
</tr>
</tbody>
</table>


Industry can be achieved without heavy fixed-capital investments, but with the simple accumulation of capital. All state insurance regulators impose minimum solvency requirements. Yet no modern commentator has asserted that solvency require-

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16. For the same reason, exit costs are low; this is an important, though often neglected, feature of competitive markets.
ments shield existing firms from competition in any substantial way.\textsuperscript{17}

The intrinsically financial character of insurance also means that, besides new entry, there are no serious limitations to expansion by existing firms. The very substantial change from year to year in the success of individual firms in specific commercial casualty sublines is evidence of this. Even within individual states, firm rankings, in terms of commercial casualty premiums written, change dramatically from year to year,\textsuperscript{18} which is characteristic of high levels of competition.

Beyond the competition provided by existing carriers, commercial casualty insurers face potential competition from insured firms themselves. Not all commercial firms purchase insurance. Indeed, the corporate purchase of commercial liability insurance has proven something of a puzzle because corporations have many potential methods of diversifying to reduce the effect of potential losses.\textsuperscript{19} As I shall discuss in more detail below, the extent of corporate self-insurance has increased substantially over time through the creation of firm or industry captive insurance subsidiaries and industry-wide mutuals.\textsuperscript{20} Again, in concept, the potential competition from corporate self-insurance should be included in any concentration calculation. Thus, viewed more generally as a form of financial diversification, commercial casualty insurance faces competition from a very wide set of financial instruments.

The Medical Malpractice subline of the commercial casualty line is characterized by somewhat greater concentration than the Other Liability subline. Nationally, in 1986, the largest medical malpractice insurer possessed only an 18.2 percent market share; the four-firm concentration ratio for the subline was less than 35 percent.\textsuperscript{21} Within individual states, however, concentration was greater. Typically, high concentration resulted from the large size of medical association and residual mutual

\textsuperscript{17} For a careful description of ease of entry and exit within a specific state, see Florida Academic Task Force for Review of the Insurance and Tort Systems, Final Fact-Finding Report on Insurance and Tort Systems, 135, 144-50 (Mar. 1, 1988) [hereinafter Florida Task Force].


\textsuperscript{19} Studies of the corporate purchase of insurance are surveyed in Priest, \textit{Insurance Crisis}, supra note 1, at 1560-62.

\textsuperscript{20} See \textit{infra} Figures 1 & 2; notes 24-28 and accompanying text.

\textsuperscript{21} Insurance Comm'n Report, \textit{supra} note 4, at 14.
carriers that were created to offer coverage at lower premiums than market insurers. Because these carriers are controlled either by state regulators or by insured doctors themselves, their high market shares do not generally suggest potential monopoly behavior. Moreover, as noted before, these market shares and concentration ratios are calculated without regard to potential entry into the industry—including entry by further shifts toward self-insurance or to other forms of financial diversification—and thus exaggerate concentration.

The large numbers of carriers in every state, extremely low concentration, and great ease of entry all imply that anticompetitive practices are unlikely to be successful in the commercial casualty industry. Indeed, on these grounds alone, commercial casualty probably more closely resembles the atomistic ideal of perfect competition than any other nationwide industry. The particular character of commercial casualty underwriting reinforces the point. Much of the insurance coverage implicated in the antitrust suits and in the recent crisis consists of what is called special risk underwriting: the provision of insurance in a highly individualized manner to insured firms, with premiums set according to the particular characteristics of the insured firm itself. Some industry experts have argued that, because special risk underwriting involves such a high degree of individualized rate-setting and coverage definition, all insurance commission attempts to regulate the commercial casualty industry will be ineffectual.22 These characteristics of special risk underwriting, however, make attempts to coordinate insurer action equally ineffectual. To be successful, cartelization requires a standardized product sold to uninformed consumers,23 just the opposite of commercial casualty insurance, in which individualized insurance products are sold to expert commercial consumers.

The low concentration level of the commercial casualty insurance industry apparently has remained constant for decades. But since the early 1970s, an important change has occurred in the character of the industry: a steadily increasing shift away from market insurance toward corporate self-insurance of expected liability exposure. The increased self-insurance has taken three principal forms. First, many corporations have formed their own captive insurance subsidiaries to write and

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manage coverage of the firm’s expected losses. Second, in
selected industries, firms have formed industry-wide mutuals.
These mutuals typically provide for subsequent assessments
against firm members based upon the liability experience of the
mutual for the year. The mutual form thus provides insurance
against risks specific to individual firms while binding together
all member firms to self-insure risks common to the industry.
The third and more basic form of corporate self-insurance has
been the greater retention of exposure by means of higher
deductibles, greater coinsurance proportions, and more exten­sive coverage exclusions.

Figure 1 illustrates the growth in numbers of captive insur­ance subsidiaries since 1970.24 Though not all captives write
equivalent amounts of coverage (specific totals are unavailable),
Figure 1 illustrates the dramatic increase since 1970 in employ­ment of the captive form.

Figure 2 presents estimates that show the increase in self­insurance as a percentage of total casualty premiums and costs for the Other Liability line, most central to the antitrust suits and the recent crisis. The Premiums curve represents actual pre­miums paid to captive and mutual insurers as a percentage of total Other Liability premiums. Figure 2 shows that from 1970 to 1986 self-insurance premiums rose from 1.5 to 31.9 percent of total Other Liability premiums. Although the Premiums curve represents both premiums paid to mutuals and those paid to cap­tives, mutual premiums in 1986, according to Best’s, constituted only 11.1 percent of total Other Liability premiums.25 Though these estimates may not totally correspond, they suggest that captive premiums constitute around twenty percent of total Other Liability premiums.

The Total Costs curve in Figure 2 is derived from estimates of firms’ total liability costs, including premiums paid to captives
or mutuals as well as all other retentions of exposure through
deductibles, coinsurance, and the like.26 The curve shows self­insurance expenditures as a proportion of total liability expendi­

26. The estimate was compiled through a survey of risk managers reporting liability
FIGURE 1
NEW CAPTIVES CREATED
Commercial Casualty

Cumulative Number


tures for Other Liability exposures. The Total Costs curve reveals that the corporate shift toward self-insurance since 1970 has been more dramatic than is suggested by the rise in premiums alone. Total self-insurance costs have increased from 4.9 percent in 1970 to 51.7 percent of aggregate Other Liability expenditures in 1979. Thus, over half of Other Liability expenditures in 1979 were self-insurance expenditures. Although there

are no available estimates of total self-insurance costs more recent than 1979, the Premiums curve in Figure 2 shows that, from 1979 to 1986, the proportion of self-insurance premiums almost doubled (from 16.7 to 31.9 percent). Even if there were no additional increases in self-insurance costs (though it is clear there were, especially during the crisis of 1985-1986),

27 total self-insurance costs must have been at least in the range of 60 to 80 percent of aggregate Other Liability expenditures in 1986.

Expenditures for more basic forms of self-insurance—deductibles, coinsurance, coverage exclusions—appear as the difference between the Total Costs and Premiums curves. As is

27. For examples of increases in deductibles, coinsurance, and exclusion, see generally Priest, *Insurance Crisis*, supra note 1.
evident, expenditures on these forms of self-insurance were rising rapidly through 1979, especially in the years after 1974.

There are no equally detailed data available for the Medical Malpractice line, but the shift to self-insurance has been similar, and probably more extensive. Conning & Co. estimates that in 1983 and 1986 self-insurance premiums for Medical Malpractice constituted 30.4 and 40 percent of total casualty premiums, respectively, an amount greater than the 29.6 and 31.9 percent of Other Liability self-insurance premiums for both years.\(^\text{28}\)

What accounts for the tremendous increase in self-insurance in the Other Liability and Medical Malpractice lines? There are no general accounts of the determinants of the shift from market insurance to self-insurance. Professor Ayres and Mr. Siegelman hint that the shift may be the consequence of the coverage withdrawals themselves: when insurers refuse to offer coverage, firms must self-insure.\(^\text{29}\) But Ayres and Siegelman derived their interpretation innocent of the information presented above, showing that the shift to self-insurance has been continuous and progressive since the early 1970s. No one has claimed that insurers began colluding to withdraw coverage in the 1970s. Though there were insurance premium crises in the products liability and medical malpractice fields in the late 1970s, no coverage withdrawals occurring during that period compare to those suffered during 1985-1986. There were certainly no year-to-year coverage withdrawals that might correspond to the steady increase in captive formation or in self-insurance premiums and costs illustrated in Figures 1 and 2. Most importantly, the Ayres-Siegelman interpretation is inconsistent with their own presumption that insurers, whether operating under conditions of competition or monopoly, will attempt to maximize profits.\(^\text{30}\) As Ayres and Siegelman realize, encouraging a shift toward corporate self-insurance would reduce, rather than increase, insurance industry profits.\(^\text{31}\)

To understand the shift toward corporate self-insurance, it is necessary to define the conditions under which a market insurer will possess a comparative advantage in terms of loss


\(^{29}\) Ayres & Siegelman, supra note 7, at 985 n.62.

\(^{30}\) Id. at 980-81.

\(^{31}\) This is the basis on which Ayres and Siegelman criticize the Attorneys General for failing to define a coherent theory of the antitrust case. Id. at 980. For a further discussion of this point, see infra notes 107-11 and accompanying text.
diversification. All corporations possess assets whose value is to some degree firm-specific. Disposing of these assets to satisfy liability judgments imposes real costs on a firm, costs that can be reduced by investments of greater diversification. Market insurers in the first instance are diversification agents; they translate premiums to diversified equity markets. Market insurers also provide a pooling service, reducing the costs of risk-bearing by taking advantage of the statistical independence of loss. Risk reduction through pooling, of course, can only occur when losses are probabilistic and uncorrelated.\(^{32}\)

A risk is uninsurable when market insurers have no comparative advantage to commercial insureds in terms of either pooling or premium investment. There are two separate conditions under which risks will be uninsurable in commercial markets. First, under conditions of extreme adverse selection, when pooled risks are extremely disparate, insurance pools can unravel and doom market insurance.\(^{33}\) Put differently, when there are substantial differences in risks brought to a pool and insurers have difficulty segregating low-risk from high-risk insureds, low-risk insureds may drop out of the pool because of the difference between the necessary pool premium and the risk the insured brings to the pool. When risks are extremely disparate, the pool may unravel completely.\(^{34}\) Second, when the risks faced by insureds are not independent, but are highly correlated, the reserves required by a market insurer may equal or exceed the reserves required by a self-insuring firm.\(^{35}\) In such cases, there is no comparative advantage to market insurance over self-insurance.

The steady increase since the early 1970s in captive insurer formation (Figure 1) and the similarly steady increase in the difference between self-insurance costs and captive premiums (Figure 2) are strong evidence of both conditions of uninsurability. A firm forms a captive insurer when it believes that the premiums necessary to support the captive are less than those charged

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34. For examples of this phenomenon, see Priest, *Insurance Crisis*, supra note 1, at 1553-63.
35. *Id.* at 1578. A limiting example is when the firm faces prospective bankruptcy because its liabilities, unlike the insurer’s, might be greater than available assets. In such cases market insurance would be more costly than self-insurance.
by market insurers. The captive insurance form thus is advan-
tageous to an insured who knows or believes that the risk level
that it is generating is less than the risk level estimated by the
market insurer. This is adverse selection, the consequence of the
increasing variance of risks within risk pools. The growth of the
captive insurance form represents the effects of increasing
adverse selection in commercial casualty markets.36

The shift toward greater levels of basic self-insurance—
deductibles, coinsurance, coverage exclusions—may illustrate
either increasing variance of risk or increasing dependence of
risk, or both. An increase in a deductible or a coinsurance term
has two effects. First, it is a method of charging a greater pro-
portion of total liability costs to relatively high-risk—rather than
to low-risk—pool members. A large deductible or a high coin-
surance term is more costly to a firm that generates claims with
relatively great frequency or magnitude. A low-risk pool mem-
ber, thus, is better off if insurance coverage is offered with high
deductibles, coinsurance, and exclusions than if the premium
were raised to offset the costs of full insurance for the pool. It
follows that the shift toward greater self-insurance of this nature
is a method of reducing adverse selection in order to make mar-
ket insurance more attractive to low-risk members in the face of
increasing risk variance.

Deductibles, coinsurance terms, and exclusions may also be
increased, however, as a consequence of increasing dependence
of risks. For example, when all members of a risk pool are cer-
tain to suffer losses of some amount, there is little advantage in
insuring for that amount. True insurance would be impossible
because the losses would not be probabilistic. Similarly, if the
occurrence of some category of loss were highly correlated
among firms, an insurer would have no comparative advantage
over the firms themselves in providing coverage of the loss.37

The growth of the mutual insurance form also provides evi-
dence of diminution in the independence of corporate liability
exposure. As described above, mutuals set premiums by making
assessments to member firms after, rather than before, the loss

36. Ayres and Siegelman criticize my adverse selection explanation of the recent
insurance crisis as based on "highly restrictive assumptions." Ayres & Siegelman, supra
note 7, at 987. Far from assumption, Figure 1 provides very substantial evidence of the
phenomenon.

37. Captives may also represent pure self-insurance of this form if there is no true
pooling of firm-specific risks over time.
experience, thus insuring for variations in loss among the firms, but providing self-insurance for losses common to mutual members. Why would a market insurer not provide such coverage? If there is substantial correlation in some loss category among mutual members, a market insurer will have no comparative advantage in pooling risks related to this category of loss. The market insurer might deal with this problem by offering coverage for some group losses, excluding coverage of the highly correlated loss. But exclusions—if enforced by the courts—are only effective for narrow loss categories. If the particular loss category is not sufficiently narrow, the mutual form may be preferable. The mutual allows the firms to achieve pooling for individual firm risks—however minor—while unavoidably linking the firms for risks common to the group.

The growth of captives and mutuals and the expansion of the various forms of more basic self-insurance provide evidence of increasing variance of risk and increasing dependence of risk within the commercial casualty industry. Why would corporate risks become more disparate and less independent since the early 1970s? There is an obvious explanation. In the mid-1960s, courts began to expand tort liability for corporate activities, both by extending affirmative duties and restricting available defenses. The expansion of corporate tort liability will have two effects. First, expanded corporate liability shifts insurance burdens from first-party to third-party insurance sources. The shift to third-party liability insurance increases the variance of risk and encourages adverse selection. Second, the expansion of corporate liability reduces the independence of corporate risks. Though some legal decisions implicate only individual firm practices, many decisions, especially doctrinal innovations, simultaneously affect large numbers of corporations and corporations within specific industries in particular. Decisions of this nature reduce the independence of corporate risks, reduce the comparative advantage of market insurers, and encourage the shift from market to self-insurance.

The link between the shift toward greater self-insurance and

38. Priest, Insurance Crisis, supra note 1, at 1579-81.
40. Priest, Insurance Crisis, supra note 1, at 1534-37.
41. Obvious examples are decisions relaxing causation or design defect standards.
the expansion of corporate tort liability is clear. The broadest expansion of tort liability has occurred exactly in fields classified as Other Liability coverage—products liability, professional liability, general liability for personal injuries from corporate operations—as well as in Medical Malpractice. The increases in damage payouts through judgments and settlements in these fields are well documented. Similar increases in tort claims and payouts have been reported by self-insured firms or entities, providing strong evidence that increases in insurance costs are not related solely to market insurer practices. Though some have emphasized that the increase in commercial casualty premiums has been greater than the apparent increase in liability costs, the criticism ignores the effects of adverse selection. When low-risk members drop out of insurance pools, insurance premiums must rise even if there is no change in underlying liability costs. As a consequence, the expansion of tort liability is the most plausible explanation for the commercial casualty insurance industry's dramatic structural shift toward greater self-insurance.

As mentioned earlier, the Attorneys' General antitrust claims against the insurers largely neglect reference to changes in industry structure over the past two decades. Part II of this Article attempts to repair that deficiency by evaluating the antitrust claims against the evidence of the massive shift in commercial casualty lines toward self-insurance.

II. THE ATTORNEYS' GENERAL ANTITRUST CLAIMS IN THE CONTEXT OF COMMERCIAL CASUALTY INDUSTRY STRUCTURE

This Part examines in detail the Attorneys' General allegations that the specific coverage withdrawals by major insurers and reinsurers violate the antitrust laws. Section A reviews the legal basis for the claims. It concludes that the various coverage

42. Priest, Insurance Crisis, supra note 1, at 1538.
45. Florida Task Force, supra note 17, at 14-15. I have also commented on this point, criticizing what I regarded as simplistic conclusions by the Justice Department. Priest, Insurance Crisis, supra note 1, at 1523. But see infra text accompanying notes 105-06.
withdrawals cannot have caused antitrust injury. As a consequence, even if the withdrawals were achieved in concert as alleged, they cannot constitute an antitrust violation. Section B considers the coverage withdrawals in the context both of the more general shift toward self-insurance in the commercial casualty industry and of the more specific phenomenon of the liability insurance crisis of 1985-1987. It shows that the coverage withdrawals represent only an extension of the trend toward greater self-insurance in commercial casualty lines and that the withdrawals are closely similar to other responses of insurers and self-insured firms during 1985-1987 to the prospect of expanded liability.

A. The Coverage Withdrawals, the McCarran-Ferguson Act, and the Purpose of the Antitrust Laws

The Attorneys General claim that groups of insurers and reinsurers illegally colluded to achieve three changes in the standard Commercial General Liability policy: The exclusion of pollution coverage, the adoption of a claims-made rather than an occurrence basis for the policy, and the inclusion of defense costs in the policy's aggregate limits. To simplify discussion, these coverage changes will be referred to as the withdrawal of pollution, occurrence, and defense cost coverage, although the term withdrawal is an overstatement. Even as alleged, defense cost coverage was not withdrawn, but merely subsumed within total policy limits. Moreover, it is not clear how extensively these coverage changes were introduced or whether the forms of coverage withdrawn by the defendants were available from other insurers on other policy forms. In my view, this factual issue is ultimately unimportant to the resolution of the antitrust case. Thus, for discussion, we may presume widespread introduction

46. Some of the discussion in this Part derives from Senate testimony I presented on the antitrust suits. See The Liability Crisis, the Antitrust Suits and the McCarran-Ferguson Act, Hearings Before the Subcommittee on Antitrust, Monopolies and Business Rights, Committee on the Judiciary, United States Senate, 100th Cong., 2d Sess. (June 14, 1988) (testimony of G.L. Priest). I presented this testimony at the request of the American Insurance Association, but on the condition that I would present my views alone, many of which (I learned) are not shared by the Association. See supra note 4 and accompanying text.

of the coverage changes.\footnote{48}{I will try to show that the coverage changes did not generate antitrust injury however extensive their introduction. See infra notes 83-86 and accompanying text.}

The Attorneys General allege that four major insurers agreed upon these coverage changes and then implemented them, first, by pressuring the Insurance Services Office to promulgate a new Commercial General Liability policy incorporating the changes and, second, by inducing co-conspiring reinsurers to insist upon such changes as a precondition for reinsurance.\footnote{49}{Complaint, \textit{supra} note 47, at 1-2.} Although, as in most antitrust cases, there is likely to be substantial controversy over the nature of the alleged agreement, I believe that both the existence and terms of agreement among the indicted insurers and reinsurers are largely irrelevant to underlying antitrust issues.\footnote{50}{See infra notes 83-86 and accompanying text.} Thus, again for discussion, we may presume some form of joint agreement.

The McCarran-Ferguson Act\footnote{51}{McCarran-Ferguson Insurance Regulation Act, 15 U.S.C. §§ 1011-1015 (1982).} exempts many joint insurer practices from the antitrust laws, but in section 3(b) excludes "any agreement to boycott, coerce, or intimidate."\footnote{52}{\textit{Id.} § 1013(b).} The more precise legal claim in the suit, therefore, is that the defendants' withdrawal of pollution, occurrence, and defense cost coverage constituted an act of boycott, coercion, or intimidation, which through section 3(b) remains subject to the Sherman Act. To date, the parties to the litigation have expended substantial effort in considering whether the defendants' practices are better characterized as acts of boycott, coercion, or intimidation that are subject to the Sherman Act, or as some other form of insurance practice, such as a change in terms of coverage, which the McCarran-Ferguson Act exempts. There is no definitive law on this issue.\footnote{53}{But see UNR Indus., Inc. v. Continental Ins. Co., 607 F. Supp. 855, 862 (N.D. Ill. 1984) (claim that a concerted switch from occurrence to claims-made coverage was an illegal boycott dismissed as a change in "terms of coverage") (quoting St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 544 (1978)).} Over the years, the Supreme Court has characterized a wide range of disparate activities as horizontal boycotts subject to Sherman Act prohibition.\footnote{54}{See, e.g., Federal Trade Comm'n v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); United States v. Topco Assocs., 405 U.S. 596 (1972).} But very few cases have interpreted section 3(b) of the McCarran-Ferguson Act or, more particularly, its terms "coercion" and "intimidation."

In the absence of controlling interpretation, the McCarran-
Ferguson terms "boycott," "coercion," and "intimidation" could be given internal meanings of their own. It seems more sensible, however, to define these terms with reference to the purposes and goals of the antitrust laws of which they form a part. The antitrust laws do not prohibit all industrial agreements. Many, perhaps the large majority, of industrial agreements enhance consumer welfare. The antitrust laws prohibit only industrial agreements that restrain trade.

A restraint of trade is an artificial interference with market forces designed to increase the profits of a cartel or a monopolist. The antitrust laws acknowledge that consumers may be affected in many ways by normal market forces: price or output may increase or decrease for reasons related to nothing more than changes in supply or demand. The antitrust laws, therefore, are not aimed at price increases or output reductions in themselves, but at increases or reductions that result from artificial constraints rather than from underlying changes in supply or demand. It is the artificial agreement to manipulate the market in order to increase cartel or monopolist profits that constitutes an illegal restraint of trade. Thus, to determine whether the defendants' practices should be characterized as an "act of boycott, coercion, or intimidation" under the McCarran-Ferguson Act, one must determine whether the practices constitute an artificial manipulation of the market designed to increase cartel profits.

The practice at issue is the defendants' alleged agreement to sell particular forms of insurance coverage. Courts that have interpreted the Sherman Act have been very suspicious of horizontal agreements involving refusals to sell or buy products, and they have employed the prohibition of boycotts diversely to strike down such agreements. Most typically, courts find illegal those boycotts that are designed to maximize defendant profits by eliminating competitors. For example, in *Eastern States Retail Lumber Dealers' Association v. United States*, a group of

55. Regrettably, this approach appears to be the one employed by Judge Schwarzer of the Northern District of California, who has insisted first on trying summary judgment motions on solely McCarran-Ferguson Act issues. See DiBlase, *Judge Restricts Discovery Process in States' Suits*, Bus. Ins., June 27, 1988, at 1, col. 4.

56. 16 U.S.C. § 1013(b).

57. Because by this standard the defendants' practices could be interpreted as constituting a boycott, it is unnecessary to consider whether the terms "coercion" and "intimidation" possess independent meaning.

58. 234 U.S. 600 (1914).
lumber retailers was convicted of an antitrust violation for agreeing to boycott wholesalers who were also selling at retail. The group’s tactic restrained trade in violation of the antitrust laws because it was designed to increase defendant profits by reducing the group’s retail competition. Similarly, in the classic *Fashion Originators’ Guild* case, a group of dress designers violated antitrust laws by agreeing to boycott retail dealers who were selling the dresses of competing designers. Again, the boycott restrained trade because it was designed to increase Guild profits by reducing the extent of design competition.

The case that inspired the McCarran-Ferguson Act, *South-Eastern Underwriters’ Association*, was of exactly the same nature as *Fashion Originators’ Guild*. The Underwriters’ Association was indicted for agreeing to boycott both insurance agents who wrote policies of non-Association members and the commercial insureds who purchased such policies. Here again, the boycott was designed to increase Association profits by reducing the extent of insurance competition.

The Supreme Court has recently clarified the meaning of the term “boycott” by emphasizing that, in enforcing the antitrust laws, courts should be particularly suspicious of refusals to deal that are designed to increase profits by eliminating or disadvantaging competitors. According to the Court, boycotts designed to increase profits by harming competitors constitute per se violations of the Sherman Act. The Court acknowledged that other forms of boycotts remain governed by the antitrust laws, although subject only to review by the much less restrictive rule of reason.

The defendants’ withdrawal of pollution, occurrence, and

59. Thus, this case involved a purchasers’ boycott.
60. *Eastern States Retail Lumber Dealers’ Ass’n*, 234 U.S. at 614.
62. The Guild claimed that the targeted designers had illegally pirated Guild members’ designs, but the Court found the point irrelevant for antitrust purposes. *Id.* at 468.
63. *Id.* at 465, 467.
66. *Id.* at 294.
67. *Id.* at 295. The rule of reason obliges a court to consider the broad range of competitive conditions in the industry as well as all possible pro-competitive explanations of the practice at issue.
defense cost coverage cannot easily be regarded as a classic boycott designed to harm competitors. The refusal to offer certain types of coverage to insurance consumers does not eliminate insurance competition in any straightforward way. The boycotts in the *Fashion Originators' Guild* and *South-Eastern Underwriters'* cases were methods of punishing customers and agents who patronized competitors. The ambition of both boycotts was to force the customers to abandon the competitors in favor of the conspiring defendants. Quite in contrast, the insurance coverage withdrawals bear no obvious relationship to the practices of competing insurers and have no clear impact on customers of competing insurers.

Indeed, to the contrary, the defendants' coverage withdrawals are most likely to feed competition. If pollution, occurrence, or defense cost coverage could be offered at a profit, the defendants' agreement to withdraw coverage would push insurance consumers to competing insurers willing to offer these forms of coverage. Here, evidence of the structure of the commercial casualty industry is most illuminating. Part I demonstrated the very high level of actual and potential competition in the commercial casualty industry in general, and in the Other Liability line in particular. The costs are low for new firms to enter the market, it is easy for existing insurers to expand coverage offerings, and the continuous trend toward corporate self-insurance provides a persistent incentive for insurers to design coverage attractive to their commercial clients.

In the face of these many sources of competition, how could defendant insurers gain by artificially withdrawing pollution and occurrence coverage and subsuming defense costs within the aggregate policy limit? For commercial insureds that desire these forms of insurance coverage, the withdrawals reduce the attractiveness of the commercial insurance package offered by the defendants. Following the coverage withdrawals, insureds who anticipate future pollution claims or who face relatively substantial defense costs will be more, not less, inclined to search for a better insurance deal from insurers competing with the

68. I consider more specifically the Ayres-Siegelman hypothesis that the coverage withdrawals excluded competitors by raising rivals' costs, *infra* Part III. The Ayres-Siegelman hypothesis, apparently, is not shared by the Attorneys General. *But see* Ayres & Siegelman, *supra* note 7, at n. * (Professor Ayres has been retained by the plaintiffs as an expert witness in the case.).

69. *See supra* notes 13-23 and accompanying text.
defendants. Given the extent of and potential for competition in the industry, an artificial agreement to reduce the attractiveness of the insurance product would be economic suicide.\(^{70}\)

The coverage withdrawals, therefore, cannot plausibly be construed as the typical horizontal boycott designed to harm competitors.\(^{71}\) If there were victims to the alleged agreement to withdraw coverage, the victims were insurance consumers. The Supreme Court has established that the antitrust laws reach refusals to sell aimed solely at consumers,\(^{72}\) and it is upon these cases that the Attorneys General must build the current lawsuits. As we shall see, however, each of the Supreme Court cases has involved a plausible (although sometimes thinly plausible) theory according to which the refusal to sell increased defendant profits and was an artificial interference with market processes.

The case that appears to provide the greatest support for the Attorneys’ General suit is *St. Paul Fire & Marine Insurance Co. v. Barry,*\(^{73}\) in which the plaintiff accused four insurance companies of conspiring to boycott consumers of medical malpractice insurance in order to compel them to accept claims-made coverage rather than occurrence coverage. The four defendants were the only commercial malpractice insurers in the market, and thus appeared to possess market power, though the trial court did not consider in its market power calculation alternative forms of physician risk diversification, including self-insurance by means of captive insurance sources or asset diversification. According to the complaint, the illegal boycott consisted of St. Paul’s announcement that it would only write claims-made malpractice coverage, pursuant to a conspiracy with the other three insurers who refused to offer malpractice coverage on any terms, forcing the insureds to accept claims-made policies from St. Paul.\(^{74}\)

*St. Paul* was not decided on antitrust grounds, but rather on

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\(^{70}\) In subpart II(B), *infra,* I present reasons to believe that other commercial insureds might prefer general liability coverage that excluded pollution, occurrence, and defense cost coverage, suggesting that the coverage withdrawals were consistent with competitive behavior designed to enhance insurance sales.

\(^{71}\) As a consequence, according to *Northwest Wholesale Stationers,* 472 U.S. at 297, the case must be evaluated under the rule of reason. *See supra* note 67 and accompanying text.


\(^{73}\) 438 U.S. 531.

\(^{74}\) *Id.* at 535.
a motion for summary judgment regarding whether the term "boycott" in section 3(b) of the McCarran-Ferguson Act applied, as alleged, to boycotts of consumers, or applied only, as in South-Eastern Underwriters', to boycotts designed to harm competitors. The Supreme Court held that Congress had intended section 3(b) to extend beyond boycotts aimed against competitors and affirmed the reversal of the trial court's summary judgment in favor of the insurer defendants.\footnote{Id. at 546-52.}

The claims of the Attorneys General concerning the insurance coverage withdrawals are similar to the claims in St. Paul. The decision in St. Paul itself, of course, provides support for no more than denial of summary judgment against the Attorneys General. More importantly, however, in the years since St. Paul there have been many changes in antitrust law and, in particular, in the law relating to summary judgment of antitrust claims.

The Supreme Court decided St. Paul in 1978, just as it began to develop its modern economic efficiency analysis of industrial practices under the antitrust laws.\footnote{The beginning of the new approach was signalled in 1977 in Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36 (1977).} In the intervening years, the Court has much more rigorously defined the prerequisites of an antitrust offense. To establish a violation of the antitrust laws, a plaintiff must show that conspiring defendants have acted in a way to enhance their profits by harming competition.\footnote{See, e.g., Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 489 (1977).}

Very recently, the Supreme Court has clarified the standard for summary judgment of an antitrust claim. In Matsushita Electric Industrial Co. v. Zenith Radio Corp.,\footnote{475 U.S. 574 (1986).} the Court upheld summary judgment in favor of defendants when, despite substantial factual issues concerning the nature of the conspiracy, the acts alleged to violate the antitrust laws would not have increased defendant profits or harmed competition. If St. Paul were re-analyzed according to the Matsushita standard, its outcome would not be so clear. Mere allegations of conspiracy, sufficient in 1978, would not be sufficient under Matsushita to support a trial. Most importantly, under Matsushita it is necessary for complainants to establish that the defendants' actions were economically rational ways to increase their profits by restraining trade. As a result of Matsushita, the complainants
would have to explain why three other insurers agreed to boycot
St. Paul's insureds, forcing them to obtain St. Paul's claims-
made coverage. An economically rational firm has no obvious
reason to help a competitor retain its clients, not to mention
retaining clients on terms that the clients find unattractive. The
incentives of competitors, in fact, are just the opposite. There­
fore, it is puzzling how the three other conspirators imagined to
profit from the alleged agreement.

Perhaps one could allege that St. Paul divided monopoly
returns from the shift to claims-made coverage with the other
three insurers. But the factual prerequisites of this theory are
even more complex. For the scheme to be an economically
rational method of maximizing profits, it would be necessary to
show that (1) the profit-maximizing output for the industry was
effectly equal to St. Paul's insurance capacity (given the with­
drawal of the other firms); (2) insurance delivery was achieved
most efficiently by St. Paul alone (thus maximizing industry
profits), rather than by some combination of the four; (3) indus­
try profits were maximized by changing the nature of the pro­
duct (to claims-made coverage), rather than by the more typical
cartel strategy of simply increasing the price of the existing
product (occurrence coverage); and (4) St. Paul had shared the
industry monopoly profits (according to what shares?) with the
other three conspirators. It was exactly such a series of implau­
sible factual premises that led the Supreme Court to uphold
summary judgment in favor of the defendants in Matsushita.79
In contrast, the more plausible explanation in St. Paul is that the
other insurers had withdrawn and St. Paul had shifted to claims­
made coverage because of the increasing uncertainty of liability
exposure in the medical malpractice line.

More recently, in Federal Trade Commission v. Indiana
Federation of Dentists,80 the Supreme Court found that the Fed­
eration illegally boycotted consumers. Even in this decision,
however, it is clear that plaintiffs must demonstrate that the
practice at issue increased defendants' profits by means of an

79. Id. at 588-95; see also First Nat'l Bank v. Cities Serv. Co., 391 U.S. 253, 277
(1968) (rejection of a claim of an illegal boycott of consumers on grounds that the boycott
"conceivably might also have resulted from a whole variety of non-conspiratorial motives
involving the exercise of business judgment.").

For an explanation of how claims-made coverage is superior to occurrence coverage
for insureds who face long-duration exposure, see infra notes 90-94 and accompanying text.

artificial interference with market forces, rather than by underlying changes in supply or demand.

In *Indiana Federation of Dentists*, the Federal Trade Commission (FTC) accused the Federation of agreeing to a concerted refusal to supply X-rays to dental insurers wanting to monitor dental insurance claims. The dentists obviously sought to gain supracompetitive returns from the practice because without X-ray evidence it would be substantially more difficult for the insurers to deny dentists' claims relating to the provision of dental services. The refusal to supply X-rays thus was not a typical product boycott, but rather a method of implementing some agreement or understanding to charge greater than competitive prices. It is also obvious that the refusal to submit X-rays was an artificial interference in market processes. The dentists alleged that X-ray submission led to inferior dental care. But the Court disregarded the argument totally, concluding that there was no credible pro-competitive explanation for the agreement. Thus, again, the prerequisite of an offense—increase in profits through artificial interference in the market—was easily satisfied.

Does the withdrawal of pollution, occurrence, and defense cost coverage by the insurer defendants serve to increase profits by an artificial interference in the market sufficient to be characterized as an illegal boycott? It is difficult to see how coverage withdrawals either increase insurer profits or constitute an artificial interference with the market. In contrast, as explained in more detail in subsection B, there are strong reasons to believe that the coverage withdrawals were responses to standard market forces of increased supply costs because of the expansion of tort liability.

Complicated empirical study would be necessary to determine whether the premiums that pollution, occurrence, and defense cost coverage could command in the market were greater or less than the expected future coverage costs. The empirical calculation, however, is not necessary to the resolution

81. *Id.* at 448-49. The Court characterized the victims of the conspiracy as "customers," *Id.* at 459, although the seller-customer relationship is complicated because of the third-party claim feature of the case. Strictly, dental patients are the consumers and the insurers are the consumers' agents. The insurers, however, were particularly vulnerable in this case because of existing contracts with patients allowing patients the choice of dentist. *Id.* at 452.

82. *Id.* at 459, 465.
of the antitrust claims. At the time of withdrawal, these forms of coverage either could be offered to commercial insureds profitably or could not. Under either factual showing the withdrawals cannot have violated the antitrust laws.

First, if pollution, occurrence, or defense cost coverage could have been offered profitably, then their withdrawal would have reduced the defendants' profits and increased the profits of the defendants' competitors.\(^{83}\) In this context, the coverage withdrawals would be economic idiocy, but hardly a restraint of trade.\(^{84}\) In some contexts it is possible to devise complicated price discrimination theories to explain how changes in the price/quality mix of product characteristics can increase profits.\(^{85}\) But price discrimination is unlikely to have occurred in this case because price discriminating behavior must include charging a price. The withdrawal of pollution, occurrence, and defense cost coverage reduces the price/quality opportunities of any insurer or group of insurers.\(^{86}\)

The alternative factual possibility is that pollution, occurrence, and defense cost coverage could not have been offered at a profit at the time of the defendants' agreement. The lay impression that the insurance coverage withdrawals increased insurer profits by reducing insurer losses derives from such a view. Surely, if the insurers withdrew losing forms of insurance coverage, their losses would decline and their net profits would increase.

Withdrawing losing products, however, cannot be regarded as an illegal restraint of trade. If the withdrawal of an unprofitable product were to constitute a boycott, the antitrust laws would stand for the encrustation of industrial obsolescence that would destroy a competitive economy. Firms withdraw products in response to changes in demand or supply at all times, and

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83. Again, I consider the Ayres-Siegelman exclusionary hypothesis, infra Part III.
84. Ayres & Siegelman make a similar point. Ayres & Siegelman, supra note 7, at 979-81.
86. Here, it may be relevant to consider the inclusion of defense costs in the aggregate policy limits not as a withdrawal of coverage, but as a change in the price/quality product mix. But there is no clear explanation why including defense costs in the aggregate policy limits would enhance profits artificially, though there is a compelling explanation of why the coverage change would enhance insurance availability. See infra notes 95-96 and accompanying text.
it is an important characteristic of a competitive economy that they be free to do so.

The issue of product withdrawal is potentially confusing because of the common simplification that the antitrust laws are designed to condemn practices that artificially increase firm profits. Price-fixing increases net profits; withdrawing losing products also increases net profits. Are both restraints of trade? One response, of course, is that withdrawing losing products from markets is not artificial, but is at the heart of competitive behavior. A more precise analysis derives, however, from defining the aim of the antitrust laws as improving the allocation of resources in the economy. Our society wants to remove those products from markets whose production costs (and thus prices) are greater than what consumers are willing to pay in order to reallocate resources to goods whose value to consumers exceeds their costs. In contrast, the antitrust laws condemn practices that increase profits by denying consumers products for which they are willing and able to pay, such as by fixing prices at greater than competitive levels. Thus, price fixing that enhances profits by raising prices above competitive levels should be distinguished from a product withdrawal that reduces losses because cost has become greater than the competitive price consumers will pay. Put differently, the withdrawal of products for which consumers are unwilling to pay is quite different from the fixing of prices of products for which consumers are willing to pay, but would prefer to pay less.

In the present case, of course, the allegations that the insurance companies made the withdrawals in concert may appear more telling. Surely, individual firms may withdraw losing products from markets without violating the antitrust laws. However, should it be illegal for a group of firms or an industry to withdraw products collectively?

Again, in the absence of an explanation how the coverage withdrawals affirmatively generated profits unavailable in competitive markets, even concerted withdrawals cannot violate the antitrust laws because there is no antitrust injury. Of course, insurance differs from other industries with respect to joint industry agreements because of very strong state regulatory pressure to standardize insurance policies. The purpose of this state regulation is to simplify insurance forms in order to facilitate consumer comprehension of insurance offerings. The easier it is for consumers to compare different policies, the greater the level
of competition in the industry and the more the competition will focus on price rather than less fungible differences in insurance coverage. Along with preserving insurer solvency, standardization is the most basic justification for insurance industry regulation.

In many contexts the policy in favor of insurance standardization complicates the antitrust evaluation of insurance industry agreements. It is frequently necessary to weigh uniformity interests against antitrust interests when considering insurance industry practices. This is the point of the McCarran-Ferguson Act. There is no policy conflict of this nature, however, with respect to the withdrawal of pollution, occurrence, and defense cost coverage. Because these coverage withdrawals could not have increased insurer profits, they could not have caused antitrust injury.

It follows, therefore, that, on antitrust grounds the Attorneys' General claims lack merit. The analytical case is a simple one. Either the forms of insurance coverage withdrawn by the defendants could be offered at a profit or they were losing products for which no profitable market existed. If these forms of coverage were potentially profitable, then their withdrawal would have reduced, rather than increased, defendants' profits. On the other hand, if these forms of coverage could not be offered at a profit, then their withdrawal was perfectly consistent with behavior one would expect of competitive firms. On either empirical showing, the coverage withdrawals generated no antitrust injury and cannot be held to have violated the antitrust laws.

Demonstrating the weakness of the antitrust claims, however, is different from affirmatively understanding why these forms of insurance coverage were withdrawn. Subsection B presents a different explanation for the coverage withdrawals by returning to the evidence of the shift in the structure of the commercial casualty industry toward self-insurance. It shows that the coverage withdrawals represent merely an extension of the shift toward corporate self-insurance of particular risks. Subsection B also shows that the most plausible explanation for the insurers' actions is that the coverage withdrawals at issue were designed to enhance insurance availability to low-risk insureds by segregating the low-risk members into pools incorporating smaller differences in risks.
B. The Competitive Purpose of the Coverage Withdrawals

This Section explains how the defendants’ withdrawals of pollution, occurrence, and defense cost coverage were responses to competitive market forces in the commercial casualty insurance industry. As noted in Part I, since the early 1970s firms with Other Liability exposure have increasingly shifted from market insurance to forms of self-insurance. This shift most probably is the result of the expansion of corporate tort liability. Expanded tort liability increases the variance of some corporate risks (because of the third-party insurance delivery mechanism) and increases the dependence of other risks. Part I showed how the increase in risk variance and risk dependence, in the aggregate, stimulated the growth of captive insurance subsidiaries; the expansion of self-insurance expenditures through deductibles, coinsurance, and exclusions; and the increase in corporate use of the mutual insurance form. This Section shows how the withdrawals of pollution, occurrence, and defense cost coverage were only specific instances of this aggregate industry trend.

How will insurers in competitive markets respond to the increase in risk dependence and risk variance to maximize insurance sales? When corporate risks become more dependent (more highly correlated), there are very few competitive responses available to market insurers. Greater dependence of risks diminishes the comparative advantage of market insurance. At the limit, if some event is certain to occur, the reserve needed by a market insurer equals the reserve needed by a corporate self-insurer. When there are no gains available from pooling, market insurers can only decline or exclude coverage.

Insurers, however, have greater opportunities for competitive response to increases in risk variance. For every insurance pool, the pool premium must be set equal to the average risk of the pool. Thus, the pool premium will always be greater than the risk brought by low-risk members. When risk variance increases, the difference increases between the premium and the risk level of low-risk members.

Within any insurance pool, low-risk insureds will always be the marginal insurance purchasers. Sales competition within the insurance industry consists largely of efforts to attract the relatively low-risk insureds of a competitor by more careful underwriting, either by reassigning the insured to a pool incorporating

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87. See supra notes 32-38 and accompanying text.
lower risks (at a lower premium) or by redefining coverage to meet more precisely the low-risk insured's needs. Both tactics make possible lower premiums for low-risk insureds.

Because an increase in risk variance compels an increase in insurance premiums, the expansion of liability increases the dissatisfaction of relatively low-risk insureds with the insurance deal that they are receiving. The expansion of liability, thus, will encourage low-risk insureds to seek a better insurance deal from competing insurers or, at the limit, to drop out of the pool to self-insure rather than to continue paying premiums greater than the risk they bring to the pool.

The expansion of liability thus will increase competition in the commercial casualty industry. Competition will consist of efforts to reassign low-risk insureds to lower-risk pools or to redefine coverage to make it more attractive to such insureds. Put differently, insurers under competition will attempt methods of more accurate segregation of low-risk from high-risk members. More accurate risk segregation, if feasible, restores (or helps to restore) the previous relationship between the premium and the risk brought to the pool by low-risk members. More extensive risk segregation, therefore, enhances insurance availability to low-risk insureds.

Given these legal and market conditions, how can we evaluate the withdrawal of pollution, occurrence, and defense cost insurance coverage?

1. The Withdrawal of Pollution Coverage

It is well-known that liability for pollution-related losses has expanded in recent years. This expansion of liability is a result of the judicial recognition of new rights of action as well as the relaxation of causation standards and the erosion of earlier interpretations of statutes of limitation. Allowing new remedies in tort law for pollution-related losses will increase risk variance by substituting third-party insurance delivery. New remedies may also increase corporate risk dependence, especially for firms, municipalities, or industries heavily involved in the production or disposal of toxic wastes.

The expansion of pollution liability will not affect all firms

88. Of course, insurers may also compete by lowering expenses or achieving greater investment returns, both of which would similarly make possible lower premiums.

or municipalities equally. Firms or municipalities that have had little association with hazardous wastes will be largely indifferent to the expansion. In contrast, firms that in the past have generated or have disposed of wastes, or municipalities that have supervised disposal, may be heavily affected by the expansion of liability.

Commercial General Liability coverage is standardized; it is offered on largely identical policy terms to all firms and all municipalities. To the extent that the policy provides coverage of pollution-related losses, an increase in pollution liability will compel an increase in the policy premium. This premium increase will benefit firms and municipalities that face relatively greater pollution-related claims; it is of relatively less benefit to firms and municipalities with little or no pollution exposure. In this respect, firms and municipalities that face pollution-related claims bring high risks to the pool; firms and municipalities that do not face such claims bring low risks.

Again, the expansion of liability and the consequent increase in risk variance will increase competitive pressures to provide alternative insurance that is more attractive to low-risk insureds. In the context of the expansion of pollution liability, Commercial General Liability coverage could be made more attractive to the low-risk insured in two ways. First, insurers could increase investments in underwriting to evaluate firms and municipalities more discriminately according to their potential pollution exposure, and set premiums accordingly. This tactic will be successful to the extent that such predictions can be made accurately at costs less than the increased return from such discrimination.

Second, insurers can attempt to segregate into separate risk pools firms and municipalities that face pollution exposure from those that do not. The exclusion of pollution coverage from the basic policy serves this segregation purpose and reduces differences in risk (reduces risk variance) between members of the pool because it makes all insureds within the pool equivalent with respect to potential pollution claims. The pollution exclusion prevents the prospective costs of pollution from being averaged into the premiums of nonpolluters.

In this way, the pollution exclusion makes the basic policy less attractive to firms or municipalities that anticipate future pollution-related claims. However, it makes the policy more attractive to low-risk insureds who are not likely to face such

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exposures. Again, in all insurance markets, low-risk insureds are the marginal insurance purchasers over whom the major competition in insurance occurs. As a competitive device, the exclusion allows Commercial General Liability coverage to be offered at a lower premium that is more attractive to nonpolluting, low-risk insureds. The exclusion will expand insurance availability (that is to say, sales) to this group.

The exclusion of pollution coverage from the Commercial General Liability policy does not necessarily imply that insurance for pollution-related losses will be totally unavailable. Instead, the exclusion compels firms and municipalities potentially responsible for pollution-related injuries to buy pollution coverage separately or to self-insure for such claims. Pollution coverage will be totally unavailable chiefly when the expansion of liability has so increased risk dependence that market insurers have no comparative advantage to the insureds themselves in providing coverage of pollution losses.

2. The Withdrawal of Occurrence Coverage Through Adoption of the Claims-Made Policy

All insurance is sold for a specific time period subject to renewal at the end of the period. An occurrence policy provides coverage for losses from accidents that occur during the policy period, regardless of when claims relating to the losses are filed. A claims-made policy, in contrast, provides coverage for all claims filed during the policy period, regardless of when underlying accidents occur.

For most types of accidental liability, no effective difference exists between an occurrence and a claims-made policy because claims under the policy will be filed within a short period of the occurrence of the accident. For example, there would be little difference if an auto liability policy were written on a claims-made or an occurrence basis because typically there is little delay between the occurrence of an accident and the filing of a claim.

The claims-made policy will differ from the occurrence policy, however, in contexts in which there is substantial time between the occurrence of the accident and the filing of the claim. These contexts are referred to as involving "long tail" liability. Examples of such contexts are diseases that have long latency periods like those caused by asbestos inhalation or expo-
In all insurance contexts, when an insurer gains information leading to a more accurate prediction of future claims costs, the insurer will adjust the premium charged for the next period, either up or down, depending upon the new estimate. Claims-made and occurrence policies differ chiefly in the opportunity available to the insurer to acquire and to act upon this information. For losses characterized by long-tail liability, an insurer is far more readily able to revise its prediction of the underlying risk level if coverage is offered on a claims-made rather than on an occurrence basis. For example, under a claims-made policy, when claims involving long latency periods begin to accumulate, the insurer can revise its expectations of future liability and increase the premium or, in extreme cases, decide not to renew coverage, thus requiring the affected firm to self-insure. In contrast, if such coverage had been written on an occurrence basis years before (that is, at the time the latent injuries first "occurred"), the insurer would be bound to the premiums set at that earlier time. The insurer would have no ability to revise premiums based upon its new appreciation of the risk level.

The claims-made policy, thus, allows the insurer a much greater opportunity to revise its premium according to the losses incurred by the insured. It also resembles policies that incorporate retrospective rating or adopt the mutual form, in both of which the final premium is set largely after the loss experience occurs.

In comparison to the occurrence policy, the claims-made policy can be viewed as shifting much of the risk of long-tail liability from the insurer back to the insured. In this respect, the claims-made policy represents another form of increased corporate self-insurance for losses. Under claims-made coverage, an insured that generates long-tail liability will pay, through revised premiums, a much greater portion of total liability costs. Note

90. The period of time between occurrence and claim, of course, depends on the legal definition of occurrence. See infra note 92.

91. Thus, auto insurers increase or reduce premiums based upon previous accident or moving violation experience. These adjustments allow premiums to be kept low for low-risk insureds, such as safe drivers.

92. For latent diseases, there is substantial delay between the occurrence of an injury and the claim only when "occurrence" is defined as the first exposure to or harm from the injurious substance. If courts defined the occurrence of the injury as its first manifestation, there would be no substantial delay between the occurrence and the claim and no need for a claims-made policy.
again, however, that the claims-made policy shifts risks back to the insured only for long-tail liability exposure. To the extent that the policy covers more typical accidents, for which there is little delay between the occurrence and the claim, no effective difference exists between claims-made and occurrence coverage.

Why would insurers introduce the claims-made policy? As liability for latent diseases expands, low-risk firms not facing such liability will find insurance premiums increasingly greater than the risk they bring to the pool. The claims-made policy, like the pollution exclusion, provides a way of splitting off those who generate long-tail liability from the rest of the business community. The claims-made policy ensures that the expected future costs of long-tail liability are not averaged into the premiums of commercial insureds that do not generate such liability. The adoption of claims-made coverage, thus, is a means of competing for low-risk insureds by offering coverage more appropriate for their insurance needs.

Indeed, the claims-made policy provides a particularly clever method for segregating low- from high-risk insureds. Again, in contexts in which claims are filed within a short period of the accident, there will be little difference between claims-made and occurrence coverage. Thus, with the claims-made policy, the insured is not forced to expend the costs necessary for the careful estimation of the particular long-tail liability exposure of each insured. Instead, the subsequent claims experience of each insured will reveal how much of its liability is long- versus short-tail. Many parties have objected to claims-made coverage because it appears to grant substantially greater discretion to insurers to subsequently revise premiums.93 In fact, claims-made coverage should be attractive to low-risk insureds because they will receive coverage equivalent to that under an occurrence policy, but at a cost less than the premium necessary to cover the long-tail liability expenses of high-risk insureds.94

3. The Inclusion of Defense Costs in the Aggregate Coverage Limit

During the crisis of 1985-1986, widespread reductions

93. See Insurance Comm'n Report, supra note 4, at 152. These objections are largely fanciful, not only because of the high levels of competition in the commercial casualty industry, but also because insurers typically possess unilateral discretion to raise premiums under occurrence policies annually.

94. For a further discussion of this point, see infra note 112.
occurred in the aggregate coverage limits offered under commercial policies, but the defendants are accused of agreeing to a more particular form of aggregate limit reduction—reduction by the inclusion of defense costs. Including defense costs in the aggregate limit means that for a policy offering one million dollars in aggregate coverage, the costs to the insurer of defending or settling claims against the policy will be charged (along with actual liability payouts) against the one million dollar limit, rather than being absorbed by the insurer separately, as under previous policies.

Why would insurers change policy terms to include defense costs within the policy aggregate? More precisely, if insurers desire to reduce aggregate policy limits, why would they reduce them by including defense costs in the limit rather than by (or in addition to) reducing them directly, for example by offering only $800,000 rather than $1,000,000 aggregate coverage?

The general expansion of corporate liability is likely to affect firms disparately. Business entities will certainly differ in terms of the increase in the frequency of claims. They may also differ in terms of the increase in the complexity of underlying claims. In addition, though firms may face equivalent increases in claims frequency or complexity, they may differ in their abilities through internal counsel to manage the claims filed against them.

The costs to the insurer of settling or defending claims must be added into the policy premium. Those firms generating relatively more frequent or complex claims will contribute more to these costs than firms generating fewer and simpler claims. Similarly, firms less able to manage their claims load will contribute more to these costs than firms more skilled at claims management.

When there are substantial differences among insured firms in terms of expected insurer defense expenses, those firms generating lower expenses become the relatively low-risk members of commercial risk pools. For such firms, paying premiums that reflect average defense expenses charges them more than the expenses they generate. These firms become the marginal insurance consumers over which market insurers will compete.

As with the pollution and occurrence coverage exclusions,
incorporating defense costs in the aggregate policy limit is a way of offering insurance at lower premiums to these relatively low-risk firms. The defense cost inclusion has the effect of imposing greater total expenditures on firms generating relatively higher defense costs because such firms will more rapidly exhaust the aggregate and be forced to self-insure the remaining liability exposure. In this respect, like claims-made coverage, the defense cost inclusion is another example of the long-term shift toward greater corporate self-insurance. More directly, however, the defense cost inclusion is a device that insurers would adopt to compete better for the custom of low-risk insureds.

In addition to lowering premiums for low-risk insureds, the inclusion of defense costs in the coverage limit may also serve to reduce societal expenditures on defense costs. When defense costs are paid totally by the insurer, the insured firm has little concern about defense cost magnitude. Indeed, except for effects on future premiums (effects necessarily diffused because of the pooling process), the insured firm would prefer the insurer to expend infinite amounts on defense to help reduce the insured's liability exposure. In contrast, when defense costs are included in the coverage limit, insured firms have a substantial interest in reducing or controlling the extent of necessary defense expenditures in order to maximize basic insurance coverage. These differential incentives are referred to as moral hazard, a pervasive insurance phenomenon most typically addressed by deductibles and coinsurance. 96 Including defense costs in the coverage limit, therefore, is also an example of a method to control insured moral hazard, adopted after the increase in defense expenditures impedes insurance sales to low-risk insureds.

4. The Coverage Exclusions Reconsidered

The defendants' withdrawals of pollution, occurrence, and defense cost coverage are closely similar in several ways. First, for each area of coverage, expenditures are highly likely to have increased in recent years as a consequence of the expansion of tort liability, such as pollution and long-tail liability for the consequences of toxic substances. Of course, the general expansion of corporate liability will increase aggregate defense expenditures.

Second, for each of these areas, the expansion of liability is likely to affect insured firms differently. Some firms will face heavy increases in liability exposure, yet others will face little increase. Differential effects of this nature will increase risk variance within commercial casualty risk pools, increasing incentives for low-risk members to seek alternative coverage from a competing market insurer or through self-insurance.

Third, the exclusions of pollution, occurrence, and defense cost coverage each operate in the same way: each exclusion serves to define the extent of insurance coverage to reflect more accurately the insurance needs of low-risk members, essentially, by removing from the risk pool not high-risk members in their entirety, but the sources of the high risks these members generate. The exclusion of pollution coverage culls out pollution claims; the exclusion of occurrence coverage through adoption of the claims-made policy culls out claims deriving from long-tail liability; the inclusion of defense costs in the aggregate culls out (after exhaustion of the limit) greater than average defense expenditures. In each case, removing the sources of high risk serves to equalize members of the risk pool in terms of the costs they add to the pool and thus to reduce insurance premiums for relatively low-risk members.

Each of these reasons suggests that the coverage exclusions represent competitive responses to changes in the underlying market for commercial liability insurance. The expansion of corporate liability increases the costs of providing liability insurance. Each coverage withdrawal represents an effort to soften the effects of the underlying cost increase in order to maximize insurance sales. The alternative response available to insurers when underlying liability costs increase is not to exclude coverage, but simply to average in the greater pollution, occurrence, and defense cost expenses in the premiums of all insureds. To have pursued this alternative, however, would clearly have increased premiums and necessarily have reduced insurance sales by a greater amount. Put differently, relative to the passing along of average cost increases through raising premiums, these exclusions of coverage serve to increase insurance output. It is well-established in economic analysis that the best test of the pro-competitive or anti-competitive character of a practice is whether it increases or contracts industry output. Because the coverage withdrawals increased insurance output (again, com-
pared to the alternative of general premium increases), they enhanced competition in commercial casualty insurance.

In addition, each coverage withdrawal at issue resembles, and is consistent with, the more general trend toward greater corporate self-insurance in commercial casualty insurance since the early 1970s, as illustrated in Figure 2 above. Indeed, more prominent during 1985-1986 than the coverage withdrawals were the broader increases in deductibles and coinsurance for many commercial insureds. Moreover, during this period many other forms of coverage were excluded from commercial policies, such as coverage of claims relating to mergers and acquisitions from Directors' and Officers' policies, coverage of claims involving sex abuse from day-care policies, and coverage of claims against high-risk nurse midwives from medical malpractice policies. Each of these insurance changes reflects the broader trend toward corporate self-insurance. The withdrawals of pollution, occurrence, and defense cost coverage are only more specific examples.

There is substantial evidence, in addition, that the underlying change in liability costs that generated the coverage withdrawals inflicted similar effects beyond the commercial casualty insurance industry. At the same time the defendants were withdrawing insurance coverage because of expanded liability, self-insured entities, in the face of increases in liability costs, decided to withdraw products and services from markets for liability reasons. The self-insured City of New York, for example, removed diving boards from city schools. Many self-insured ski areas closed down for liability reasons. More generally, of the nation's largest manufacturers, the Fortune 500, whose size and obvious capacity for self-insurance make them least vulnera-

97. For examples of increases in deductibles, see Priest, Insurance Crisis, supra note 1, at 1571 (deductible for city of Baton Rouge, Louisiana, increased from $100,000 in 1984 to $500,000 in 1985) (citing Bus. Ins., July 8, 1985, at 1). For examples of coinsurance increases, see Priest, Insurance Crisis, supra, at 1573.


99. Priest, Insurance Crisis, supra note 1, at 1572; see Sorry, Your Policy Is Cancelled, supra note 95, at 20.

100. Priest, Insurance Crisis, supra note 1, at 1579; see N.Y. Times, Mar. 31, 1986, at B7, col. 2.


102. Id. at 87.

103. Id. at 23-24.
ble to insurance industry crises, twenty-five percent removed high-risk products from markets for liability reasons. 104

The accumulated force of these similar phenomena deeply undercuts the Attorneys’ General allegations that the coverage withdrawals were the result of nothing more than insurer conspiracy. The steady and continuous trend toward self-insurance as illustrated in Figure 2 does not appear to be the result of conspiracy; the coverage withdrawals are closely similar. Moreover, the uniformity of the increase in liability costs to both insurers and the self-insured, and the withdrawal of high-risk products and services by the self-insured, make highly implausible the claim that these phenomena derived solely from an insurer and reinsurance agreement. It is most unlikely that self-insured entities, including cities and municipalities, would be partners to an insurance industry conspiracy.

Ayres and Siegelman criticize my earlier (and less detailed) explanation of the coverage withdrawals, which was made along the same lines, on the grounds that many insureds resisted the coverage withdrawals. According to Ayres and Siegelman, if the coverage withdrawals reduced insurance premiums and expanded insurance availability, the withdrawals should have been a source of welcome, not complaint, to both low-risk firms (whose premiums would decline) and high-risk firms (who otherwise might be denied coverage altogether). 105

There is a point here, but not a telling point. It must be remembered that, according to my explanation, the coverage withdrawals represented a competitive attempt to soften the effects of the underlying increase in liability costs. It is not clear (and I have not claimed) that the coverage withdrawals could have totally offset the underlying increase in costs. If not, then the insurance package offered to all commercial insureds, even including the coverage withdrawals, would have represented an increase in total insurance costs over costs in preceding periods. All humans complain about increases in costs.

Ayres and Siegelman would have a point and my pro-competitive explanation of the coverage withdrawals would be undercut, however, if it could be shown that the insurance package (defined to include both the extent of coverage and the premium), were less advantageous to low-risk insureds after the

105. Ayres & Siegelman, supra note 7, 988-89.
coverage withdrawals than before. That is, the appropriate comparison is not between a 1984 insurance package that provides pollution, occurrence, and defense cost coverage and a 1985 package that does not. All consumers may very well complain about this difference. To understand the effects of the coverage withdrawals, instead, one must compare the attractiveness to a low-risk insured of a 1985 policy including full pollution, occurrence, and defense cost coverage, given the premium necessary to support such coverage, with a 1985 policy that, by excluding these forms of coverage, can be offered at a lower premium.

This counter-factual comparison has never been attempted and can only be answered analytically. Again, because the premium of the full coverage policy must be set by averaging into the premium the greater liability costs of high-risk insureds, it is most improbable that relatively low-risk insureds would prefer the policy with full coverage. More generally, when there is substantial variance in liability costs across insured firms, those firms generating low costs are better off with exclusions of high-risk coverages than they are paying the larger premium full coverage would necessitate.

Finally, it must be emphasized again that there is no coherent anticompetitive explanation for the coverage withdrawals. This section has shown that the principal effect of the withdrawals is to segregate low-risk from high-risk members of commercial casualty pools by culling out high-risk exposures. There is no reason to believe that segregation of this nature would be of some special advantage to a cartel or monopolist. In theory, cartels and monopolies can gain from price discrimination by charging different prices to consumer groups reflecting greater or lesser price elasticity of demand. Toward this end, consumers reflecting low price elasticity (consumers with relatively more product alternatives) are charged lower prices; consumers reflecting high price elasticity (those with fewer alternatives) are charged higher prices.

Excluding insurance coverage to provide lower premiums to low-risk members facing greater self-insurance alternatives is consistent with this aim. But it is not consistent, indeed it is contradictory, to exclude coverage to the high-risk rather than to reprice these forms of coverage at greater than competitive levels. The ambition of price discrimination is to charge a greater than competitive price to consumers reflecting high price elasticities, such as high-risk insureds. The exclusion of pollu-
tion, occurrence, and defense cost coverage cannot be a means of illegally maximizing profits because no revenues can be generated where the insurance product is kept from the market. Again, excluding coverage is not a rational means of maximizing profits.

III. THE AYRES-SIEGELMAN EXCLUSIONARY THEORY OF THE COVERAGE WITHDRAWALS

This Part briefly discusses the hypothesis put forward by Ayres and Siegelman that the defendants' coverage withdrawals restrained trade by raising competitors' costs to enhance the defendants' competitive position. They concede that their theory is speculative and that a definitive estimate of the effect of the defendants' practices on competitors' costs must await further study.106 Nevertheless, it is worth reviewing the data presented in Part I concerning the structure of the commercial casualty industry because such data allow a clearer view of the plausibility that the coverage withdrawals raised rivals' costs.

It is accepted in principle, although there have been few confirming empirical examples, that a cartel or monopolist can gain if it can arrange a method to raise the production costs of competitors at no, or at a lesser, increase in cost to itself. The higher costs faced by competitors establish a margin within which the cartel or monopolist can charge a supracompetitive price.

According to Ayres and Siegelman, the defendants' coverage withdrawals might raise rivals' costs in two ways. First, the shift to the claims-made policy might increase some set of fixed actuarial costs, which would more seriously harm small insurers than the relatively large defendants.107 Second, the definition of retroactive coverage dates (dates from which coverage begins) in claims-made policies might reduce competition by binding insureds to original insurers to benefit the larger defendants over their smaller competitors.108 Note that Ayres' and Siegelman's exclusionary hypotheses applies only to the adoption of claims-made coverage; Ayres and Siegelman do not claim that the exclusions of pollution or defense cost coverage affected rivals' costs in any way.109

106. Id. at 991.
107. Id. at 989-90.
108. Id. at 990-91.
109. Again, Ayres and Siegelman appear skeptical of the Attorneys' General claims
How plausible is it that the claims-made policy was adopted as a means to raise rivals' costs rather than to segregate out insureds with long-tail liability exposure? Part I showed that, by all measures, the costs of entry in the commercial casualty industry are very low. Concentration levels are low. Individual insurer market shares are low. Substantial changes occur from year to year in individual insurer rankings in terms of the volume of premiums written.110

These empirical characteristics of the industry—low concentration levels, low individual market shares, and frequent shifts in individual insurer premium volume—all undercut the assertion that there are heavy fixed costs in insurance underwriting. Industries in which there are heavy fixed production costs, in contrast, are characterized by high concentration, high individual firm market shares, and infrequent changes in sales volume.111

According to Ayres and Siegelman, adoption of the claims-made policy might increase the fixed costs of insurance that derive from the use of computer programs and the need for large-scale actuarial estimation. There is no evidence, however, that fixed actuarial costs have a substantial influence on industry structure. If fixed costs were an important determinant of insurance premium levels, market shares would be substantially higher than they are. It is extremely difficult to imagine that the computer programming investments necessary for administration of claims-made policies would be so substantial in the absolute that they would empower supracompetitive pricing.

Certainly the claims-made policy will require new and perhaps different actuarial calculations, but it is the function of organizations such as the Insurance Services Office to provide information of this nature. As a consequence, it is highly implausible that the principal purpose of the claims-made policy was to disadvantage competitors rather than to segregate long-tail liability exposures.112

110. See supra notes 13-23 and accompanying text.

111. A limiting case is a natural monopoly industry.

112. Ayres' and Siegelman's chief support for the hypothesis is the resistance to the introduction of claims-made coverage by smaller insurers and by some set of insureds. Ayres & Siegelman, supra note 7, at 988-91. For a discussion of insured resistance, see supra note 105 and accompanying text. Of course, the claims-made is only superior to the...
Ayres' and Siegelman's second hypothesis is that the claims-made policy was introduced in order to employ the retroactive date feature to bind insureds to the originating insurer. A retroactive date (sometimes called a retro-date) represents a form of melding of occurrence and claims-made coverage. Those claims-made policies actually introduced in the market were never pure claims-made policies, as I had described them earlier, but policies for which the claims-made period was preceded by a period of occurrence coverage commencing at what is called the retroactive date. According to Ayres and Siegelman, the provision of a retroactive period of occurrence coverage is conditioned on the continued purchase of claims-made coverage from the same insurer. Thus, insureds who consider switching to competing insurers face the prospect of losing this level of occurrence coverage if they switch. Ayres and Siegelman suggest that large insurers might benefit more from the binding effect of the retroactive date because insureds, knowing that they will be bound, are likely to differentially prefer larger insurers (such as the defendants) because they appear more solvent.

How plausible is it that the defendants pressed for adoption of the claims-made policy to achieve the binding effect of the retroactive date because it would create relatively greater consumer preference for large and solvent insurers? The thread of supposition seems quite thin. Indeed, the Ayres-Siegelman hypothesis contains an internal inconsistency.

Consumer preference to be insured by relatively large and solvent insurers is likely to be greater under occurrence than under claims-made coverage. Given legal definitions of accident occurrence, the coverage purchased under an occurrence policy may be in force for a very long period of time. In contrast, coverage under a pure claims-made policy terminates at the end of the policy period. Insured concerns about the continued longevity and ultimate solvency of the insurer, thus, are certain to be much greater under occurrence than under claims-made

occurrence policy for insurers whose clients comprise firms with substantial exposure to long-tail liability. For insurers without such clients, adoption of the claims-made adds little and imposes adjustment costs which, however small, may generate resistance.

113. Id., at 986-87, 996-97.
114. See supra subpart II(B)(2).
115. Ayres & Siegelman, supra note 7, at 990.
116. See supra note 92.
117. See Priest, Insurance Crisis, supra note 1, at 1526.
policies. Indeed, this point is the basis for Ayres’ and Siegelman’s belief that the occurrence feature of the retroactive date provision would serve to advantage large and solvent insurers such as the defendants.

According to this view, however, large insurers like the defendants are likely to benefit more from the maintenance of occurrence coverage than from adoption of claims-made coverage. On these grounds, the defendants should have resisted introduction of the claims-made policy, rather than have conspired to achieve it. If there were no other effects on premiums, claims-made coverage would benefit small and relatively poorly financed insurers whose likelihood of survival is much greater for the short period of claims-made coverage than for the long and extended periods of occurrence coverage. By this view, the defendant insurers appear victims of the adoption of the claims-made policy. Ayres’ and Siegelman’s analysis of the effect of the retroactive date would seem to exonerate the defendants from exclusionary motives.

It is more plausible to view the retroactive date provisions of claims-made policies as themselves representing additional evidence of the high level of competition in the commercial casualty industry. Efforts to introduce pure claims-made coverage into commercial casualty appear to have failed. The retroactive date provision restores some period of occurrence coverage. The failure of pure claims-made coverage suggests that the extent of differences in risk deriving from long-tail liability are not sufficient to offset the desire of commercial insureds for some long-tail coverage. Every insured faces some prospect of long-tail liability. Long-tail liabilities that are probabilistic in nature can be successfully insured. It is only where long-tail liabilities are highly correlated among insureds that insurers must respond by culling them out from normal commercial risk pools. It is possible, of course, that the introduction of more specific coverage exclusions, such as the exclusion of pollution coverage, were sufficient to isolate those long-tail liabilities that are highly correlated. More precise explanations require further study, but it is clear that the conception of claims-made coverage has suffered many amendments in the face of commercial casualty competition.

As a consequence, neither of the hypotheses of Professor Ayres and Mr. Siegelman provides a plausible explanation of how the withdrawal of occurrence coverage excluded competi-
tors to restrain trade. In contrast, as described in Part II, there are strong reasons to believe that the coverage withdrawals were efforts to define coverage to maintain the custom of low-risk insureds.

IV. THE LAWSUITS IN THE CONTEXT OF BROADER SOCIAL POLICIES TOWARD INSURANCE

It is a basic ambition of a moral society to provide the greatest level of insurance against losses suffered by its citizens. Equally it is the basic ambition of a competitive economy, as with any other product, to expand insurance availability to satisfy consumer insurance demands more fully. In general, enforcement of the antitrust laws serves to expand production. It is the specific ambition of the antitrust suits against the insurers to deter what the Attorneys General believe are anticompetitive practices restraining trade in insurance.

The careful examination of the Attorneys’ General case in Part III, however, shows that the insurance antitrust suits will not generate that result. Where there is an increase in risk variance, insurance availability is expanded by facilitating the segregation of risks into narrow risk pools. Often this segregation is achieved by more extensive insurance discrimination, as here, by excluding some forms of coverage from risk pools altogether.

There is an additional public policy ground for encouraging the segregation of polluters and other high risk insureds into separate risk pools. A central ambition of tort liability is to create financial incentives to improve the level of safety in our society. It is a fundamental premise of modern law to charge manufacturers and other tortfeasors differentially according to the levels of injury that their products and activities cause. Our society invests very little in the direct regulation of product safety. Instead, we rely in largest part on the marketplace to police safety levels. Accordingly, we expect that if one product is relatively more dangerous than another, the higher liability costs that tort law imposes will either compel the manufacturer to invest to make the product safer or will compel the product to be sold at a higher price, with resulting lower demand. This is the basic underlying premise of strict products liability.118

It has long been recognized that insurance for liability costs

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blunts safety incentives. The purpose of insurance is to lower the expected costs of risky activities. Expected liability costs with insurance will be lower than expected liability costs without insurance. Again, since the premium for an insurance pool must be set with respect to the average risk of the pool, the more that low-risk insureds are merged with high-risk insureds, the lower the effective premium to those generating high costs.

It follows that more extensive segregation according to risk level increases the correspondence of insurance costs to the costs the insured has imposed on society by its activities. Put more simply, segregation in insurance makes tortfeasors pay more of the injury costs that they generate. The pollution exclusion, the claims-made policy, and the inclusion of defense costs help to better achieve the ends of tort law by making tortfeasors pay their own way.119

The attack by the Attorneys General on the coverage exclusions, therefore, is particularly counterproductive. The Attorneys' General lawsuits will deter insurance segregation and reduce insurance availability. As suggested earlier, the Attorneys' General attack reflects deep confusion about the role of insurance in society and the means of increasing insurance availability. Because much of modern policy toward insurance has derived from viewing insurance solely as a distributive risk-spreading mechanism, rather than as a mechanism for reducing risks, little attention has been given to specific public policies that constrict insurance availability.

Perhaps ironically, the insurance antitrust suits provide an excellent occasion for reversing this policy focus. The antitrust laws, unlike much of state regulation, are strongly committed to expanding output. It is only through the persistent focus on means of expanding insurance availability that the strong moral and economic goals of providing greater insurance against loss can be achieved.

119. It is on this basis that the State of New York in the early 1970s required insurers to exclude pollution coverage, 1971 N.Y. Laws 2633 (repealed 1982), just as many states today compel insurers to exclude coverage of punitive damages. See, e.g., KAN. STAT. ANN. § 40-2, 115 (1986).