

A PRINCIPLED APPROACH TOWARD INSURANCE LAW: THE ECONOMICS OF INSURANCE AND THE CURRENT RESTATEMENT PROJECT

*George L. Priest**

INTRODUCTION

The American Law Institute (“ALI”) initiated a project in 2010 to propose the Principles of the Law of Liability Insurance (“Principles”). A Principles project by the ALI is different from a Restatement of Law, for which the ALI is better known. A Restatement seeks to restate the common law of the fifty U.S. jurisdictions in systematized form. The ALI was organized many decades ago to achieve this ambition, in particular to counter the criticism that varying common law principles in the many different states in the U.S. made the law confused and contradictory across the states.¹ The ALI has been successful and has published many volumes of Restatements over the succeeding years, generally disproving this point.

A Principles project of the ALI is different. A Principles project proposes to state the law “as it should be,” presumably as discussion material or talking points for lawyers and academics to address over some time in the future. Toward this end, the ALI contracted with two law professors, Tom Baker of Pennsylvania and Kyle Logue of Michigan, to commence a definition of these “Principles.”² Both scholars are known for their very strong advocacy of policyholders’ rights in liability insurance markets.³ The “Principles of the Law of Liability Insurance” that these two scholars announced weighed heavily toward changing the law to benefit policyholders. There was controversy over these proposals, though the members of the ALI approved the first two volumes of the Principles project.

* Edward J. Phelps Professor of Law and Economics, Yale Law School. This project has been supported by a grant from the American Insurance Association. The Association and its members have had no influence on the ideas expressed in this paper and may, very well, disagree with them. The views expressed here are totally my own and draw from earlier writings.

¹ See George L. Priest, *The Curious Treatment of Capitalism in Legal Education*, 49 *SOC’Y* 216, 218 (2012).

² I view myself as a friend of both Professor Baker and Professor Logue; Logue more seriously: he attended a class of mine at Yale and was an intramural basketball teammate (he is a very good basketball player).

³ See generally, e.g., TOM BAKER & KYLE D. LOGUE, *INSURANCE LAW AND POLICY: CASES AND MATERIALS* (3d ed. 2013) (collecting pro-policyholder cases from across jurisdictions (I taught the previous edition of the book.))

For reasons that are not totally clear, in August 2014, before the Principles project was completed and before extensive discussion of the rule changes that had been recommended in the parts of the Principles that had been completed, especially in the academic literature, the ALI decided to change the project from a statement of aspired-to (by the Reporters) “Principles” to a Restatement of the Law.⁴ The ALI continued to retain Professors Baker and Logue as Reporters to prepare this Restatement.⁵ It is not evident what the ALI’s earlier approval of the first two chapters of the Principles project has on its consideration of the revised chapters in the proposed Restatement. More recently, in April 2015, the ALI recast the proposed Restatement as a Discussion Draft for discussion by its members at a forthcoming meeting.⁶

Although the Reporters have toned down some of their earlier aspirations reflected in the partial Principles draft, again in the proposed Restatement, and yet again in the Restatement Discussion Draft, it remains a strikingly pro-policyholder⁷ statement, not generally reflective of the law in the various U.S. jurisdictions.⁸ The Reporters justify this approach chiefly on two grounds: first, that policyholders do not read policies and so are in ignorance of the terms imposed upon them by insurers;⁹ and, second, by the invocation of the “objectives of the underlying liability regime, which may depend on the presence of liability insurance,” or by the invocation of “special considerations of insurance law.”¹⁰ By this, the Reporters appear to mean that, if there is a loss, it should be covered by insurance to pay for it.¹¹

This approach is not quite a principle, and surely not a restatement. It is an idea about the redistribution of risks. To my mind, the Reporters’ central understanding of insurance is that it serves simply to redistribute risks from persons who have suffered a loss to persons who have not. This conception

⁴ See American Law Institute, Restatement of the Law of Liability Insurance Preliminary Draft No. 1 iv (March 2, 2015), <http://www.nge.com/files/Uploads/Images/ALIDraft.pdf> [hereafter Restatement PD No. 1].

⁵ *Id.*

⁶ See American Law Institute, Comparison: Principles of the Law of Liability Insurance TD No. 1, Chapter 1 (revised after 2015 Annual Meeting) to Restatement of the Law, Liability Insurance Discussion Draft (April 30, 2015) [hereafter Discussion Draft].

⁷ Of course, there are persons or entities insured under a policy who are not the original policyholders. I will use the terms “policyholder” and “insured” interchangeably, so as to limit the extent to which readers must pay attention to the last letter of the term “insured.” Mr. Eugene Anderson convinced me of this approach.

⁸ This paper is meant to be conceptual and will not specifically address differences between the proposed rules and the law in the several jurisdictions. As shall be occasionally indicated, there are many differences.

⁹ They extend this explanation even to a wide range of commercial policyholders.

¹⁰ Discussion Draft, *supra* note 6 at 68, 160. Page numbers in the Discussion Draft refer to the redlined version.

¹¹ See, e.g., BAKER & LOGUE, *supra* note 3, at 17–24, for an elaboration of this point.

provides grounds for a very large expansion of insurance in favor of policyholders who have suffered loss, as reflected in each of these documents. As I shall explain, however, the idea of insurance as centrally a redistribution of risks is innocent of the economic reasons that insurance serves to reduce the costs of risks in the society.

Not all risks can be insured. Some risks are more effectively reduced by the policyholder than by the insurer. Other risks, for economic reasons, cannot be effectively insured. From an economic standpoint, an insurance contract represents a joint allocation as between the policyholder and insurer as to how best to minimize the risks that the policyholder faces in the context of the risks that the insurer can effectively reduce. Insurance policies allocate responsibilities in these ways. The Reporters do not seriously consider insurance as a market activity.

As shall be explained, I have no animus to policyholders.¹² The Restatement Reporters' apparent understanding of insurance as simply risk shifting, however, ignores the economics of the provision of insurance. It ignores what risks a policyholder is willing to pay an insurer to cover—as opposed to what risks the policyholder may more effectively bear—and it ignores the related point that some risks cannot be effectively borne by insurers or, more accurately, effectively borne at premiums a policyholder is willing to bear.

The most important objective of the law governing liability insurance is to maximize the availability of insurance, which helps all of society, but especially those with a low income. The question then is, will the rules that the Reporters have advocated in the proposed Restatement or the Restatement Discussion Draft accomplish that end? It is my view that the Reporters' approach even in the Restatement Discussion Draft will have the economic effect of reducing the ability of citizens to acquire insurance.

Part I discusses the economics of insurance with some references to the Restatement Discussion Draft. Part II discusses the rules advocated in the Restatement Discussion Draft in greater detail.

I. HOW LIABILITY INSURANCE OPERATES

I take it as axiomatic that the most compelling principle for considering rules governing insurance contracts is to design those rules so as to maximize the availability of insurance coverage to the society.

Insurance is an important service in a society because it allows individuals and entities to engage in activities generating risk in which they otherwise might not engage or might engage in differently in the absence of insurance. It thus expands the opportunities for all to enrich their lives. As simple examples, few of us would drive on open highways or drive the way all of us do if not protected from the calamity of a potential loss from an accident by

¹² I have testified on behalf of policyholders as an expert witness in many cases, though more frequently on behalf of insurers.

the availability of auto insurance. Similarly, our houses would be designed differently—perhaps with much greater levels of physical protection—if not for the availability of homeowners' insurance. Commercial entities in particular could not engage in risky activities providing valuable products and services to consumers without the availability of commercial general liability insurance. Employees would make different work decisions if not protected by employers' insurance coverage. Insurance vastly increases the opportunities of a society to enhance the lives and the positions of its citizens. It could be argued, though to my knowledge it has not yet been shown, that the great productivity of the U.S. over other countries importantly derives from its well-developed insurance market.

The economic alternative to insurance is the prevention of loss or, where losses still occur, savings to compensate for them.¹³ Savings is a means of protecting against future liabilities or economic calamities. All of us retain savings to address some level of personal calamities, so savings remain an important part of each family's and entity's economic planning. But savings, from an economic standpoint, is an inferior—by which I mean more costly—means to deal with losses than insurance, where insurance can effectively reduce the financial impact of losses. Today, in the U.S., a person can acquire \$300,000 worth of auto liability insurance for a few hundred dollars a year as protection in case the person or a member of the family causes an accident. Compare the costs to the family of maintaining \$300,000 in an auto accident savings reserve, not to mention the costs of maintaining reserves for the potential costs of homeowners' liabilities, the death of a family member, or other potential liabilities relating to the activities in which family members engage. This is true for commercial entities as well, however well diversified they or their shareholders may be. And the point is especially true for low-income individuals or families who might never be able to acquire equivalent savings amounts. Insurance for potential losses is far less costly. The implication of these points for a society is to increase the availability of insurance to the extent possible.

As I will explain, however, there are limits—defined by economic realities—as to what risks can be effectively insured, as opposed to suffered directly by the policyholder because there is no advantage to insurance. Many risks are not insurable in the market because the policyholder can more effectively protect against them. This is a simple, but central, economic point. As I shall explain, there are other economic reasons that prevent the effective insurance of risks. But if risks can be insured, a market concept, insurance is a far more effective means to protect oneself from future economic liabilities than savings. For many centuries, savings have served as the principal means of protection from potential economic losses. The modern age has been propelled by insurance.

¹³ This analysis is elaborated in George L. Priest, *A Theory of the Consumer Product Warranty*, 90 YALE L. J. 1297, 1308 (1981) [hereafter Priest, *Consumer Product Warranty*].

The principal question, then, is how to design rules for the administration of insurance contracts to maximize insurance availability. I have mentioned insurance availability to allow individuals to undertake risky activities. Again, this point is especially true for the low income in the society who, if insurance premiums are low, may acquire insurance that might not otherwise be available. This makes it possible for those that might be crippled by potential economic catastrophes to engage in a wide range of everyday activities.

With respect to the laws governing insurance contracts, it follows that any change in these rules that reduces mutual costs as between insurers and policyholders serves to reduce the cost of insurance and increases insurance availability to the benefit of all, but especially of the low income.

Insurance contracts, like other contracts, are designed to provide a service at a price (premium) to make use of the relative comparative advantages of the insurer and the policyholder. If a policyholder is in a position to reduce loss (by prevention) at a lower cost than what the insurer would charge for coverage of the loss, it is to the advantage of both parties for the policyholder to do so. This reduces insurance premiums and expands the availability of insurance. In other contexts, some risks cannot be effectively reduced by insurance, as will be explained.¹⁴ Most insurance policy provisions can be explained on these grounds. The drafters of the proposed Restatement and the Restatement Discussion Draft consistently avoid these propositions.

This Part presents an economic analysis of the provision of insurance. These principles are well known and are uncontroversial. There is nothing new in this analysis, except that much of it has been ignored in the insurance literature and, in particular, by the drafters of the proposed Restatement.

Much of the (especially) legal description of insurance refers to it as a mechanism of “spreading risks.” This is not quite inaccurate, but it can be understood in a way that misdiagnoses the economic purpose of insurance to reduce the effects of risk through statistical and economic means. The “spreading risks” explanation can be interpreted to mean that spreading risks is chiefly a redistributive mechanism, charging people who have not suffered a loss with the costs faced by those who have. This form of “spreading risks” is typically justified on the principle of equalizing marginal utilities of wealth or shifting assets from the more risk averse to the risk neutral or risk preferring. In my view, much of the impetus for the changes in law recommended by the drafters of the proposed Restatement and the Restatement Discussion Draft derives from a view that insurance is basically a redistributive instrument. Most of the changes in law that the drafters have adopted seek to shift the distribution as between insurers and policyholders in favor of policyholders. I do not disregard or diminish the interests of policyholders. But these efforts to overturn the terms of basic liability insurance policies will serve to reduce insurance availability in the society.

¹⁴ See *id.* at 1318 (elaborated here).

True insurance goes far beyond redistributing economic positions of citizens based on the principle of the declining marginal utility of wealth or on the basis of differential risk aversion. One can argue about whether ideas about the declining marginal utility of wealth should overcome contractual agreements between policyholders and insurers. Similarly, the risk aversion explanation is not totally convincing. From an economic standpoint, insurance can be offered to a risk pool containing all risk-averse individuals provided by an entity that itself is risk averse.

On economic grounds, true insurance serves in various ways to reduce the actual risk level, something not achieved by simple redistribution among policyholders or as between the risk averse and risk neutral.

There are three principal features of the operation of insurance that determine the extent to which an insurance regime effectively reduces the risk level: the aggregation of risks, the segregation of risks into separate risk pools, and the control of moral hazard through deductibles, coinsurance, and exclusions of coverage.¹⁵

A. *The Aggregation of Risks*

Insurance operates where losses have some stochastic or probabilistic character.¹⁶ Losses that are certain to occur in some particular period cannot be insured against; one can only accumulate savings before the loss occurs or after the loss is suffered to restore the previous economic position. Imagine a commercial policyholder who seeks coverage after the fact for liabilities deriving from mesothelioma deaths suffered at its plant. Or imagine a person whose house has burned down seeking subsequent insurance coverage for the loss. There is no point to such insurance.

Similarly, losses cannot be effectively insured if they can be prevented at low cost by the policyholder.¹⁷ It would be uneconomic for a policyholder to pay an insurer to estimate the risk, to maintain reserves for it, and to engage in subsequent loss adjustment where the policyholder can cheaply prevent the loss.

In contrast, for insurance to reduce the risk level, the policyholder losses must be probabilistic, either as to whether or not the losses will occur at all (for example, whether a product will prove defective or a house will burn

¹⁵ George L. Priest, *Government Insurance versus Market Insurance*, 28 GENEVA PAPERS ON RISK & INS. 71, 76 (2003) [hereafter Priest, *Government Insurance*]. There is a fourth risk-reduction function of insurance relating to the investment of insurance premiums. For a discussion, see George L. Priest, *Compensation for Injury in the United States*, in COMPENSATION FOR PERSONAL INJURY IN SWEDEN AND OTHER COUNTRIES 127, 131–32 (Carl Oldertz & Eva Tidefelt, eds., 1988). This function is not implicated by the liability rules in the proposed Restatement and Restatement Discussion Draft.

¹⁶ I apologize for the great deal of economics in this discussion, but its relation to the insurance liability rule changes in the proposed Restatement and Restatement Discussion Draft will become obvious in Part II, *infra*.

¹⁷ See generally Priest, *Consumer Product Warranty*, *supra* note 13 for many examples.

down) or as to when losses certain to occur actually will occur (for example, whether one will die before or after full life expectancy).

For a loss or a set of losses to be probabilistic means that the occurrence of the loss can be described by a probability distribution. The mean of the distribution represents the most likely probability of occurrence of the loss; the distribution or error term surrounding the mean represents the greater or lesser likelihood that the loss or set of losses will occur. The expected cost of the loss is determined by summing the amount of the loss weighted by these probabilities. Obviously, regardless of the mean expected magnitude of the loss, the broader the probability distribution around the mean, the greater the total expected cost. More precisely, expected cost is determined by the variance of the distribution around the mean. The variance of the distribution measures the risk associated with the loss.¹⁸

Insurance can reduce the risk of losses by aggregating uncorrelated losses. To the degree that losses are uncorrelated (that is, statistically independent),¹⁹ aggregation will reduce variance by leading the error terms of the risks to cancel out. Aggregation does not change the extent of underlying loss. But the cumulative risk of loss, measured by the variance of the distribution, can be reduced by aggregation, again, to the extent that the individual risks are statistically independent. For statistically independent risks, the sum of the aggregated risks is less than the sum of the risks taken individually. This is one of the central differences between true insurance and insurance as “risk spreading.” Risk spreading does not reduce the magnitude of loss. True insurance does.²⁰

The risk-reducing function of aggregation derives from operation of the law of large numbers—the empirical phenomenon according to which the probability density function of a loss tends to become concentrated around the mean as the sample number increases.²¹ The law of large numbers implies that as one increases the number of policyholders possessing independent and identically valued risks, one also increases the accuracy of prediction of the risk generated by each individual. The increase in predictive accuracy is important to the operation of insurance and derives from the reduction in the variance of risk of expected outcomes.

Some scholars who have employed the term “law of large numbers” to refer to the insurance function seem to have understood large numbers as

¹⁸ The variance of a distribution is the sum of the squares of the differences between the mean of the distribution and each random variable: $\text{variance} = \sigma^2 = E(X - \bar{x})^2$, where \bar{x} = the mean of the distribution and X = each random variable.

¹⁹ Losses are statistically independent to the extent that the occurrence of one loss does not affect the probability of occurrence of the other.

²⁰ See Priest, *Government Insurance*, *supra* note 15, at 73.

²¹ See John M. Marshall, *Insurance Theory: Reserves Versus Mutuality*, 12 *ECON. INQUIRY* 476, 484–85 (1974).

relevant only for broad loss-spreading, rather than for risk-reduction.²² It is important, however, to distinguish between employing a large population of policyholders to *shift* losses based on assumptions concerning utility levels or distributional preference and employing a large population of policyholders to *reduce* the risk level by canceling out risk terms. The important difference is that, to the extent that the losses and accompanying risks are truly independent, their aggregation not only spreads them, diminishing the impact of a loss on an individual policyholder, but also reduces the total risk level of the pool below the pre-aggregated sum of individual risks.

Loss spreading, in contrast, serves only a distributional end. Spreading does not change the risk level; it merely distributes existing risks across a set of the population different from the set that faced the risks in the first instance. The operation of the law of large numbers on statistically independent risks, in contrast, increases the ability to predict the risk level (which is what is meant by canceling out risk terms) and thus reduces the effective risk level.²³

The law of large numbers will not apply, however, if the risks faced by members of the pool are not statistically independent to some degree. Aggregating such risks would be unproductive because the savings reserves an insurer would have to maintain would equal or, perhaps, exceed the reserves individuals would have to maintain if uninsured, because of insurer loading costs.²⁴ This is why society-wide calamities, such as nuclear war, are uninsurable and, thus, are excluded in all policies. Where losses are highly correlated, they *cannot* be effectively reduced by spreading them among those subject to the risk. As we shall see, many limitations on liability insurance coverage reflect this problem.

By reducing the risk level, effective risk aggregation reduces the premium necessary to insure a given risk. This can mean that fuller insurance coverage (larger insurance benefits) can be offered for the same dollar premium. Or it can mean that insurance can be made more broadly available for risks that would otherwise be uninsured. To the contrary, loss spreading, because it does not change the risk level, does not directly achieve either of these benefits.

The method of aggregation chosen by the insurer can affect the extent to which aggregation will reduce the risk level. The second basic insurance function—risk segregation—is a method of improving the gains from basic aggregation to reduce the risk level even further.

²² See, e.g., Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 203 (2012); Jeffrey W. Stempel, *Rediscovering the Sawyer Solution: Bundling Risk for Protection and Profit*, 11 RUTGERS J.L. & PUB. POL'Y 170, 174 (2013).

²³ See Priest, *Government Insurance*, *supra* note 15, at 73.

²⁴ See Marshall, *supra* note 21, at 477, 482.

B. *The Segregation of Risks*

Risk segregation refers to insurer efforts to distinguish relatively high-risk from low-risk policyholders and then to assign them to narrowly defined risk pools. In the insurance industry, risk pool definition is referred to as insurance underwriting, although the principle affects the structure of the industry in other ways. Risk segregation reduces the risk level in two separate dimensions. First, segregation can reduce statistical variance below that of a more broadly aggregated pool. Second, segregation can influence the level of the risky activity itself by setting the insurance premium to more closely reflect the risk the activity adds to the pool. Here, again, insurance is much different from savings and represents more than simple redistributive risk spreading.

Most basically, “[s]egregating high- from low-risk policyholders can reduce risk variance and, thus, reduce the expected costs of insured injuries.”²⁵ The statistical basis for the effect is straightforward. Imagine two populations of policyholders, one characterized by high risk, the other by low risk, for which the risks within and across each population are independent. Risk pool variance is calculated by summing the squares of the differences between each pool element and the pool mean.²⁶ If the two populations are aggregated into a single pool, pool variance equals the sum of the squared differences between each high-risk and low-risk element and the mean of the combined pool. If, in contrast, the two populations are segregated into separate pools, the variance of each pool equals the sum of the squared differences between each element and the respective means of each segregated pool. It is straightforward that, to the extent of the difference between the means of the two pools, the summed variance of the two segregated pools will be less than the variance of the single undifferentiated pool.²⁷ Because segregation reduces variance, it reduces the risk level and reduces aggregate insurance premiums.

Segregating risks by risk level reduces risk variance in a manner very similar to reducing risks by aggregation. As described above, by aggregating independent risks into risk pools, the insurer increases predictive accuracy by exploiting the law of large numbers. Increasing predictive accuracy reduces the risk level of the pool, even if it does not affect in any way the frequency of losses that actually occur. Segregating risks into separate pools according to risk levels serves a complementary function. Like aggregation, segregation according to risk level improves an insurer's ability to predict expected loss, making possible greater predictive accuracy. Again, this is

²⁵ George L. Priest, *The Government, the Market, and the Problem of Catastrophic Loss*, 12 J. RISK & UNCERTAINTY 219, 222 (1996) [hereafter Priest, *Government, Market, & Catastrophic Loss*]; see also Priest, *Government Insurance*, *supra* note 15, at 74.

²⁶ See Priest, *Government, Market, & Catastrophic Loss*, *supra* note 25, at 222.

²⁷ See THOMAS H. WONNACOTT & RONALD J. WONNACOTT, *INTRODUCTORY STATISTICS FOR BUSINESS AND ECONOMICS* 213–19 (4th ed. 1990).

what is meant by reducing risk variance. Thus, relative to broader and undifferentiated risk pools, segregation reduces both pool riskiness and total insurance costs.²⁸

It is commonly believed that there is a tension between the advantages of segregating policyholders into particularized risk categories and of spreading losses broadly over the population. Many seem to think that the more individualized the risk calculation, the lower the extent of loss spreading.²⁹ This view, too, however, derives from the confusion between the loss-spreading and risk-reducing functions of insurance. To the extent that risks are uncorrelated and probabilistic in nature, their segregation into narrowly drawn risk pools can reduce them. Policyholders can gain from such transactions, up to the costs of segregation, because segregation lowers the effective risk to each pool member. The premium charged to each member of the pool will be lower than the cost of self-insurance, because self-insurance would necessarily require taking into account a greater range of possible outcomes.

Of course, high-risk policyholders pay lower premiums with less than with more differentiated risk pools because their risks are averaged into those of a less risky population. If more precise differentiation is economically feasible, however, the lower premium to the high-risk from the less-differentiated pool is a subsidy, not a return from insurance aggregation. The subsidy to the high-risk pool will reduce insurance availability by increasing premiums to the low-risk pool. Increasing predictive accuracy by segregation reduces risk maximally. Even if there are justifications for subsidizing the high-risk (which is doubtful), reducing these risks maximally reduces the extent of the necessary subsidy and increases insurance availability.

In essence, the unwitting emphasis on risk spreading leads to the advocacy of general social insurance, the broadest possible form of loss spreading.³⁰ As the earlier example demonstrated, however, lumping a wide set of undifferentiated societal risks into a single social insurance risk pool will surely increase rather than reduce the risk level faced by the society, another advantage of the broad private insurance market in the U.S. and other countries.³¹

The second risk-reducing function of segregation is to set an insurance premium that most accurately reflects the risk that a policyholder brings to

²⁸ See Keith J. Crocker & Arthur Snow, *The Efficiency Effects of Categorical Discrimination in the Insurance Industry*, 94 J. POL. ECON. 321, 328 (1986).

²⁹ See generally, e.g., GUIDO CALABRESI, *THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS* 48-49 (1970); Fleming James, Jr., *Accident Liability Reconsidered: The Impact of Liability Insurance*, 57 YALE L.J. 549, 556 (1948).

³⁰ Kenneth Arrow, among other achievements, regards this point as important to his career. See KENNETH J. ARROW, *ESSAYS ON THE THEORY OF RISK BEARING* 135-38 (1971). See also CALABRESI, *supra* note 29, at 46-47; James, *supra* note 29, at 550 n.1. Because Judge Calabresi includes so many other values besides loss spreading in his analysis, his support of social insurance is far more constrained than that of Professor James. See CALABRESI, *supra* note 29, at 64-67 (arguing that total loss spreading through social insurance would not create collectively adequate incentives to reduce the accident rate).

³¹ See Priest, *Government Insurance*, *supra* note 15, at 73-77.

the pool. Here, relative to undifferentiated insurance pools, precise risk segregation can reduce the level of underlying injuries actually suffered. Charging policyholders a premium related to underlying risk informs the decisions of potential policyholders as to whether and how much to engage in the activity generating the risk. Oftentimes the concept of internalizing costs is invoked with this meaning. For example, the higher auto premiums charged 16- to 25-year-old males (or their parents) because of higher expected claims costs serves as a market-rationing device for teenage male driving. Some young males are prevented from driving or are encouraged to drive more carefully because of the higher premiums charged or the fear of subsequent higher premiums if they become involved in an accident or commit a traffic violation.³² As a result, relative to a regime without risk segregation, the accident rate will be lower.³³ All forms of insurance premium discrimination have this effect.

Just as risk segregation charges appropriately higher premiums to the high risk, it charges appropriately lower premiums to the low risk. Here, precise risk pool definition extends insurance availability by controlling adverse selection. Adverse selection is a problem central to every insurance context. An insurer must collect into a risk pool individuals with a sufficiently narrow range of exposure to risk for the insurance to remain financially attractive to each member of the pool. Since insurance premiums must be set according to the average level of risk brought to the pool, the wider the range between high-risk and low-risk pool members, the greater the difference between the premium set equal to the average risk and the risk of the low-risk members. If the disparity between the premium and the risks added by low-risk members becomes too substantial, low-risk members will drop out of the pool because they find alternative means of protection cheaper than market insurance.³⁴ At the extreme, as low-risk members drop out, the insurance pool will unravel.³⁵ One of the most important reasons that some risks are uninsurable is that insurers are unable to narrow the assortment of risks within a risk pool. Those insurers who are better at identification and segregation can offer

³² I have family experience to this effect.

³³ Many studies demonstrate this result. For a demonstration of a dramatic increase in the accident rate following the prohibition of insurance discrimination in Quebec by age, sex, violation record, and accident experience, see e.g., Rose Anne Devlin, *Liability Versus No-Fault Automobile Insurance Regimes: An Analysis of the Experience in Quebec*, in CONTRIBUTIONS TO INSURANCE ECONOMICS 499 (G. Dionne ed., 1992).

³⁴ For an empirical demonstration of adverse selection following the adoption of non-discriminating no-fault auto insurance in Quebec, see id. at 501-14.

³⁵ George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 492-94 (1970) (discussing this phenomenon in the context of medical insurance). For examples of the unraveling effect in commercial liability insurance, see George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1556-59 (1987) [hereafter Priest, *Insurance Crisis*].

lower premiums to low-risk policyholders and can thus expand insurance availability.

The importance of these points about the aggregation and segregation of risks to lower insurance premiums is implicated in the serious problems insurers face with adverse selection. Another aspect of adverse selection is the phenomenon of asymmetric information as between a potential policyholder and the insurer.³⁶ Where a potential policyholder knows that it is likely to suffer a loss or knows that it is differentially susceptible to suffering a loss, there is an information asymmetry from the insurer who may, lacking that information, place the policyholder into an incorrect risk pool. If the policyholder has misrepresented its risk profile in some way on its insurance application or in discussions with an agent, these informational asymmetries may substantially affect the insurer's underwriting.

As a consequence, it is well established that the more precisely insurers can accurately segregate risks by insurance discrimination, the more broadly insurance can be offered in the society.³⁷ A court that wanted to maximize insurance availability in the society would adopt policies that encouraged maximally effective discrimination in order to segregate risks into the narrowest possible pools. Unfortunately, much of the modern judicial treatment of insurance issues, much of modern insurance regulation, and many of the rule changes proposed in the new Restatement and the Restatement Discussion Draft have been influenced by conceptions of loss spreading, rather than risk reduction, and have diminished (or will if approved diminish) insurance availability by thwarting risk segregation through insurance discrimination.³⁸

The difference between the view of insurance as loss spreading and insurance as risk reduction becomes quite sharp at this point. Loss spreading is often defended solely on distributional grounds. Spreading shifts the costs of bearing losses away from parties that generate losses to parties viewed as better able to bear them. For example, assigned risk pools in auto insurance or residual market carriers in medical malpractice insurance shift the costs generated by more risky drivers or doctors to the less risky.³⁹ Loss shifting of this nature can only be achieved by compulsion and can only be defended on grounds of distributional preference.⁴⁰ But the implications of such loss shifting are often neglected. By defeating the risk-reduction benefits of segregation, this form of loss shifting increases the risk level, increases the underlying injury level, and reduces insurance availability. The gains to the subsidized high-risk policyholders are paid for in increased risk, increased injury,

³⁶ Kenneth Abraham emphasizes this point. See Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942, 946-47 (1988).

³⁷ See Crocker & Snow, *supra* note 28, at 322-30; Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629, 634-37 (1976).

³⁸ For examples, see Priest, *Insurance Crisis*, *supra* note 34, at 1535-36, 1538-39.

³⁹ See CALABRESI, *supra* note 29, at 52-54, for many other examples.

⁴⁰ Judge Calabresi openly admits this point. *Id.* at 281-83.

and less available insurance, losses ignored in the emphasis on simple wealth distribution. One should not confuse some distributional desirability of aiding certain high-risk classes with the means chosen to aid them. Whatever a society's distributional ends, there is less need for compulsory distribution where insurance reduces risks as much as possible.

The aggregation and segregation functions of insurance, then, are similar both in method and effect. Both serve to increase predictive accuracy in order to reduce the risk level and the effective costs of injuries. Reducing injury costs, however, necessarily generates offsetting effects. Where expected injury costs are lower, the underlying level of activity and the underlying injury rate will increase. This is known in economics as moral hazard.⁴¹ All insurance regimes generate this effect. The third function of insurance design is to mitigate this moral hazard in order to maximize the gains from insurance.

C. *Controlling Moral Hazard Through Deductibles, Coinsurance, and Exclusions of Coverage*

Moral hazard is a second chief problem in the administration of insurance. Ex ante moral hazard is the reduction in precautions taken by a policyholder to prevent the loss because of the existence of insurance.⁴² Ex post moral hazard is the increase in claims against the insurance beyond the services the claimant would have purchased if not insured.⁴³ Moral hazard increases the costs of injuries and, thus, increases the risk level. Ex ante moral hazard increases the frequency of loss; ex post moral hazard increases the costs of losses that have actually occurred. Insurance regimes can reduce risk by controlling both ex ante and ex post moral hazard. Insurers will attempt to control both forms of moral hazard by the definition of insurance coverage and by the design of insurance benefits.

Insurers will constrain or, at the limit, exclude coverage of losses particularly susceptible to policyholder moral hazard. The omnipresent exclusion in life insurance policies of coverage for death by suicide is an obvious example. The exclusion serves to control moral hazard by removing the incentive that providing large monetary amounts to beneficiaries would add to other forces compelling the act.⁴⁴ Less dramatically, the exclusion in con-

⁴¹ The costs of the increase in injuries because of insurance will be less than the reduction in effective costs achieved by insurance; otherwise there will be no demand for insurance.

⁴² Priest, *Insurance Crisis*, *supra* note 35, at 1547.

⁴³ *Id.*

⁴⁴ Today, life insurance policies typically exclude coverage for death by suicide only for the first two policy years. It is not clear that the two-year limitation on the exclusion derives from insurer judgment that two years is a sufficient margin to control moral hazard. More probably, the limitation derives from direct regulatory pressure or indirect judicial pressure from the desire to allow coverage whenever possible

sumer product warranties of coverage of easily broken glass parts or the easily marred product finish, or the exclusion in auto warranties of coverage of engine damage from racing or towing heavy loads, serves a similar function.⁴⁵ These exclusions place the burden of these particular losses on the policyholders themselves, increasing policyholder preventive efforts and, at the same time, culling out (segregating) high-risk policyholders relatively more susceptible to such losses.⁴⁶

Exclusions serve to segregate risk pools in a different way. For example, most commercial general liability policies exclude coverage of liabilities deriving from property owned by the policyholder. This does not mean that property-related liabilities cannot be insured; rather, these liabilities can be insured more precisely in a separate property insurance market. Similarly, the introduction of the pollution exclusion in commercial general liability policies in the 1980s forced policyholders expecting the possibility of pollution liability to purchase separate pollution coverage, lowering the premiums of commercial general liability coverage to those policyholders not expecting such liabilities.⁴⁷

Insurers also control moral hazard by the definition of insurance benefits, in particular, the introduction of deductibles and coinsurance. Deductibles and coinsurance shift part of a loss suffered by a policyholder back to the policyholder itself. Only less completely than coverage exclusions, deductibles and coinsurance reduce indifference to preventive investments, and they reduce the incentives to consume what, from an *ex ante* view, are excessive levels of insurance services.

Although deductibles and coinsurance reduce insurance benefits, they are generally essential to the maximization of insurance benefits net of insurance costs. Deductibles and coinsurance, obviously, reduce insurance coverage by some proportion. The proportionate reduction in coverage is attractive to the dominant set of insurance purchasers because with full coverage, the insurance premium would be much higher. More precisely, the existence of moral hazard means that, in comparing full coverage to reduced coverage

and the consequent refusal to enforce exclusions deemed unreasonable because not fully understood by judges or regulators. It is an interesting question to compare the suicide rate among life insurance policyholders without the two-year limitation, but it is implausible that the surely dominant majority of policyholders *not* contemplating suicide would voluntarily wish to purchase coverage for death by suicide after the second policy year to protect for that contingency.

⁴⁵ See Priest, *Consumer Product Warranty*, *supra* note 13, at 1317–18, for many other examples.

⁴⁶ Direct risk monitoring by insurers (such as requiring the installation of specific safety devices and inspecting for compliance) is very similar to the control of moral hazard by exclusions.

⁴⁷ See Sharon M. Murphy, *The "Sudden and Accidental" Exception to the Pollution Exclusion Clause in Comprehensive General Liability Insurance Policies: The Gordian Knot of Environmental Liability*, 45 VAND. L. REV. 161, 167, 170–71 (1991).

with deductibles and coinsurance, the proportionate increase in premium necessitated by full coverage is greater than the proportionate increase in insurance benefits to the dominant set of policyholders.⁴⁸

There is a broader implication of the dramatic extent to which deductibles, coinsurance, and coverage exclusions allow reductions in insurance premiums. Reductions in coverage of this nature ultimately increase the extent to which citizens can obtain insurance coverage. The cost savings achieved by the introduction of exclusions, deductibles, and coinsurance necessarily will make insurance available to individuals who may not otherwise be able to pay the costs of full insurance. Societies like ours in which the level of income is not so uniform that all citizens are able to purchase private insurance must be attentive to methods of making insurance more affordable. Any technique—such as the introduction of a \$50 deductible—that reduces insurance premiums by a large number may well have a significant impact on the ability of low-income citizens to obtain private insurance coverage.⁴⁹

The beneficial effects of deductibles, coinsurance, and coverage exclusions as methods of controlling moral hazard have been largely neglected. Because these insurance provisions directly allocate losses to the policyholder, their existence might seem antithetical to broad loss spreading.⁵ But here again the limitations of the loss-spreading metaphor become clear. Deductibles and coinsurance admittedly place some proportion of loss on the policyholder; a coverage exclusion places all of the loss on the policyholder.

⁴⁸ An example, though dated (it is very rare to obtain statistics of this nature), suggests the insurance benefit calculus. Some years ago, the famous New Zealand Accident Compensation Scheme, which provides national insurance for a specific set of accidents, faced severe financial constraints, approaching bankruptcy. A study group, appointed to rescue the system, analyzed the effects of introducing deductibles and coinsurance in place of the full coverage offered before. The group discovered that the introduction of modest deductibles would have massive effects on total compensation system costs. For example, for 1987, total estimated expenditures on a category of costs relating to medical, hospital and dental treatment were \$120.9 million, given no deductible. The group estimated that the introduction of a \$250 deductible would reduce these costs by \$80 million, over 66 percent. Similarly, total estimated 1987 expenditures on general practitioner treatment were \$50.9 million. The group estimated that the introduction of a \$50 patient deductible would reduce these costs by \$30 million. These figures are surely underestimates, since they are calculated simply by subtracting aggregate past claims expenses for amounts less than the proposed deductibles. Thus, they do not adjust for the decline in consumer demand for these services that would likely result from the increase in their effective price. J.T. CHAPMAN, ET AL., 1 REVIEW BY OFFICIALS COMMITTEE OF THE ACCIDENT COMPENSATION SCHEME [*sic*] 42–43 (1986).

The New Zealand examples illustrate how insurers in competitive insurance markets define levels of insurance coverage. Of course, policyholders who expect frequent or extensive claims against the insurance are likely to prefer full coverage without deductibles or coinsurance, perhaps even at the higher premium necessitated by that level of coverage. But if there exists a set of policyholders who want basic insurance coverage, but do not expect frequent or extensive claims, then the insurer may optimize insurance sales by tailoring coverage to better meet its needs through incorporating deductibles, coinsurance, and specific coverage exclusions. If insurance coverage in New Zealand were defined by private firms in a competitive market, for example, one might discover that insurance sales were optimized by offering general practitioner coverage with a \$50 deductible at a premium reduced by 60 percent.

⁴⁹ See *e.g.*, *id.* at 43.

To this end, these provisions conflict with simple loss spreading. But as such provisions lower total insurance costs, they allow the extension of basic insurance benefits more broadly to the society. Thus, for example, the exclusion of life insurance coverage to suicides allows the premium for basic life insurance to be lower, and makes it possible for some individuals who would not or could not purchase life insurance at a higher premium to obtain basic life insurance protection. Similarly, the exclusion of coverage of engine damage from racing in the standard auto warranty keeps the costs associated with this high-risk activity from being averaged into the warranty cost component of the average auto purchaser. Thus, though seemingly paradoxical, reducing insurance benefits through deductibles, coinsurance, and coverage exclusions can maximize the available insurance coverage to the society.

D. *Insurance as Contract*⁵⁰

Contracts generally provide for the distribution of duties and responsibilities between the parties to the contract. This distribution is based upon the relative comparative advantages of each party in contributing towards the objective of the contract.

Insurance contracts are no different. In their multiple provisions, they assign duties to policyholders: principally, through deductibles, exclusions, and other limitations of coverage, to prevent losses themselves where it is economical to do so. They exclude coverage of risks that cannot be effectively insured (such as the nuclear liability exclusion). They also assign duties to insurers: to provide a defined level of coverage for losses that are insurable.

In most cases—putting aside complicated commercial manuscript policies—insurance contracts are standardized, as are most contracts in our complex society. It has become typical in the insurance literature to describe insurance contracts, because drafted by insurers (in fact, the drafting process is more complicated) as one-sided and as contracts of adhesion. It is argued that insurance contracts are seldom read by policyholders and, on these grounds, their provisions ought to be preempted. This is certainly the approach of the drafters of the proposed Restatement and the Restatement Discussion Draft, as I shall show in the next Part.⁵¹

But this approach neglects modern reality. In an age of mass production, consumers enter contracts of the nature of insurance contracts daily, from the purchase of cell phone programs, to the licensing of computer programs, to

⁵⁰ I use this term in a somewhat different way than in Kenneth S. Abraham, *Four Conceptions of Insurance*, 161 U. PA. L. REV. 653, 658 (2013), because I acknowledge an important regulatory role. The concept is also different from the view of the Reporters who deny the importance of mutual agreement, see Discussion Draft, *supra* note 6, § 2, cmt. h, at 15, and also maintain (without explanation) that insurance contracts should be treated differently than other contracts. *Id.*

⁵¹ See Part II, *infra*.

FedEx or UPS or Postal Service mailings, to the purchase of other consumer products whose contractual warranties are only discovered after the product is delivered, discovered later if the product proves defective. In the U.S., the same is true with respect to contracts with service providers such as public utilities.

The drafters of the proposed Restatement make much of their assertion that consumers do not read the terms of their insurance contracts before entering into them, and, as I shall explain, use this point to advocate for broader policyholder privileges, against the terms of basic insurance policies.

The claim, first, is surely not true and should not be the basis of new rules regarding insurance. Consumers read basic insurance terms: limits of coverage; deductibles; and special provisions related to their personal insurance situation (protection for valuable collections, jewelry, and the like).

Second, in a context of a highly regulated industry, where regulatory officials read and regulate *all* of the provisions of a policy before authorizing it, the consumer can confidently delegate the details of non-central terms to a regulator, focusing itself on the basic terms.⁵² Moreover, in the U.S., commercial and personal lines of insurance are highly competitive.⁵³ There is no general reason to believe that insurance contracts exploit policyholders; indeed, the omnipresent advertisements among competing insurers dictate the opposite. Policy terms in most insurance contracts are designed to benefit policyholders in terms of coverage versus premium. Insurance policies, in these respects, are far more likely to have been consented to than many other consumer contracts in our society.

As the next Part illustrates, however, the proposed revisions of the new Restatement of Liability Insurance and the Restatement Discussion Draft depart from these economic principles in substantial ways. As will be explained, these proposals seem to derive from the view that insurance is chiefly redistributive—spreading risks—and seek to shift that distribution substantially more toward policyholders, upsetting the allocation of responsibilities found optimal in the current insurance market.

II. THE NEW RULES OF THE RESTATEMENT DISCUSSION DRAFT CONSIDERED

This Part addresses the Restatement Discussion Draft both in conception and with respect to the specific rules that it aspires to discuss. It should be noted at the outset, before addressing the specific rule proposals, that, in my view, the Reporters of the proposed Restatement, initially contracted to draft an aspirational “Principles” project, later transmuted into a proposed

⁵² See AMERICAN INSURANCE ASSOCIATION, PROPERTY-CASUALTY INSURANCE BASICS 3, http://www.aiadc.org/File%20Library/Resources/Industry%20Resources/Insurance%20101/Ins_101.pdf.

⁵³ *Id.* at 7.

Restatement, and then into the Restatement Draft Discussion, view themselves as visionaries and not bound by the common law method or its principles which has been the backbone of the ALI's Restatement projects over the many past decades.

For example, as mentioned, they introduce new categorizations of rules as either "mandatory" rules—which cannot be changed by contractual agreement⁵⁴—or as "default" rules, controlling unless explicitly changed by contract.⁵⁵ Although a few courts have used these terms, they are not endemic to the common law.⁵⁶ This distinction has become a fashion in the academic world, elaborating a categorization of legal rules initiated many years ago by a dear colleague of mine.⁵⁷ But they are rules befitting of a state-ordered codification, not of the workout of legal decisions in multiple cases decided by separate courts over many years.

This point, however, is merely a prelude to the discussion of the Reporters' normative aims in the Principles project, in the proposed Restatement, and, again, in the Restatement Discussion Draft: to push the law toward more policyholder-friendly rules, regardless of the insurance contract that the parties entered. Section A identifies this normative objective. Sections B, C, and D address the Reporters' substantive proposals dealing with misrepresentation on the part of policyholder; the insurer's duties with respect to defense; and, separately, settlement. As shall be explained, in each of these areas, the Reporters' proposals will have the economic effect of reducing insurance availability in the society.

A. *Initial Considerations: The Approach of the Reporters*

It was evident in the Principles project, but is also evident in the proposed Restatement, and in the Restatement Discussion Draft, that the Reporters are aspiring to move the law so that it puts policyholders in a better position than they are in the insurance contracts that they currently enter. Again, this is a normative ambition of the Reporters and ignores the market circumstances that lead policyholders and insurers to enter the insurance contracts that they do.

⁵⁴ Restatement PD No. 1, *supra* note 4, § 1(9) (manuscript at 2); Discussion Draft, *supra* note 6, § 1(7) (manuscript at 2); *Id.* at cmt. e (manuscript at 7–8).

⁵⁵ Restatement PD No. 1, *supra* note 4, § 1(10) (manuscript at 2); Discussion Draft, *supra* note 6, § 1(8) (manuscript at 2); *Id.* at cmt. e (manuscript at 7–8).

⁵⁶ The Reporters admit this point. See Discussion Draft, *supra* note 6, § 1, cmt. c (manuscript at 6).

⁵⁷ See Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1096–97 (1972). For the modern extrapolation, see the work of another dear colleague, Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87, 91–92 (1989).

The examples in the proposed Restatement and Discussion Draft are replete and appear to derive from the conclusion that policyholders are unable to grasp the complexities of insurance:⁵⁸

[C]urrent practices in the consumer insurance market make it unlikely that a consumer will receive a complete copy of a liability insurance policy before purchase. [No empirical evidence provided.]. It is not assumed or expected that consumers ordinarily read their insurance policies, nor that legal rules can do very much to change consumer behavior in this regard.⁵⁹

[A] court should take into account the sophistication of the insured and the practical reality that ordinary people do not read, and cannot reasonably be expected to read, their insurance policies.⁶⁰

These are examples; the approach suffuses the proposed Restatement and Discussion Draft and appears to motivate the specific rule proposals that I next address.

In succeeding Parts, I discuss the proposed drafts of the Restatement Discussion Draft addressing rules regarding policyholder misrepresentation, and insurers' obligations to defend and, separately, to settle claims: the contents of the currently completed sections of the proposed Restatement and the Discussion Draft. The question with respect to each of these issues is whether these proposed rules are in the long-term interest of policyholders with respect to maximizing the availability of insurance to the society.

B. *Misrepresentation*

The term "misrepresentation" refers to a potential policyholder's attempt to obtain insurance by failing to disclose in an insurance application or a renewal application facts that would either lead an insurer to deny coverage altogether or allow the insurer to put the applicant into a less favorable risk pool.⁶¹

According to current law, a misrepresentation of a material fact by an applicant for insurance voids the insurance contract.⁶² This is also the law

⁵⁸ More sharply in the proposed Restatement than in the Discussion Draft, the Reporters sought to distinguish large commercial policyholders from individual or small commercial policyholders. Although no longer a black letter proposal, there remain many references to this distinction in the Discussion Draft. See e.g., Discussion Draft, *supra* note 6, § 21 cmt. a (manuscript at 154–56); *Id.* at § 7 cmt. f (manuscript at 76–77).

⁵⁹ Restatement PD No. 1, *supra* note 4, § 2 cmt. c (manuscript at 11); Discussion Draft, *supra* note 6, § 2 cmt. d (manuscript at 13–14).

⁶⁰ Restatement PD No. 1, *supra* note 4, § 6 cmt. c (manuscript at 49); Discussion Draft, *supra* note 6, § 6 cmt. c (manuscript at 65).

⁶¹ Restatement PD No. 1, *supra* note 4, § 7 (manuscript at 56).

⁶² Kevin Gatzlaff, et al., *Material Misrepresentations in Insurance Litigation: An Analysis of Insureds' Arguments and Court Decisions*, 34 J. INS. REG. 1, 2 (2015).

regarding other areas of contracts. There are good economic reasons supporting these rules. Parties to contracts need to know the risks they are facing in order to create a contract that maximizes mutual value to them.

With respect to insurance, a potential insurer will want to know whether a teenage son in the applicant's family with access to the car has had zero, three, or six accidents or infractions during the past year or what the driving experience of the family (put aside the son) has been. Similarly, a potential homeowner insurer will want to know what the claims history of the family has been with respect to home losses. A potential life insurer will want to know if the applicant smokes or has a family history of cancer or heart disease.⁶³ These facts are essential for placing potential policyholders into appropriate risk pools. They are also cost effective in terms of maximizing the possibilities of insurance. The potential policyholder is in the best position to know its experiences and the facts of the losses it has suffered in the past.

The misrepresentation rules proposed by the Reporters substantially constrain this effort. In the Restatement, the Reporters proposed limiting the insurer misrepresentation defense to only misrepresentations that were intentionally or recklessly committed.⁶⁴ This proposal would have eliminated for an insurer the defense of misrepresentation where the policyholder can claim that it was "merely" negligent.⁶⁵ This would be a significant change in the law and entirely opposite to the aim of reducing costs to increase insurance availability.

As discussed earlier, the ambition of an insurance contract, as of all other contracts, is to maximize the joint product of the two parties entering the contract. In this light, is there any value in shielding one party to the contract from revealing the risks it poses to the agreement? Misrepresentation defeats the important objective of insurer segregation of risks to increase insurance availability.

In the Discussion Draft, the Reporters have changed this rule to also allow an insurer defense to negligent policyholder misrepresentations.⁶⁶ The Discussion Draft, however, continues to contain many passages suggesting that the insurer defense should only extend to misrepresentations that are intentional or reckless.⁶⁷

The Reporters, even in the Discussion Draft, defend the restriction of the defense to intentional or reckless misrepresentations by arguing that since prospective policyholders are buying insurance to protect themselves from

⁶³ Life insurance is not controlled by this proposed Restatement or Discussion Draft, though the obvious differences in rules relating to these two common insurance areas bring the Reporters' proposals into question.

⁶⁴ Restatement PD No. 1, *supra* note 4, § 7(2)(a) (manuscript at 66).

⁶⁵ *Id.* at § 7, cmt. c (manuscript at 57-58).

⁶⁶ Discussion Draft, *supra* note 6, § 7(2) (manuscript at 73).

⁶⁷ *E.g.*, *id.* at § 7(2)(a) (manuscript at 73); *Id.* at § 7 cmt. a (manuscript at 74); *Id.* at § 7 cmt. g (manuscript at 77); *Id.* at § 7, Reporters' Notes cmt. c (manuscript at 84); *Id.* § 9, cmt. b (manuscript at 113).

negligent behavior in other contexts—auto driving, home ownership—why not expand insurer liabilities to protect these applicants from negligence in the application process?⁶⁸ But this is sophistical, not persuasive. It is a different matter entirely when an insured drifts into a different lane or mistakes the brake for the gas pedal in parking or neglects to trim trees (leading to a branch fall that causes loss) than where an insurance applicant “mistakes” the son’s driving record or the number of claims filed against previous insurers on an application sitting right before him. Ask the IRS whether insurance is available for negligence in our tax returns.

The Reporters further seek to shift insurance responsibility by placing a burden on insurers to investigate the past history of the applicant, rather than relying on the applicant’s representations in an insurance or renewal application.⁶⁹ The ignorance of cost effectiveness is evident in this proposal. How does it add value to a possible insurance contract for an insurer to spend money in investigation, rather than requiring the applicant to fully tell the truth?

The Reporters further add with respect to these proposals, though not unpredictably, that any misrepresentation defense, to void the insurance contract, must be material⁷⁰ and lead to substantial detrimental reliance by the insurer.⁷¹ They propose very strong standards for an insurer to prove materiality and detrimental reliance. These provisions simply add to the shift in responsibility from the insurance applicant to the insurer in determining the risk attributes of the applicant. Even as amended, these rules, if adopted, will have the economic effect of reducing insurance availability to the society by increasing the costs and reducing the predictability of the underwriting process.

C. *The Insurer’s Defense of Claims*

Many policies—most personal policies, some commercial policies—provide for the insurer to possess the right and duty to defend claims against the policyholder or against those insured under the policy. In some situations, there are issues as to whether the claims fall within the coverage agreement of the policy, since all risks cannot be insured and since policyholders do not always acquire insurance to cover all of the risks that they face. In those situations, the insurer may provide the defense, but reserve rights to contest coverage later, as further facts develop. In other situations, an insurer may simply decline to provide the defense, essentially denying coverage of the claim and leaving the policyholder or insured to defend the claim on its own.

⁶⁸ *Id.* at § 7, cmt. j (manuscript at 78–79).

⁶⁹ *Id.* at § 7 cmt. b (manuscript at 75); *Id.* at § 9, cmt. d (manuscript at 115).

⁷⁰ *Id.* at § 8 (manuscript at 98).

⁷¹ *Id.* at § 9 (manuscript at 111).

The coverage issue of course remains litigable, and policyholders can sometimes demonstrate that coverage and defense should have been provided where the insurer denied them. If successful, this constitutes an insurer's breach of the duty to defend.

The Reporters propose extremely punitive rules to govern these cases. Section 19(1) of the Discussion Draft provides that "[a]n insurer that breaches the duty to defend a claim loses the right to assert any control over the defense or settlement of the claim and the right to contest coverage for the claim."⁷² It is not evident as to how many claims some parts of this rule will apply. If the insurer is found to have breached the duty to defend, presumably it has denied its right of defense or association and, consequently, its control over settlement of the claim, though perhaps there are exceptions.⁷³

The most important part of the Reporters' approach, however (including supplemental rules which shall be discussed), is the proposal that, if the insurer has breached the duty to defend, it loses its right to contest coverage of the claim.⁷⁴ The Reporters concede that this is not the majority rule in the states, but claim it is a "better rule":

About half of the states have held that an insurer that breaches the duty to defend does not automatically forfeit its coverage defenses, but a respectable minority has held that it does. The better rule is the minority rule adopted here.⁷⁵

This is a radical rule and violates the principle of increasing insurance availability.⁷⁶ The Reporters do not conceal that the rule is meant to be punitive. The rule is not founded in principle. There may be losses to a policyholder from an insurer's breach to defend a claim, especially litigation costs that an insurer cannot control if it has denied coverage. If there is a breach, as in other contractual contexts, those losses should be recompensed.

But why should the insurer forfeit a coverage defense? Many claims against policyholders involve losses that may be covered by insurance and losses that are not. Does the breach of the duty to defend make the non-insurable (or non-insured) losses insurable? All agree, for example, that the losses from a nuclear attack on the country are non-insurable; that is why all insurance policies include a nuclear loss exclusion. What is the point of limited redistribution after losses of these dimensions? But if a policyholder showed that, just before such an attack, the insurer had breached its duty to

⁷² Discussion Draft, *supra* note 6, at § 19(2) (manuscript at 153–54). According to the Reporters, this is the minority view among courts. *Id.* at § 19 cmt. a (manuscript at 154). See *infra* notes 75–80 and accompanying text.

⁷³ An exception might be if the insurer recants on the denial of defense, though this is not explained in the Restatement or the Discussion Draft.

⁷⁴ Discussion Draft, *supra* note 6, at § 19(1) (manuscript at 153–54).

⁷⁵ *Id.* at § 19 cmt. a (manuscript at 154).

⁷⁶ The Reporters concede this point: "the forfeiture-of-coverage-defense rule may increase the cost of liability insurance." *Id.* at § 21, cmt. a (manuscript at 156).

defend, should it recover from insurers for those losses? Or, more realistically, imagine that a policy includes a standard pollution exclusion, relegating the policyholder, as explained above, to acquire separate pollution coverage. Should the standard policy that excludes pollution coverage have the coverage exclusion banned and the pollution losses added to the non-pollution pool because of the insurer's breach? What happens if the policyholder possessed separate pollution coverage? The proposed Restatement and Discussion Draft do not explain.

The Reporters propose additional subsidiary rules that are equally punitive and will equally have the effect of reducing insurance availability. For example, the Reporters propose that, when an insurer defends a full claim against a policyholder and issues a reservation of rights, but it is later determined that some aspects of losses claimed were not covered under the policy,⁷⁷ the insurer may not recoup any portion of defense costs related to the defense of uninsured loss.⁷⁸

This proposal raises a similar problem. Why should the insurer and consumers placed in the underlying insurance pool be saddled with the costs of defending claims not within the offered insurance? The Reporters acknowledge that this proposal conflicts with other longstanding rules stated in other ALI Restatements, in particular the Restatement of Restitution, which, admirably, and for good economic reasons, assigns costs to those that generate them.⁷⁹ They invoke "special considerations of insurance law" to justify their position, considerations asserted, but not explained, in the current proposed Restatement or in the Discussion Draft.⁸⁰

The Reporters also make a serious attack on "Other Insurance" clauses in insurance policies. There are various versions of "Other Insurance" provisions.⁸¹ Basically, they become important where a policyholder or insured possesses multiple policies that may cover a particular loss. These clauses are often confusing because an insurer in a position of providing coverage to a policyholder, or insureds who have complicated insurance arrangements,⁸² is unlikely to know or be able to adequately contemplate what the other insurance commitments of the policyholder or insureds are. Courts in many cases have worked out these complications.

The Reporters of the proposed Restatement and Discussion Draft do not attempt or provide a solution for working them out and, essentially, reject the common law approach to this issue. The Reporters propose to abrogate

⁷⁷ When some portions of a multifaceted claim fall within the coverage of the policy, it is a general rule that the insurer's duty to defend includes defense against all aspects of the claim.

⁷⁸ Discussion Draft, *supra* note 6, § 21 (manuscript at 178).

⁷⁹ *See id.* at § 21, cmt. b (manuscript at 67). As between the proposed Restatement and the Discussion Draft, the Reporters hedge this point. *See id.* at § 21, cmt. b (manuscript at 67–68); *cf.* Restatement PD No. 1, *supra* note 4, at 153–54..

⁸⁰ Discussion Draft, *supra* note 6, at § 21 cmt. b (manuscript at 68).

⁸¹ *See* Abraham, *supra* note 50, at 679–86.

⁸² These issues are not common in personal insurance lines.

“Other Insurance” clauses and the common law relating to these clauses by proposing a rule of joint and severable liability for all insurers involved in multiple insurance situations.⁸³ They describe, without analysis, Other Insurance provisions as “mutually repugnant”⁸⁴ and as “‘escape’ clauses.”⁸⁵

I accept the fact that Other Insurance clauses are not well understood empirically and have been under-analyzed. But the proposals of the Reporters miss the point. No policyholder, prior to a loss, wishes to pay twice for coverage of a prospective loss. Other Insurance clauses, among other provisions of insurance policies, address this issue. The joint and several liability proposals of the Reporters will require all insurers in a position of potential multiple representation to take all possibilities of loss into account, increasing insurance premiums and reducing the availability of insurance.

D. *Insurers' Duties in the Context of Settlement*

Most claims are settled prior to judgment.⁸⁶ In the context of insurance, the law requires the insurer, who possesses the right and duty to defend these claims, to do so in the best interest of the policyholder, which means in the best interest of both parties to the insurance contract.

Questions arise when an insurer has rejected a settlement demand by a claimant against a policyholder within policy limits, but the resulting judgment after trial exceeds policy limits.⁸⁷ As a general matter, many courts have found in these circumstances that insurers that had not engaged in “reasonable” settlement discussions should be liable for the full amount of the judgment, despite the limits of coverage of the insurers’ policies.⁸⁸

⁸³ Discussion Draft, *supra* note 6, at § 20(4)(b) (manuscript at 167).

⁸⁴ *Id.* at § 20, cmt. a (manuscript at 168).

⁸⁵ *Id.* at § 20, Reporter’s Note, cmt. a (manuscript at 174).

⁸⁶ I have studied this issue with regard to all claims, not simply insurer-defended claims, which could not be separately identified. See George L. Priest, *Private Litigants and the Court Congestion Problem*, 69 B.U. L. REV. 527, 531 (1989).

⁸⁷ Obviously, if the judgment is within policy limits, the insurer pays the full amount.

⁸⁸ See, e.g., *Gen. Accident Fire & Life Assurance Corp. v. Am. Casualty Co.*, 390 So.2d 761, 764 (Fla. 1980) (“The courts have developed an action for bad faith in order to protect insured persons from unnecessary excess judgments resulting from the willingness of insurance companies to risk trials rather than negotiate and settle claims against insured individuals. The insurance company, usually in control of settlement under policy provisions requiring its consent, is obligated to comply with its concomitant duty to exercise reasonable diligence and decide in good faith whether to settle a claim.” (citing *Auto Mut. Indem. Co. v. Shaw*, 184 So. 852 (Fla. 1938)); *Rova Farms Resort, Inc. v. Investors Ins. Co.*, 323 A.2d 495, 507 (N.J. 1974) (“We . . . hold that an insurer, having contractually restricted the independent negotiating power of its insured, has a positive fiduciary duty to take the initiative and attempt to negotiate a settlement within the policy coverage. Any doubt as to the existence of an opportunity to settle within the face amount of the coverage or as to the ability and willingness of the insured to pay any excess required for settlement must be resolved in favor of the insured unless the insurer, by some affirmative evidence, demonstrates there was not only no realistic possibility of settlement within policy limits, but also that the

These cases, however, raise the question as to what are “reasonable” offers by insurers in settlement? If an insurer views the value of the claim as \$10,000, and the claimant demands \$50,000, is the insurer’s refusal to pay the settlement demand “reasonable,” negating the requirement of paying if the judgment proves to be greater than policy limits?

The Reporters address this issue in several ways. First, they propose a formalistic approach to determining settlement reasonableness. They propose a mathematical formula, presumably to be filled in by expert witnesses (who will chiefly be lawyers) to assess the relative probability of the success of the claim. These experts’ probability estimates will define a range of probable success for the claim and whether the insurer’s settlement behavior was reasonable by falling within that range. If the insurer’s settlement offer did not, then the insurer is liable for the full judgment.⁸⁹

One can question whether this evaluation should be delegated to expert witnesses rather than given to a judge or jury. The Reporters correctly acknowledge that there is likely to be a substantial hindsight bias in these probability-of-success estimates since the eventual judgment proved greater than the insurer anticipated prior to trial.⁹⁰

Though this proposal was dropped as between the Principles project, the proposed Restatement, and the Discussion Draft, the Reporters extensively discuss (as to keep the option open) that an insurer’s reasonable settlement offer should include the insurer’s expected litigation costs, which obviously would increase the amount of what a court might view as a “reasonable” offer by an insurer and increase the chances that the insurer would be held in breach of the obligation to settle.⁹¹

The insurer’s expected legal expenses, however, do not increase the value that a claimant is willing to accept to settle a case based on the expected value to the claimant of the verdict.⁹² To include these litigation costs in the formula defining a “reasonable” settlement offer from an insurer would have the effect of increasing the settlement range in favor of claimants, against policyholders and insurers, reducing insurance availability. This proposal, though still entertained by the Reporters, was appropriately deleted as between the Principles project, the Restatement and the Discussion Draft.

As with the Reporters’ discussion of defense obligations, they propose with regard to settlement that an insurer who settles a claim—not simply an insurer who breaches the obligation to settle—should not be able to recoup

insured would not have contributed to whatever settlement figure above that sum might have been available.”).

⁸⁹ Discussion Draft, *supra* note 6, § 24, cmt. a, illus. 1 (manuscript at 93–94); *Id.* at § 24, cmt. f, illus. 2 (manuscript at 97–98); *Id.* at § 24, cmt. j, illus. 6 (manuscript at 103).

⁹⁰ *Id.* at § 24, cmt i (manuscript at 100); *Id.* at § 24, Reporter’s Note, cmt c (manuscript at 107).

⁹¹ Discussion Draft, *supra* note 6, § 14(a) (manuscript at 114).

⁹² I have studied this extensively. See generally *e.g.*, George L. Priest & Benjamin Klein, *The Selection of Disputes for Litigation*, 13 J. LEGAL STUD. 1 (1984).

from the policyholder amounts paid for non-covered portions of the claim.⁹³ To justify this proposition, they again invoke a sophisticated explanation. According to the Reporters, the current practice is not to seek recoupment, so non-recoupment must be efficient.⁹⁴ They admit that this proposal is contrary to the Restatement of Restitution⁹⁵ and that courts are split on the question.⁹⁶ They again invoke “special insurance law reasons”⁹⁷ without explaining what those are. But they admit that, if adopted, the rule “may mean that insurance premiums are somewhat higher than they would be under an alternative, pro-recoupment default rule.”⁹⁸

The Reporters, however, also propose that, in the context of settlement discussions that fail, insurers must bear the burden of all subsequent punitive damages judgments against policyholders or insureds, as well as damages for other losses such as emotional distress and harm to business reputation.⁹⁹ These proposals are controversial (for good economic reasons), and the Reporters concede that they do not have the majority of jurisdictions behind them.¹⁰⁰ Again, without serious analysis, they support the proposition on the simple grounds of protecting policyholders.

There are two serious problems with these proposals. First, most (though not all), insurance policies exclude coverage of punitive damages judgments against policyholders or insureds.¹⁰¹ There are good economic reasons for such an exclusion, especially in personal policies. Punitive damages are typically levied against individuals who have committed willful, malicious, or heinous acts, within the control of the policyholder, not the insurer. Such acts can more effectively be reduced by the policyholder. What is gained by making the insurer—and the inclusive risk pool—liable for the harms caused by such acts, rather than putting the burden on the egregious policyholder? Willful, malicious, or heinous acts are not probabilistic and would not want to be insured against by normal policyholders.

Second, and even more tellingly, many jurisdictions prohibit the insurance of punitive damages on grounds of public policy: offenders should bear the costs of their offensive behavior, not be insulated by being insured for them.¹⁰² The Reporters purport to overturn the laws of these states, again, by invoking the need to protect policyholders.

⁹³ Discussion Draft, *supra* note 6, § 25(2) (manuscript at 119).

⁹⁴ *Id.* at § 15, cmt. a (manuscript at 122–23). The Reporters do not consider the costs of litigation over recoupment relative to the gains in making this (unsupported) empirical assertion.

⁹⁵ *See id.* at § 25, cmt. d (manuscript at 125).

⁹⁶ *See id.* at § 15, Reporter’s Note, cmt. d (manuscript at 128–30).

⁹⁷ *Id.* at § 25, cmt. d (manuscript at 125).

⁹⁸ *Id.* at § 2, cmt. c (manuscript at 123).

⁹⁹ Discussion Draft, *supra* note 6, at § 27, cmts. a–b (manuscript at 137–39).

¹⁰⁰ *Id.* at § 27, cmt. d (manuscript at 143).

¹⁰¹ *See* George L. Priest, *Insurability and Punitive Damages*, 40 ALA. L. REV. 1009, 1011–12 (1989).

¹⁰² *See id.*

Requiring coverage for alleged damages from other foreseeable harms, such as emotional distress, harm to business reputation, among other possible claims, suffers a similar problem.¹⁰³ The Reporters propose that the breach of the contractual duty to settle should be treated as a tort.¹⁰⁴

The acquisition of insurance is a financial or business activity. The breach of a duty to settle a claim, after adjudication or settlement to be fully compensated by the insurer, is a breach of a contract, not a defamation nor a personal injury that causes physical pain and suffering.

I do not need to emphasize the radicalism of these views. My point is simply that the inclusion of punitive damages or damages for alleged losses such as emotional distress will affect the judgments paid by insurers who either have excluded punitive damages coverage or are in jurisdictions that refuse punitive damages coverage on grounds of public policy and will increase insurance payouts which will diminish insurance availability. This is obviously true if punitive damages and damages for other intangible losses are included in judgments or settlements. The Reporters sum up their discussion of insurers' obligations to settle, clearly indicating their insensitivity to expanding insurance availability: "[M]inimization of liability insurance premiums is not the primary objective of the duty to make reasonable settlement decisions."¹⁰⁵

CONCLUSION

Professors Baker and Logue sought in the ALI's Principles project to suggest rules for insurance law that promoted the position of policyholders. The Principles project reflects these ambitions, which I view as entirely admirable as aspirations, though not fully discussed in the academic literature and, to my view, insufficiently attuned to the economics of insurance.

Though the project was transformed into an ALI Restatement, and now, Discussion Draft, the Reporters have continued their efforts, in many instances regardless of the law of the states that often conflicts with their proposals.

In my view, regrettably, the Reporters have not sufficiently considered the economics of the insurance process in formulating their proposed rules. Believing that insurance consists principally of shifting risks, they continue to seek to shift risks in favor of policyholders, despite the market allocation of risks in current insurance contracts.

These efforts, if adopted, will reduce insurance availability generally and, especially, for the low income in the society.

¹⁰³ Discussion Draft, *supra* note 6, at § 27 cmt. a–b (manuscript at 137–39).

¹⁰⁴ *Id.* at § 27, cmt. b (manuscript at 138–39).

¹⁰⁵ *Id.* at § 24, cmt. g (manuscript at 99).

Liability insurance is an extraordinarily important service in our society, indeed in any society. Proposals that diminish insurance availability do not enhance the possibilities of broader activities by members of the society.