The Law & Economics of Insurance

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Insurance concepts routinely play an important role in law and economics scholarship. This is perhaps clearest in the law and economics literature on torts, where insurance principles provide the dominant framework on issues ranging from the desirability of emotional distress damages (Shavell 1987; Avraham 2005) to the appropriate scope of products liability law (Calabresi 1970; Epstein 1985). But insurance ideas also play a prominent role in a broad spectrum of law and economics scholarship on other topics, spanning contract law (Posner and Rosenfield 1977; Shavell 2004), property law (Blume, Rubinfeld, and Shapiro 1984), and financial regulation (Scott 1987; Myerson 2014), to name just a few.

Despite the wide-ranging importance of insurance concepts to law and economics generally, law and economics scholarship specifically addressing insurance law is surprisingly limited. This is particularly true when insurance law is defined to exclude insurance regulation or when law and economics is defined to exclude traditional economics scholarship published outside of legal journals. In the remaining set of legal scholarship focused on court-made insurance law, the scholarly tradition has been principally doctrinal rather than rooted in law and economics, at least outside of a few select areas such as liability insurers’ duty to settle claims against their policyholders.

This chapter therefore takes a broad approach to defining the law and economics of insurance. It provides an overview of both economically-oriented legal scholarship and traditional economics scholarship addressing judicial doctrines of insurance, insurance regulation, and insurance legislation. Aside from defining a deep, but manageable, scope for the Chapter, this broad vantage point offers several interrelated benefits.

First, it reveals the centrality of information asymmetries to insurance law and regulation. Like insurance economics (Rothschild and Stiglitz 1976; Akerlof 1970; Arrow 1963), insurance law and legal scholarship have been substantially influenced by the prospect that insurers may know less about consumers’ riskiness than consumers themselves know. For instance, adverse selection— which focuses on consumers’ private knowledge of their own “fixed-in-advance” riskiness—has been explicitly invoked by roughly 200 federal and state court opinions since 1913 and has had widespread influence on both judicial and regulatory understandings of insurance markets (Siegelman 2004). Concern for adverse selection also lies at the
heart of both the Affordable Care Act’s “individual mandate” as well as state insurance anti-discrimination laws (Avraham, Schwarcz, and Logue 2014). Similarly, over 700 federal and state court opinions since 1868 have explicitly discussed moral hazard, or the prospect that insurance gives consumers less reason to avoid risks in ways that are unobservable to insurers.

Insurance law is also deeply influenced by information asymmetries that, in contrast to adverse selection and moral hazard, favor insurers over policyholders. Such information asymmetries may be common with respect to various features of the insurance relationship, including insurance policy terms and conditions, insurers’ financial strength, and the appropriate matching of policies and consumers. In some cases, insurers may be able to exploit these deficits in policyholder information or sophistication by providing more limited coverage than policyholders believe they are purchasing, or by adopting excessively aggressive claims-handling strategies. A core goal of insurance law is to respond to these types of consumer protection concerns.

The chapter’s broad vantage point also provides a second benefit: it suggests ways in which the law might be improved by embracing more sophisticated understandings of the economics of information asymmetries. For instance, in many cases, insurance law and regulation assume that adverse selection and moral hazard are important problems in all insurance markets, even though both phenomena come in varying degrees, so that their magnitude is an empirical question (Cohen and Siegelman 2010).² An equally significant lacuna in much insurance law is the absence of an equilibrium approach that anticipates insurance market reactions to legal interventions. Similarly, courts, regulators, and legal scholars are only beginning to assimilate the specific insights of behavioral economics to understand anomalies in insurance demand and how the law might respond.

All of this indicates that the law and economics of insurance is still ripe for development. By weaving together the insights of traditional economics scholarship and economically-sophisticated legal scholarship on a broad range of insurance law topics, this Chapter attempts to jumpstart this development.

I. Insurance Regulation

The business of insurance is subject to extensive ex ante regulation in virtually all developed countries. From an economic perspective, the desirability of such regulation depends, first, on the existence of market failures and, second, on the possibility that regulatory policies can effectively and efficiently counteract them. As to the former, while insurance markets are well known for potential market-failures, the magnitudes and potential social welfare consequences of such

²To be fair, the empirical economics of insurance has lagged far behind the theory, perhaps because insurance data are largely proprietary, making it difficult for researchers to test theoretical predictions.
failures are highly variable. Similarly, the potential for ex ante regulation to efficiently and effectively correct substantial market failures is itself context-dependent. This Section explores these broad themes in four areas of ex ante insurance regulation: (i) solvency regulation, (ii) consumer protection regulation, (iii) anti-discrimination laws, and (iv) government nudges to improve consumer decision-making.

A. Solvency Regulation

There are multiple market failures that might justify insurance solvency regulation. Perhaps the most compelling is a principal-agent problem involving policyholders and insurers. Insurance is distinctive because it operates on an inverted production cycle: policyholders pay premiums in exchange for future, contingent, promises of payment. For this reason, insurers can, and almost always do, rely principally on policyholders to finance their operations. Unlike traditional firms, insurers generally maintain only limited debt and, in the case of mutual companies, they do not even have shareholders (Jaffee and Russell 1997).

Policyholders face substantial difficulties, relative to either creditors or shareholders, in monitoring insurance managers so as to safeguard their interests (Plantin and Rochet 2007; Weber 2011). Policyholders are generally quite dispersed: no single policyholder is likely to provide more than a very small fraction of the premiums collected by a particular insurer. Policyholders also tend to have limited interest or expertise in the details of their carriers’ ongoing operations and strategies because they think of themselves as having purchased a product from the company rather than having “invested” in it. Finally, most policyholders (unlike shareholders) have no “voice” in how their insurer operates and often have few exit opportunities as well. Thin or non-existent secondary markets for their interests and contractual limitations on their ability to terminate policies without forfeiting a substantial sum or a pre-purchased benefit make it very difficult for policyholders to switch if they are dissatisfied with their current insurer.3

These features of insurance financing mean that all insurance—and particularly insurance that is long-term, such as life, annuities, long-term care, disability, and long-tail liability—is subject to potentially substantial principal-agent problems. In particular, insurance managers may have incentives to pursue excessively risky strategies from the standpoint of policyholders. Managers may enjoy various benefits from increasing the short-term profitability of the companies they operate, particularly if the company is a stock company. By contrast, policyholders are generally exposed only to the downside of such risk-taking.4

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3 As an example of the latter, consider a level premium term life insurance policy. In essence, policyholders over-pay in initial years so that they can under-pay for the same coverage in later years, when their risk of dying increases. Although a policyholder could stop paying premiums in response to financial troubles at the company, he or she would thereby forfeit the pre-purchased benefit.

4 Unless their policies include potential dividends, as with some life policies.
divergence of interests between managers and policyholders may become particularly acute for carriers that are facing financial difficulties: in these instances, managers have incentives to adopt very risky strategies to stave off the threat of losing their jobs, whereas policyholders have strong interests in avoiding risk because they will principally bear the costs of insolvency (Bohn and Hall 1998).

In addition to this corporate governance justification, solvency regulation can also be justified (in many, though not all, markets) on the basis of more straightforward consumer protection analysis. To the extent that policyholders undervalue insurers’ financial strength at the time of purchase, insurers may have insufficient incentives to avoid risky, but profitable, investment strategies. Some policyholders may indeed have limited information about insurers’ financial strength at the time of purchase, though this problem is mitigated by the availability of financial strength ratings from private rating agencies. Perhaps more convincingly, many policyholders may unduly discount the prospect that their chosen insurer may experience financial trouble. Alternatively, insurance consumers may fail to appreciate the adverse consequences that they could experience if their insurer’s financial strength were compromised.

A different – and increasingly important – justification for insurance solvency regulation may be that it is necessary to limit systemic risks, which are a form of negative externality. Prior to 2008, conventional wisdom in regulatory and policy circles was that, unlike banking, the insurance industry posed no meaningful risk to broader financial stability in the economy. But the prominent role of American International Group and financial guarantee insurers in the crisis, as well as the temporary but substantial capital deterioration of many life insurers in 2008–2009, poses a challenge to this view (Harrington 2009). Systemic risk in insurance is clearest in the case of insurance companies that engage in many of the same types of financial transactions as banks, such as writing credit default swaps and providing financial guarantee insurance (Cummins and Weiss 2014). But the risk may be broader, given insurers’ extensive involvement in various financial markets and their constantly-evolving product designs and investment strategies (Schwarcz and Schwarcz 2014).

In response to these risks, insurers are subject to an extensive array of solvency regulations. These rules govern how much insurers must set aside in reserves to pay future claims, the character of their risk-management practices, and the permissibility of major transactions that may implicate the company’s financial health. They provide regulators with the authority to take over financially troubled insurers and, in some countries, protect policyholders from insolvency through guaranty funds (Klein 2009). Perhaps most importantly, they dictate the amount of

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Yet another potential justification for solvency regulation is that it is necessary precisely because market discipline is blunted by the existence of guarantee funds that protect policyholder funds even when their insurer becomes insolvent. Of course, this explanation begs the question why guarantee funds are necessary which, in turn, tends to revert back to the justifications discussed in the text.
capital—which consists roughly of assets minus liabilities—that insurers must hold on their balance sheets. Larger amounts of regulatory capital increase the size of losses that must be borne by the company's owners before policyholders are impacted. For that reason, they also encourage insurers to operate more conservatively, an effect that, in many respects, resembles a deductible on an insurance policy.

Substantial scholarly attention has assessed the efficiency and effectiveness of the US's Risk-Based Capital (RBC) rules, which seek to calibrate insurers' capital requirements to their overall risk level (Brown and Klein (2015) survey the literature.) To do so, these rules rely on a complex set of formulas that attempt to measure a carrier's exposure to various types of risks, such as a decrease in asset values or an increase in insured losses. Cummins, Harrington, and Klein (1995), find that the RBC formula for property-casualty companies does a poor job of predicting insurance company failures. They propose several modifications, including changing the weight of various factors within the formula and including the organizational form of the insurer (mutual or stock) as well as firm size. While echoing some of these criticisms, Harrington (2005) suggests that the best solution may be simpler and less stringent capital rules for insurers. Still others, such as Holzmuller (2009) and Cummins and Phillips (2009), have argued that capital requirements should move beyond formula-based approaches to calculating capital and embrace more advanced risk-management techniques, such as stochastic modeling. Some commentators, such as Myerson (2014), note that risk-based capital can increase systemic risk by concentrating assets in categories that might not turn out to be safe (for instance, sovereign debt of EU member governments).

Recently, insurers' capital requirements have come under renewed scrutiny because of requirements in the Dodd-Frank Wall Street Reform and Consumer Protection Act that the Federal Reserve impose consolidated capital requirements on insurance companies that are designated as systemically important or that own federally-insured depository institutions. There are numerous different ways to implement a consolidated capital requirement, but its key feature is that it applies across the various legal entities within a firm. The appropriateness of such capital

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6Eling and Holzmuller (2008) provide a good overview of alternative approaches to risk-based capital requirements used in other parts of the world.

7Myerson's analysis applies equally to banks and to insurance companies.


9The Federal Reserve recently released an Advance Notice of Proposed Rule-Making that outlined two approaches to developing a consolidated capital standard. The first, which it labeled a building-block approach, would simply aggregate capital requirements and resources across different legal entities. The second would instead focus on a consolidated balance sheet for the entire enterprise, an approach that would be insensitive to where any particular assets or liabilities were located within the entire consolidated enterprise. The Notice suggested that the building block approach would be more appropriate for non-systemically significant entities,
requirements is a matter of substantial debate in regulatory and policy circles, though scholarly analysis of the issue is currently limited.\(^\text{10}\)

An important set of recent papers has focused attention on the risks associated with insurers’ liabilities, which primarily consist of reserves set aside to pay future claims. Kojien and Yogo (2013) find that many U.S. regulated life insurers have reinsured a substantial percentage of their business with affiliated, “unauthorized” reinsurance companies, which are subject to much looser regulatory rules than those governing the ceding insurer. Schwarcz (2015) describes how these types of shadow insurance transactions create four distinct types of risks: (i) the risk that captive reinsurers will default on their obligations to the underlying insurers; (ii) the prospect that an insurer will no longer be allowed to receive favorable accounting treatment for shadow insurance transactions; (iii) the risk that a single financial shock will similarly affect multiple individual companies within a broader financial conglomerate, and (iv) risks arising from increased linkages between the insurance and banking sectors. State regulatory rules governing insurers’ reserve levels can not only generate regulatory arbitrage, but can also distort insurers’ market behavior. Kojien and Yogo (2014a) find that these rules caused many insurers to sell life insurance and annuities to the public at huge economic losses in the midst of the financial crisis in order to generate accounting profits. In a policy-focused summary of their work, Kojien and Yogo suggest that these findings indicate that a market-based approach to valuing insurers’ liabilities may reduce the costs of financial regulation while providing a more transparent accounting of insurers’ long-term obligations (Kojien and Yogo 2014b).

\textbf{B. Consumer Protection Regulation}

Much state insurance regulation consists of consumer protection rules: licensing requirements for insurers and agents; content and rate rules for insurance products; prohibitions against unfair or misleading underwriting, claims-paying and advertising; regulator-operated complaint hotlines; and disclosure rules. These consumer protections are usually grounded in two potential failures in insurance markets.

The first involves policyholders’ limited information regarding the character and quality of the insurance they purchase. Depending on the type of coverage and policyholders at issue, insurers may have better information than policyholders regarding the generosity of the insurance contract, its appropriateness for the purchasing policyholder, and the insurer’s claims paying practices. The potential prevalence of these asymmetries reflects the fact that insurance is a classic

\(^{10}\) For discussion of the importance of consolidated capital rules in insurance generally, see Schwarcz (2015).
“credence good,” in that its true value is often difficult for policyholders to assess even after purchase (Darby and Karni 1973). This is for several reasons. First, the insurance product itself is a complicated legal document whose implications are not always clear even to experts. (Abraham 1986). Second, by design, most policyholders rarely or never use the coverage they purchase (particularly for low-probability, high-cost events), so that they have a limited store of experience with how that policy operates in practice. Third, reputation may provide weak or inconsistent information to insurance policyholders because of the context-specific nature of coverage disputes or mismatches between insurance products and consumer needs (Schwarcz 2007).

A second potential market failure in insurance that may justify consumer protection regulations involves systematic and pervasive behavioral biases among policyholders. The character and magnitude of these biases varies greatly among types of coverage and policyholders. As described more extensively below, individuals are subject to various well-established heuristics and biases when it comes to making insurance decisions. These biases may justify regulatory intervention because market forces can otherwise compel firms to exploit biases in ways that decrease social welfare (Bar-Gill 2012). For instance, insurers may offer limited coverage for non-salient risks while providing coverage for salient risks that are sufficiently low magnitude that insurance makes little sense. (As we suggest below, however, the equilibrium effects of behavioral biases in markets with informational asymmetries are far from straightforward.)

Because these two rationales for regulatory intervention depend so substantially on the nature of the insurance purchaser, the stringency or applicability of consumer protection rules often corresponds to the purchaser’s presumed characteristics and the type of coverage at issue. For instance, policy forms are generally more substantially regulated in life, annuities, homeowners and automobile insurance markets than they are in commercial property/casualty markets (Butler 2002). Similarly, rate regulation is much more prevalent in personal coverage lines than commercial lines (Tennyson 2007). One interesting, and arguably troubling, inversion of this pattern involves the legal duties of insurance intermediaries: intermediaries serving commercial clientele often are deemed to owe greater loyalty and obligations to their clients than are those who operate in personal lines markets, where consumers are presumably in greater need of expert assistance (Schwarcz 2008; Schwarcz and Siegelman 2015).

The effectiveness of consumer protection regulation in insurance varies across fields and jurisdictions. The most widely studied consumer protection tool is rating restrictions that are designed to prevent insurers from charging excessive prices. Not surprisingly, economic studies have shown that this form of rate review can have substantial unintended negative consequences, such as intensifying rate volatility and discouraging carriers from decreasing their rates (Tennyson 2007). There is even evidence that this form of regulation does not, in fact, result in the reduction of rates over the long run (Harrington 2002). Some studies, however,
indicate that rate review can be effective when it is appropriately implemented, pointing to California’s apparently successful regulatory regime as an example (Jaffee and Russell 2002; Rosenfield 1998).

Literature on the effectiveness of other insurance consumer protection strategies is generally quite thin. One recent study found that the content of homeowners insurance policies varies substantially across insurance companies in ways that were deeply opaque to consumers (Schwarcz 2011). Moreover, most of the deviations from the standard-industry form tended to reduce coverage for consumers. These results suggest that insurance regulation as well as the insurance industry itself have generally done a poor job of making coverage differences across carriers transparent to consumers or market intermediaries, a trend that Schwarck argues elsewhere extends to other consumer protection issues, such as differentials in claims-handling quality, the availability and limits of guaranty fund protection, and the availability and affordability of coverage for traditionally underserved populations (Schwarcz 2014). These results are broadly in keeping with the regulatory capture literature which suggests that regulations initially designed to help consumers may end up being used by sellers to restrict competition and increase profits (Carpenter and Moss 2013). The underlying logic is that consumers are a diffuse group with little incentive to acquire the knowledge needed to monitor regulators, while producers are much more highly invested in manipulating policy in their favor.

A small literature also examines the need for regulations designed to protect policyholders from biased or incompetent advice from insurance intermediaries (for a recent survey, see Schwarck and Siegelman (2015.)). Several papers offer competing predictions about this risk, with much depending on the sophistication of policyholders as well as various institutional and behavioral details (Cummins and Doherty 2006; Gravelle 1994; Schwarck 2007, 2008). Meanwhile, empirical evidence about the quality of insurance intermediary advice is limited, but provides some reason to believe that biased and incorrect advice is not uncommon, especially in consumer-oriented markets (Eckardt 2007; Anagol, Cole, and Sarkar 2012; Browne, Knoller, and Richter 2012; Brown and Minor 2012). Virtually none of this literature, however, examines the potential effectiveness of ex ante regulation in addressing the risk of biased or misleading agent advice. One exception, Lex, Richter, and Tennyson (2014), provides reason to be skeptical that insurance agent licensing standards are an effective means for ensuring quality. They find that new licensing rules for insurance agents in Germany substantially reduced the total number of agents, but did not produce any meaningful difference in rates of policy cancellation between the customers of agents who dropped out of the market and those who did not, which they use as a proxy for the quality of agents’ advice.

C. Insurance Anti-Discrimination Laws

A broad range of insurance laws and regulations attempt to restrict insurers’ ability to discriminate among policyholders in underwriting or rating. Such laws
limit insurers’ consideration of policyholder characteristics such as race, gender, health status, genetic information, and credit information, to name a few. From an economic perspective, these restrictions on “discrimination” create the prospect of “regulatory adverse selection,” as they may increase the cost of insurance for observably low-risk policyholders, who may consequently opt for more limited coverage or for no coverage at all (Hoy 2006; Hoy and Ruse 2005). The risk of such regulatory adverse selection actually transpiring depends on numerous factors, including the size and risk levels of the population with the “high-risk” characteristic whose use is prohibited, the elasticity of demand among the population of “low-risk” policyholders, and the ability of high-risk policyholders to purchase large sums of insurance (Avraham, Schwarcz, and Logue 2014).

Despite their costs, insurance anti-discrimination laws can be justified on the basis of economic considerations, in addition to the more abstract fairness based concerns that are often cited in the legal literature. Perhaps most importantly, risk classification restrictions are a potentially important response to market failures that prevent insurers from offering coverage against “classification risk,” or the prospect that an individual will become high-risk in the future, and thus unable to obtain insurance at reasonable rates (Abraham and Chiappori 2015). Commentators disagree about the ability of markets to supply such classification risk coverage (Cochrane 1995; Crocker and Snow 2000; Abraham and Chiappori 2015). Although this type of coverage is broadly available in life insurance, it is generally unavailable in other contexts, such as health and property insurance. In the extreme, where a policyholder’s high-risk status exists prior to birth—as in the case for various genetic disorders—market solutions seem virtually impossible. Risk-classification restrictions can also potentially be justified on other efficiency grounds: insurers’ classification practices may deter private acquisition of valuable information (as in the case of genetic information) or may result in costly efforts to classify policyholders into different risk pools that result only in the reallocation of policyholders among carriers rather than real changes in the overall insured population (as potentially may be the case in health insurance) (Avraham, Schwarcz, and Logue 2014).

Given these competing costs and benefits to risk-classification restrictions, their efficiency will often depend on various context-specific factors. But such laws can be paired with complementary strategies that attempt to limit their primary cost: the risk of adverse selection. Perhaps most notably, regulations can pair insurer-side anti-discrimination restrictions with a mandate that customers purchase insurance (and a penalty for failing to do so). This strategy, of course, is employed by the Affordable Care Act to offset the risk of adverse selection that might result from its prohibitions on discrimination based on health characteristics and gender, and its limitations on age-based discrimination. Similarly, laws may pair anti-discrimination rules with minimum-coverage requirements for insurance policies, so as to limit the ability of insurers to indirectly classify risks by offering less generous coverage options that are specifically designed to attract low-risk
policyholders (a practice known as “cream-skimming”). This strategy, as well, is a centerpiece of the Affordable Care Act.

D. Nudging Towards Better Insurance Equilibria

As noted above,11 there has been a long scholarly tradition describing the failures of insurance consumers to act rationally (i.e., in accordance with the canonical Expected Utility model of choice under uncertainty).12 By now, the evidence for behavioral anomalies in insurance can be fairly characterized as overwhelming. Framing effects, loss-aversion, availability bias, affective clouding and a large and growing catalog of other behavioral frailties have been demonstrated in both experimental and real-world insurance purchases. (Kunreuther, Pauly, and McMorrow (2013) survey the experimental results). For instance, consumers routinely buy insurance they should rationally avoid, such as bicycle theft coverage (Browne, Knoller, Richter 2012), homeowner policies with low deductibles (Sydnor 2010), and extended warranties on relatively inexpensive consumer durables (Baker and Siegelman 2014). Simultaneously, consumers avoid or under-consume insurance they should rationally want, such as flood or life insurance (Kunreuther, Pauly, and McMorrow 2013; Cutler and Zeckhauser 2004; Logue 2001). Consumers’ insurance purchases are significantly clouded by “affective” or emotional considerations that have no place in the economic theory of insurance demand (Hsee and Kunreuther 2000).

These findings have begun to generate concrete policy applications, although scholars have predictably been ahead of regulators in this respect. For example, Baker and Siegelman (2010) suggest that many young people are overly optimistic about their chances of getting sick, which reduces their demand for health insurance. They propose to encourage this group to buy health insurance by bundling it with a “prize” that they could collect if they didn’t “need” to use the insurance (i.e., if they remained healthy). Kunreuther and Pauly (2013) note that consumers tend to have myopic perceptions of risk: they are willing to take out flood insurance just after a major flood occurs, but they let it lapse if they do not experience a flood for a few years. To overcome this problem, they suggest requiring that sellers move from single-year coverage to policies with a much longer time-horizon, making lapses less likely. The UK Office of Fair Trade (discussed in Baker & Siegelman (2014, 53)) relied on behavioral economics to design regulations controlling the over-selling of extended warranties—small-scale insurance policies—on consumer durables.

11 See Part I.B, supra.
12 For an introduction to the classic model of insurance demand, see Eeckhoudt, Gollier, and Schlesinger (2005). Eisner and Strotz (1961) is an early applied theory paper exploring the irrational purchase of flight insurance. Kunreuther (1978) and his co-authors (Johnson et al. 1993) pioneered the experimental and theoretical analysis of behavioral anomalies in insurance demand; see Kunreuther, Pauly & McMorrow (2013) for a book-length treatment of these issues. Cutler and Zeckhauser (2004) is another important reference.
While behavioral insights are beginning to find their way into insurance regulation, they have thus far made less explicit inroads into judge-made law: there are only three federal or state cases that use both “behavioral economics” and “insurance,” and none of these are actually insurance cases. But given the strong empirical support for irrational behavior in insurance demand, it may only be a matter of time before judges and regulators begin to take more explicit account of consumers’ behavioral frailties.

Ultimately, however, insurance law will need to do more than merely try to correct for consumers’ deviations from rational behavior. It will need to expressly consider how insurance markets equilibrate in the presence of behavioral anomalies. Otherwise, well-intended efforts to correct irrational behavior may turn out to be welfare-reducing. Consider one relatively straightforward example. Handel (2013) examines “inertia” in individuals’ choice of employer-provided health insurance plans and finds strong evidence that people tend to stick with a given plan, even when other offerings are clearly better for them. Such irrational inertia obviously leads to individual welfare losses, and one might be tempted to conclude that policy should strive to reduce choice-stickiness, for example, by educating consumers about the menu of choices they face. But the upside of inertia is that it reduces adverse selection, precisely because it retards consumers’ tendency to utilize any informational advantage in choosing the insurance plan that is best for them. A welfare analysis thus needs to combine both inertia and adverse selection. That, in turn, requires a model of how insurers would react to the increased selection pressures that result from reducing consumer inertia. For example, Handel (2013) concludes that an intervention that “reduces inertia by three-quarters . . . improves consumer choices conditional on prices, but . . . also exacerbates adverse selection, leading to a 7.7% reduction in welfare” (emph. added). In this case, at least, the upshot is that regulatory intervention to improve consumer choice may actually decrease consumer welfare.

II. Insurance Law in the Courts

Courts play a fundamental role in most insurance markets. Many types of insurance policies—including property, casualty, health, disability, and long-term care—often raise difficult issues about what they actually cover because they turn on the application of broad policy language to facts about a specific loss. Liability insurance presents special coverage and coverage-related issues for courts because of its fundamental role in funding the litigation system in the United States and providing compensation for injured plaintiffs. Additionally, courts often play an important ex post regulatory role on insurance issues ranging from misleading or abusive sales tactics to unreasonable claims handling to unfair discrimination. In all

13 It is for precisely this reason that the American Law Institute has been developing a Restatement of Liability Insurance, a project that is ongoing as of 2016. For one very good, law-and-economics oriented, overview of some of the key issues in the project, see Geistfeld (2015).
of these cases, economic principles can, and often do, help to influence the role of courts in insurance markets. This Section describes the role of courts in insurance law and regulation through four parts: (1) insurance policy interpretation and regulation, (2) bad faith, (3) the duty to defend, and (4) the duty to settle.

A. Insurance Policy Interpretation and Ex Post Policy Regulation

Courts routinely resolve disputes regarding the proper application of policy language to a particular loss. Economic principles can play an important role in these cases because they often help illuminate the intended purpose of contested policy language. For instance, courts frequently invoke a concern for moral hazard to justify pro-insurer readings of exclusionary clauses. Thus, in In W. Bend Mut. Ins. Co. v. Arbor Homes LLC,14 a contractor whose obvious fault caused an injury to its customer was denied coverage because it settled with the customer before obtaining consent from its insurer. The court noted that the contractor behaved honorably, but that policy language excluding coverage for “Voluntary Payments” made to a plaintiff without the insurer’s consent was necessary, among other things, to prevent moral hazard. Similarly, in Amerisure Ins. Co. v. Nat’l Sur. Corp.,15 the court read a “Cross Liability” exclusion to deny coverage for a suit between two parties covered by the same insurance. “Without the Exclusion,” the court suggested, “parties insured under the same policy would have no disincentive to sue one another...[which] sets up what is known to economists as a moral hazard, because the party taking the risk will not bear the costs of its behavior.”

Although moral hazard explanations of coverage exclusions often play a central role in coverage disputes, courts may be too quick to invoke moral hazard Justifications. Just because a policy exclusion might help to address a moral hazard concern does not mean that it in fact does so. The prospect of moral hazard itself depends, among other things, on the extent to which money compensates for a covered loss and individuals are in control of loss-producing behavior (Baker 1997). And even when moral hazard is a concern, policy exclusions will only limit this risk (rather than shifting it to policyholders) to the extent that policyholders are informed about the coverage exclusion (Schwarcz 2011).

Concern for adverse selection has had a similar influence on judicial decisions. Courts have invoked adverse selection in a variety of areas, from employer-provided health insurance to antitrust law to the coverage of mental illness in health insurance policies (Siegelman 2004). For example, during the mid 1980’s Blue Cross of Rhode Island began to worry that it would lose younger, healthier customers to HMOs, which offered more comprehensive preventive health plans, leaving it with an older, frailer and more costly pool of insureds. It therefore implemented a series of changes in its contracts, giving employers an incentive not to offer their workers an HMO that would compete with Blue Cross’ plan. This so-

14 703 F.3d 1092,1096 (7th Cir. 2013).
15 695 F.3d 632, 635 (7th Cir. 2012)
called “adverse selection program” raised serious antitrust concerns, but the court nevertheless upheld it because of a fear that adverse selection might otherwise destroy the health care market altogether. As with moral hazard, however, law often embraces the overly simplistic notion that all insurance markets are equally susceptible to adverse selection. In fact, empirical research has increasingly demonstrated that adverse selection is a highly-context specific phenomenon whose actual impact on insurance markets is quite variable (Cohen and Siegelman 2010).

Focusing courts on the intended purpose of policy language—whether or not that purpose is couched in insurance economics terms—does encourage them to adopt an ex ante perspective in their interpretations of that language. This approach is particularly important in coverage disputes, which generally pit sympathetic policyholders against an insurance company resisting coverage. To concretize this point, Ronen Avraham suggests that judges facing insurance coverage disputes should explicitly evaluate total social welfare on two hypothetical islands, each one of which adopts a different interpretation of contested policy language (Avraham 2012). This approach can help judges implement an ex ante perspective by forcing them to think through the impact that their determinations may have on insurance market rates, coverage options, and insurance uptake.

Law and economics also helps illuminate several distinctive principles of insurance contract interpretation. The most important generally-applicable interpretive principle in insurance is contra proferentem, which requires that ambiguities in insurance policies should be interpreted against the drafter (Abraham 1996). This rule can be justified as a classic penalty default rule: it fills gaps in contracts with a default that is less favorable to the more informed party (Ayres and Gertner 1989). This, in turn, should have the effect of inducing the more informed party (i.e. the insurer) to fill the gap with its desired term and thereby convey information to the less informed party (Boardman 2013). The ambiguity rule can also be defended on the more general basis that, by favoring policyholders in cases of doubt, it helps to offset some of the potential inefficiencies that may result from policyholders’ lack of understanding of policy terms (Keeton and Widiss 1989). Both rationales for the rule, of course, mirror the general justification for the ex ante regulation of insurance policy forms described above.

Several commentators have criticized the efficiency of the contra proferentem doctrine. Boardman, for instance, has argued that the doctrine ultimately exacerbates consumer ignorance of coverage terms. The very act of finding a clause ambiguous, she argues, tends to lock in unclear policy language by providing it with a fixed meaning that insurers can price. Consequently, insurers often retain policy language that courts have previously deemed ambiguous, precisely because that determination sets insurers’ coverage responsibilities going forward, even though the language remains ambiguous to uninformed consumers (Boardman 2006). Rappaport (1995) argues that the doctrine fosters uncertainty in insurance markets.

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and results in costly insurer redrafting of ambiguous language, thus making insurance policy language even more opaque to ordinary policyholders. He also argues that the rule is ill-suited to address information asymmetries between insurers and policyholders because it targets ambiguities, rather than presumptively inefficient terms.

These criticisms of contra proferentem raise larger questions of whether courts, rather than legislatures and regulators, are best situated to improve transparency in insurance markets. In theory, regulators and legislatures have numerous advantages over courts in advancing this objective: they have more expertise in both insurance and consumer literacy, they can observe company responses to rules over time and adjust accordingly, they receive feedback from policyholders routinely, and they can test different strategies to determine their effectiveness. Despite these advantages, US insurance regulators devote relatively limited attention to improving policyholder comprehension of coverage terms, with most states having sparse, and generally ineffective, disclosure and transparency rules about the scope of coverage (Schwarcz 2014). Of course, some have argued that such disclosure-based approaches to improving consumer information in regulated markets are bound to fail (Ben-Shahar and Schneider 2014). But others express more faith in such strategies to make meaningful inroads when they are appropriately designed (Bar-Gill 2012; Craswell 2013).

The reasonable expectations doctrine is another generally-applicable principle of insurance that has been the subject of economically-oriented critique. Although the doctrine has several versions, in its classical form—which has been explicitly adopted by only a small number of courts—it provides that policyholders are entitled to coverage consistent with their objectively reasonable expectations, notwithstanding policy language suggesting otherwise (Keeton 1970). Unlike the ambiguity rule, the reasonable expectations rule thus creates the possibility that courts could refuse to enforce clear policy language.

The primary economic justification for the reasonable expectations doctrine is that insurers may draft inefficiently restrictive policy terms. Rational consumers would respond to such coverage restrictions by reducing their willingness to pay for the insurance, which is of course worth less the more restrictive it is. But given the various informational and cognitive limitations of policyholders described above, insurers might be able to restrict coverage without having to decrease price enough to compensate policyholders for more limited coverage.¹⁷ In this sense, the rationale for the doctrine is simply a specific application of the broader literature on the efficiency (or lack thereof) of standard form contracts (Schwartz and Wilde 1979; Korobkin 2003; Bar-Gill, 2012). Consistent with this rationale, the doctrine

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¹⁷ Whether this is possible in a competitive equilibrium is not clear as a theoretical matter. Game-theoretic models (e.g., Gabaix and Laibson 2006) suggest that if some consumers lack foresight, competition will not eliminate these problems.
generally is not applicable in cases involving sophisticated policyholders (Stempel 1993).

Even if insurance contract language is inefficiently restrictive in some markets, however, scholars have expressed mixed views regarding the capacity of a robust reasonable expectations doctrine to efficiently counteract this market failure. Abraham, for instance, argues that the reasonable expectations doctrine opens the door for “judge-made” insurance, which will tend to undermine the efficiency of insurance markets by supplanting the cost-benefit calculations of insurers with the inexpert ex post decisions of judges (Abraham 1986). Others have emphasized that the doctrine is too unpredictable and unmoored to presumptive efficiency failures to serve as an effective tool against inefficiently restrictive coverage (Schwarcz 2007). As an alternative, Schwarcz (2007) suggested a products liability framework that would hold insurers liable for failing to “warn” consumers of specific coverage issues and employ explicit cost/benefit analysis to determine whether particular policy terms are “defective.” By contrast, in the context of health insurance, Korobkin (1999) has argued that legislatures are institutionally better situated than courts to solve market failures that may produce inefficiently restrictive policies, but that expert administrative bodies may be an even better option for determining optimal benefit mandates.

The pseudo-regulatory nature of the reasonable expectations doctrine raises the broader question of whether courts, rather than regulators and legislatures, should be regulating the content of insurance policies. Several prominent commentators, including Abraham (1999) and Baker and Logue (2015), have suggested that regulators are better situated than courts to regulate policy language. Indeed, many of the classic advantages of regulators over courts—particularly their expertise and capacity to monitor over time—are important in the context of regulating policy terms. Additionally, such regulation inevitably involves making tradeoffs that are inherently political. This may favor regulators, who are more democratically accountable than courts, since insurance commissioners are either directly elected or appointed by the state’s governor.

At the same time, one important institutional advantage that courts have over regulators is that they actually observe the ways in which insurance policy language is applied in specific cases (Schwarcz 2007). Policy language that may seem relatively unobjectionable when evaluated in isolation can conceivably present substantial concerns when applied in specific cases. Consider the “absolute pollution exclusion,” which broadly limits insurers’ exposure to liability involving the release of pollution, even if the release is “sudden and accidental.” In isolation, this exclusion seems eminently reasonable, at least in part because pollution liability is subject to substantial adverse selection concerns—firms with private knowledge of their potential pollution liability would be able to insure against such liability at rates that do not reflect their higher-than-average risk. However, insurers have occasionally invoked the broad language of these clauses to deny coverage in situations that do not involve paradigmatic pollution or the risk of adverse selection.
In one case an insured’s employees accidentally spilled ammonia from a blueprint machine in the course of moving equipment. In another case, a construction worker applied a sealant to a warehouse floor that immediately contaminated the food stored in the building. Courts, rather than regulators, are better situated to observe such over-reach and to limit the scope of exclusionary language accordingly. Additionally, courts may be less subject to regulatory capture than state regulators precisely because they are less political actors.

Law and economics also provides helpful guidance on the general question of which insurance law doctrines or policy terms should be immutable, and which parties should be able to contract-around. In the first comprehensive treatment of this question, Baker and Logue (2015) suggest a straight-forward efficiency-based answer: courts should draw this line such that the mutability of a particular insurance law principle and the justification for that principle are consistent. Applying this perspective, courts would, for instance, refuse to enforce insurance policy terms that attempted to disclaim the reasonable expectations doctrine. Because that doctrine is itself premised on information asymmetries between insurers and policyholders, it would make little sense to credit insurers’ attempts to disclaim this rule. By contrast, Baker and Logue suggest that virtually all rules in insurance law should be default rules in the case of sophisticated policyholders, at least when the underlying rationale for the rule is based on information asymmetries or similar consumer-oriented rationales.

B. Bad Faith

In many settings, insurers have an incentive to be too aggressive in denying legitimate claims or delaying claims payment. As with solvency risk, this prospect stems from the inverted production cycle of insurance, whereby the policyholder first pays premiums and the insurer then performs by paying a claim if, and only if, a covered loss occurs. This sequence of performance may allow insurers to profit by denying legitimate claims: every dollar that an insurer avoids paying in claims adds to its bottom line. Similarly, insurers may profit in the short-run by delaying payment, allowing them to continue to benefit from the time value of money. Moreover, delaying payment gives insurance companies leverage to settle disputed claims on favorable terms, as policyholders who have recently incurred a loss typically have high discount rates (Sykes 1996).

Although insurers can clearly benefit in the short term by adopting excessively aggressive claims handling strategies, the long-run profitability of such an approach would be uncertain if it caused policyholder demand for the insurer’s coverage to decrease. However, consumer demand in some markets may not be substantially responsive to overly aggressive claims handling due to information asymmetries and behavioral anomalies. If prospective purchasers of insurance

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cannot distinguish between companies that adopt excessively aggressive claims handling and those that do not, or if consumers discount the probability that they will make a claim in the future, then market forces will exert a muted impact on insurers’ claims handling practices. Policyholders may be particularly poor judges of the reasonableness of different carriers’ claims handling because it is very difficult to differentiate between legitimate and illegitimate claims denials, which turn on the specific facts of individual cases.

The actual prevalence of insurer bad faith is a hotly contested issue, precisely because of the inherently fact-bound nature of each alleged instance. However, there is compelling evidence that some insurers have deliberately adopted a company-wide strategy of illegitimately minimizing claims paid (Langbein 2007; Feinman 2010), and most insurers face at least some incentives to reduce payouts. On the other hand, others have argued that many instances in which insurers have been found to have engaged in bad faith involve reasonable claims-paying judgments by insurers (Sykes 1996).

Estimating the prevalence of insurer bad faith is made even more difficult by the fact that insurers may need to adopt aggressive claims handling to deal with the risk of fraudulent claims. Estimating the rate of fraudulent claims is obviously difficult, but there is abundant anecdotal evidence of significant fraud. Dornstein (1998) discusses the “Friends of the Friendless,” a large and sophisticated fraudulent auto accident enterprise in Southern California, involving several doctors and lawyers. Knowledgeable observers believe that while “few people cut false claims from whole cloth, . . . nearly everyone exaggerates his loss.” (Ross 1970; quoted in Derrig 2002). More rigorous estimates of the amount of fraud founder on the difficulties of defining and identifying it, but virtually all estimates suggest that it is a substantial problem for insurers (Derrig 2002). This in turn means that there is an inherent tension between two valid goals: paying legitimate claims and denying payment of illegitimate ones.

In order to counteract the risk of excessively aggressive claims handling, many states allow successful policyholder-litigants to receive attorneys’ fees, emotional distress damages, statutory penalties and even punitive damages in cases where insurers are deemed to have unreasonably denied or delayed claims payment. These forms of damages, which are ordinarily unavailable in contract breach cases, are usually tied to some negligence, recklessness, or intentional misconduct in the insurer’s denial or delay of a claim. These laws clearly have a substantial impact on insurer claims-handling practices. Browne, Pryor, and Puelz (2004) find that settlements are significantly larger in states that permit tort-based bad faith liability against insurers. Asmat and Tennyson (2014) reach a similar conclusion using panel (combined time-series and cross-section) data that allow for stronger causal inferences about the effect of bad faith liability on settlement amounts. They also find that bad-faith liability reduces the chances that a claim is substantially underpaid (by about 7 percent).
The extant literature provides little concrete guidance on whether bad faith laws ultimately enhance social welfare. Sykes (1996), for instance, argues that these laws create more problems than they solve because courts tend to be unduly aggressive in identifying bad faith and the underlying risk of insurer bad faith is relatively limited as a result of market discipline. Tennyson and Warfel (2010), argue that bad faith law increases the incidence of fraudulent insurance claiming and discourages rigorous claims handling investigations. Asmat and Tennyson (2015) are more cautious in their welfare assessment.

Once again, the literature and law are remarkably sparse with respect to assessing the competence of courts, relative to regulators and legislatures, in disciplining insurers' claims handling practices. Virtually every state has adopted some version of the Model Unfair Claims Settlement Practices Act (UCSPA), which authorizes state regulators to take action in cases of flagrant or repeated unfair claims practices. But little evidence exists regarding the impact of these laws. Whether insurers’ claims practices are best controlled by regulatory oversight ex ante or by litigation by aggrieved policyholders ex post, or some combination of the two, thus remains a largely unsettled question.

C. Duty to Defend

The basic scope of a liability insurer’s duty to defend is set by the so-called “eight-corners rule,” which provides that when an insured is sued by a third party, the insurer’s duty to defend depends only on the terms of the underlying insurance policy and the pleadings of the third-party claimant (two documents, eight total ‘corners’), without regard to the truth of the plaintiff/victim’s allegations. This duty has been the subject of very little scholarship in law and economics (an excellent recent survey by Silver (2015) appears to be the sole exception), but has received considerable attention from lawyers and legal scholars (Stempel 1999; with updates; Ostrager and Newman 2012). Despite the lack of law and economics scholarship on the topic, liability insurers’ duty to defend has a significant impact on the conduct of ordinary litigation. For instance, plaintiffs’ lawyers understand that virtually all of any recovery will come from the defendant’s insurance company (Baker 2001; Zeiler et al. 2007), and often attempt to frame their pleadings so as to trigger the insurer’s duty to defend—that is, to “plead into coverage.” Similarly, the duty can create innumerable difficulties and potential conflicts among insurers, policyholders, and insurance defense council (Silver and Syverud 1995).

From an economic perspective, there is an obvious efficiency rationale for bundling the insurer’s duty to defend claims against the insured with its duty to indemnify, as occurs under typical liability insurance policies. By providing insurance against litigation expenses, the insurer is generally also able to control

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20 See Employers Mut. Cas. Co. v. PIC Contractors, Inc., 24 F. Supp. 2d 212, 216 (D.R.I. 1998) (suggesting "a plaintiff cannot ‘plead into’ coverage by labeling the claim as something that is inconsistent with the factual allegations in the complaint.").
key litigation decisions as well as the identity of defense counsel. Pairing indemnity insurance with defense cost insurance thus helps ensure that the party who bears the cost of a potential judgment also makes the decision about how much to invest in defending against such a judgment. This should generally result in an efficient amount being devoted to defending liability claims. By contrast, consider a defendant who is fully covered against underlying liability, but has to spend out-of-pocket to defend a lawsuit. Such a defendant would choose to spend nothing on the lawsuit, since any savings from a successful defense would redound only to the insurer’s benefit.

Nonetheless, there are some insurance policies that do not pair indemnity coverage with insurance defense coverage and/or the right to control the defense. Table 1 (reproduced from Silver (2015)) gives examples of various combinations of the duty to indemnify, the duty to defend and the right to control the conduct of the defense in different types of insurance policies.21 While the typical policy allocates all three rights/duties to the insurer, as in row 1, Silver (2015) explains why the bundle might differ across different insurance products, and explains the variety of ancillary contractual devices used to generate approximately efficient outcomes when the three duties are disaggregated. For instance, Directors and Officers Liability insurance often packages indemnity coverage with a duty to defend, but without the right of the insurer to control the litigation. Consequently, the insured is potentially entitled to spend very large amounts of the insurer’s money defending against liability. The moral hazard problem this creates might make sense, however, if the object is to deter litigation in the first instance. Potential plaintiffs are less likely to sue if they know the defendant can spend almost unlimited amounts of its insurer’s money fighting the lawsuit.22

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21 There are technically eight possible combinations of these three binary features (2^3). But a policy lacking all three would be a logical impossibility, as would a policy that had only a right to control the defense with no duty to defend or indemnify.

22 We thank Steve Thel for this insight.
### Table 1: Types of Insurance Policies With Identified Features

<table>
<thead>
<tr>
<th>Duty to Indemnify</th>
<th>Duty to Defend</th>
<th>Right to Defend</th>
<th>Types of Policies*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Personal Auto; Commercial General Liability (CGL); Medical Professional Liability</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Director &amp; Officer (D&amp;O) Ins.; Lawyers Professional Liability Coverage</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Financial Institutions Risk Protector</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Pure Indemnity; D&amp;O Ins.; Excess Coverage</td>
</tr>
<tr>
<td>No?</td>
<td>Yes</td>
<td>Yes</td>
<td>None?</td>
</tr>
<tr>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Medical Liability Mutual Ins. Co.; Employment Practices Liability</td>
</tr>
</tbody>
</table>

*Note: Some policies of this type have this set of features, but the same type of policy may come with different features and thus may appear in more than one row.

The duty to defend is also important from an economic perspective for at least two other reasons. First, it is a significant part of the overall risk-transfer from policyholder to insurer, simply because the costs of defending against a legal claim are often very substantial in their own right. Second, the duty has the effect of concentrating specialized expertise (both in the substance and procedure of litigation) in the hands of liability insurers. This presumably leads to better decisions about litigation strategy, and may also encourage more competitive pricing by defense-side lawyers who are retained by the insurers.

### D. Duty to Settle

As the previous section explained, efficiency generally dictates that the party who must ultimately pay for any liability should also control the defense against that liability. This assignment of responsibility works well when the insured’s potential liability is less than the limits of her liability insurance policy. But when potential damages may be larger than the limits of the defendant’s insurance coverage, the insurer and the insured will have a conflict about how to manage the litigation. This conflict is most acute with respect to the decision whether to accept a settlement offer. Giving full control over settlement decisions to insurers—as most policies purport to do—creates important conflicts of interest when there is a potential above-limits judgment. This is because insurers evaluating settlement offers will give insufficient consideration to the risk that going to trial will expose policyholders to personal liability from an above-limits judgment.\(^{23}\)

\(^{23}\)The exact obverse of this problem occurs when a policy contains a deductible and expected liability is less than this amount. Now, the insurer will be eager to settle for the amount of expected liability, since settlement costs will be borne entirely by the insured defendant. And it is the defendant who will prefer to go to trial, since its maximum loss is capped by the deductible.
A simple numeric example illustrates this conflict of interest. Suppose a victim has sued an insured defendant for an injury the latter has caused. Suppose also that:

- The insured’s liability policy only covers payouts up to 100; any award above this amount must be paid by the defendant out of her own pocket.
- The defendant is known to be liable to the victim, but the extent of harm is unknown, and is either 60 or 140. This amount is to be determined at trial, but ex ante, each result is equally likely.
- There are no costs of trial.

In this example, the expected trial outcome is an award of \( \frac{1}{2} \times 60 + \frac{1}{2} \times 140 = 100 \). Absent liability insurance, risk aversion should lead both plaintiff and defendant to be willing to settle for this amount. (The parties would be even more willing to settle if there were trial costs to be saved). However, the liability insurer in this example would be unwilling to accept this settlement offer, because it would expect to pay only 80 \( \frac{1}{2} \times 60 + \frac{1}{2} \times \text{policy limit} = 100 \) by going to trial.24

Courts have responded to this problem by creating a “duty to settle:” a liability insurer must accept a reasonable settlement demand in a lawsuit against its policyholder. If it fails to do so, it forfeits its policy limit and is liable for the full amount of any subsequent damages award.25 In determining whether a particular settlement offer is, in fact, reasonable, courts and commentators have often invoked the “disregard the limits” test, which asks whether the settlement offer would have been accepted if the insurer had no policy limits.

A substantial scholarly literature critiques the efficiency of the duty to settle rule. Perhaps the most commonly-debated issue is whether the doctrine could be improved by moving to a strict liability standard, under which insurers who rejected within-limits offers would always be required to pay any subsequent above-limit judgment (Schwartz 1975; Syverud 1990; Logue 1993; Hyman, Black, and Silver 2011). A strict liability approach would force insurers to evaluate the full costs and benefits of settlement offers by removing the possibility that some of the costs of failing to settle could be shifted to the policyholder. It should therefore produce more efficient settlement decisions than the ex post judgments of courts regarding whether a particular settlement offer was reasonable at the time it was made. Additionally, a strict liability approach may reduce administrative costs associated with litigating the reasonableness of settlement demands and be more consistent with policyholders’ risk-aversion. On the other hand, such an approach limits the usefulness to liability insurers of coverage limits and potentially may induce strategic settlement offers by plaintiffs looking to increase the pool of insurer-provided funds to pay an eventual judgment.

24 This is an example of the marginal claimant principle that recurs often in law and economics. For a lucid explanation of the general problem, and solutions, see Cooter (1985).
Although the optimal form of the duty to settle has been much debated in the literature, few have questioned the efficiency of some sort of limitation on liability insurers’ discretion to settle. An exception is Sykes (1994), who emphasizes that the duty to settle did not emerge as a voluntary term in insurance policies—suggesting that it may not, in fact, be efficient—and points out that the duty to settle might weaken the overall bargaining position of the combined defendants (insurer and policyholder) when the defendant would otherwise be partially judgment proof. Of course, Sykes’ argument can reasonably be flipped: if a court-designed duty to settle is in fact inefficient, then it is unclear why the parties do not contract-around this rule, as there is no strong reason to believe that it is a mandatory, rather than a default, term. Additionally, as Logue (1993) emphasizes, Sykes’ judgment-proof argument can be reasonably addressed by an alternative rule, proposed by Schwartz (1975), in which damages for violation of the duty to settle are capped at the policy limit plus the policyholder’s collectible assets.

The impact of the duty to settle on litigation has also been examined in the literature. Hyman, Black, and Silver (2011) find that the existence of a duty to settle substantially affects settlement dynamics, resulting in the faster resolution of cases and an increased number of cases that settle at, or near, the defendant’s policy limits.

Squire (2012; 2015) points out that the canonical conflict of interest animating the duty to settle is only one among several potential conflicts created by policy limits. He emphasizes that limits can result in excessive settlement amounts when defendant-policyholders are able to compel settlement over an insurer’s objection. This can happen, he notes, when a plaintiff makes an above-limit settlement demand, and courts compel insurers to contribute the policy limits towards that settlement because the policyholder is willing to pay out of pocket the difference between the settlement amount and the policy limit. Using the example above, suppose that the plaintiff makes a demand to settle the case for 110. Unless trial costs exceed 10, this is an excessive settlement demand, because it exceeds the expected trial outcome. Nonetheless, suppose that the policyholder would be willing to accept this settlement and pay the 10 above the policy limit, because the policyholder’s expected cost of going to trial is 20. Imposing a duty on the insurer to “contribute” its limits to this settlement thus results in overpayment of plaintiffs

Squire suggests that a solution to this problem—and to the misaligned incentives of policyholders and insurers more generally—is to allow each party to separately resolve its slice of potential liability with the plaintiff. Under this

26 Of course, society as a whole has a stake in the amount of the settlement, since the liability of defendants is the principal means by which deterrence is realized (Meurer 1992). Taking account of this externality greatly complicates any welfare analysis.

27 Half of the time, the plaintiff collects 60 from the insurer and the policyholder pays nothing. Half the time, the plaintiff collects 140, of which 100 (the policy limit) comes from the insurer and the remaining 40 from the defendant herself: \( \frac{1}{2} \times 0 + \frac{1}{2} \times 40 = 20. \)
proposal, the policyholder in the above example would be free to settle its potential individual liability to the plaintiff, but this would not impact the insurer's ability to proceed to trial to determine what percentage of its policy limits it owes to the plaintiff. The virtue of this approach is that it would eliminate the capacity of any party—insurer, policyholder, or excess insurer— to shift potential exposure to liability on to another party. On the other hand, this proposal might plausibly be objected to because it would increase risk to policyholders, who might often be asked to contribute some amount to settlement, and complicate the insurer’s obligation to fund defense expenses associated with advising policyholders on settlement offers.

Conclusion

The law and economics of insurance is both a fragmented and under-developed field. Yet core economic concepts—particularly information asymmetries—are fundamental to a coherent normative understanding of insurance law and regulation. For this reason, there is substantial scope for future scholarly inquiry in the law and economics of insurance. By drawing together a variety of insurance-related topics that are often addressed within silos of the academy, we hope that this Chapter helps facilitate and encourage that development. The results could be a substantial improvement not only in the scholarly domain, but also in the legal and regulatory spheres, where policy is too often either divorced entirely from economics or based on reductionist understandings of economic concepts.

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28 Excess insurance is coverage that only kicks in after the exhaustion of a primary layer of coverage, which may be in the form of a self-insured retention or a primary insurance policy.
BIBLIOGRAPHY


