

SHOULD ANTITRUST PRINCIPLES BE USED TO ASSESS  
INSURANCE RESIDUAL MARKET MECHANISMS, SUCH AS  
NEW YORK'S MEDICAL MALPRACTICE INSURANCE PLAN?

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State-created insurance residual market mechanisms are typically designed to address flaws in markets in which a significant number of purchasers have difficulty obtaining affordable insurance; such programs, however, have often led to crises in such markets, and occasionally to economic catastrophe.<sup>1</sup> In this Paper, particular attention will be paid to New York's Medical Malpractice Insurance Plan (MMIP or Plan), which presents the latest warning that there will be widespread market failures unless greater thought is given to the dynamics of such programs.<sup>2</sup> If the best

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<sup>1</sup> See AM. ACAD. OF ACTUARIES, THE WORKERS' COMPENSATION SYSTEM: AN ANALYSIS OF PAST, PRESENT AND POTENTIAL FUTURE CRISES 6 (2000), <http://www.actuary.org/pdf/casualty/workers.pdf> ("Because the residual market rates approved by regulators were often severely inadequate during the late 1980s, most assigned risk pools operated essentially as insolvent insurance companies."); COMMONWEALTH AUTO. REINSURERS, REPORT OF THE LOSS RESERVING COMMITTEE: QUARTER ENDING MARCH 31, 2007, at 2 (2007), <http://www.commauto.com/reports/financial/lossreserv/policyYearDeficits.pdf> (reporting Massachusetts's Commonwealth Automobile Reinsurers' underwriting deficit of \$237,262,000 as of March 31, 2007, for all private passenger insurance for Policy Year 2003); INS. INFO. INST., PUBLIC/PRIVATE MECHANISMS FOR HANDLING CATASTROPHIC RISKS IN THE UNITED STATES 41 (2005), <http://archives.tci1.org/publications/disasterpaper.pdf> (discussing \$516 million deficit of Florida's Citizens Property Insurance Corporation); John D. Worrall, *Private Passenger Auto Insurance in New Jersey: A Three-Decade Advertisement for Reform*, in DEREGULATING PROPERTY-LIABILITY INSURANCE: RESTORING COMPETITION AND INCREASING MARKET EFFICIENCY 81, 111-14 (J. David Cummins ed., 2002), <http://aei-brookings.org/admin/authorpdfs/redirect-safely.php?fname=../pdffiles/Chapter3.pdf> (discussing the possibility of over \$1 billion in losses by New Jersey's Market Transition Facility, the state's automobile insurer of last resort from 1990 to 1993).

<sup>2</sup> Many residual market mechanisms operate in financially challenged markets, where there is a temptation to create compulsory programs at reduced rates. See Patricia M. Danzon & Scott E. Harrington, *Workers' Compensation Rate Regulation: How Price Controls*

teacher of the right way is the wrong way, then the MMIP is an excellent source of instruction. Laden with features that have resulted in hundreds of millions of dollars in losses, the MMIP has been a financial debacle that invites the attention of the legal and economic communities. Although the MMIP is susceptible to attack on several levels,<sup>3</sup> the MMIP's shortcomings are particularly obvious when analyzed through the prism of antitrust law principles, specifically those used in construing the Sherman Act (the Act).<sup>4</sup> To be certain, residual market programs, including the MMIP, may be largely exempt from the antitrust laws, as two recent federal circuit court decisions have noted;<sup>5</sup> yet, the application of the Act's legal and economic tests to the MMIP's operations provides learning opportunities, and suggests the need for reform. For a greater appreciation of the subject matter, this Article will: (1) consider the nature of insurance as a commodity, (2) discuss residual market mechanisms in general and the MMIP program in particular, (3) evaluate the MMIP on the basis of economic and legal tests developed in applying the Act, (4) address relevant exemptions that place aspects of residual market programs beyond the reach of the antitrust laws, and (5) suggest ways that the MMIP and similar programs can be improved through remedial legislation.

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*Increase Costs*, 44 J.L. & ECON. 1, 33 (2001) (concluding that workers' compensation rate suppression effectively cross-subsidizes high risks at the expense of low ones, with the size of the cross-subsidy varying directly with the degree of rate suppression, and that such suppression "seems implausible in the absence of political pressure from beneficiaries"); Jon S. Hanson, *The Interplay of the Regimes of Antitrust, Competition and State Insurance Regulation on the Business of Insurance*, 28 DRAKE L. REV. 767, 863 (1978-79). See generally Encyclopedia Britannica, Price System, <http://www.britannica.com/nobelprize/article-9106205> (last visited Jan. 1, 2008) (explaining that one purpose of governmental price regulation is the protection of "large and well-organized producer groups"). New York's medical malpractice insurance market is a stark illustration of what can happen if inadequate rates are set and admitted carriers are made potentially responsible for the resulting losses.

<sup>3</sup> For example, the MMIP's imposition of the full burden of insuring high risks for medical malpractice upon a handful of admitted medical malpractice carriers may constitute either a taking or a violation of substantive due process, under the United States and New York Constitutions. U.S. CONST. amends. V, XIV, § 1; N.Y. CONST. art. I, §§ 6-7. In addition, the setting of inadequate MMIP rates by New York State's Superintendent of Insurance is subject to administrative challenge. See *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Muhl*, 684 N.Y.S.2d 312, 315 (App. Div. 1999).

<sup>4</sup> 15 U.S.C. §§ 1-6 (2000).

<sup>5</sup> *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 66 (1st Cir. 2005); *Gilchrist v. State Farm Mut. Auto. Ins. Co.*, 390 F.3d 1327, 1330 (11th Cir. 2004).

## I. NATURE OF INSURANCE AS A COMMODITY

### A. *Markets for Goods in General*

Insurance may be viewed as a commodity, and as with any good, the market for its purchase and sale can be visualized in terms of classic supply and demand curves. Figures 1 and 2 are graphs representing the purchase and sale of insurance in the voluntary market from one individual insurer, and from all insurers in the voluntary market, respectively.<sup>6</sup> In each graph, the vertical axis shows the premium, which in the insurance market is the equivalent of price, charged per \$1,000 of insurance coverage written by the insurer(s).<sup>7</sup> Premiums for each individual insured, in turn, are calculated based on formulas known as rates, which are often subject to governmental approval. The horizontal axis represents the total amount of insurance coverage written by the insurer(s) (or, viewed alternately, purchased by insureds), the equivalent of output in the insurance market.<sup>8</sup> The demand curve (DD in Figure 1 and  $D_I D_I$  in Figure 2) represents “the quantity of [the] good that [consumers will] purchase at each price.”<sup>9</sup> The supply curve (SS in Figure 1 and  $S_I S_I$  in Figure 2) shows “the quantity of [the] good that suppliers . . . [will] sell at each price.”<sup>10</sup>

There are two categories of production costs: fixed costs (FC) and variable costs (VC). An illustration of the former, which is unrelated to the quantity produced, would be the rent for the firm’s premises.<sup>11</sup> The latter varies with the firm’s “level of output.”<sup>12</sup> An example of VC is a firm’s payroll.<sup>13</sup>

Marginal cost (MC) is the expense of producing one additional

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<sup>6</sup> See *infra* app. figs.1 & 2. To distinguish the curves in Figure 1 from those in Figure 2, those in Figure 2 are marked with the subscript I for “industry” and correspond to the entire market as opposed to any individual firm. See also Roger D. Blair & Scott D. Makar, *The Structure of Florida’s Medical Malpractice Insurance Market: If It Ain’t Broke, Don’t Fix It*, 5 YALE J. ON REG. 427, 431 fig.1 (1988). The voluntary market consists of carriers licensed in the jurisdiction in which the putative insured conducts business.

<sup>7</sup> See *infra* figs.1 & 2.

<sup>8</sup> See *infra* figs.1 & 2.

<sup>9</sup> PAUL A. SAMUELSON & WILLIAM D. NORDHAUS, *ECONOMICS* 734 (14th ed. 1992); see *infra* app. figs.1 & 2.

<sup>10</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 747; see *infra* app. figs.1 & 2.

<sup>11</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 120.

<sup>12</sup> *Id.*

<sup>13</sup> See *id.*

unit of the product offered for sale.<sup>14</sup> In Figure 1, the marginal cost curve (MC curve) represents the MC at every level of output.<sup>15</sup> Since FC does not change with output, MC consists entirely of VC. At low levels of output the MC curve is downward-sloping (i.e., falling from left to right).<sup>16</sup> This reflects the fact that as a firm initially starts producing, increases in the amount of one input, such as capital or labor, while holding the others constant, will lead to proportionately greater increases in output.<sup>17</sup> This phenomenon is called increasing marginal returns.<sup>18</sup> At higher levels of output, this curve becomes upward-sloping.<sup>19</sup> This is because as output increases beyond a certain level, increases in the amount of any one input, while holding the others constant, will lead to proportionately smaller increases in output.<sup>20</sup> This circumstance is called diminishing marginal returns.<sup>21</sup> Because increasing marginal returns exist at low levels of production, and decreasing marginal returns prevail at high levels, the MC curve will have a U-like shape.<sup>22</sup> This has been empirically shown to be true of the insurance industry specifically.<sup>23</sup>

When prices are set by competitive market forces, the firm's supply curve (SS) will be identical to the upward-sloping portion of the firm's MC curve.<sup>24</sup> This identity results from the fact that as long as the cost of each additional unit of a good produced is less than the price at which the good is sold, the seller will continue to produce.<sup>25</sup>

The average cost (AC) curve (AC curve) represents the average

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<sup>14</sup> *Id.*

<sup>15</sup> *See infra* app. fig.1.

<sup>16</sup> *See* SAMUELSON & NORDHAUS, *supra* note 9, at 121 & fig.8-1(b), 124–25, 126 fig.8-4.

<sup>17</sup> *See id.*

<sup>18</sup> *See id.* at 111, 126 & fig. 8-4(b).

<sup>19</sup> *See id.* at 27–28, 108–09, 121 & fig.8-1(b), 124–25, 126 fig.8-4.

<sup>20</sup> *See id.*

<sup>21</sup> *See* source cited *supra* note 19. In some industries, MC continues to decline, regardless of the level of output. In such an industry, a single firm can produce the entire industry's output at a lower cost than can multiple firms, all of which would be producing at levels carrying greater average cost (AC) and MC. As described in the text accompanying note 23, however, the insurance industry is not such an industry.

<sup>22</sup> *See* source cited *supra* note 16.

<sup>23</sup> *See generally* HAROLD D. SKIPPER, JR., INT'L INS. FOUND., FOREIGN INSURERS IN EMERGING MARKETS: ISSUES AND CONCERNS 1 (1997), <http://www.iifdc.org/pubs/skipper.pdf> (discussing issues related to foreign insurers in new and rising markets); Frances A. Katrishen & Nicos A. Scordis, *Economies of Scale in Services: A Study of Multinational Insurers*, 29 J. INT'L BUS. STUD. 305 (1998) (examining the likelihood of economies of scale existing in multinational insurers).

<sup>24</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 141–43 & fig.9-2.

<sup>25</sup> *Id.*

cost of production among all the units a given firm produces, or put another way, the “total cost divided by the number of units produced.”<sup>26</sup> Its U-like shape corresponds to the U-like shape of the MC curves. Because AC is merely the sum of the FC and the average of the MC of all of the units produced, AC will fall whenever MC is below it, and rise whenever MC lies above it.<sup>27</sup> Consequently, MC will intersect AC at AC’s lowest point.<sup>28</sup>

To arrive at the market-wide figures for cost in Figure 2, one adds up each firm’s output as it corresponds to a given level of that firm’s cost (be it AC or MC).<sup>29</sup> The sum of these outputs is the market’s output, as a whole, associated with that cost. The market supply curve is derived by adding together each firm’s supply curves in the same manner.<sup>30</sup> As each individual firm’s cost and supply curves have similar shapes (i.e., U-like MC, AC, and SS), so will the corresponding market curves (MC<sub>I</sub>, AC<sub>I</sub>, and S<sub>I</sub>S<sub>I</sub>).

In Figure 2, the demand curve (D<sub>I</sub>D<sub>I</sub>) represents the aggregate amount of insurance that will be purchased from all insurers at any given price level.<sup>31</sup> For most products at the market level, the demand curve is downward-sloping, i.e., as a consumer buys more units of a good, he is not willing to pay as much on average for each individual unit thereof.<sup>32</sup> This reflects that the more units of a given product a consumer purchases, the less enjoyment, or utility, the consumer will derive from each additional unit.<sup>33</sup> As he would receive less utility from another unit, he is not willing to pay as much for it as he paid for its predecessors.<sup>34</sup> Because the market demand curve is simply the sum of all consumers’ individual demand curves, and each consumer’s demand curve is downward-

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<sup>26</sup> *Id.* at 121–22.

<sup>27</sup> *Id.* at 123.

<sup>28</sup> *Id.* at 123 & fig.8-2(b).

<sup>29</sup> *See infra* app. fig.2.

<sup>30</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 145 & fig.9-4.

<sup>31</sup> *See infra* app. fig.2.

<sup>32</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 86–87; *see infra* app. fig.2. The supply and demand curves in each graph are oversimplifications. For example, although only one demand curve and one supply curve are shown in each graph, there are distinct consumer groups, such as upstate anesthesiologists and downstate obstetricians, hospitals, dentists, and nurses. Each of these groups has its own, quite different, insurance needs, and each will be paying premiums that reflect its own particular activities, location, loss history, and other distinct factors. These considerations should also be taken into account when considering the residual market graph shown in this Article. *See infra* app. fig.3.

<sup>33</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 86–87.

<sup>34</sup> *Id.* at 86.

sloping, the market demand curve is downward-sloping as well.<sup>35</sup> In Figure 1, however, which represents an individual insurer's market, the demand curve is horizontal.<sup>36</sup> This reflects the assumption that one individual producer (here, insurer) is too small, in proportion to the aggregate of all producers in the market, to be able to affect market price, regardless of how much such firm produces.<sup>37</sup>

In a free-market setting, the market equilibrium point is where the curves in the market graph intersect, i.e., where the forces of supply and demand coincide.<sup>38</sup> The equilibrium point sets the premium that insureds are willing to pay for and the aggregate coverage that insurers are willing to write.<sup>39</sup> In Figure 2, this equilibrium,  $E_I$ , is the point where supply meets demand, i.e., consumers are willing to pay for the same amount of output as suppliers are willing to sell.<sup>40</sup> At  $E_I$ , the price,  $P_I$ , is \$2.50 (per \$1,000 of insurance coverage), and output,  $Q_I$ , is \$250 billion (of aggregate insurance coverage).<sup>41</sup>

As long as the AC curve remains below the premium charged at the equilibrium, there will be a profit on the insurance written.<sup>42</sup> In Figure 2, the AC curve intersects the equilibrium output level at point B, which is below  $E_I$ .<sup>43</sup> The area  $AE_I BC$  shows the aggregate profits realized by all insurers, i.e., price (\$2.50) minus average cost (\$2.25) equals profit (\$0.25 per \$1,000 in coverage purchased); \$0.25 profit multiplied by 0.001 (per \$1,000) multiplied by \$250 billion (aggregate of insurance coverage purchased) equals \$62.5 million in profit for the industry.<sup>44</sup>

As described above, the firm in Figure 1 is a price taker that cannot affect the market price arrived at in Figure 2, so the price

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<sup>35</sup> *Id.* at 88–89 & fig.6-2; *see infra* app. fig.2.

<sup>36</sup> *See infra* app. fig.1.

<sup>37</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 141. This assumption is often an oversimplification, as frequently there are few enough firms in a market that an individual one's changes in output can significantly affect overall market output. For example, in New York's medical malpractice insurance admitted market, four firms write the vast majority of the policies. *See infra* Part II.B.1.a. Even in an oligopoly, however, the individual firms have less control over market output than does a monopolist, to which the perfect competition situation will be compared later in this Article. *See infra* Part III.C.

<sup>38</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 59.

<sup>39</sup> *Id.*

<sup>40</sup> *See infra* app. fig.2.

<sup>41</sup> *See infra* app. fig.2.

<sup>42</sup> *See infra* app. fig.2.

<sup>43</sup> *See infra* app. fig.2.

<sup>44</sup> *See infra* app. fig.2.

charged in Figure 1 is the same as that in Figure 2, i.e., \$2.50 per \$1,000 in insurance written.<sup>45</sup> To maximize its profits, the firm will produce up to the point at which the marginal cost of the last unit produced equals the price received from the sale of the last unit produced.<sup>46</sup> This is the level of output at which the MC curve intersects the DD curve, at point E, which is \$250 million in Figure 1.<sup>47</sup> The individual firm's profit is the area of the rectangle AEBC in Figure 1.<sup>48</sup>

### *B. Distinguishing Characteristics of Insurance as a Good*

Insurance policies are not widgets, i.e., they are not simple articles as to which value is easily determinable. The value of liability insurance is the insurer's contractual obligation to satisfy losses within the limits of the policy, here assumed to be claims-made.<sup>49</sup> Over its fixed term, an insurance policy covering liability claims is, from the insured's perspective, a wasting asset that over time declines in value. A claims-made liability policy has intrinsic worth only as a source of protection against risk during the time that the policy is in force. Any premium paid in advance of the coverage period is earned by the insurer with the passage of time over the life of the policy, and in the defense and indemnification of covered claims.

The cost of issuing policies is comprised of many components, some readily calculable, others quite difficult to assess. With regard to VC, insurers vary significantly from other producers. This is because insurers, unlike other producers, incur significant costs related to their products even after their sale. Insurers' VC includes claims resolution costs, which are the insurers' cost of honoring the policy. The seller of a typical commodity, the cost of which is incurred prior to sale, is relieved of liability upon transfer of title and, therefore, is indifferent to whom the product is sold.<sup>50</sup>

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<sup>45</sup> See *infra* app. figs.1 & 2.

<sup>46</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 142–43.

<sup>47</sup> See *infra* app. fig.1.

<sup>48</sup> See *infra* app. fig.1.

<sup>49</sup> Claims-made policies are those which cover any claim reported within the policy period. In contrast, an occurrence policy covers any claim accruing during the policy period, regardless of when reported.

<sup>50</sup> To be sure, non-insurers can be responsible for costs associated with their products after sale in the event that defects in their products cause injury. This Article assumes, however, that such after-sale costs are generally insignificant in comparison to the cost of the good's production. By contrast, claims resolution costs compose the bulk of the variable costs

With insurance, the precise opposite occurs. Claims resolution costs arise when events trigger the insurer's obligation to defend, and possibly indemnify, the insured. Unlike other commodities, the cost of this "good" is not incurred prior to "sale," but only after the policy is issued.<sup>51</sup> Insurers are, therefore, very concerned about the identity of the persons to whom they issue their product, and use underwriting guidelines to screen applicants based on the potential risk posed by insuring them. Insureds that are high risks<sup>52</sup> will increase VC and AC and thereby reduce, or eliminate, insurer profitability.<sup>53</sup> For this reason, under ordinary market conditions, insurers will charge high risks greater premiums for policies which provide the same coverage as those issued to lower risks.

In addition, the uncertainties of claims trends, that is, the frequency with which claims occur and their severity, make estimation of future claims resolution costs quite difficult. Consequently, insurers need to be able to collect somewhat more in premiums—from both high risks and low risks—than would be necessary to cover expected losses. This "cushion" ensures that they will be able to cover losses that exceed those expected. The fewer insureds an insurer has, the greater the chance is that cumulative losses among those insureds will exceed the average. This is due to the law of large numbers: the more insureds, the greater likelihood that any upward deviations from average losses incurred by one insured will be balanced out by below-average losses of another insured. Consequently, to cover this greater possibility of catastrophic losses, small insurers may seek a greater cushion, which is reflected in a higher premium than is charged by large insurers.<sup>54</sup> As a general proposition, this makes competing in terms

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incurred by insurers.

<sup>51</sup> For medical malpractice payments made in 2005, the last year for which figures are available, the average delay between a medical malpractice incident and the payout on that incident was 4.66 years nationally. U.S. DEP'T OF HEALTH & HUMAN SERVS., 2005 NAT'L PRACTITIONER DATA BANK ANN. REP. 8, [http://www.npdb-hipdb.com/pubs/stats/2005\\_NPDB\\_Annual\\_Report.pdf](http://www.npdb-hipdb.com/pubs/stats/2005_NPDB_Annual_Report.pdf) [hereinafter NAT'L PRACTITIONER DATA BANK]. For New York State, the average such delay was 5.56 years. *Id.* at 70 tbl.13.

<sup>52</sup> Risk is the possibility, posed by a would-be insured, that an event will occur triggering an obligation under a policy of insurance. A high risk is an insured who is unusually likely to incur such an event.

<sup>53</sup> This circumstance is, in part, the reason insurance companies may not experience increasing marginal returns at high levels of output, i.e., as they issue more policies they are likely writing higher risks that present great claims resolution costs that reduce profit.

<sup>54</sup> Small insurers often address the possibility that losses will exceed those anticipated by purchasing reinsurance, which transfers a portion of the risk to another carrier for a portion

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of price difficult for small insurers. Moreover, if small insurers cannot charge higher premiums to create an appropriate cushion, they are placed at greater risk of being driven out of business by greater-than-average losses.

Also impacting price and output is government activity, which includes, for example, enacting laws making insurance coverage compulsory with respect to certain types of risks (which is reflected by the demand curve being fixed at a certain quantity level). Government activity also includes regulating insurance rates. This sets market price at a specific price and output is then where the supply curve intersects that price instead of where it intersects the demand curve. Governments also mandate that carriers in the voluntary market assume responsibility for insuring high risks that they would otherwise decline to cover, i.e., the risks which represent the residual market (which generally shifts insurers' MC and supply curves upward).<sup>55</sup> As will be discussed, New York State's Superintendent of Insurance ("Superintendent"), in essence, sets rates for determining premiums, so the supply curve will not be set by market forces.<sup>56</sup> As a consequence of practical considerations, the demand curve will not be set by market forces, either.<sup>57</sup>

## II. NATURE OF INSURANCE RESIDUAL MARKET MECHANISMS AND OF THE MMIP

### A. Insurance Residual Market Mechanisms

Currently, there are scores of insurance residual market mechanisms operating throughout the United States. Many states require persons or entities to obtain liability insurance in order to engage in certain activities. For example, as of 1997, forty-five states require that all licensed motor vehicles be covered by minimum insurance, to ameliorate the hardship of accident victims who might otherwise be unable to collect judgments for injuries sustained in car accidents.<sup>58</sup> The compulsory nature of automobile

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of the premiums.

<sup>55</sup> The residual market consists of insureds that are unable to obtain coverage in the voluntary market.

<sup>56</sup> See *infra* Part II.A–B.

<sup>57</sup> All of these considerations should also be taken into account when considering the voluntary market graphs shown in this Article. See *infra* app. figs.1–5.

<sup>58</sup> David R. Francis, *Auto Insurance and Traffic Fatalities*, NBER DIGEST (Nat'l Bureau of Econ. Research, Cambridge, Mass.), Nov. 2003, at 2,

insurance makes it a prerequisite for the often-necessary activity of driving a motor vehicle. Similarly, most states require employers to purchase workers' compensation insurance or to qualify as an approved self-insurer.<sup>59</sup> Other activities, such as the practice of medicine, may not have compulsory insurance requirements, but present such substantial risks of liability that, for all practical purposes, those exposed to potential loss will obtain insurance before engaging in such activities.<sup>60</sup>

Unless they receive premiums commensurate with the greater potential liability, however, insurers are not willing to cover those would-be insureds who are regarded as unfavorable risks. Where insurance is a *de jure* or a *de facto* requirement of doing business, those high risk potential insureds that cannot obtain coverage may be forced to withdraw from the market.<sup>61</sup> Moreover, those that might otherwise come into the subject jurisdiction to engage in the insured activity may not do so without the availability of affordable insurance.

To deal with this dilemma, states have established insurance residual market mechanisms in certain fields to guarantee the availability of insurance to those unable to obtain coverage in the voluntary market at "affordable" prices.<sup>62</sup> Such mechanisms may take the form of assigned-risk plans. These plans require licensed carriers to issue policies to those risks directly in proportion to the amount of business in the state which each such insurer writes voluntarily. Another common form of residual market mechanism is the joint underwriting association (JUA), in which responsibility for high risks is "pooled."<sup>63</sup> In the context of a JUA, either "a limited number of [carriers] act as servicing carriers" in writing insurance for high risks, or policies are issued by an entity

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<http://www.nber.org/digest/nov03/nov03.pdf>.

<sup>59</sup> AM. ACAD. OF ACTUARIES, *supra* note 1, at 6.

<sup>60</sup> Even in situations where medical malpractice insurance is not compulsory under state law, hospitals, nursing homes, clinics, and healthcare insurance plans often require a policy of insurance as a pre-condition for entering into a relationship with a healthcare provider. *See, e.g.,* Emory Johns Creek Hosp., Dependent Allied Health Professional Job Description, <http://www.emoryhealthcare.org/departments/credentialing/documents/ahpstejc.doc> (last visited Jan. 1, 2008). Consequently, as a practical matter, such insurance might also be considered compulsory, though not necessarily state-mandated.

<sup>61</sup> Not necessarily so, however. They may decide to pay higher rates. *See infra* text accompanying notes 158–60 (noting that higher income makes obtaining coverage easier).

<sup>62</sup> The meaning of "affordable" is relative, falling somewhere between what insurers would charge without government regulation, and what insureds would consider fair.

<sup>63</sup> *See* AIPSO, Joint Underwriting Associations (JUAs), <http://www.aipso.com/jua.asp> (last visited Jan. 1, 2008) [hereinafter AIPSO, JUAs].

sustained by the plan.<sup>64</sup> In both instances, the JUA must write insurance for all insurance consumers unable to obtain insurance in the voluntary market,<sup>65</sup> and all licensed carriers writing a certain class of insurance<sup>66</sup> are JUA members, and as such share in the profits or losses from such underwriting in proportion to their voluntary business.<sup>67</sup> The JUA establishes underwriting guidelines for writing assigned-risk coverage within the parameters set by the state.<sup>68</sup> In contrast to an assigned-risk program, the JUA pools all high risks and spreads the aggregate risk among all of its members. By joining a JUA, insurers can therefore avoid the possibility that the risks they would otherwise be directly assigned would generate higher losses than would be expected from the statistical average loss of the residual market.

Although they vary considerably in the details surrounding their structures and operations, residual market mechanisms share certain basic characteristics. They are typically instituted in situations where a lack of coverage of high-risk insureds presents a potential public problem. The most common of these residual market mechanisms concerns automobile insurance. Forty-three U.S. jurisdictions<sup>69</sup> allocate these risks through assigned-risk programs.<sup>70</sup> A handful of states have instead established JUAs.<sup>71</sup>

In addition to automobile coverage, residual market mechanisms for workers' compensation insurance, which covers employees for on-the-job injuries, have been established in all states.<sup>72</sup> Where such coverage is compulsory, employers are faced with a dilemma when workers' compensation insurers refuse to write policies at rates that such employers can afford. Workers' compensation

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<sup>64</sup> *Id.*

<sup>65</sup> FRANK A. SLOAN, THE PROJECT ON MED. LIABILITY IN PA., PUBLIC MEDICAL MALPRACTICE INSURANCE 24 (2003).

<sup>66</sup> The precise class of licensed carriers required to be members varies between JUAs. See discussion of the burdened class of a JUA *infra* pp. 244–45.

<sup>67</sup> AIPSO, *JUAs*, *supra* note 63; AIPSO, Automobile Insurance Plans (AIPs), <http://www.aipso.com/aip.asp> (last visited Jan. 1, 2008) [hereinafter AIPSO, *AIPs*]. The state may ultimately use state funds to compensate the JUA for any losses sustained in its provision of insurance, however. See *infra* pp. 244.

<sup>68</sup> Certain state-created JUAs permit insurers to opt out of the JUA by directly insuring high risks in proportion to the insurer's share of the subject market. In this way, insurers can effectively convert the JUA to an assigned-risk program.

<sup>69</sup> Here, "jurisdiction" refers to a state or the District of Columbia.

<sup>70</sup> See AIPSO, *AIPs*, *supra* note 67.

<sup>71</sup> AIPSO, [http://www.aipso.com/which\\_mech.asp](http://www.aipso.com/which_mech.asp) (last visited Jan. 1, 2008) (noting the assignment of risks to residual-market mechanisms that exist in all states).

<sup>72</sup> Danzon & Harrington, *supra* note 2, at 2.

residual market mechanisms offer such employers a means of obtaining the required workers' compensation insurance policies.

Residual market mechanisms have also been established for medical malpractice insurance.<sup>73</sup> High-risk healthcare providers are afforded the opportunity to obtain insurance when licensed insurers are given the Hobson's choice, discussed above, of either writing assigned risks directly, or covering high risks through a JUA in which admitted carriers share responsibility for income and losses in proportion to the volume of business they write in the voluntary market.<sup>74</sup> For simplicity's sake, the remainder of this Article will generally refer to residual market mechanisms only in the context of JUAs, although assigned-risk programs are an alternative form of those mechanisms.

All JUAs have benefited and burdened classes. The benefited class includes those who receive some direct financial advantage through the mechanism, that is, those who are better off than if the mechanism did not exist. By contrast, those who are worse off than they would be in the mechanism's absence constitute the burdened class. Since a legal or practical requirement of obtaining insurance is not an aspect of the JUA itself—though it very well might be the inspiration for the JUA's creation—any comparison of JUA versus non-JUA situations must assume that the requirement exists either in both circumstances or in neither.

Those receiving insurance through the JUA, which enables them to engage in their desired activity, are direct beneficiaries.<sup>75</sup> There are also indirect beneficiaries. For example, in the case of automobile residual market mechanisms, some indirect beneficiaries would be accident victims, a broad group that can be characterized as the general public. In the absence of the JUA, individual members of this group might otherwise be unable to collect money judgments compensating them for injuries caused by car accidents involving uninsured motorists. Notably, these beneficiaries do not directly pay for any part of the cost of the programs.

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<sup>73</sup> SLOAN, *supra* note 65, at 23.

<sup>74</sup> See *supra* pp. 238–39.

<sup>75</sup> The degree to which a JUA insured is benefited depends on the level of the premium the insured must pay. Obviously, an insured is benefited more by a lower premium than by a higher one, all other things being equal. If the premium is higher than the insured is willing to pay, however, the insured can still choose not to engage in the proposed activity covered by insurance and, therefore, avoid having to pay the premium. In this way, the would-be insured is no worse off than if there were no JUA.

Under the right circumstances, JUA members themselves may also be part of the benefited class.<sup>76</sup> Rate regulation sets a limit on the premium that can be charged in the voluntary market. An insurer may be unwilling to insure a particular insurance consumer at that premium level. It may be willing to insure at a higher premium which the insurance consumer is actually willing to pay, and which makes the sale of such insurance profitable to the insurer. Because rates are regulated, though, the insurer cannot sell insurance at such a premium, and therefore the insurance consumer cannot obtain insurance in the voluntary market. When a JUA exists and is able to charge higher premiums than the voluntary market, insurers (through the JUA) are theoretically able to write insurance profitably to such insurance consumers, whereas they could not have done so otherwise.<sup>77</sup> Whether the JUA is able to make such a profit depends on how high the regulators set the JUA's rates. If they exceed the cost of providing such insurance, then the JUA is profitable; if not, as in the case of the MMIP, the JUA loses money.

Moreover, other than the rate differential from the voluntary market, JUA members receive a number of advantages over writing insurance directly. First, as mentioned above, the spreading of risk across the entire JUA membership decreases the chance that an individual member will experience losses from the JUA that significantly exceed the average expected loss from such business. This doubly benefits the member, which then will not need to charge a higher premium on its voluntary market policies to account for the possibility of a catastrophic loss from its payments on residual market business.

Second, due to increasing marginal returns from writing insurance business, at least at low levels of output, the JUA may be

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<sup>76</sup> Initially, it should be observed that even in the absence of voluntary market rate regulation, JUA members could never charge premiums through the JUA that exceeded those they would charge individual high-risk would-be insureds in the voluntary market. If they attempted to do so, providers who would not pay the premiums charged in the voluntary market would not pay the higher premiums charged by the JUA, either. This assumes, from the insurance consumer's perspective, that JUAs do not present any advantages over individual carriers outside of the premiums charged.

<sup>77</sup> This assertion does not conflict with the other statements in this Article that rates in the residual market are higher than those in the voluntary market. As a general matter, insurance consumers in the former market represent greater risks than those in the latter, so they will be charged higher rates. This is not to say, however, that any particular high-risk consumer will be charged more in the residual market than in the voluntary market. The distinction is between how much each market can charge the same insurance consumer.

able to write high-risk business at a lower administrative cost. The JUA, therefore, realizes greater profits (or smaller losses) than individual carriers. Whether this occurs depends on whether the JUA would be producing in the area of increasing or decreasing marginal returns. Also relevant is whether the administrative aspects of the writing of high-risk business are sufficiently different from those of voluntary market business so that a JUA member writing only in the former market will have a marginal cost advantage over an insurer that writes primarily in the latter, but writes more insurance business overall than does the JUA.

Third, a state may offer the JUA financial benefits that are unavailable to individual insurers. For example, JUA profits may be partly or wholly tax-exempt.<sup>78</sup> Alternatively, the state could reimburse a JUA or its members for net losses incurred. These compensating benefits shift to the government (and, by extension, the taxpaying general public) a portion of the burden of the JUA which would otherwise be borne by the JUA's members. Even if these advantages over voluntary-market insurance writing exist, whether a JUA member receives a net benefit from such membership depends in part on the JUA rates. If such rates are grossly inadequate, the advantages discussed in this paragraph will be insufficient to place the JUA members in a better position than they would be in were there no JUA. This is true unless the state covers not only JUA losses, but also provides members with some form of compensation for being a JUA member.

All residual market mechanisms also have a burdened class or classes. Certainly, the burdened class includes all those who have direct financial responsibility for any losses incurred in residual markets. If rates for JUA business are set significantly below the rates the individual insurers could obtain by writing the same insurance directly in the voluntary market, then the JUA will receive a lower profit (or greater loss) than if such business was insured in the voluntary market. This burden would be shared proportionately amongst the JUA's members (by virtue of their sharing proportionately in the profits and losses of the JUA), leaving them as members of the burdened class. The degree to which such burden falls upon the JUA's membership is dependent not only on the relative inadequacy of rates, but also upon the size

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<sup>78</sup> See, e.g., *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 63 (1st Cir. 2005) (stating that profits from Puerto Rico's automobile insurance JUA are tax-exempt).

and scope of such membership. Such programs can include all property and casualty companies doing business within the state as constituents. For example, New York's now-dissolved Medical Malpractice Insurance Association (MMIA), the immediate predecessor to the MMIP, included all licensed property and casualty carriers except assessment cooperative fire insurers.<sup>79</sup> In such a situation, the overall burden is spread widely, and, thus, the burden on each individual insurer is likely to be small. More often, JUA membership is confined to those writing the same type of insurance. For instance, the MMIP is restricted to medical malpractice insurance carriers.<sup>80</sup> The smaller the size of the membership, the greater the burden is on each individual insurer.

Additionally, the public itself may be burdened by the residual market program if the costs of the program are passed along to them. This might happen if, as discussed earlier, JUA profits are tax-exempt; in that case, the government passes the cost along to the public.<sup>81</sup> In the case of workers' compensation insurance, employers could shift part of the cost of the program to their customers by raising prices.<sup>82</sup> Similarly, if members of a medical malpractice insurance JUA attempted to cover losses from the JUA by increasing their own insureds' premiums, and those insureds (healthcare providers) then tried to make up the difference by increasing the fees they charge patients for services, the public (those patients) would be burdened.

The degree of governmental involvement in insurance markets varies significantly. In many cases, the state adjusts supply and/or demand curves to produce conditions under which coverage is compulsory, but can be afforded. Often, the state enacts legislation compelling insureds to purchase minimum coverage that, in essence, artificially establishes demand at that minimal level. At the same time, the state artificially creates supply through legislation creating the JUA, thus compelling insurers to fund the writing of coverage at a set premium.<sup>83</sup>

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<sup>79</sup> N.Y. INS. LAW § 5502(a) (McKinney 2000 & Supp. 2007).

<sup>80</sup> N.Y. COMP. CODES R. & REGS., tit. 11, § 430.2(b) (2001).

<sup>81</sup> See *supra* text accompanying note 78.

<sup>82</sup> Alternatively, employers could shift part of the cost of the program to their employees by reducing their salaries or benefits, in which case those employees would be paying the cost of a program that was initially devised to benefit them.

<sup>83</sup> This situation is distinguishable from mere rate-setting by the state, in which the insurer is not obligated to write any specific policy, but if it chooses to, must write it at a premium calculated using that rate. The latter is the situation in New York's voluntary market.

Figure 3 shows these forces in the form of a graph of a residual market; the only consumers (insureds) served by this market are high-risk insureds that could not obtain coverage in the voluntary market.<sup>84</sup> Suppliers (insurers) are compelled by law to participate in the JUA that issues policies to high-risk insureds. When either the law or practical considerations compel coverage,<sup>85</sup> insurance must be purchased regardless of the price.<sup>86</sup> The minimum insurance purchased per insured, irrespective of price, aggregates to a vertical demand curve ( $D_J D_J$ )<sup>87</sup>—here, hypothetically at \$400 billion in aggregate coverage.<sup>88</sup> The supply curve ( $S_J S_J$ ) is a horizontal line that reflects that insurers must write all assigned risks (insureds) who pay the regulator-set premium—here, hypothetically \$4.50 per \$1,000 in coverage.<sup>89</sup> The intersection of these two curves is point  $E_J$ .<sup>90</sup> Note that in the absence of this state-created market, given the industry's market supply curve of  $S_I S_I$ , insurers would offer a premium of \$6.50 per \$1,000 in coverage (see Point K) when an aggregate of \$400 billion is purchased.<sup>91</sup> Given the industry demand curve ( $D_I D_I$ ), however, in a free market, insureds would voluntarily pay only \$1.50 per \$1,000 of insurance when \$400 billion in aggregate insurance coverage is written (Point M).<sup>92</sup>

The \$4.50 premium shown in the graph may have been set in any of a number of ways.<sup>93</sup> In some cases, an initial rate is proposed by insurers and approved by regulators, with any increases subject to prior approval. In other instances, rates may be set by the insurer in the first instance, but may subsequently be challenged by the Superintendent or Commissioner of Insurance if found excessive or discriminatory. There are even situations where the actual premiums, as opposed to the rates, are set by regulators.<sup>94</sup> The

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<sup>84</sup> See *infra* app. fig.3.

<sup>85</sup> The latter is the situation in New York's voluntary market. See *supra* text accompanying note 60.

<sup>86</sup> The only alternative for the would-be insured is withdrawal from the market.

<sup>87</sup> See *infra* app. fig.3. The Js stand for "JUA."

<sup>88</sup> See *infra* app. fig.3. As a practical matter, some practitioners would withdraw from the market, or unlawfully continue to practice without insurance, rather than pay the higher premiums. For simplicity's sake, however, Figure 3 assumes neither of these circumstances occurs.

<sup>89</sup> See *infra* app. fig.3.

<sup>90</sup> See *infra* app. fig.3.

<sup>91</sup> See *infra* app. fig.3.

<sup>92</sup> See *infra* app. fig.3.

<sup>93</sup> See *infra* app. fig.3.

<sup>94</sup> See, e.g., *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 61–62 (1st Cir. 2005)

question of paramount importance is whether the rates are adequate to maintain program self-sufficiency.<sup>95</sup> Where the rates are inadequate, not only is the program threatened, but so are JUA members, that may be responsible for the JUA's losses.

As Figure 3 shows, the premium for residual market risks will be higher than that for the voluntary market because such risks present the potential for greater frequency and severity of claims and, therefore, justify a higher premium.<sup>96</sup> Although such higher premium may still be inadequate and generate losses, it is possible to realize a profit in the residual market.<sup>97</sup>  $AC_L$  represents a cost curve in which average cost is less than premiums charged at the aggregate quantity of insurance written.<sup>98</sup> Using that AC curve in Figure 3, the AC at point N, the intersection of  $AC_L$  and  $D_JD_J$ , is \$4.40, and there will be a profit of \$0.10 on every \$1,000 in coverage written, for a total profit of  $RE_JNW$ .<sup>99</sup> Assuming that the market return—the profit on favored risks—on policies written by a hypothetical individual carrier in the voluntary market is \$0.25 per \$1,000 in coverage, the rate of profit for the individual firm on JUA business is forty percent of that for business written in the voluntary market.<sup>100</sup> It must be borne in mind that JUA business is not written directly by the JUA member, however, and that the additional JUA business does not impact any JUA member's voluntary premium level or its AC.<sup>101</sup> Therefore, the profit on the business written through the JUA is pure; once the member receives its share of the JUA's profits, such share is not offset by any costs or any reductions in its own premiums.<sup>102</sup>

On the other hand, if average cost exceeds premiums at the aggregate quantity of insurance written, such as represented by the

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(explaining that under the JUA created pursuant to Puerto Rico's Compulsory Motor Vehicle Liability Insurance Act, the premiums themselves are set by the Commonwealth's Insurance Commissioner).

<sup>95</sup> See N.Y. INS. LAW § 2303 (McKinney 2006) ("Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers.").

<sup>96</sup> See *infra* app. fig.3.

<sup>97</sup> This issue is separate from that of who constitutes the benefited and burdened classes of a JUA, as writing coverage through a JUA may be profitable overall but not as profitable as writing through the voluntary market, in which case insurers are burdened.

<sup>98</sup> See *infra* app. fig.3. Here, "L" stands for low cost.

<sup>99</sup> See *infra* app. fig.3.

<sup>100</sup> See *infra* app. fig.1.

<sup>101</sup> A member's AC is affected, however, to the extent it is compelled to provide administrative services for the JUA, e.g., as a servicing carrier.

<sup>102</sup> See *infra* app. fig.3 (indicating the rectangular  $RE_JNW$  area).

$AC_H$  curve in Figure 3, there is a loss.<sup>103</sup> As shown, average cost is \$6.00 at the intersection of the  $AC_H$  curve and the  $D_J D_J$  curve at Point Y, resulting in a \$1.50 loss on every \$1,000 in insurance coverage written.<sup>104</sup> The rectangular area  $TYE_J R$  shows the loss written on JUA business, that is, the difference between premiums collected and costs incurred.<sup>105</sup>

As shall be discussed, the imposition of JUA losses can have a substantial adverse competitive effect on not only JUA members, but also upon those insured by JUA members, particularly if such insureds own the JUA member. It is worthwhile to turn now to the MMIP, in which setting such consequences will be reviewed.

*B. New York's Medical Malpractice Insurance Markets and the MMIP*

1. New York's Medical Malpractice Insurance Markets

Three basic markets compose New York State's medical malpractice insurance industry. In insurance parlance, there are voluntary, residual, and alternative markets. As discussed below, the term "market" has a particular antitrust meaning which may not necessarily coincide with the meaning that it has in the insurance industry. For the time being, we will refer to these three medical malpractice insurance markets, but with the understanding that they may be market groups made up of actual markets or submarkets. Moreover, as will be discussed, a market or submarket may be further distinguished by the activity insured, e.g., performing anesthesiology.<sup>106</sup>

*a. The Voluntary Market*

The voluntary market, consisting of domestic licensed medical malpractice carriers, is composed of what are sometimes called admitted carriers, including Medical Liability Mutual Insurance Company (MLMIC), which has approximately fifty-seven percent of the state's medical malpractice insurance market,<sup>107</sup> Physicians'

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<sup>103</sup> See *infra* app. fig.3. Here, "H" stands for high cost.

<sup>104</sup> See *infra* app. fig.3.

<sup>105</sup> See *infra* app. fig.3.

<sup>106</sup> See *infra* pp. 271-72.

<sup>107</sup> N.Y. STATE INS. DEP'T, MEDICAL MALPRACTICE INSURANCE MARKET SHARE ON GROSS

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Reciprocal Insurers (PRI), and Academic Health Professionals Insurance Association, a Reciprocal Insurer (Academic), who are reciprocal insurers<sup>108</sup> with market shares of roughly twenty-seven and two percent, respectively.<sup>109</sup> Because MLMIC, PRI, and Academic are member-owned,<sup>110</sup> their insureds are also insurers. There is also Hospitals Insurance Company, Inc. (HIC), a private stock insurance company that insures approximately five percent of the market.<sup>111</sup> These are the primary admitted carriers writing medical malpractice insurance for individual physicians and, in the case of MLMIC, PRI, and Academic, dentists in New York State.<sup>112</sup>

Each of New York's licensed medical malpractice carriers has membership qualifications that render its underwriting practices selective. To a significant extent, MLMIC, PRI, and Academic are in competition for the insurance business of physicians and dentists.<sup>113</sup> Although Academic's book of business is primarily limited to healthcare professionals who are in academia and engage in the clinical practice of medicine and dentistry under the auspices of a university medical teaching system,<sup>114</sup> PRI and MLMIC could provide coverage to Academic's insureds. MLMIC and PRI could also provide coverage to each other's insureds. Perforce, the three should be treated as economic rivals.

All of New York's admitted carriers are subject to a high degree of state regulation. Admitted carriers are required to file quarterly and annual financial statements with the Superintendent<sup>115</sup> and are

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PREMIUMS WRITTEN: CALENDAR YEAR 2005 (2006) [hereinafter MARKET SHARE] (on file with author).

<sup>108</sup> Reciprocals are a form of subscriber-owned insurers.

<sup>109</sup> MARKET SHARE, *supra* note 107.

<sup>110</sup> Academic Group, <http://www.academicins.com/index.html> (last visited Jan. 1, 2008) [hereinafter Academic Group]; Medical Liability Mutual Insurance Company, <http://www.mlmic.com/portal/> (last visited Jan. 1, 2008); Physicians' Reciprocal Insurers, <http://www.pri.com/index.htm> (last visited Jan. 1, 2008).

<sup>111</sup> See Hospitals Insurance Company, Inc., <http://hicgroup.com/> (last visited Jan. 1, 2008); MARKET SHARE, *supra* note 107.

<sup>112</sup> See N.Y. State Ins. Dep't, Authorized Insurers Writing Medical Malpractice Insurance in New York, <http://www.ins.state.ny.us/mmialist.htm> (last visited Jan. 1, 2008); MARKET SHARE, *supra* note 107.

<sup>113</sup> HIC insures primarily medical professionals affiliated with the five academic hospitals in the New York City metropolitan area that are beneficiaries of HIC's owner, the FFH Hospitals Trust. HIC does not presently insure a significant portion of the market of physician-insureds outside of those at these facilities. Interview with Martin L. Kern, Exec. Dir. & Gen. Counsel, Academic Health Prof'ls Ins. Ass'n, a Reciprocal Insurer, in New York, N.Y. (Nov. 1, 2007). Therefore, for the purposes of this Article only, HIC will not subsequently be discussed as a potential competitor of MLMIC, PRI, or Academic.

<sup>114</sup> See Academic Group, *supra* note 110.

<sup>115</sup> N.Y. INS. LAW §§ 307(a)(1), 315(b)(1) (McKinney 2006 & Supp. 2007); N.Y. INS. LAW §

subject to extensive audits by State-retained auditors.<sup>116</sup> Moreover, requests for rate increases are subject to prior approval by the Superintendent.<sup>117</sup> When each carrier submits its annual request for an increase in rates, it files its own loss data with the Superintendent.<sup>118</sup> Pursuant to the power vested in the Superintendent under Chapter 266, Laws of 1986 (the 1986 Law),<sup>119</sup> the Superintendent<sup>120</sup> has usually denied all or a part of every requested rate increase<sup>121</sup> by such carriers.<sup>122</sup> Each admitted carrier must also contribute to a state guaranty fund, which will honor the policies of any admitted carrier that becomes insolvent.<sup>123</sup>

To a large extent, the terms and conditions of policies are also addressed by statute or regulation.<sup>124</sup> This results in policies that are largely homogenous in nature. As a consequence, competition between admitted carriers is less a matter of the product, namely, the policy offered, than of the service provided and of the credibility of the insurer that may be called upon to honor claims against insureds. Competition among admitted carriers is blunted by the fact that ownership of carriers by their own insureds provides an insured with an incentive to remain with its own insurer, and to promote its success.<sup>125</sup>

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7605 (McKinney 2000 & Supp. 2007).

<sup>116</sup> *Id.* § 307(b)(1) (permitting Superintendent to review communications between an insurer and its accountant); N.Y. COMP. CODES R. & REGS. tit. 11, § 89.2(c) (2001) (allowing, like the Insurance Law, the Superintendent to review communications between insurers and their accountants).

<sup>117</sup> 1986 N.Y. Laws 2021, 2046.

<sup>118</sup> *Id.*

<sup>119</sup> *Id.*

<sup>120</sup> At the beginning of 2007, a new Superintendent took office. Any criticisms of “the Superintendent” in this Article are addressed to prior Superintendents, not the present one.

<sup>121</sup> *See, e.g.*, N.Y. STATE INS. DEPT, 2003 ANN. REP. OF THE SUPERINTENDENT OF INS. TO THE N.Y. LEG. 49, <http://www.ins.state.ny.us/acrobat/annrpt03.pdf>.

<sup>122</sup> There is no justification for doing so with respect to the request of admitted New York medical malpractice carriers. Any increase in rates would have been approved by these carriers’ governing bodies, who, unlike commercial carriers, are themselves insureds, so that such approval would constitute an expression of the owner-insureds’ will to maintain adequate reserves in a company through higher premiums that those insureds were willing to pay.

<sup>123</sup> N.Y. INS. LAW § 7603 (McKinney 2000 & Supp. 2007).

<sup>124</sup> *Id.* § 2307(b).

<sup>125</sup> For example, in the case of a New York reciprocal, the Superintendent must consent to the return of the subscriber’s capital advance. *See id.* § 1307(b). If the insurer is financially unsound, in which case there would ordinarily be a greater reason for the subscriber to withdraw from the reciprocal, the Superintendent is unlikely to approve the return of the advance, and the withdrawing subscriber might lose capital surplus. Currently, given the rising trends in frequency and severity facing admitted carriers, it is unlikely that such approval would be given.

*b. The Residual Market*

The second basic market in New York State is the residual market. As of December 31, 2006, this market, embodied in the MMIP, included 894 individuals receiving primary insurance coverage,<sup>126</sup> including 578 physicians, 209 dentists, 80 podiatrists, 5 nurse-anesthetists, and 22 nurse-midwives, as well as 34 professional corporations.<sup>127</sup> Also receiving primary coverage from the MMIP were 340 medical facilities.<sup>128</sup> This market is beset by the same problems that affect the voluntary market, e.g., increasing frequency and severity of claims, the long period over which such claims develop,<sup>129</sup> and great difficulty in predicting the value of claims,<sup>130</sup> only such problems are more pronounced.

Created by statute in 2000, and commencing its operations on July 1 of that year, the MMIP is a medical malpractice insurance residual market program prompted by New York State Insurance Law section 5502(c)(2)(D). This section instructs the Superintendent to create a plan for the equitable distribution to admitted medical malpractice carriers of medical malpractice insurance risks which the voluntary market refuses to cover. After receiving this direction, the Superintendent promulgated Part 430 of Title 11 of New York State's administrative code. The regulation, providing for compulsory membership in the MMIP of all admitted medical malpractice carriers (MMIP members),<sup>131</sup> defines the Plan's responsibilities,<sup>132</sup> and specifies the composition of its Board of Directors.<sup>133</sup> This regulation permits Plan members either to write assigned risks directly<sup>134</sup> or to become part of a JUA that creates a pooling mechanism, subject to the Superintendent's approval.<sup>135</sup> Members of this JUA would share proportionately in its income,

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<sup>126</sup> In the case of the New York State admitted market, carriers often issue policies covering the first \$1.3 million in payouts on any given claim. This is referred to as primary coverage. Excess insurance is insurance covering payouts above this \$1.3 million layer.

<sup>127</sup> MED. MALPRACTICE INS. POOL OF N.Y. STATE, MMIP INFORCE POLICY COUNT 2006 [hereinafter MMIP POLY COUNT] (on file with author). In addition, over 700 more practitioners receive excess insurance coverage from the MMIP. *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> See NAT'L PRACTITIONER DATA BANK, *supra* note 51, at 70 tbl.13.

<sup>130</sup> See *supra* Part I.B.

<sup>131</sup> N.Y. COMP. CODES R. & REGS. tit. 11, § 430.2(b) (2001).

<sup>132</sup> *Id.* §§ 430.2(c), 430.3.

<sup>133</sup> *Id.* § 430.4(a).

<sup>134</sup> *Id.* § 430.2(b).

<sup>135</sup> *Id.* § 430.4(b)(4)(ii).

costs, expenses, and losses.<sup>136</sup> Because of the benefits of pooling high risks as discussed above,<sup>137</sup> all MMIP members have chosen Scylla over Charybdis in satisfying their state-imposed MMIP obligation by participating in such a JUA (the MMIP Pool).<sup>138</sup>

*c. The Alternative Market*

The third market for medical malpractice insurance in New York consists of the non-admitted, or the so-called alternative, market. Non-admitted medical malpractice carriers insure approximately 5,000 physicians in New York through trusts created by or affiliated with hospitals through which these physicians practice. As of 1997, there were also twelve risk retention groups (RRGs) insuring healthcare providers in New York.<sup>139</sup> These are member-owned insurers licensed pursuant to the Federal Liability Risk Retention Act,<sup>140</sup> which sets forth certain basic parameters that facilitate the formation and operation of RRGs, and exempts RRGs from much of the regulation of states other than those in which they are chartered.<sup>141</sup> Such exemption bars state agencies from regulating the rates RRGs charge.<sup>142</sup> States may require RRGs to participate in residual market mechanisms,<sup>143</sup> though New York has declined to do so.<sup>144</sup> On the other hand, RRGs are not eligible for the protection of state insolvency guaranty funds.<sup>145</sup> As a consequence, RRGs and New York captives<sup>146</sup> provide an alternative to the admitted market, and can compete with licensed carriers, even

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<sup>136</sup> *Id.* The regulation does not define “proportionately,” but presumably it means in proportion to the members’ shares of the voluntary market for medical malpractice insurance.

<sup>137</sup> *See supra* Part II.A.

<sup>138</sup> JANET L. KAMINSKI, CONN. GEN. ASSEMBLY, OFFICE OF LEGISLATIVE RESEARCH, MEDICAL MALPRACTICE-FLORIDA AND NEW YORK (2004), <http://www.cga.ct.gov/2004/rpt/2004-R-0548.htm> [hereinafter MEDICAL MALPRACTICE-FLORIDA AND NEW YORK]. Medical Liability Mutual Insurance Company is the servicing carrier for the MMIP Pool. *Id.*

<sup>139</sup> NEIL D. LEVIN, N.Y. SUPERINTENDENT OF INS., THE STATUS OF THE PRIMARY AND EXCESS MEDICAL MALPRACTICE MARKET AND THE FUTURE NEED FOR THE MEDICAL MALPRACTICE INSURANCE ASSOCIATION 7 (1997), <http://www.ins.state.ny.us/acrobat/medmal2.pdf>.

<sup>140</sup> 15 U.S.C. §§ 3901–3906 (2000).

<sup>141</sup> *Id.* § 3902(a).

<sup>142</sup> *Id.* § 3902(a)(1).

<sup>143</sup> *Id.* § 3902(a)(1)(C).

<sup>144</sup> *See* N.Y. COMP. CODES R. & REGS. tit. 11, § 430.2 (2001).

<sup>145</sup> 15 U.S.C. § 3902(a)(2).

<sup>146</sup> In essence, a captive insurer is one which is owned by a parent entity with a controlling interest therein and which writes policies only at the parent’s direction. *See* N.Y. State Ins. Dep’t, New York Captive Insurance Solutions—What is a Captive?, <http://www.ins.state.ny.us/website3/captives/capwhat.htm> (last visited Jan. 1, 2008).

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though the policies they offer may be less desirable.

## 2. The MMIP

State involvement in the MMIP is extensive. The Superintendent's broad mandate that insurance through the MMIP is to be offered to virtually all healthcare providers that cannot obtain insurance in the voluntary market is a sweeping directive that dramatically disables MMIP members in setting underwriting guidelines. MMIP policy provisions are also the subject of the insurance law and regulations, and must be approved by the Superintendent.<sup>147</sup> Within the framework established by the Superintendent, the insurer-member's role is largely administrative. As noted above, the power to set rates, which overshadows all others, is exclusively in the Superintendent.<sup>148</sup>

Insurance Law section 5502(c) is silent as to the MMIP's purpose, and the legislative history thereof is not revealing.<sup>149</sup> Three interrelated motives are likely behind this program. The first is to maintain the availability of medical services offered by healthcare providers that, in the absence of affordable insurance, might withdraw from the market. This was the stated purpose of the 1975 formation of the MMIA, which was created at a time when soaring medical malpractice rates and unaffordable insurance posed the threat that healthcare providers might retire early from the practice of medicine, leave the state, or be discouraged from initially establishing practices in New York.<sup>150</sup> The New York State

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<sup>147</sup> N.Y. INS. LAW § 2307(b) (McKinney 2006 & Supp. 2007); N.Y. COMP. CODES R. & REGS. tit. 11, § 430.3(a).

<sup>148</sup> 1986 N.Y. Sess. Laws 503 (McKinney); N.Y. COMP. CODES R. & REGS. tit. 11, § 430.3(b).

<sup>149</sup> Section 5502(c) of the New York Insurance Law was enacted as Part JJ of Chapter 407 of the Laws of 1999, the state's budget for that year. There are no references to that particular provision in the *New York Legislative Annual* or *McKinney's New York Session Laws*. Instead, reference must be made to other malpractice legislation enacted by New York State, and the legislative history thereof. N.Y. INS. LAW § 5502(c) (McKinney 2000 & Supp. 2007); 1999 N.Y. Laws 2838.

<sup>150</sup> 1975 N.Y. LEGIS. ANN. 226. The crisis was addressed by the enactment of the Medical Malpractice Reform Act (1975 Act). 1975 N.Y. Sess. Laws 134 (McKinney). In addition to creating the MMIA, which offered coverage to healthcare providers who could not obtain insurance in the voluntary market, the 1975 Act modified the substantive and procedural law of malpractice to enable "the prompt and fair disposition of medical malpractice claims; . . . establish[ed] a . . . [financial source] within the State Insurance Fund to provide medical malpractice insurance [in the event] the [MMIA] . . . bec[a]me insolvent; and provide[d] improved procedures for [the] professional discipline of [physicians]." 1975 N.Y. Sess. Laws 1599 (McKinney). As it turned out, rather than obtain their insurance through the MMIA, the majority of insureds formed their own member-owned carriers. Press Release, Med. Soc'y of the State of N.Y., Medical Liability in New York State: The Problem and the Solution,

Legislature also cited this as a factor in its passage of medical malpractice reform legislation in 1985<sup>151</sup> and 1986.<sup>152</sup>

When the MMIA was abolished and replaced by the MMIP in 2000, however, New York's then-Governor Pataki justified it as an adjustment to a marked improvement in the condition of the voluntary market since the passage of the 1975, 1985, and 1986 malpractice reform legislation.<sup>153</sup> Under such circumstances, there was no reason to believe that without the MMIP, there would be significant withdrawals from the market. In 2000, it was entirely possible that the assigned risks of the MMIP would continue serving patients, while obtaining insurance from other sources, albeit at higher premiums. There was also no basis for concluding that, to the extent there were any withdrawals, existing healthcare providers could not service all patients. Currently, such basis is still lacking. Among New York State's 50,000 actively practicing physicians,<sup>154</sup> only 578, or roughly one percent, receive primary insurance coverage from the MMIP.<sup>155</sup> Even in the event of a mass exodus of physicians from the residual market because of higher premiums, it would therefore appear that the voluntary market and the thousands of physicians in the alternative market could address such withdrawals.

A second possible reason for the MMIP is to reduce health care costs to the public. The Legislature cited this as an additional rationale for the 1985<sup>156</sup> and 1986<sup>157</sup> medical malpractice reform legislation. It is unclear, however, whether this was a reason for the provisions therein regarding the MMIA specifically, or for other provisions in that legislation (such as, e.g., changes in substantive and procedural tort law).

The third possible purpose behind the MMIP was to ensure that patients are able to collect money judgments against healthcare

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<http://www.unitedformedicalaccess.org/press-releases1.htm> (last visited Jan. 1, 2008).

<sup>151</sup> 1985 N.Y. Laws 2138.

<sup>152</sup> 1986 N.Y. Laws 2021 (reforming medical and dental malpractice and professional conduct).

<sup>153</sup> "Conditions in the voluntary market have improved markedly since [1975] and have remained stable for over a decade. Thus, there is no longer the need for an instrumentality of the State to provide such insurance coverage." 2000 N.Y. LEGIS. ANN. 110.

<sup>154</sup> Press Release, N.Y. State Ins. Dep't, Superintendent Serio Announces Continued Stabilization of Medical Malpractice Rates for New York's Physicians (July, 1, 2004), available at <http://www.ins.state.ny.us/press/2004/p0407011.htm> [hereinafter Superintendent Serio Press Release].

<sup>155</sup> MMIP POL'Y COUNT, *supra* note 127.

<sup>156</sup> 1985 N.Y. Laws 2138-39.

<sup>157</sup> 1986 N.Y. Laws 2021-22.

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providers who would otherwise be without medical malpractice coverage. This goal is mentioned in New York's 1985 medical malpractice reform law.<sup>158</sup> There have been no studies concerning whether plaintiffs could satisfy claims against high-risk healthcare providers who would lack insurance in the absence of the MMIP. There is good reason, however, to conclude that such providers would obtain insurance even if premiums were quite high. These providers have licenses, earn income well above the national median,<sup>159</sup> and are likely to have substantial assets.<sup>160</sup> These wealth-related factors invite insurance protection. Moreover, for at least the past thirty-two years, there has been some state-created residual market program pursuant to which they have obtained insurance, i.e., the MMIA or the MMIP, so the economic culture includes acquiring protection.<sup>161</sup>

Regardless of which of the three aforementioned purposes is the genuine goal of the MMIP, the public is the ultimate beneficiary class, and MMIP insureds are, at best, incidental beneficiaries. Concern over the withdrawal of physicians as healthcare providers focuses upon the impact of such withdrawal upon the public. Similarly, the issue of how to provide financial recourse to plaintiffs injured as a result of medical malpractice is public in nature, and any legislation answering the problem benefits the public.

In part, both the public and the insureds, though beneficiary classes, also potentially bear the burden of the MMIP. In the case of the public, such onus will occur if healthcare providers are able to pass the cost of the MMIP onto their patients.<sup>162</sup> With respect to whether insureds pay for the MMIP, the issue turns upon the same considerations that apply to whether the insureds of any residual market program pay its cost, viz., the issue is based on the level at which MMIP rates are set and upon one's perspective as an insured or insurer. As will be discussed below, MMIP rates, particularly at the first excess layer, are below those that would have been set if

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<sup>158</sup> 1985 N.Y. Laws 2138–39.

<sup>159</sup> See SLOAN, *supra* note 65, at 21.

<sup>160</sup> See *id.*

<sup>161</sup> This situation can be contrasted with certain recent assigned risk automobile insurance programs, such as the Compulsory Motor Vehicle Liability Insurance Act, Law 253 (“CMVLIA”), which requires property damage insurance for all commercial and passenger vehicles in Puerto Rico. P.R. LAWS ANN. tit. 26, §§ 8051–8061 (1997 & Supp. 2005). Prior to CMVLIA, seventy to seventy-five percent of all vehicles did not carry such insurance, and it is therefore logical to conclude that the law created a market for such coverage. *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 60–61 (1st Cir. 2005).

<sup>162</sup> See *supra* Part II.A.

the insurer's supply curve had been followed.<sup>163</sup> Because the MMIP is compelled to offer insurance below the premium its members would otherwise demand, MMIP insureds may be considered part of the benefited class.

In practice, the MMIP has operated at a substantial loss. From its inception through December 31, 2006, Pool costs have exceeded revenues by approximately \$507.4 million.<sup>164</sup> The chief cause of the MMIP's financial problem is the Superintendent's inadequate rate setting, despite the fact that, as with all other medical malpractice insurance rates in New York, the MMIP's rates are supposed to be calculated to provide adequate reserves and to assure continued solvency.<sup>165</sup> Rate setting in the New York medical malpractice field essentially begins when a carrier is first licensed and seeks approval of rates by which premiums are calculated.<sup>166</sup> Thereafter, pursuant to the 1986 Law, each year the admitted medical malpractice carriers in New York file advisory rates with the New York State Department of Insurance, and the Superintendent ultimately sets the base rates.<sup>167</sup> Rates are based upon specialties and territory.<sup>168</sup> MMIP rates, initially approved by the Superintendent pursuant to the 1986 Law, have increased in the face of rising severity and frequency of claims, but for the most part not as much as requested by MMIP members.<sup>169</sup> In practice, the Superintendent has set rates so low that the MMIP has sustained losses<sup>170</sup> for each of the years that it has been in existence.<sup>171</sup>

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<sup>163</sup> See *infra* pp. 256–57.

<sup>164</sup> MED. MALPRACTICE INS. POOL OF N.Y. STATE, STATUTORY STATEMENTS OF ADMITTED ASSETS, LIABILITIES AND MEMBERS' DEFICIT (2006) (on file with author).

<sup>165</sup> See N.Y. INS. LAW § 2303 (McKinney 2006) ("Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition or detrimental to the solvency of insurers.").

<sup>166</sup> Interview with Martin L. Kern, Executive Dir. and Gen. Counsel, Academic Health Prof'ls Ins. Assoc., a reciprocal insurer, in New York, N.Y. (Oct. 11, 2005) [hereinafter Kern Interview]. See generally Academic Group, Executive Management, <http://www.academicins.com/executiveManagement.html> (last visited Jan. 1, 2008).

<sup>167</sup> 1986 N.Y. Laws 2046.

<sup>168</sup> Kern Interview, *supra* note 166.

<sup>169</sup> See Superintendent Serio Press Release, *supra* note 154. An issue related to the MMIP's rates is the absence of any capitalization. See *infra* p. 257.

<sup>170</sup> MMIP POLY COUNT, *supra* note 127. These losses are currently being carried on the books of MMIP member-insureds, but no demand for payment has yet been made upon MMIP members.

<sup>171</sup> A healthcare provider's past loss experience can be a portent for future claims. Accordingly, the rate formulas permit the consideration of the provider's loss experience, in that the insurer can impose a surcharge on premiums for providers with significant claims history. The rates set by the Superintendent, however, have still not permitted premiums to be high enough to cover anywhere near the full cost of claims against MMIP insureds. Press

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Although rate inadequacy is the most significant factor in MMIP's losses,<sup>172</sup> the MMIP was also financially challenged from the outset by virtue of its lack of initial capitalization. The MMIP's predecessor, the MMIA, was capitalized by advances and surcharges imposed upon high-risk insureds.<sup>173</sup> Even so, and despite the fact that the Superintendent will not license a carrier unless it is adequately funded,<sup>174</sup> this approach was abandoned when the MMIP was formed. This lack of capitalization resulted in the absence of a financial base upon which carriers traditionally rely not only for investment income, but also as a cushion to guard against insolvency if rates are set too low.

The inadequate rates, combined with a lack of initial capitalization, pose a potential liability for MMIP member-insurers, that are made responsible for the MMIP's losses,<sup>175</sup> and are required to report MMIP Pool losses on their financial statements as liabilities.<sup>176</sup> If MMIP members are called upon to pay this loss, it will result, in effect, in a forced subsidization by MMIP members of MMIP insureds. In the case of the mutual and reciprocal insurers that are MMIP members, the real cost of the MMIP will fall upon MMIP member-insurers' owner-insureds, because of their equity interest in such insurers as set forth above.<sup>177</sup> To the extent such owner-insureds have a financial interest in the MMIP member-insurer, such interest would be threatened by any imposition of the MMIP's losses upon their insurer. MMIP members have vainly attempted to avoid losses by urging rate adequacy, but have been generally unsuccessful in convincing the Superintendent that higher rates are needed.<sup>178</sup>

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Release, N.Y. State Ins. Dep't, Rate Increase Staves Off Looming Insurance Industry Crisis as New Task Force Confronts Medical Malpractice Reform (July 2, 2007), available at <http://www.ins.state.ny.us/press/2007/p0707021.htm>.

<sup>172</sup> Such inadequacy is particularly pronounced at the excess level.

<sup>173</sup> N.Y. INS. LAW § 5509(b) (McKinney 2000 & Supp. 2007) (original version at 1986 N.Y. Laws 2046) (establishing the MMIA stabilization reserve fund to be funded by contributions by MMIA policyholders).

<sup>174</sup> New York State's Insurance Law provides for minimum capitalization for carriers, and the Superintendent may insist upon greater funding. *E.g., id.* §§ 4103(a)(1), 4202.

<sup>175</sup> N.Y. COMP. CODES R. & REGS. tit. 11, § 430.4(b)(4)(ii) (2001).

<sup>176</sup> NAT'L ASS'N OF INS. COMM'RS, STATEMENT OF STATUTORY ACCOUNTING PRINCIPLES NO. 5, at 5-3 to -4 (2001) (on file with author) (requiring reporting of contingent liabilities on financial statements).

<sup>177</sup> *See supra* Part II.B.1.a.

<sup>178</sup> *See supra* p. 256. Recently, the Superintendent authorized rate increases for the MMIP, suggesting that he is considering the concerns underlying this Article. However, such increases are designed to address rate adequacy for the present year, not to eliminate debts accrued over prior years in which rates were inadequate. In this way, the recent rate

In part, this forced subsidization could involve what might be called intra-class subsidization. The latter occurs when one insured (Subsidizing Insured) is compelled to pay part of the cost of another insured (Subsidized Insured) who is also a competitor in the market in which the Subsidizing Insured conducts business (Insureds' Market). Providing intra-market coverage is the very essence of the business of insurance and is to be expected in the context of a particular insurer. For example, a medical malpractice insurer is likely to cover more than one anesthesiologist practicing in a particular geographic area, and anesthesiologists in such geographic area may be in competition with one another. When the insureds are not covered by the same carrier, however, but are forced to subsidize their competitors, this indirect, discriminatory "tax" raises issues of both fairness and economics. If, to change slightly the illustration given, lower-risk upstate anesthesiologists who are members of an admitted carrier were forced to subsidize higher-risk upstate anesthesiologists who were part of the residual market, an issue would be presented as to whether this compelled transfer of risk was fair and efficient. The imposition of MMIP losses upon MMIP members involves a transfer of cost and of risk within the market in which the insurers compete (the "Insurers' Market," the sum of the voluntary, residual and alternative markets discussed above), and a forced subsidization of costs involves a transfer within the Insureds' Market, which raises concerns relating to competition.

Any subsidization would also involve inter-class cross subsidies, where lower-risk members of one specialty would be subsidizing higher-risk healthcare providers practicing in another specialty. An illustration of inter-class subsidization would be low-risk upstate anesthesiologists paying higher premiums to cover the losses of high-risk downstate obstetricians. This form of forced subsidization also has anticompetitive effects to the extent that only some low-risk class members are forced to subsidize high-risk insureds, e.g., anesthesiologists who are members of admitted carriers which are MMIP members are subject to such subsidization, while anesthesiologists who are insured by RRGs are not.

The requirement that admitted carriers shoulder the burden of MMIP losses effectively shifts upward the individual carriers' MC curves in the voluntary market. This is because, at each level of insurance written by an admitted carrier in the voluntary market,

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increases are merely a stopgap measure, even assuming they are adequate.

the carrier must also assume a proportional percentage of MMIP's losses, which can be thought of as added costs that increase the individual carriers' marginal costs. An individual carrier's share of MMIP losses may reduce any profit it generates in the voluntary market, or even exceed such profit so that the carrier runs at a loss overall.

The MMIP's inadequate rates, the challenged medical malpractice market in New York, and the significant administrative barriers to entry into the medical malpractice market are reflected in the fact that since the MMIP was formed seven years ago, no new medical malpractice carriers have entered the voluntary market.<sup>179</sup> The lack of entry of new carriers into the field at least theoretically deadens initiative, lessens competition, and harms insureds by potentially reducing services.<sup>180</sup>

### III. THE ANTI-COMPETITIVE NATURE OF THE MMIP

#### A. Introduction

Although nothing herein is meant to suggest that the antitrust laws should be applied to MMIP members that are compelled to become parties to its operations and have been unfairly made responsible for its losses, principles developed in the application of these laws provide great insight into the deficiencies of the MMIP. These deficiencies frustrate basic objectives of the Act, while the MMIP fails to accomplish the goals it was presumably created to achieve. As shall be discussed, the MMIP turns antitrust law policy on its head,<sup>181</sup> but because of perceived immunities, New York's half-baked residual market creation has not been subject to antitrust enforcement that would reintroduce free-market forces.

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<sup>179</sup> When Hospital Underwriters Mutual Insurance Company, an admitted carrier, withdrew from the market, it also divested itself of its nursing home insureds, resulting in their becoming part of the MMIP Pool. See N.Y. STATE INS. DEPT, 2004 ANN. REP. OF THE SUPERINTENDENT OF INS. TO THE N.Y. LEG. 49, <http://www.ins.state.ny.us/acrobat/annrpt04.pdf>. There is a current attempt to form a reciprocal insurance company of nursing homes and adult facilities. See, e.g., C.A.L.M.-A Liberty Legal Plan, Liability Management, [http://www.libertylegalplans.net/Liability\\_Management.html](http://www.libertylegalplans.net/Liability_Management.html) (last visited Jan. 1, 2008).

<sup>180</sup> These negative aspects of market concentration, in the form of either monopoly or oligopoly, may well be offset by the fact that member-owned organizations are committed to maintaining quality products, even in the absence of direct competition. See, e.g., Medical Liability Mutual Insurance Company, *supra* note 110.

<sup>181</sup> See *infra* Part III.C.3.

When the MMIP is evaluated against legal and economic standards that are applied in cases brought under the Act, however, its shortcomings are apparent.

Although there is far from universal agreement on all of the Act's ends, there is a significant consensus that one of its primary missions is to preserve competition through the price system, which is the mechanism by which society places relative values upon goods and services, and allocates scarce resources.<sup>182</sup> There is also widespread agreement that the ultimate societal benefit of the price system is the maximization of consumer welfare, which is often considered in the application of the antitrust laws.<sup>183</sup> How to achieve the goal of preserving competition through the pricing system is a matter of debate, however. Economic and political theory are both implemented in the application of the Act, which was passed at a time when Congress was concerned with concentration of business power that was sometimes accompanied by predatory practices.<sup>184</sup> There was concern over the loss of entrepreneurial freedom, and of the redistribution of wealth from consumers to monopolists.<sup>185</sup>

The sponsor of the Act acknowledged that the statute does not clearly demarcate between lawful and unlawful acts and combinations.<sup>186</sup> In light of the Act's generality, there has been significant controversy over the way in which it is to be implemented. One school of thought believes that in preserving competition through the price system, the sole focus of the Act should be efficiency,<sup>187</sup> but even here there are competing

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<sup>182</sup> See, e.g., STEPHEN F. ROSS, PRINCIPLES OF ANTITRUST LAW 10 (1993).

<sup>183</sup> See, e.g., *id.* at 6–7, 9.

<sup>184</sup> *Id.* at 6–9, 11; E. THOMAS SULLIVAN & JEFFREY L. HARRISON, UNDERSTANDING ANTITRUST AND ITS ECONOMIC IMPLICATIONS § 1.02, at 3–4 (3d ed. 1998) (citing S.1, 51st Cong. (1st Sess. 1889), 21 CONG. REC. 2460, 2457, 3146, 3152 (1890), reprinted in 1 THE LEGISLATIVE HISTORY OF THE FEDERAL ANTITRUST LAWS AND RELATED STATUTES 89–90 (Earl W. Kintner ed., 1978)); Harlan M. Blake & William K. Jones, *In Defense of Antitrust*, 65 COLUM. L. REV. 377, 384 (1965); John J. Flynn, *Antitrust Jurisprudence: A Symposium on the Economic, Political and Social Goals of Antitrust Policy*, 125 U. PA. L. REV. 1182, 1187–88 (1977); Eleanor M. Fox, *The Modernization of Antitrust: A New Equilibrium*, 66 CORNELL L. REV. 1140, 1141–42 (1981); Robert H. Lande, *Wealth Transfers as the Original and Primary Concern of Antitrust: The Efficiency Interpretation Challenged*, 34 HASTINGS L.J. 65, 68–70 (1982); Louis B. Schwartz, *“Justice” and Other Non-Economic Goals of Antitrust*, 127 U. PA. L. REV. 1076, 1078 (1979); E. Thomas Sullivan, *The Economic Jurisprudence of The Burger Court's Antitrust Policy: The First Thirteen Years*, 58 NOTRE DAME L. REV. 1, 59 (1982).

<sup>185</sup> See sources cited *supra* note 184.

<sup>186</sup> SULLIVAN & HARRISON, *supra* note 184, § 1.03, at 7 (quoting 21 CONG. REC. 2460 (1890)).

<sup>187</sup> See, e.g., ROBERT H. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 91

contentions. Essentially, two categories of efficiency are considered in the application of the Act.<sup>188</sup> The first is allocative, and relates to the use of goods and services in those ways “in which they [will] have the highest value.”<sup>189</sup> It has been said that “allocative efficiency concerns overall placement of resources in the economy.”<sup>190</sup> There is, however, a tendency to confuse the aggregate welfare of society (both consumers and producers), which is maximized by optimum allocative efficiency, with consumer welfare alone.<sup>191</sup>

Monopolists have a propensity to reduce allocative efficiency by reducing output and, thereby, generating what is called deadweight loss. Deadweight loss results from a firm’s tendency to continue to produce only provided that the change in the firm’s total revenue from selling the last unit of the good, i.e., the marginal revenue (MR),<sup>192</sup> exceeds the MC of that unit’s production.<sup>193</sup> In most cases, a good’s MR is equal to its price. This is true of any firm operating under the classical model of perfect market competitors in atomistic competition,<sup>194</sup> as in Figures 1 and 2.<sup>195</sup> Any one such small firm, which cannot produce a significant portion of the products in its market, cannot affect the market’s total production of the good in question, or the market’s supply.<sup>196</sup> Since price is set by the intersection of the supply and demand curves, and such firm alone cannot affect either curve, the firm cannot affect the market price of the good, either. Its only incentive to restricting output is to avoid continuing to produce after its marginal cost has equaled price.

In contrast, as depicted in Figure 4,<sup>197</sup> a graph contrasting perfectly competitive and monopoly markets, the monopolist produces the entire supply in a given market. Since the price of a good depends on how many units of the good are offered for sale—the greater the number of units produced, the less the demand for

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(1978).

<sup>188</sup> *Id.* (noting that the two types of efficiency are “allocative” and “productive”).

<sup>189</sup> Howard A. Shelanski & J. Gregory Sidak, *Antitrust Divestiture in Network Industries*, 68 U. CHI. L. REV. 1, 18 (2001) (citing PAUL A. SAMUELSON & WILLIAM D. NORDHAUS, *ECONOMICS* 264 (15th ed. 1995)).

<sup>190</sup> Lande, *supra* note 184, at 78.

<sup>191</sup> See Reza Dibadj, *Saving Antitrust*, 75 U. COLO. L. REV. 745, 751, 753–54 (2004).

<sup>192</sup> See SAMUELSON & NORDHAUS, *supra* note 9, at 173.

<sup>193</sup> *Id.*

<sup>194</sup> *Id.* at 172, 175.

<sup>195</sup> See *infra* app. figs.1 & 2.

<sup>196</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 169 fig.10-3.

<sup>197</sup> See *infra* app. fig.4.

each unit and the lower the price per unit—and the monopolist controls market production, the monopolist's actions affect the good's price.<sup>198</sup> The more units the monopolist produces, the lower the price each one will have.<sup>199</sup> Perforce, the marginal revenue the monopolist receives for its last unit sold will not simply be that one unit's price because the sale of the last unit decreases the price of all the units produced earlier.<sup>200</sup> For a monopolist, then, marginal revenue is the price of the last unit it sells, less the decline in the aggregate value of all of its previous production as a result of the last unit's production.<sup>201</sup> The monopolist's marginal revenue curve will lie below the industry demand curve, because its revenue from selling any unit after its first will be less than that individual unit's price.<sup>202</sup> As a perfect competitor does, a monopolist will stop producing when "marginal revenue equals . . . marginal cost,"<sup>203</sup> assuming the monopolist has the same marginal cost curve as the perfectly competitive firm. This intersection, however, will occur at a lower level of output.<sup>204</sup> Thus, production in Figure 4<sup>205</sup> in a perfectly competitive market is where  $MC=D$ , or at point  $E_i$ , output ( $Q_i$ ) being \$250 billion in insurance, the same as in Figure 2;<sup>206</sup> whereas when a monopoly exists, the monopolist will stop selling where  $MC=MR$ , or at point  $H$ , where output is  $Q_M$ ,<sup>207</sup> approximately \$180 billion in insurance.<sup>208</sup> As consumers who wish to purchase the product must buy from the monopolist, however, consumers will purchase at the price on the demand curve corresponding to the new output level, i.e.,  $P_M$ , which is \$2.75 per \$1,000.00 of insurance sold.<sup>209</sup>

Ordinarily, societal welfare is maximized at the level of production of the perfectly competitive market.<sup>210</sup> Societal welfare can be thought of as total economic surplus, consisting of two forms of surplus.<sup>211</sup> One type is consumer surplus.<sup>212</sup> As indicated by the

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<sup>198</sup> See SAMUELSON & NORDHAUS, *supra* note 9, at 171–72.

<sup>199</sup> See *id.*

<sup>200</sup> *Id.*

<sup>201</sup> *Id.*

<sup>202</sup> See *id.* at 172.

<sup>203</sup> *Id.* at 173.

<sup>204</sup> See *id.* at 190.

<sup>205</sup> See *infra* app. fig.4.

<sup>206</sup> See *infra* app. fig.2.

<sup>207</sup> See *infra* app. fig.4. Here, the subscript "M" represents "monopoly."

<sup>208</sup> See *infra* app. fig.4.

<sup>209</sup> See *infra* app. fig.4.

<sup>210</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 150.

<sup>211</sup> *Id.*

downward-sloping demand curve, the more units of a particular good that are in existence, the less value consumers place on each individual unit.<sup>213</sup> Thus, the buyer of the first unit will place a greater value on the good than will the buyer of, e.g., the hundredth unit.<sup>214</sup> Yet, under the assumption that in a perfectly competitive market all units are sold at the same price, each consumer pays the same amount for his or her unit.<sup>215</sup> Thus, all but the last consumer of the good, e.g., the one hundredth, will buy his or her unit at a price less than the value such ninety-nine consumers ascribe to it. Such ninety-nine consumers obtain a greater value than that for which they paid.<sup>216</sup> This value, realized by the first ninety-nine consumers, is the consumer surplus,<sup>217</sup> which is a way of measuring consumer welfare. It is represented in Figure 2 by the area of the triangle  $FE_I A$ ,<sup>218</sup> and in Figure 4, in the event of a competitive market, by the triangle  $FE_I A$ .<sup>219</sup>

The second type of economic surplus is producer surplus.<sup>220</sup> Because the MC curve is upward-sloping, and a producer continues producing until its MC equals its MR, the revenue for each unit it produces<sup>221</sup> until the last exceeds the cost of such unit. Producer surplus is the sum of these differences between the prices and marginal production costs of each unit.<sup>222</sup> In Figure 2, this is the area of the shape  $AE_I X$ , where the lower boundary of this shape is the  $MC_I$  curve between  $E_I$  and  $X$ .<sup>223</sup> In Figure 4, if the market is competitive and output is at  $Q_I$ , this is the area of the shape  $AE_I X$ , where the lower boundary of this shape is the  $MC_I$  curve between  $E_I$  and  $X$ .<sup>224</sup> Economic surplus, the sum of the consumer and producer surpluses, is the area of the shape  $FE_I X$  in Figure 2,<sup>225</sup> or of the shape  $FE_I X$  in Figure 4 when the market is competitive.<sup>226</sup>

When a monopolist restricts its output, there is a loss of the

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<sup>212</sup> *Id.*

<sup>213</sup> *See id.* at 92.

<sup>214</sup> *Id.*

<sup>215</sup> *Id.*

<sup>216</sup> *Id.*

<sup>217</sup> *Id.*

<sup>218</sup> *See infra* app. fig.2.

<sup>219</sup> *See infra* app. fig.4.

<sup>220</sup> BORK, *supra* note 187, at 91; SAMUELSON & NORDHAUS, *supra* note 9, at 150.

<sup>221</sup> Assuming that production is in the range of increasing marginal costs.

<sup>222</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 150.

<sup>223</sup> *See infra* app. fig.2.

<sup>224</sup> *See infra* app. fig.4.

<sup>225</sup> *See infra* app. fig.2.

<sup>226</sup> *See infra* app. fig.4.

difference in the incremental surplus that would be realized at output levels between that of the monopoly and that in a competitive market.<sup>227</sup> The monopolist aggregates to itself the benefit of the higher price it charges at the expense of the consumer, without providing any countervailing advantage to offset the loss in total surplus stemming from the output restriction.<sup>228</sup> As alluded to earlier, this loss in total surplus is deadweight loss, and exists to the detriment of allocative efficiency.<sup>229</sup> In Figure 4, if the market is a monopoly, output is reduced to  $Q_M$ .<sup>230</sup> As noted above, at this output, price is \$2.75 per \$1,000.00 of insurance sold.<sup>231</sup> Consumer surplus is now represented by the triangle  $FE_MG$ .<sup>232</sup> Producer surplus is now the shape  $GE_MHX$ , where the lower boundary is the  $MC_I$  curve running from H to X.<sup>233</sup> Total surplus is now the area of the shape  $FE_MHX$ .<sup>234</sup> It is now less than  $FE_IX$ , surplus in the competitive equilibrium, by an amount equal to the area of  $EMEI_H$ .<sup>235</sup> Although the monopolist's price increase has enabled it to transfer  $GE_MRA$  from consumer surplus to producer surplus, its reduced production has made  $EMEI_H$  unavailable either to itself or to consumers.<sup>236</sup>

Deadweight loss does not occur only in the context of a monopoly, however.<sup>237</sup> Other market distortions which cause marginal revenue to lie below the demand curve will also cause deadweight loss.<sup>238</sup> For example, if an excise tax is imposed on a given product (e.g., gasoline), and the producers are required to collect it, they will increase their prices by the amount of the tax at each level of output.<sup>239</sup> This change is represented by an upward shift in the supply curve by the amount of the tax.<sup>240</sup> Because the demand

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<sup>227</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 190–91.

<sup>228</sup> *Id.*

<sup>229</sup> *Id.* at 191; *see also* Econweb.com, Industrial Policy: Structure & Efficiency, <http://www.econweb.com/Sample/IndustryPolicy/Industry-Efficiency12.html> (last visited Jan. 1, 2008).

<sup>230</sup> *See infra* app. fig.4.

<sup>231</sup> *See infra* app. fig.4.

<sup>232</sup> *See infra* app. fig.4.

<sup>233</sup> *See infra* app. fig.4.

<sup>234</sup> *See infra* app. fig.4.

<sup>235</sup> *See infra* app. fig.4.

<sup>236</sup> *See infra* app. fig.4.

<sup>237</sup> SAMUELSON & NORDHAUS, *supra* note 9, at 190–91.

<sup>238</sup> *Id.*

<sup>239</sup> Daniel S. Goldberg, *E-Tax: Fundamental Tax Reform and the Transition to a Currency-Free Economy*, 20 VA. TAX REV. 1, 14 (2000).

<sup>240</sup> *See* Robert William Alexander, *The Collision of Tribal Natural Resource Development and State Taxation: An Economic Analysis*, 27 N.M. L. REV. 387, 408 (1997).

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curve is downward-sloping and not flat, some consumers will not buy the product at the higher price, so the price will not increase by the full amount of the tax.<sup>241</sup> The new equilibrium, however, will be at a lower level of output with a resultant deadweight loss, just as in the monopoly example given above.<sup>242</sup> In this instance, there is a shift in the remaining total surplus, but rather than going from consumers to producers, it goes from both to the government.<sup>243</sup>

The second type of efficiency is productive efficiency, which refers to “individual firms’ use of their resources in the most effective manner.”<sup>244</sup> Where producers minimize their cost in using goods or services, productive efficiency is achieved.<sup>245</sup> Although productive efficiency was one of the goals considered by Congress in passing the Act, it was not a prime consideration.<sup>246</sup> The concept is of assistance, however, in screening out claims of antitrust injury which are actually the consequence of greater productive efficiency on the part of the claimants’ competitor.<sup>247</sup> Productive efficiency is also considered in relation to market concentration, it being generally believed that with greater concentration, there is likely to be greater productive efficiency.<sup>248</sup> Thus, the antitrust laws will not be used to condemn monopolies which exist by virtue of economies of scale,<sup>249</sup> i.e., the circumstance that increasing all factors of production in the same proportion (in effect, increasing the size of the monopoly company) has resulted in an increase in productivity or decrease in average cost of a product.<sup>250</sup> Antitrust laws have also been applied in such a way as to avoid other disincentives to productive efficiency. An illustration of this is *Broadcast Music, Inc.*

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<sup>241</sup> Richard Craswell, *Passing on the Costs of Legal Rules: Efficiency and Distribution in Buyer-Seller Relationships*, 43 STAN. L. REV. 361, 367–68 (1991).

<sup>242</sup> *Id.* at 367.

<sup>243</sup> See generally KARL E. CASE, *ECONOMICS AND TAX POLICY* 27–28 (1986) (discussing the effect of government taxes on supply and demand curves).

<sup>244</sup> Lande, *supra* note 184, at 78.

<sup>245</sup> Shelanski & Sidak, *supra* note 189, at 18.

<sup>246</sup> See Lande, *supra* note 184, at 89–90.

<sup>247</sup> *U.S. Gypsum Co. v. Ind. Gas Co.*, 350 F.3d 623, 627 (7th Cir. 2003).

<sup>248</sup> See Lande, *supra* note 184, at 90–93.

<sup>249</sup> See, e.g., *United States v. United Shoe Mach. Corp.*, 110 F. Supp. 295, 337, 343 (D. Mass. 1953), *aff’d per curiam*, 347 U.S. 521 (1954). Even commentators who favor “no-fault” liability for antitrust violations, such that liability does not depend upon a defendant’s anticompetitive purpose, do not favor liability for monopolization resulting from economies of scale. See Donald F. Turner, *The Scope of Antitrust and Other Economic Regulatory Policies*, 82 HARV. L. REV. 1207, 1220 (1969); Oliver E. Williamson, *Dominant Firms and the Monopoly Problem: Market Failure Considerations*, 85 HARV. L. REV. 1512, 1524–25 (1972).

<sup>250</sup> See SAMUELSON & NORDHAUS, *supra* note 9, at 735.

*v. CBS, Inc.*<sup>251</sup> There, the Supreme Court applied the rule of reason test, rather than the *per se* rule,<sup>252</sup> to the blanket licensing of copyrighted musical recordings.<sup>253</sup> It did so in part because of the prohibitive costs involved in obtaining licensing on the traditional song-by-song basis.<sup>254</sup>

Another consideration of the Act is whether there is market concentration, that is to say, how great a share one firm has of the market,<sup>255</sup> and whether that concentration was the product of anti-competitive behavior. Although the Jeffersonian vision of atomistic markets is not a primary goal in applying the Act, an approach that protects small competitors may be considered.<sup>256</sup> Doing so, however, may be in tension with the goal of promoting productive efficiency, because greater concentration in an industry may lead to economies of scale which enhance productive efficiency. In any event, the greater a dominant firm's share of the market, the more closely its actions will be scrutinized. Some antitrust scholars have even advocated "no-fault" monopoly liability,<sup>257</sup> i.e., enforcement of the Act against any firm that achieves a dominant share of the relevant market. Violations of Section 2 of the Act, however, have been found only where there has been willful acquisition or maintenance

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<sup>251</sup> *Broad. Music, Inc. v. CBS, Inc.*, 441 U.S. 1 (1979).

<sup>252</sup> The Supreme Court uses two different methods of analyzing restraints for Section 1 violations. The more frequently used standard is that of the rule of reason, in which the Court will rule the restraint illegal only if it is unreasonable, i.e., if it causes significant interference with, or negative impact on, competition, and such anticompetitive effects outweigh any countervailing pro-competitive effects. *See, e.g.*, *Tanaka v. Univ. of S. Cal.*, 252 F.3d 1059, 1063 (9th Cir. 2001). Some forms of restraint, however, are inherently uncompetitive and thus by their nature unreasonable and violations of Section 1, regardless of their business justification or the degree of impact on competition. *See, e.g.*, *NHL Players' Ass'n v. Plymouth Whalers Hockey Club*, 325 F.3d 712, 718 (6th Cir. 2003).

<sup>253</sup> *Broad. Music, Inc.*, 441 U.S. at 19–25.

<sup>254</sup> *Id.* at 20–21.

<sup>255</sup> For example, actual monopolization in violation of section 2 of the Act is generally established only if the alleged monopolist has a share of approximately seventy percent of the relevant market. Thomas A. Piraino, Jr., *Identifying Monopolists' Illegal Conduct Under the Sherman Act*, 75 N.Y.U. L. REV. 809, 813 (2000); *see also* *United States v. E. I. du Pont de Nemours & Co.*, 351 U.S. 377, 379, 391 (1956) (assuming monopoly status would exist if defendant's share were to compose seventy-five percent of the relevant market as defined by the court); *Colo. Interstate Gas Co. v. Natural Gas Pipeline Co.*, 885 F.2d 683, 694 n.18 (10th Cir. 1989) (stating "lower courts generally require a . . . 70%[-]80% [share]"); *Heattransfer Corp. v. Volkswagenwerk, A. G.*, 553 F.2d 964, 981 (5th Cir. 1977) (finding that a "71%–76% . . . share of the . . . market is sufficient to establish a monopoly power").

<sup>256</sup> *See* *United States v. Von's Grocery Co.*, 384 U.S. 270, 275 (1966); *Brown Shoe Co. v. United States*, 370 U.S. 294, 344 (1962), *superseded on other grounds by statute*, Act of Nov. 19, 1988, Pub. L. No. 100-703, § 201, 102 Stat. 4674, 4676 (codified as amended at 35 U.S.C. § 271(d)(4)–(5) (2000)).

<sup>257</sup> *E.g.*, *Turner*, *supra* note 249, at 1217.

of monopoly power. In effect, a distinction has been drawn between monopoly power achieved through a better product, business acumen, or productive efficiency, which we may refer to as “benign concentration,” and that which has been obtained through anti-competitive behavior, which can be referred to as “malignant concentration.”

The kind of anti-competitive behavior that the Act condemns is that which includes exclusionary conduct, i.e., acts designed to discourage other companies from entering the relevant market, or conduct which is predatory, that is, acts intended to drive existing competitors out of the market. An illustration of anti-competitive conduct that is predatory in nature is below-cost pricing.<sup>258</sup> This misconduct occurs when a firm cuts price to a level below its “cost,” with the expectation that by doing so, the cost-cutting firm will drive competitors from the market, and then will be able to raise its prices.<sup>259</sup>

#### *B. The Application of Principles Developed Under § 1 of the Act*

The objectives of the Act are imperfectly reflected in two sections thereof. Section 1 declares illegal “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce.”<sup>260</sup> This language has been construed to prohibit concerted activity pursuant to which competitors agree to reduce competition among themselves, or to hinder others from competing, and which results in an “antitrust injury.”<sup>261</sup> By acting in concert, erstwhile economic rivals can enjoy the resulting benefits of market dominance when individually they could not have had such an impact on the relevant market. Such concerted activities are anathema to the idealized eighteenth century concept that efficiency is best achieved when there is an atomistic market in which a vast number of sellers compete against each other.

Were it not immune from antitrust prosecution, and not the case that the MMIP member-carriers are blameless in establishing and

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<sup>258</sup> There is debate over whether predatory pricing occurs when it is below average cost or when it is below variable cost. The Supreme Court has expressly reserved ruling on this issue, instead simply characterizing predatory pricing as pricing which is “below an appropriate measure of [a] rival’s costs.” *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 222 & n.1 (1993).

<sup>259</sup> *See id.* at 225–26.

<sup>260</sup> 15 U.S.C. § 1 (2000).

<sup>261</sup> *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986).

enforcing the MMIP Pool, the MMIP would not fare well if scrutinized under Section 1. Ordinarily, an organization composed of competitors who charge a uniform price to a segment of the market, and who coordinate their activities to sell their product through a jointly operated association, would clearly fall within the ambit of Section 1 as a per se violation.<sup>262</sup> As a general proposition, residual market programs encourage the kind of interference with the pricing system that raises the possibility of antitrust abuses, and in the absence of state involvement, for which there is immunity from prosecution,<sup>263</sup> the typical residual market insurance program would be subject to prosecution under Section 1.<sup>264</sup> Indeed, because the product sold (i.e., MMIP insurance) is essentially homogenous, and the MMIP's premiums are determined only after MMIP members jointly submit requests for rate increases and the Superintendent then establishes the rates, the MMIP presents some classic elements of price fixing.<sup>265</sup> Such concerted activity interferes with the forces of supply and demand and leads to inefficiency in the production and allocation of limited resources.<sup>266</sup> Price is a reflection of supply and demand forces that express the economic will of the marketplace.<sup>267</sup> External influences that establish prices frustrate the operation of such forces, and may be challenged under the Act as a form of price fixing.<sup>268</sup>

As noted above, carriers which are part of the MMIP collectively write much of the same type of insurance<sup>269</sup> in the voluntary

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<sup>262</sup> An agreement to fix prices is a classic example of a per se violation of antitrust laws. *See, e.g.*, *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940). Such price-fixing can take the form either of an agreement among competitors to charge the same price, or a pact to fix the price indirectly by limiting output. *See, e.g., id.* at 224; *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397–98 (1927).

<sup>263</sup> *See infra* discussion of *Parker* doctrine Part IV.C.

<sup>264</sup> *See* *Citizen Publ'g Co. v. United States*, 394 U.S. 131, 133–36 (1969) (holding that joint operating agreement between two newspapers, by which subscription and advertisement rates were set jointly and profits were pooled and distributed according to a fixed ratio, violated Section 1 of the Act), *superseded by statute*, Newspaper Preservation Act, Pub. L. No. 91-353, §§ 2–5, 84 Stat. 466, 466–67 (1970) (codified at 15 U.S.C. §§ 1801–1804 (2000)).

<sup>265</sup> *See, e.g., Socony-Vacuum Oil Co.*, 310 U.S. at 221 (holding that price-fixing existed where combination was formed for the purpose of setting and controlling the price of gasoline—a homogenous product).

<sup>266</sup> *See* Ben Walther, Note, *Employment Agreements and Tender Offers: Reforming the Problematic Treatment of Severance Plans Under Rule 14D-10*, 102 COLUM. L. REV. 774, 802 n.123 (2002).

<sup>267</sup> *See Socony-Vacuum Oil Co.*, 310 U.S. at 210.

<sup>268</sup> *See, e.g., id.* at 224.

<sup>269</sup> All MMIP member carriers write medical malpractice insurance in both the voluntary and, indirectly through the MMIP, the residual market. *See, e.g., PHYSICIANS' RECIPROCAL*

market. This means they are involved in implementing a residual market program which, in the absence of administratively-set inadequate rates, would at least potentially be in competition with their voluntary business. In the absence of some form of immunity, these activities minimally would be tested under a rule of reason. This standard questions whether the challenged activity has a pro-competitive purpose. It is hard to conceive how the MMIP would satisfy a rule of reason test, given the adverse effect on competition which follows from its rate inadequacy.<sup>270</sup> The MMIP is being implemented in a manner that satisfies neither the goal of efficiency, nor the goal of protecting small competitors. It is destroying both.

Inadequate rates lie at the core of the MMIP's problems, which is a reflection of the fact that a price system free from interference is the bedrock of economic efficiency in competitive markets. When the government takes the approach of setting prices so artificially low, it dramatically deviates from the basic principles that typically govern the marketplace. Even in light of the objective that medical malpractice rates be set at the lowest possible levels to insure continued solvency, the MMIP's rates fall short of that target. In the past, most state governments have been more careful to establish rates that at least do not cripple those carriers which are compelled to participate in the residual market. When they have failed to do so, disaster has followed in the wake of price inadequacy.<sup>271</sup>

Putting aside for the moment the issue of the MMIP's rating deficiencies, there are many instances where the rate set by the government for a residual insurance market generates a profit. As discussed above in reference to Figure 3, if the average cost of residual market business is low relative to where the rate is set, a

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INSURERS, 2006 ANN. REP. 10, available at [http://www.pri.com/assets/images/pdf/pri\\_annual\\_2006b.pdf](http://www.pri.com/assets/images/pdf/pri_annual_2006b.pdf). None, however, directly writes nursing home risks, and not all write hospitals. See Academic Group, FAQs, <http://www.academicins.com/faq.html> (last visited Jan. 1, 2008) [hereinafter Academic, FAQs]; Medical Liability Mutual Insurance Company, MLMIC's Mission, <http://www.mlmic.com/portal/AboutUs.aspx> (last visited Jan. 1, 2008); Physicians' Reciprocal Insurers, About the Company, <http://www.pri.com/html/hs-index.htm> (last visited Jan. 1, 2008). For example, Academic primarily writes medical liability insurance for physicians and dentists who teach medicine and dentistry and who engage in clinical practice. See Academic, FAQs, *supra*.

<sup>270</sup> See *infra* discussion Part III.D.

<sup>271</sup> See AM. ACAD. OF ACTUARIES, *supra* note 1, at 6 (discussing crisis in workers' compensation insurance industry during late 1980s resulting from inadequate rates set by state regulators).

JUA can turn a profit from writing such business.<sup>272</sup> In addition, as discussed above, the government has the means of increasing such profitability, such as making such profits tax exempt.<sup>273</sup>

When a JUA realizes a profit for its members, competing carriers may act in concert to protect these profits. The caselaw illustrates that agreements between JUA members, which compete in the voluntary market and act in concert in the residual market, can take many forms, from agreements to set the prices of insurance policies,<sup>274</sup> to agreements to reduce services offered in the residual market so as to increase members' profits.<sup>275</sup> Section 1 of the Act is designed to prevent competitors from combining their economic power in ways that injure competition. As discussed above, in the absence of immunity, such activities could be challenged under the Act.<sup>276</sup> Even in a setting where a profit is being earned in the residual market, however, consideration must be given to the fact that the carriers are being compelled to participate in a program in which profits are substantially less than what the carriers could earn in that market absent governmental intervention in the form of the JUA and rate regulation in the voluntary market. Under free-market conditions, these admitted carriers would not write residual market business without a greater increase in premiums. Consequently, such carriers should not be liable under Section 1.

*C. The Application of Principles Developed Under Section 2 of the Act*

The type of analysis that is sparked when, as in the case of the MMIP, a JUA incurs losses rather than profits may invoke considerations that are associated with Section 2, which makes it illegal to "monopolize" or "attempt to monopolize" a relevant market.<sup>277</sup> Three elements of Section 2 will now be discussed in the context of the MMIP.

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<sup>272</sup> See *supra* Part II.A.

<sup>273</sup> See *supra* Part II.A.

<sup>274</sup> See, e.g., *Uniforce Temp. Pers., Inc. v. Nat'l Council on Comp. Ins., Inc.*, 892 F. Supp. 1503, 1509 (S.D. Fla. 1995), *aff'd*, 87 F.3d 1296 (11th Cir. 1996).

<sup>275</sup> See, e.g., *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 67 (1st Cir. 2005).

<sup>276</sup> See *supra* Part III.B.

<sup>277</sup> 15 U.S.C. § 2 (2000).

## 1. Defining the Relevant Market

Under the Act, a “market is composed of products that have reasonable interchangeability for the purposes for which they are produced—price, use and qualities considered.”<sup>278</sup> In addition, the definition of a market has a geographic component: “The geographic market extends to the area of effective competition . . . where buyers can turn for alternative sources of supply. The product market includes the pool of goods or services that enjoy reasonable interchangeability of use and cross-elasticity of demand.”<sup>279</sup> Defining the term “market” for the purposes of the Act, thus, involves determining whether a homogenous product is sold within a geographic area in which consumers will purchase the product in preference to a substitute. In addressing this question, courts inquire whether products differ in nature and function, and whether consumers will treat them as substitutes.<sup>280</sup> These aspects of the definition of “market” raise interrelated concepts, e.g., whether one product can replace another is determined, in part, by functional interchangeability, which in turn involves the physical characteristics of the products used, but also includes the product’s perceived use by consumers. Regarding the product’s physical characteristics, the nature of the product and the purposes it serves are considered.<sup>281</sup>

An insurance “product” consists of a combination of factors. The most obvious is policy provisions. Other characteristics involved are the quality of the insurer’s service, however, including the insurer’s facilitation of the application and renewal processes, the claims-handling and resolution, and the quality of defense counsel retained. Another factor is the ability of the insurer to meet its defense and indemnification obligations, or, in the event of such inability, the existence of a state guaranty fund to fulfill those obligations. Whether products are interchangeable depends on how similar they are as to each of these factors.

Whether consumers perceive products as interchangeable is addressed by the concept of cross-elasticity of demand, which describes a buyer’s willingness to substitute one product for

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<sup>278</sup> United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 404 (1956).

<sup>279</sup> Tanaka v. Univ. of S. Cal., 252 F.3d 1059, 1063 (9th Cir. 2001) (internal quotation marks omitted) (alteration in original).

<sup>280</sup> Brown Shoe Co. v. United States, 370 U.S. 294, 325 (1962); *E. I. du Pont de Nemours & Co.*, 351 U.S. at 393.

<sup>281</sup> See *Brown Shoe Co.*, 370 U.S. at 325.

another.<sup>282</sup> Cross-elasticity of demand is high if buyers are willing to purchase substitutes based upon slight changes in price.<sup>283</sup>

Defining the relevant market is a flexible process. Courts have recognized that the approach is fact-sensitive and takes into account numerous factors.<sup>284</sup> When appropriate, it may be necessary to consider whether a submarket exists. Characteristics used in assessing the boundaries of a submarket include “industry or public recognition of the submarket as a separate economic entity, the product’s peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors.”<sup>285</sup> Key considerations include “the uniqueness of the product’s functions and . . . uses.”<sup>286</sup>

## 2. New York’s Medical Malpractice Insurance Markets

Turning to New York’s medical malpractice industry, these concepts should first be applied to the three markets that were previously discussed, i.e., the voluntary market, residual market, and alternative market.<sup>287</sup> With respect to the voluntary market of admitted medical malpractice insurance carriers, they all, in essence, offer a homogenous product, particularly insofar as statute and insurance regulation mandate the inclusion of certain policy provisions and regulators must approve changes to the policies. This is not to say that the products are homogenous outside distinct groups. Product categorization must be made on the basis of fundamentally different roles the insured plays, e.g., hospitals as opposed to physicians. Within these broad groups, however, policies may have significant similarities.

The rates for policies also vary among groups and among specialties, e.g., rates upon which anesthesiologists’ premiums are based will be lower than those upon which obstetricians’ are based. Moreover, premiums will vary among insurers with respect to the same specialty. Since rates must be pre-approved by the Superintendent, however, there is some similarity within specialties. Insofar as there are differences between specialties, the voluntary medical malpractice insurance market should, where

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<sup>282</sup> *E. I. du Pont de Nemours & Co.*, 351 U.S. at 380–81.

<sup>283</sup> *Id.* at 400.

<sup>284</sup> *See Brown Shoe Co.*, 370 U.S. at 325.

<sup>285</sup> *Id.*

<sup>286</sup> 54 AM. JUR. 2D *Monopolies, Restraints of Trade, and Unfair Trade Practices* § 59 (1996).

<sup>287</sup> *See supra* Part II.B.

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appropriate, be viewed as consisting of numerous smaller markets or submarkets, based on geography and rates. For example, premiums for anesthesiologists practicing in upstate New York will not compare with premiums for obstetricians practicing in Brooklyn. When deciding from whom to purchase insurance, however, practitioners in these separate specialties will be interested in the offerings of all carriers within their geographic areas.<sup>288</sup>

As a consequence of differences between the basic policy offered by an admitted carrier and that offered by a non-admitted carrier, competition among admitted carriers is more probable than that between admitted carriers and non-admitted carriers.<sup>289</sup> What largely distinguishes admitted carriers from one another are the services they provide and the ways they are structured. The first issue is self-explanatory; with respect to the second, PRI and Academic are reciprocals, while MLMIC is a mutual. With both reciprocals and mutuals, a form of investment is made at the inception of the policy, but there are differences in the way that investment is treated while the insured is a subscriber. In all instances, a certain degree of inertia surrounds the subscriber's continued membership in an organization in which the insured has an ownership interest and in which there is a degree of self-governance.

Another source of inertia is that no new insurers have entered the voluntary market since the MMIP was formed. In the last seven years, the only change in the composition of the voluntary market's producers has been Frontier Insurance Company's 2001

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<sup>288</sup> As a practical matter, however, there are no licensed out of state carriers offering physicians or dentists affordable medical malpractice insurance in New York. Although the alternative market is in potential competition with the admitted market, for the most part only RRGs, which are part of the former market, offer a possible alternative to the latter although for practical reasons the RRG policy may be unacceptable. *See supra* Part II.B.1.c (noting that RRGs do not offer protection through the state guaranty fund). Insureds of captives, which are part of the non-admitted market, are more likely to have their source of insurance coverage determined by factors that are not related to competition, e.g., the existence of a trust fund available to pay claims against physicians on staff at a particular hospital.

<sup>289</sup> As discussed, the admitted carrier offers a policy that is backed by the state guaranty fund, and the insurer issuing such policies is subject to a high degree of state regulation. *See supra* Part II.B.1.a. Despite these attractions, however, there is a point, fast approaching in New York, when competition between the admitted and alternative markets will occur, largely because of adverse financial conditions facing the admitted market, including potential MMIP Pool losses.

insolvency.<sup>290</sup> The potential burden of compulsory MMIP Pool membership discourages new carriers from entering the voluntary market.<sup>291</sup>

Turning to the residual market, all insureds within the same specialty are offered, at a set rate, the same product through the MMIP Pool. There is no competition within this market itself, and there is no competition between this market and the voluntary market. The absence of such competition is based upon the fact that before any insured can be written in the residual market, the insured must be turned down by insurers in the voluntary market.<sup>292</sup> There is theoretical competition, however, between the residual market and the alternative market. Insureds are not required to be turned down by the alternative market, as opposed to the voluntary market, before obtaining insurance through the residual market. If the alternative market can charge lower rates than the MMIP, then it has the ability to entice away MMIP insureds. This would only occur in a case where the voluntary market either has no product to offer the insured or has refused to insure, and an alternative market insurer believes that it can realize a profit even at rates lower than those charged by the MMIP Pool. Where an alternative market insurer is able to identify situations where the voluntary market has not been able to recognize an opportunity, and the MMIP's rates are adequate with respect to the particular risk insured, then such a non-admitted carrier may compete against the MMIP Pool. This is an unlikely scenario, given the inadequacy of the MMIP's rates. Consequently, there is little competition between the MMIP Pool servicing the residual market and carriers issuing policies in the alternative market.

This lack of competition reflects the fact that the MMIP does not promote competition through the pricing system. By setting inadequate MMIP rates, the Superintendent has created an environment where premiums charged in the residual market

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<sup>290</sup> Frontier Ins. Group, Inc., Current Report (Form 8-K), at 2 (Apr. 16, 2001).

<sup>291</sup> Only in the case where MMIP rates are viewed as excessive will there be any competition with the MMIP Pool, and an incentive for a new admitted carrier to enter the market. This scenario may have come into being with respect to adult nursing home insureds, which, as of this writing, are attempting to form their own admitted reciprocal insurer.

<sup>292</sup> See N.Y. INS. LAW § 5502(c)(2)(D) (McKinney 2000 & Supp. 2007) (directing superintendent to promulgate regulations for those unable to obtain coverage in the voluntary market); N.Y. COMP. CODES R. & REGS. tit. 11, § 430.2(a) (2001).

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reflect neither supply nor demand, and which discourages other carriers from competing for business in the residual market in New York, as set forth above. While it is recognized that by their nature, residual markets involve price interference, when such interference is significant it becomes destructive of the primary goal of antitrust law, by hindering rather than promoting competition.

Not only does rate inadequacy discourage alternative market insurers from competing within the residual market, the potential burden of compulsory MMIP Pool membership discourages new carriers from entering the voluntary market and, therefore, the MMIP Pool. Just like the voluntary market, the residual market has had no new entrants in seven years.<sup>293</sup> With the lack of recent market entry, and rate inadequacy continuing to discourage new entrants, there has been a total lack of innovation in the residual market. Innovation in the setting of an insurance market might be reflected in programs designed to control risks, offer consumers a better insurance product, provide superior services, or streamline claims processing. Studies show, however, that where there is rate inadequacy, or where components by which rates are set do not provide incentives for innovations, carriers will not improve their product.<sup>294</sup> The inadequacy of rates strips the JUA of any funds that could be used to initiate programs to reduce losses, provide better administration of the program, or incentivize JUA members to provide better service.

There is potential competition, however, between carriers in the alternative and the voluntary markets. As discussed earlier, the products sold in the three insurance “markets” are not homogenous because the policies of admitted carriers are backed by the state guaranty fund and such carriers are highly regulated, leading to greater assurance that they will honor their contractual commitments to insureds.<sup>295</sup> The greater desirability of policies

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<sup>293</sup> *But see supra* note 291 (noting that as of the time of this writing, nursing home insureds were trying to form their own admired reciprocal insurer).

<sup>294</sup> *See* Danzon & Harrington, *supra* note 2, at 8.

<sup>295</sup> *See supra* Part III.C.2. Another advantage afforded by law to physicians of insureds of admitted medical malpractice carriers is free excess insurance, viz., coverage of losses incurred over \$1.3 million through \$2.3 million. 1986 N.Y. Sess. Laws 487 (McKinney). This advantage does not inure directly to the benefit of admitted medical malpractice insurance carriers, however, which, although they receive premiums paid by the state, are still responsible for losses covered by the excess insurance. MEDICAL MALPRACTICE-FLORIDA AND NEW YORK, *supra* note 138. Therefore, the balance of admitted carriers is not affected by the fact that the State, rather than their insureds, pays for such coverage. There is an indirect benefit to the insurers, however, because the free excess insurance increases their

issued by voluntary carriers, however, is tempered by economic considerations. Admitted carriers are saddled with expenses that are not imposed upon non-admitted carriers. These include payments to the state guaranty fund and costs associated with compliance with state regulations, such as auditing costs. One of the most significant potential costs is the responsibility that admitted carriers have for the MMIP Pool. With admitted carriers collectively reporting aggregate losses of over \$507 million on their balance sheets,<sup>296</sup> the financial indicators that are used to evaluate those carriers' financial stability have been adversely affected. As a consequence, independent rating organizations that assess the financial strength of insurance carriers have reduced their ratings of New York admitted medical malpractice carriers, some of which in response have chosen not to be rated altogether.<sup>297</sup> Ratings that are reduced, or outright absent, have negatively impacted the ability of these carriers to attract new business, insofar as these ratings are considered by prospective insureds. At the point where the advantages afforded by admitted carrier policies are outweighed by the additional costs and the potential burden facing such carriers, consumers will purchase in the alternative market to the extent they are able to do so. Many insurance consumers will choose not to be insured by admitted carriers, knowing that such carriers are operating under the shadow of the MMIP Pool.<sup>298</sup>

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attractiveness to insureds relative to alternative market carriers, the insureds of whom do not receive free excess insurance.

<sup>296</sup> MMIP POL'Y COUNT, *supra* note 127.

<sup>297</sup> See, e.g., *A.M. Best Downgrades MLMIC Group, Princeton and OHIC Ratings*, CLAIMS J., June 16, 2003, <http://www.claimsjournal.com/news/east/2003/06/16/29870.htm>; *MLMIC Withdraws from A.M. Best Rating System*, NEW DEV. (Med. Liability Mutual Ins. Co., N.Y.), Fall 2004, at 14, available at [http://www.mlmic.com/portal/Files/Dateline/DatelineFall04\\_10.pdf](http://www.mlmic.com/portal/Files/Dateline/DatelineFall04_10.pdf) (announcing MLMIC's withdrawal from annual rating by A.M. Best Company).

<sup>298</sup> Legislation has been introduced in the New York State Assembly that would remove the MMIP's accumulated losses from MMIP members' balance sheets. See Assemb. 6471, 2007 Leg., 230th Sess. (N.Y. 2007), available at <http://assembly.state.ny.us/leg/?bn=A06471>. It would dissolve the MMIP Pool and create in its place a new Medical Liability Insurance Association (MLIA), of which all admitted medical malpractice insurers in New York would be members, to provide medical malpractice insurance to the residual market. *Id.* sec. 1, § 5502 & (D). The MLIA would receive all of the MMIP Pool's assets and assume all of its liabilities, and "[t]he historical net impact of the [MMIP] pool on a member's financial statement . . . shall be removed by reducing to zero any asset or liability directly relating to the pool and reflected in the member's most recent filed statutory financial statement." *Id.* sec. 1, § 5502(D). This bill has been referred to the Assembly's Committee on Insurance. *Id.*

### 3. Applying Section 2 Economic Principles to the MMIP

When economic principles developed in applying Section 2 of the Act are considered in relation to the competitiveness of the voluntary market, an irony is presented. Ordinarily, increased industry concentration results in a strengthening of the remaining individual competitors' financial well-being, with oligopolists enjoying a superior status to that afforded by atomistic competition, and with monopolists enjoying even greater benefits than oligopolists. As discussed earlier, a monopolist can, by restricting output, raise prices and transform consumer surplus into producer surplus.<sup>299</sup>

The concentration among MMIP insurers, however, produces economic weakness, not strength. As noted above, by discouraging new entrants into the voluntary market because of potential exposure to the MMIP Pool's losses, the Superintendent has maintained a de facto oligopoly of admitted carriers, albeit an involuntary one.<sup>300</sup> At the same time, the MMIP has eroded the capital base of the already financially challenged admitted carriers. Continued rating inadequacy will lead to the progressive failure of such admitted carriers, which will be unable to absorb their proportionate share of MMIP Pool losses because of diminishing reserves. As each carrier is unable to pay such losses, it will fail or withdraw from the market, leaving fewer remaining admitted carriers to shoulder the burden of the MMIP. Eventually, only one carrier may remain in the market, or none at all if the burden of the MMIP becomes too great to bear.<sup>301</sup>

This is precisely how predatory pricing impacts upon a market and results in concentration, except that in the typical predatory pricing situation, it is the last remaining competitor that has generated the conditions which drove competitors from the market, and with the knowledge that its own financial strength will ultimately enable it to increase prices when there is no competition. Here, the state has performed that function, but in the process, it has weakened all admitted carriers, perhaps leading to a situation where there are no survivors. Presumably, the way in which this

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<sup>299</sup> See *supra* Part III.A.

<sup>300</sup> See *supra* Part III.C.2.

<sup>301</sup> During the late 1980s, the costs of subsidizing workers' compensation residual market mechanisms were so great that the voluntary insurance market collapsed in a few states. AM. ACAD. OF ACTUARIES, *supra* note 1, at 6.

condition can be corrected is if the state, at some point, raises MMIP rates to ensure adequacy. In the meantime, all that the Superintendent would have accomplished during this time period is to defer a problem, weaken the voluntary market, and possibly lead to its greater concentration because carriers may fail between now and the time rates are raised to an adequate level.

The kind of concentration resulting from the Superintendent's inadequate rate setting is not benign concentration because such concentration is not achieved through a superior product, business acumen, or productive efficiency. While it cannot be termed malignant concentration insofar as it has not been achieved through its members' anti-competitive behavior, any concentration brought about because the MMIP insulates its members from competition warrants comparison to malignant concentration because it is achieved through a pricing mechanism that discourages competition.

In the event that all carriers fail, the state's anti-competitive actions will result in an implosion when the last carrier is unable to recoup losses and is overwhelmed by the inadequate rate structure imposed by the Superintendent. During the time that this completely perverse process occurs, there would be more and more pressure for insureds to look to the alternative market. When any admitted carrier fails, it is unlikely that its insureds will choose to be covered by another admitted carrier that may very well be the next to be overwhelmed by the same adverse forces that drove their previous carrier into insolvency.

The three insurance markets are not the only ones affected by the MMIP Pool. Consideration must be given to the Insureds' Market.<sup>302</sup> As has been noted, imposing the losses of the MMIP Pool upon low-risk insureds would force the three insurance markets to subsidize high-risk insureds.<sup>303</sup> To the extent such losses are actually paid, MMIP member-owner insureds will be burdened with the financial onus of assuming losses of the MMIP Pool's insureds, with some of whom they are in competition. In this context, such subsidization works counter to the free enterprise model that encourages efficiency, rather than rewards inefficiency.<sup>304</sup> The imposition of MMIP losses upon MMIP member

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<sup>302</sup> Defined *supra* Part II.B.2.

<sup>303</sup> As noted above, MMIP losses are imposed upon the JUA's members, which means that their insured-owners become responsible for losses. See *supra* Part II.A.

<sup>304</sup> See *Brown Shoe Co. v. United States*, 370 U.S. 294, 319 (1962) (discussing the role of

insurers would decrease the competitiveness of the insureds of such carriers. The subsidizing carrier's insureds would either be forced to raise their fees, or realize reduced profits, for reasons unrelated to the quality of their services. Ironically, health care providers incur the MMIP burden when the health care providers are superior risks.

A recent study of workers' compensation insurance programs, those that are state-dominated plans that force subsidization of various classes of insureds, concluded that such programs were inefficient in several respects.<sup>305</sup> Moreover, the programs were self-defeating because they not only failed to achieve their ostensible purpose of reducing workers' compensation insurance costs, they actually increased such costs.<sup>306</sup> The same anti-competitive qualities arising from forced subsidization are attributes of the MMIP Pool, which leads us to the following discussion of the objectives the MMIP Pool seeks to achieve.

*D. The MMIP Has Failed to Accomplish the Presumed Goals of Its Creation, While at the Same Time Frustrating the Economic Aims of the Act*

Even in terms of the objectives its creation was presumably intended to accomplish, the MMIP is self-defeating. The first possible objective of the MMIP was to prevent high malpractice insurance rates from deterring healthcare practitioners from starting or continuing to practice in New York. To the extent the MMIP results in financial injury to admitted medical malpractice carriers or their healthcare providers, it may have the additional unintended negative impact of precipitating a decline in the number of favorable risks, who would be discouraged either by the loss of equity in their member-owned carriers or, as explained below, by being excluded from the voluntary market entirely. The Superintendent's excessive interference with natural market forces in the Insurers' Market may thereby result in a reduction of services afforded in the Insureds' Market, leading to injury to the public.

Of course, if an admitted carrier's insureds are able to pass the cost of the MMIP on to the public, then such insureds would not be discouraged. The burdened class of the MMIP, however, would then

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efficiency in the application of the antitrust laws to mergers).

<sup>305</sup> Danzon & Harrington, *supra* note 2, at 32–33.

<sup>306</sup> *Id.*

be patients who would pay the price of the MMIP's losses, thus defeating the MMIP's second possible purpose of discouraging increases in health care costs.

The MMIP's third possible purpose, ensuring the ability of healthcare providers to honor judgments to injured patients, is also foiled. The MMIP places admitted carriers at a disadvantage in competing with the alternative market, thus encouraging healthcare providers to opt for the latter. Unlike admitted market carriers, however, alternative market RRGs are not protected by state guaranty funds, so claims against their insureds will go unpaid if those RRGs become insolvent. Consequently, the MMIP-induced shift toward alternative market carriers also increases the chance that claims against providers will go unpaid.

The MMIP may also be exposing patients to a greater degree of risk from healthcare providers more prone to commit medical malpractice. If MMIP insureds are high risks primarily because they are poor healthcare providers, rather than because they practice risky specialties, either such insureds should be driven out of the market by economic forces or there should be better policing of the medical malpractice professions by the State Education Department, which is responsible for identifying substandard licensed professionals. If the problem is more fundamental and implicates inherent deficiencies in the legal system, such as judicial or jural disregard of the law governing malpractice claims, then reformation of the tort system and improved quality of justice are required.

By failing to address directly the reasons MMIP insureds are high risks and the MMIP Pool is showing losses, this State-created program has sidestepped addressing the harder issues that invite long-term solutions to the medical malpractice crisis. Unfortunately, residual market programs are often influenced by political, not economic or legal, considerations.<sup>307</sup> The insureds of residual market programs are numerous and are able to promote their own agendas. The result is a patchwork of incomplete measures, such as the MMIP and limited tort reform, that lie at the periphery of the problem and often exacerbate it. Another example of this is recent New York legislation which, without addressing the root causes of insolvency, prohibited, for a period of two years, the Superintendent from liquidating insolvent medical malpractice

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<sup>307</sup> *Id.* at 33.

carriers.<sup>308</sup>

The forced subsidization of MMIP losses by admitted carriers may result in substantial weakening of not only admitted carriers and their member insureds but even MMIP insureds. At the present time, the MMIP has presented the medical malpractice insurance market with a malignant growth of rising liability. If this shortsighted solution is not followed by a permanent remedy, a catastrophe that challenges the financial stability of admitted carriers is likely. This in turn would prevent them from continuing to underwrite MMIP losses.

The forced subsidization of high risk MMIP Pool insureds by MMIP members' favorable risk member-owners should be evaluated by the economic yardsticks of productive efficiency and allocative efficiency. Under the former touchstone, the MMIP is a failure because it forces its members to use their resources inefficiently. Rather than improve the services it renders to its owner-insurers, the MMIP compels its insurers to expend resources in addressing coverage problems associated with poor risks, thereby stripping the MMIP insurers of funds necessary to implement programs designed to improve the quality of insurance they offer their owner-insureds.<sup>309</sup>

When measured in terms of allocative efficiency, the MMIP has also been unsuccessful. The MMIP's use of resources has not promoted the overall well-being of society. As set forth above, it has failed to address the cause of high risks;<sup>310</sup> rather, it provided what was at best a stopgap measure that burdened favorable insureds with a problem not of their own making. One of the reasons that monopoly power has been tolerated is because it rewards efficiency with the temporary benefit of monopoly profits.<sup>311</sup> In contrast, the MMIP discourages efficiency because favorable risks are weighed down by MMIP Pool losses. The only incentives MMIP members have are to petition the Superintendent to increase the rates of the MMIP Pool and to make the Pool's underwriting guidelines more restrictive so as to exclude the very worst of the bad risks. The

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<sup>308</sup> 2005 N.Y. Laws 2104 (amending N.Y. INS. LAW § 2343(c) (McKinney 2006)). This legislation should be renewed to protect the admitted market while a solution to the medical malpractice crisis is sought.

<sup>309</sup> See Danzon & Harrington, *supra* note 2, at 33 (discussing the effects of subsidization upon the quality of the insurance programs offered by those forced to subsidize high risks).

<sup>310</sup> See *supra* Part III.D.

<sup>311</sup> Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP, 540 U.S. 398, 407 (2004).

MMIP has not resulted in allocative efficiency when consideration is given to the effect it has upon the admitted market. In the long run, the threat the MMIP poses may well be passed along to the public in the form of higher taxes to make good the losses that MMIP members cannot satisfy, or the loss of qualified physicians who, discouraged from practicing in the New York market, will choose other states where the environment is more favorable.

Additionally, the imposition of MMIP losses creates deadweight loss. Recall from the discussion of deadweight loss earlier in this Article that market distortions tend to induce drops in output, which in turn lead to deadweight loss. Here, imposition of the MMIP's losses on carriers in proportion with their shares of the voluntary market would effectively increase those carriers' costs at each aggregate amount of insurance they write in the voluntary market. Figure 5 depicts the effect on the voluntary market in the event MMIP losses were to be imposed on voluntary market carriers.<sup>312</sup> The graph assumes that the premium set by the Superintendent,  $P_s$ , is \$2.50 per \$1,000 of insurance purchased, equal to  $P_1$ , the price derived from the market equilibria in Figures 2 and 4.<sup>313</sup> Before imposition of losses, the market equilibrium is at Point  $E_I$ .<sup>314</sup>

The imposition of MMIP losses makes writing insurance in the voluntary market more expensive for carriers at every level of output; the more voluntary market insurance written, the greater a portion of the MMIP's losses a carrier must absorb. This is represented in the graph as a shift of the industry's MC curve from  $MC_I$  to  $MC_J$ .<sup>315</sup> As a result, the industry's AC curve also shifts upward, from  $AC_I$  to  $AC_J$ .<sup>316</sup> In the absence of rate regulation, the new equilibrium,  $E_{J1}$ , would be where  $MC_J$  intersects  $D_I D_I$ , which corresponds to a lower aggregate amount of insurance written (approximately \$220 billion),  $Q_{J1}$ , and a higher premium per \$1,000

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<sup>312</sup> See *infra* app. fig.5. Because this is a voluntary market graph, the "consumers" are insurance consumers in the voluntary market, and not those in the residual market.

<sup>313</sup> See *infra* app. figs.2 & 4.

<sup>314</sup> See *infra* app. fig.5.

<sup>315</sup> See *infra* app. fig.5. The upward shift in the voluntary market's MC curve is a function of the residual market's overall losses, rather than that market's AC or MC curve. This is because the cost increases represent the portion of the residual market losses that corresponds to the portion of the voluntary market written by any one individual carrier. Since each carrier's individual MC curve is shifted upward,  $MC_I$ —which is simply the sum of all carriers' MC curves—is shifted upward as well. See *infra* app. fig.5.

<sup>316</sup> See *infra* app. fig.5.

of insurance provided (about \$2.65),  $P_{J1}$ .<sup>317</sup> As output is reduced, a deadweight loss has been created, as in the monopoly example in Figure 4.<sup>318</sup> The reduction in output means that some insureds would no longer be insured within the voluntary market; instead, they would be forced into the residual market. Empirically, those insureds would experience a welfare loss from no longer being insured by a carrier in which they own a share of equity.

Unlike the case of a monopoly, however, insurers are not necessarily better off. While the price increase has transferred some surplus from consumers to producers, this is offset at least partly by a decline in producer surplus because the industry's marginal cost curve has shifted upward. In the monopoly example in Figure 4, the MC curve remained unchanged, unaltered by the mere fact that a monopoly existed.<sup>319</sup> Since producer surplus is the difference between the price and MC curve, and since the MC curve has shifted closer to the price, producer surplus may be considerably smaller than in the case of a mere monopoly, depending on the relative sizes of the changes in price and in the MC curve. The area of surplus between  $MC_I$  and  $MC_J$  is transferred from insurers to the MMIP, similar to the transfer of surplus to the government in the event of an excise tax.<sup>320</sup> Assuming no price regulation by the Superintendent, consumer surplus has shrunk from  $FE_I A$  to  $FE_{J1} G$ .<sup>321</sup> Producer surplus has changed from  $AE_I X$  to  $GE_{J1} L$ .<sup>322</sup> The MMIP receives  $LE_{J1} ZX$ .<sup>323</sup> Economic surplus, once  $FE_I X$ , is now  $FE_{J1} ZX$ .<sup>324</sup> The deadweight loss is  $E_{J1} E_I Z$ .<sup>325</sup>

This situation is further compounded by the existing rate controls. Because the Superintendent, rather than the insurers, sets rates, the insurers cannot simply charge a higher premium. The premium continues to be fixed at  $P_S$ .<sup>326</sup> As a result, to maximize profits the industry would need to move to the left along the  $MC_J$  curve until  $MC_J$  intersects  $P_I$  at  $E_{J2}$ , corresponding to an output of  $Q_{J2}$ , approximately \$200 billion in insurance sold.<sup>327</sup> This

<sup>317</sup> See *infra* app. fig.5.

<sup>318</sup> See *infra* app. figs.4 & 5; see also *supra* notes 230–36.

<sup>319</sup> See *infra* app. fig.4.

<sup>320</sup> See *infra* app. fig.5.

<sup>321</sup> See *infra* app. fig.5.

<sup>322</sup> See *infra* app. fig.5.

<sup>323</sup> See *infra* app. fig.5.

<sup>324</sup> See *infra* app. fig.5.

<sup>325</sup> See *infra* app. fig.5.

<sup>326</sup> See *infra* app. fig.5.

<sup>327</sup> See *infra* app. fig.5.

further reduction in output would cause a more pronounced shift to the residual market, and a bigger deadweight loss. Consumer surplus is now  $FVE_{J2}A$ ; producer surplus,  $AE_{J2}L$ ; surplus to the MMIP,  $LE_{J2}HX$ ; economic surplus,  $FVHX$ .<sup>328</sup> Deadweight loss is now  $VE_1H$ .<sup>329</sup> Since they cannot increase rates, the insurers, unlike typical monopolists, cannot transfer any consumer surplus from voluntary market insureds to themselves, which might compensate for their losses due to their reduction in output and the increase in their marginal costs.<sup>330</sup> The insurers are therefore unambiguously worse off. This is another manifestation of the MMIP's effect of eliminating competition while at the same time weakening rather than strengthening the remaining competitors, as discussed above.<sup>331</sup>

In the insurance context, reducing output in the voluntary market means declining to sell insurance to those risks which present the high end of risks in that market ("marginal insureds"), where previously the marginal cost had been just below the price, i.e., the premium generated. If, however, the added MMIP Pool loss cost is imposed on the MMIP member insurers, MC may exceed price. By declining to write marginal insureds, an admitted carrier also avoids the MMIP Pool loss associated with such marginal insureds.

As a practical matter, however, carriers cannot always do this. For numerous reasons, an insurer cannot choose at will to reduce the amount of insurance it provides. To begin with, as noted earlier, the insurer's responsibility for claims against the insured does not end when the product is "sold"; rather, it lasts for years thereafter. Furthermore, practical considerations impede insurers' ability to choose not to renew insureds' policies at the end of their policy periods. Individual insureds, in their dual role as owners of the insurers, could attempt to foil any effort to cease insuring them. In addition, even if such nonrenewal is possible, it is not necessarily in the interest of the insurer. These marginal insureds may have made contributions of capital surplus to those insurers upon becoming members. To drop these members, insurers would need to return those contributions. Losing this capital, as well as the

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<sup>328</sup> See *infra* app. fig.5.

<sup>329</sup> See *infra* app. fig.5.

<sup>330</sup> This effect—drops in both consumer and producer surpluses—is more characteristic of the imposition of an excise tax than of a monopolist's actions. See Alexander, *supra* note 240, at 402 n.117; Goldberg, *supra* note 239, at 33–34 & n.211.

<sup>331</sup> See discussion *supra* pp. 272–79.

income derived therefrom, would make it more difficult for the insurer to pay for claims in the event such claims are significantly greater than expected (a distinct possibility, given the substantial uncertainty as to claim frequencies and severities as described above).<sup>332</sup> Even after a nonrenewal, the insurer would need to avoid this possibility in another manner, such as by obtaining more reinsurance.

Additionally, given the existence of the MMIP, ceasing to insure a marginal insured is not the end of the story. An insured that cannot obtain insurance from another insurer in the voluntary market may enter the MMIP Pool, in which case the insurer will then bear part of the losses incurred in the MMIP's insuring that former insured anyway, in proportion to the insurer's share of the voluntary market. Furthermore, an insurer may be reluctant to cease insuring an insured, so as not to lose an opportunity to service that insured profitably in the event the Superintendent should later permit a rate increase.

If admitted carriers continue to service the marginal insureds, however, they may lose money on such provision upon the imposition of MMIP losses, although a portion of the deadweight loss would be avoided. Moreover, the upward shift in MC has also caused AC to shift upward to AC<sub>J</sub>.<sup>333</sup> If, at the present level of output, AC<sub>J</sub> now lies above the premium established by regulator-set rates, admitted carriers may lose money on their overall business, perhaps severely enough to drive individual firms out of business. The amount of such deficit is the area of rectangle TNE<sub>1</sub>A.<sup>334</sup> This is another way in which the MMIP can eliminate competition while at the same time weaken rather than strengthen the remaining competitors, as discussed above.<sup>335</sup>

The MMIP also fails to satisfy the Act's goal of promoting the well-being of small competitors. To the contrary, those MMIP members which have smaller numbers of insureds and are, therefore, likely to have relatively smaller reserves will likely suffer a greater burden if the MMIP losses are imposed upon them, because their reserves are more sensitive to losses unassociated

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<sup>332</sup> See *supra* p. 238.

<sup>333</sup> See *infra* app. fig.5.

<sup>334</sup> See *infra* app. fig.5. Here, called a "deficit" rather than a "loss" to avoid confusion with the deadweight losses discussed above.

<sup>335</sup> See *supra* pp. 272-79.

with their actual operations.<sup>336</sup>

#### IV. ANTITRUST IMMUNITY

##### *A. Introduction*

On the basis of the states' historic interest in insurance regulation and the difficulties in applying antitrust laws to the relationships between insurers and insureds, immunities to prosecution have been developed. Insurance-related activities may be beyond the reach of federal antitrust laws on two distinct grounds. The first of these is based upon a federal statute which "reverse preempts" Congress from interfering with qualified state insurance regulatory laws.<sup>337</sup> The second source of immunity is a doctrine shaped by the courts to give deference to the exercise of state powers when a federal statute does not specifically provide for its application to states.<sup>338</sup> As recent case law demonstrates, on the bases of these fountainheads of state immunity, even behavior which is patently anti-competitive may be outside the ambit of federal antitrust law. On the other hand, courts will readily hold that there is no protection from antitrust prosecution when an insurance-related activity does not qualify for immunity. Therefore, insurers that fail to appreciate the contours of these sanctuaries from prosecution expose themselves to criminal penalties and private treble damage claims.

The author's purpose in reviewing these immunities is to ascertain if the MMIP is immune from scrutiny under the Act, and if so, whether the law should be amended to nullify such immunity.

##### *B. The McCarran-Ferguson Act's Antitrust Exemption*

The more formidable of the immunities is the Federal McCarran-Ferguson Act (McC-F).<sup>339</sup> In 1944, overruling its own precedent,<sup>340</sup> the Supreme Court found that the business of insurance constituted interstate commerce, and consequently was within the power of

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<sup>336</sup> See *supra* pp. 277–78.

<sup>337</sup> See McCarran-Ferguson Act, ch. 20, 59 Stat. 33 (1945) (codified as amended at 15 U.S.C. §§ 1011–1015 (2000)).

<sup>338</sup> See *Parker v. Brown*, 317 U.S. 341, 350–51 (1943).

<sup>339</sup> McCarran-Ferguson Act §§ 1–6, 59 Stat. at 33–34.

<sup>340</sup> *Paul v. Virginia*, 75 U.S. (8 Wall.) 168, 183 (1868).

Congress to regulate.<sup>341</sup> In reaction to this ruling, Congress promptly enacted McC-F, a statute recognizing that because states have an interest in insurance-related activities conducted within their borders, for the most part regulation of such activities should be left to state government.<sup>342</sup> Balancing federal and state interests, McC-F provides that a federal statute may invalidate, impair, or supersede a state insurance law only where the former “specifically relates to the business of insurance.”<sup>343</sup> In a proviso, McC-F states that federal antitrust laws do not apply to the business of insurance unless a state has elected not to regulate the field.<sup>344</sup> In relevant part, the statute reads:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That . . . [federal antitrust laws] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.<sup>345</sup>

The portion of this statute quoted before the “[*p*rovided” shall be referred to hereinafter as the “General Exemption.” The portion including the “[*p*rovided” and what follows shall be called the “Antitrust Exemption.”

McC-F has been broadly construed to place beyond the reach of federal antitrust laws those areas of “the business of insurance” which the state has chosen to regulate.<sup>346</sup> Even where by virtue of failing to comply with state law regulating insurance, a party has violated Sections 1 or 2 of the Act, the Antitrust Exemption immunizes the perpetrator from prosecution under the Act. The exemption applies if state law addresses an issue as part of the regulation of the business of insurance. As Areeda and Hovenkamp state in their treatise, *Antitrust Law*, “if the state’s insurance

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<sup>341</sup> United States v. S.-E. Underwriters Ass’n, 322 U.S. 533, 553 (1944).

<sup>342</sup> See 15 U.S.C. §§ 1011–1012.

<sup>343</sup> See *id.* § 1012(b). The Supreme Court has interpreted this provision as “imposing what is, in effect, a clear-statement rule.” U.S. Dep’t of Treasury v. Fabe, 508 U.S. 491, 507 (1993).

<sup>344</sup> 15 U.S.C. § 1012(b).

<sup>345</sup> *Id.*

<sup>346</sup> Although not so far as to reach the “business of insurers.” See *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232–33 (1979) (“[A]ll . . . agreements insurers may make to keep their costs under control . . . would be exempt from the antitrust laws if Congress had extended the coverage of the McCarran-Ferguson Act to ‘the business of insurance companies.’”).

industry is ‘regulated by state law,’ then the antitrust laws simply do not apply, notwithstanding that the application of antitrust law in [a] particular case in no way ‘invalidate[s], impair[s], or supersede[s]’ state law and may even be consistent with it.”<sup>347</sup> Even a practice which would otherwise be anathema under the antitrust laws, such as horizontal price fixing, would be exempt from prosecution under McC-F if state law regulated the premiums charged to insureds.<sup>348</sup>

### 1. “State Law”

A threshold issue that arises under McC-F is what constitutes a “state law” for the purposes of the Antitrust Exemption. The New York State Legislature did not create the MMIP. Section 5502(c)(2)(D) of New York Insurance Law merely authorizes the Superintendent to

promulgate regulations prescribing a plan for the equitable distribution to authorized medical malpractice insurers[,] . . . the insureds of the [MMIA,] and health care practitioners and facilities which are otherwise unable to secure coverage in the voluntary market following the dissolution of the [MMIA]. . . [T]he superintendent may designate, in lieu of the plan for the equitable distribution of policies from the [MMIA,] . . . a single entity or entities to provide such coverages consistent with such a plan if the superintendent determines that such entity or entities can provide the coverages necessary to meet the purposes and objectives of an equitable plan of distribution . . . .<sup>349</sup>

Rather than a statutory scheme, it is the Superintendent’s regulations that created the MMIP and compelled admitted medical malpractice carriers to operate the residual market and absorb its losses. It is arguable whether such actions of the executive branch of government qualify under the Antitrust Exemption as “state law.”<sup>350</sup>

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<sup>347</sup> 1 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 219c, at 339 (2d ed. 2000).

<sup>348</sup> *Royal Drug Co.*, 440 U.S. at 221, 224 n.32; *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 67 (1st Cir. 2005); *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1201 (7th Cir. 1981); *In re Workers’ Comp. Ins. Antitrust Litig.*, 574 F. Supp. 525, 531 & n.8 (D. Minn. 1983).

<sup>349</sup> N.Y. INS. LAW § 5502(c)(2)(D) (McKinney 2000 & Supp. 2007).

<sup>350</sup> In *United States Department of Treasury v. Fabe*, the Supreme Court held that the

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Although the Supreme Court has not spoken on the issue, some decisions have held that the phrase “law enacted by any State” in the General Exemption means only statutes.<sup>351</sup> If this interpretation applies to the Antitrust Exemption as well, the MMIP (or at any rate the Superintendent’s regulatory scheme regarding sharing of losses) may not fall within the McC-F exemption.

The Antitrust Exemption’s reference to state law, however, is worded differently from the General Exemption’s text, using the more general phrase “State law.” One precept of statutory interpretation is that when the legislature uses different phrasings in different parts of a statute, courts should attribute to the legislature an intent that those phrases mean different things. Moreover, courts have generally interpreted “regulated by state law” as including circumstances in which a state insurance agency has been given general authority to approve or prohibit the activities sought to be challenged under the Act.<sup>352</sup>

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definition of “state law” under the General Exemption is to be more broadly construed than under the Antitrust Exemption, in essence, requiring courts to be more stringent in determining if the state has passed laws relating to the “business of insurance,” which would thereby preempt the application of the antitrust laws. 508 U.S. 491, 504 (1993). In essence, satisfying the Antitrust Exemption is more difficult, but once that exemption is satisfied, viz., the business of insurance is regulated by state law, that exemption is more encompassing than the General Exemption as relates to antitrust law.

<sup>351</sup> Am. Heritage Life Ins. Co. v. Orr, 294 F.3d 702, 708–09 (5th Cir. 2002) (“[McC-F] bars application of the [Federal Arbitration Act] to insurance contracts only in the context of a *state statute* evincing the same, not mere policy statements of state officials or administrative rule interpretations of governmental entities. . . . Appellants try to perpetrate a judicial end-run by asserting that an attorney general’s opinion or insurance department’s regulatory, administrative policy is the functional equivalent of a state law relating to insurance, thereby triggering the provisions of [McC-F].”); Thrivent Fin. for Lutherans v. Lakin, 322 F. Supp. 2d 1017, 1024 (W.D. Mo. 2004) (noting that “the [McC-F] does not insulate a State’s regulatory stance or opinion from preemption”); Gulf Ins. Co. v. Neel-Schaffer, Inc., 904 So. 2d 1036, 1044 (Miss. 2003) (following, *inter alia*, Orr in finding that only state statutes constitute “law[s] enacted by any state,” and rejecting the argument that “in instances where a legislative branch has delegated its authority to regulate to an administrative agency and where that agency is considered the final regulatory authority, the agency’s regulations should be considered the legal equivalent to statutes,” and noting that “[McC-F] incorporates the term ‘enact.’ The use of this term seemingly denotes a *legislative* enterprise”); *see also* Miller v. Nat’l Fid. Life Ins. Co., 588 F.2d 185, 187 (5th Cir. 1979) (“The test under McCarran-Ferguson is not whether a state has enacted statutes regulating the business of insurance, but whether such state statutes will be invalidated, impaired, or superseded by application of federal law.”).

<sup>352</sup> *See, e.g.*, Dexter v. Equitable Life Assurance Soc’y, 527 F.2d 233, 236 (2d Cir. 1975) (holding that the state has “discretion to prohibit, permit, or limit insurance practices as the state sees fit”); Uniforce Temp. Pers., Inc. v. Nat’l Council on Comp. Ins., Inc., 892 F. Supp. 1503, 1509 (S.D. Fla. 1995) (stating that “regulated by state law” means that the state insurance agency “has jurisdiction . . . over the challenged practices and . . . the authority to approve or prohibit the activities”), *aff’d*, 87 F.3d 1296 (11th Cir. 1996).

## 2. The Business of Insurance

Another threshold issue under McC-F is what Congress meant by “business of insurance.” In *Union Labor Life Insurance Co. v. Pireno*, the Supreme Court identified three factors that give meaning to this term: “*first*, whether the practice has the effect of transferring or spreading a policyholder’s risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.”<sup>353</sup> In applying *Pireno*, courts have viewed these factors as relevant guideposts—not all must be satisfied to qualify under the definition of the term.<sup>354</sup>

### *a. Transferring or spreading a policyholder’s risk*

The first consideration set forth in *Pireno* implicates the essence of insurance, which involves the transfer of risk.<sup>355</sup> This description of the business of insurance has been the subject of numerous decisions and is well-settled law.<sup>356</sup> As long as the activity in question involves this basic function of insurance, viz., the contractual assumption and spreading of a policyholders’ risk,<sup>357</sup> this first and most important consideration of the *Pireno* test is satisfied.

As the court explained in *Arroyo-Melecio*, which rejected the plaintiffs’ argument that the Antitrust Exemption did not apply to Puerto Rico’s CMVLIA JUA’s automobile damage coverage plan, when insurers agree not to write a class of insureds, the Act does not apply, notwithstanding the fact that the refusal may be anti-competitive.<sup>358</sup> Concerted refusals to provide coverage are protected from federal antitrust law as part of the “business of insurance” where a state statute regulates the field of insurance.<sup>359</sup> In the case

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<sup>353</sup> 458 U.S. 119, 129 (1982).

<sup>354</sup> *Sparkes v. Morrison & Foerster Long-Term Disability Ins. Plan*, 129 F. Supp. 2d 182, 186 (N.D.N.Y. 2001).

<sup>355</sup> See *supra* text accompanying note 353.

<sup>356</sup> See, e.g., *U.S. Dep’t of Treasury v. Fabe*, 508 U.S. 491, 503–04 (1993) (stating that risk transfer occurs after performance of terms); *Bristol Hotel Mgmt. Corp. v. Aetna Cas. & Sur. Co.*, 20 F. Supp. 2d 1345, 1349 (S.D. Fla. 1998) (using the *Pireno* test to determine the “business of insurance”).

<sup>357</sup> See *supra* text accompanying note 353.

<sup>358</sup> *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 67–68 (1st Cir. 2005).

<sup>359</sup> See *id.* (citing *Uniforce Temp. Pers., Inc. v. Nat’l Council on Comp. Ins., Inc.*, 87 F.3d 1296, 1299–1300 (11th Cir. 1996), and *Slagle v. ITT Hartford*, 102 F.3d 494, 497–98 (11th Cir. 1996), for the proposition that “[h]orizontal agreements among insurers to . . . issue policies

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of the JUA established by Puerto Rico, which is treated as a state for the purposes of *McC-F*,<sup>360</sup> the state conceived a scheme contemplating that JUA members would operate the association established by the state's Insurance Commissioner,<sup>361</sup> and charge premiums, transfer risk, and spread risk among JUA members.

Applying the first factor of *Pireno* to the MMIP, there is clearly a transfer and spreading of risk. As discussed above, this is one of the problems of the MMIP because it potentially involves favorable risks subsidizing high risks.

*b. The Policy Relationship Between Insurer and Insured*

The second *Pireno* factor, which is closely related to the first, concerns whether a particular practice is an integral part of the policy relationship between insurer and insured. Numerous decisions have addressed this second factor, which highlights the difference between the business of insurance and the business of insurers.<sup>362</sup> The former alone is grounded in the policy relationship that exists between the parties to the insurance contract.

Although the focus is upon the relationship between the parties to the policy, because insurers and insureds operate through agents and brokers, the boundaries of the second *Pireno* factor appear to include these fiduciaries. Although the Supreme Court has reserved decision on whether the business of insurance includes the fixing of brokerage commissions,<sup>363</sup> federal circuit courts have held that the state regulation of agents making market decisions is within the exemption, as are regulations concerning the authority of agents to solicit individual or group policyholders.<sup>364</sup>

In *Arroyo-Melecio*, which sets forth each of the *Pireno* factors but does not apply them separately, the defendant members of the state-created joint underwriting association were alleged to have used their monopoly power to, among other things, "dictate the

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only through the residual market are within the business of insurance").

<sup>360</sup> 15 U.S.C. § 1015 (2000).

<sup>361</sup> *Arroyo-Melecio*, 398 F.3d at 62.

<sup>362</sup> *See, e.g., Uniforce*, 87 F.3d at 1300 (holding that premiums are "an integral part of the policy relationship"). The first factor of *Pireno* also addresses the circumstance that the "business of insurance" is the focal point of the exemption, not the "business of insurers." *Id.* at 1299.

<sup>363</sup> *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 224 n.32 (1979).

<sup>364</sup> *Arroyo-Melecio*, 398 F.3d at 68; *Owens v. Aetna Life & Cas. Co.*, 654 F.2d 218, 225–26 (3d Cir. 1981).

practices relating to the adjustment of claims.”<sup>365</sup> These and other activities, which were an integral part of the state-regulated relationship between insureds and insurers, were found exempt.<sup>366</sup>

Applying the second prong of the *Pireno* test to the MMIP, it is clear that the MMIP, if indeed it is “state law,” concerns the relationship between insurer and insured. The MMIP rate-setting by the Superintendent, who also sets underwriting guidelines compelling coverage of insureds unable to obtain insurance in the voluntary market, is the essence of the program.

*c. Limitation to Entities Within the Insurance Industry*

The third prong of the *Pireno* test is met when state legislation is specifically directed at the regulation of the insurance industry. State law arbitration statutes have been examined under the lens of the third guidepost of the *Pireno* test.<sup>367</sup> Where these state statutes are general in their scope, affecting the arbitration of contracts outside the insurance industry as well as within it, they do not satisfy this factor, which requires the regulations to be specifically directed at the insurance industry.<sup>368</sup>

Even if a state law specifically permits insurers to take actions with respect to third party providers as part of the regulation of the insurance industry, it is doubtful whether the third guidepost of *Pireno* will be satisfied, and insurers run the risk that by engaging in such activity, they venture beyond the umbrella of the Antitrust Exemption. The case law is replete with examples of insurers that became subject to antitrust claims for engaging in such activities such as when insurers enter into agreements with automobile repair shops to fix prices.<sup>369</sup> These agreements have been held to be outside the Antitrust Exemption.<sup>370</sup> Similarly, healthcare insurers’

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<sup>365</sup> *Arroyo-Melecio*, 398 F.3d at 68.

<sup>366</sup> *Id.* at 67–68.

<sup>367</sup> See *McKnight v. Chi. Title Ins. Co.*, 358 F.3d 854, 857–58 (11th Cir. 2004); *Standard Sec. Life Ins. Co. of N.Y. v. West*, 267 F.3d 821, 824 (8th Cir. 2001); *Mut. Reins. Bureau v. Great Plains Mut. Ins. Co.*, 969 F.2d 931, 934–35 (10th Cir. 1992); *Hart v. Orion Ins. Co.*, 453 F.2d 1358, 1360 (10th Cir. 1971); *Hamilton Life Ins. Co. v. Republic Nat’l Life Ins. Co.*, 408 F.2d 606, 611 (2d Cir. 1969).

<sup>368</sup> *Hart*, 453 F.2d at 1360; *Hamilton Life Ins. Co.*, 408 F.2d at 611.

<sup>369</sup> *Proctor v. State Farm Mut. Auto. Ins. Co.*, 675 F.2d 308, 312, 335–37 (D.C. Cir. 1982); *Quality Auto Body, Inc. v. Allstate Ins. Co.*, 660 F.2d 1195, 1201–02 (7th Cir. 1981); *Workman v. State Farm Mut. Auto. Ins. Co.*, 520 F. Supp. 610, 624–25 (N.D. Cal. 1981).

<sup>370</sup> See sources cited *supra* note 369; see also *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 (1979) (positing, as *reductio ad absurdum* argument for why agreements between insurer and retail pharmacists are not the “business of insurance,” the

agreements with physicians concerning patient services have also been held beyond the pale of this exemption.<sup>371</sup> Before entering into transactions with third parties, an insurer is well advised to ask whether the state has passed a statute that concerns this activity, and whether the statute passes the third prong of the *Pireno* test.

With respect to the MMIP, it is clear that the regulation is directed at the insurance industry. This prong of *Pireno* is therefore satisfied in the case of the MMIP.

### 3. The Boycott Exception

McC-F contains an exception to the Antitrust Exemption for acts of “boycott, coercion, or intimidation,” or agreements to commit such acts.<sup>372</sup> While it is permissible for insurers to enter into an agreement refusing to do business with third parties, when the refusal to deal concerns transactions unrelated to the subject of the refusal to deal, the exception to the Antitrust Exemption is triggered. As the Supreme Court reasoned in *Hartford Fire Insurance Co. v. California*, there is a critical distinction to be made between a conditional boycott and a concerted refusal to deal.<sup>373</sup> The former seeks to use economic coercion by means of refusal to do business with the victim in collateral, unrelated transactions, thereby forcing the victim into agreeing to transact business in accordance with demanded terms.<sup>374</sup> As the Court held, it is the “expansion of the refusal to deal beyond the targeted transaction that gives great coercive force to a commercial boycott: unrelated transactions are used as leverage to achieve the terms desired.”<sup>375</sup> In contrast, it is not a boycott where there is a collective refusal to do business as to a particular insurance transaction.<sup>376</sup>

In *Arroyo-Melecio*, the boycott exception was triggered by insurers’ alleged concerted threats against a broker and the broker’s clients in response to the broker’s attempts to place customers’ orders for compulsory insurance with private insurers rather than

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notion that if they were, then so would agreements between insurers and automobile body repair shops).

<sup>371</sup> See *Brillhart v. Mut. Med. Ins., Inc.*, 768 F.2d 196, 199–201 & n.3 (7th Cir. 1985) (implying that the defendant did not qualify for the McCarran-Ferguson Antitrust Exemption by proceeding to its Sherman Antitrust analysis).

<sup>372</sup> 15 U.S.C. § 1013(b) (2000).

<sup>373</sup> 509 U.S. 764, 801–02 (1993).

<sup>374</sup> *Id.* at 801–03.

<sup>375</sup> *Id.* at 802–03.

<sup>376</sup> See *id.* at 802.

with the JUA.<sup>377</sup> The Court denied the defendants' motion to dismiss these allegations, which supported the plaintiffs' claims of boycott in violation of the Act.<sup>378</sup>

In the case of the MMIP, there is no apparent boycott, coercion or intimidation. Rather, there is precisely the opposite: it appears that the medical malpractice carriers that are licensed in the State of New York have been impressed into service by the Superintendent and forced to assume responsibility for MMIP losses due to the MMIP Pool's inadequate rates. Unfortunately, as seen above, the economic consequences of the MMIP Pool appear to have worked in reverse by adversely affecting the competitive ability of the admitted carriers.

### C. *The State Action Doctrine*

The Supreme Court has distilled the elements of *Parker v. Brown*,<sup>379</sup> or the state action immunity doctrine, as follows: "first, the challenged restraint [on trade] must be one clearly articulated and affirmatively expressed as state policy; and second, the policy must be actively supervised by the State itself."<sup>380</sup> The *Parker* doctrine, which has been discussed in the context of assigned risk programs,<sup>381</sup> is "more stringent" than McC-F.<sup>382</sup> The state must not only clearly manifest its intention to pursue a policy that displaces antitrust law but must actively supervise the displacing activity.<sup>383</sup>

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<sup>377</sup> *Arroyo-Melecio v. Puerto Rican Am. Ins. Co.*, 398 F.3d 56, 64 (1st Cir. 2005).

<sup>378</sup> *Id.* at 71.

<sup>379</sup> 317 U.S. 341 (1943).

<sup>380</sup> *Arroyo-Melecio*, 398 F.3d at 71 (alteration in original) (internal quotation marks omitted) (quoting *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)).

<sup>381</sup> *Id.* at 71-72; *Gulf Marine Repair Corp. v. Liberty Mut. Ins. Co.*, No. 92-1576-CIV-T-21A, 1994 WL 805208, at \*10 (M.D. Fla. Jan. 13, 1994).

<sup>382</sup> *Arroyo-Melecio*, 398 F.3d at 71. Another potential exemption is the *Noerr-Pennington* doctrine. This case law exemption to the antitrust laws immunizes the process of petitioning the government. See *United Mine Workers of Am. v. Pennington*, 381 U.S. 657, 669-70 (1965); *E. R.R. Presidents Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 136-38 & n.17 (1961). An example of the application of the *Noerr-Pennington* doctrine would be concerted lobbying efforts by insurers to obtain Superintendent approval of an increase in insurance rates. Applying this doctrine to the MMIP Pool, it would enable MMIP members to pursue collective efforts to obtain rate adequacy, to avoid adverse consequences of the Pool, and to strengthen members' competitive position vis-à-vis the alternative market.

<sup>383</sup> *Midcal Aluminum*, 445 U.S. at 105. In *Arroyo-Melecio*, the Court held that the acts of the insurance commissioner were not at issue, and the JUA was not a state agency and, therefore, *Parker* immunity was not triggered. *Arroyo-Melecio*, 398 F.3d at 71-72. The Court therefore disposed of the issue of state action addressing the requirements for *Parker* immunity. *Id.* at 71.

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In *Arroyo-Melecio*, the *Parker* doctrine was found not to apply because, *inter alia*, the state regulation at issue did not articulate with sufficient clarity the state's intent to permit the alleged antitrust violations.<sup>384</sup> Such intent may not be inferred.<sup>385</sup>

*Preferred Physicians Mutual Risk Retention Group v. Cuomo* illustrates another limitation upon the *Parker* doctrine.<sup>386</sup> In that case, the court held that application of the *Parker* doctrine to state executive department actions must satisfy the additional requirement that there is a clear legislative mandate that the executive branch engage in the subject activity.<sup>387</sup> Applying this touchstone to the MMIP, Insurance Law section 5502(c), which created the MMIP, does not require the Superintendent to impose upon MMIP members losses resulting from the assigned risk program.<sup>388</sup> It therefore may be argued that the MMIP is not immunized from enforcement of the antitrust laws under the state action doctrine.

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<sup>384</sup> *Id.* at 71.

<sup>385</sup> See *Midcal Aluminum*, 445 U.S. at 105.

<sup>386</sup> 865 F. Supp. 1057 (S.D.N.Y. 1994), *vacated on other grounds sub nom.* Preferred Physicians Mut. Risk Retention Group v. Pataki, 85 F.3d 913 (2d Cir. 1996).

<sup>387</sup> *Id.* at 1071.

<sup>388</sup> As has already been discussed, regulations concerning New York Insurance Law section 5502(c)(2)(D), which authorized the creation of the MMIP, may not meet the first prong of the *Pireno* test because the regulations are not "state law" within the meaning of the Antitrust Exemption. See *supra* Part III.B. The state action doctrine requires even more than a mere enactment of state law, but a clear legislative intent that the executive branch actively supervise the displaced activity. Such intent is not clearly articulated in section 5502(c)(2)(D), which simply provides:

Prior to July first, two thousand, the superintendent shall, after a public hearing to be held not less than thirty days before such promulgation, promulgate regulations prescribing a plan for the equitable distribution to authorized medical malpractice insurers writing such coverage in the state the insureds of the [MMIA] and health care practitioners and facilities which are otherwise unable to secure coverage in the voluntary market following the dissolution of the [MMIA]. Such plan shall provide that upon initial distribution to the voluntary market the insureds of the [MMIA] receive policies in the voluntary market with provisions and at a rate which are at least as favorable to the insured as those which they would have received if they were issued a renewal policy by the [MMIA]. Such plan shall also ensure that all health care practitioners or facilities have access to medical malpractice insurance from an authorized insurer pursuant to the provisions of this chapter. Such plan may also provide for, and the superintendent may designate, in lieu of the plan for the equitable distribution of policies from the [MMIA] and the availability of coverages to health care practitioners and facilities, a single entity or entities to provide such coverages consistent with such a plan if the superintendent determines that such entity or entities can provide the coverages necessary to meet the purposes and objectives of an equitable plan of distribution were it to have been effectuated. Notice of the hearing required by this clause shall be no less than thirty days before the date of the hearing and shall include a summary of the plan proposed by the superintendent.

N.Y. INS. LAW § 5502(c)(2)(D) (McKinney 2000).

## V. PROPOSALS

Whether the Antitrust Exemption successfully achieves its underlying purposes is the subject of much debate. There are many who believe that McC-F strikes an appropriate balance between state and federal interests and has no serious anti-competitive consequences. Others vigorously condemn the statute and urge that it be repealed or substantially amended. In both houses of Congress, there is identical pending legislation that would amend the McCarran-Ferguson Act to remove its reverse-preemption of the Sherman Act, even when the business of insurance is regulated by state law.<sup>389</sup> Hearings have been held on the Senate version of the bill.

The author recommends a modest amendment, far less ambitious than the aforementioned legislation. The focal point of this Article has been the legal and economic detriment that follows from forcing licensed carriers to bear losses generated by high-risk segments of a market consisting of insureds, particularly where the burdened class is in competition with the benefitted class. With the MMIP as an illustration of how assigned-risk programs can go terribly wrong, any treatment of residual market programs should be crafted in a way that would avoid similar future disasters. The author proposes the following steps be taken:

First, there should be a required expression of the purpose underlying any state legislation which compels licensed carriers to assume, either directly or indirectly, risks with respect to a segment of the insurance market. Only by doing so can the state hope to justify the impingement of property rights that inevitably follows the implementation of the program. While it is true that the federal government cannot compel a state to set forth the purpose of any state action, the former can invalidate an action of the latter where such action affects interstate commerce.<sup>390</sup> Perforce, Congress can invalidate such an action when no purpose is articulated.

Second, studies should be conducted to ascertain whether the program would effectively fulfill its stated purpose. Without such studies, the program may not achieve optimal results. Before there is serious interference with market forces, those proposing government action should demonstrate that a residual market

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<sup>389</sup> Insurance Industry Competition Act of 2007, S. 618, 110th Cong. § 2(a)(1)(B) (2007); Insurance Industry Competition Act of 2007, H.R. 1081, 110th Cong. § 2(a)(1)(B) (2007).

<sup>390</sup> See, e.g., *New York v. United States*, 505 U.S. 144, 167–68 (1992).

program would fulfill its intended objective in the least intrusive manner. While the federal government cannot compel such studies, it can condition the validity of the state legislation upon the conducting of such a study where the subject of the legislation affects interstate commerce.<sup>391</sup>

Third, the interests of consumers should be considered. If the cost of the assigned risk program is likely to be passed along to consumers, then its implementation should be suspect. In considering this factor, any anti-competitive effects of the residual market program should be carefully reviewed.

Fourth, where the state reserves to itself the function of setting rates, or substantially influences rate setting, and the program generates losses, it should not be the responsibility of residual market insurers to absorb such losses. The state that has generated the losses should be made responsible for them, particularly where the burdened class does not cause the underlying problem with which the residual market program deals, and when membership in the residual market program is compulsory.

To implement this proposal, it is suggested that the Antitrust Exemption be amended to include the following provision:

Provided, however, that any state law which creates an assigned risk insurance plan or joint underwriting association shall not be subject to this exemption unless:

- (a) the Plan sets forth a legitimate state purpose;
- (b) there is a study into the economic feasibility of the Plan;
- (c) the Plan promotes consumer welfare, and is not anti-competitive in its overall effect; and
- (d) if the Plan is compulsory, the state does not set rates wherein the assigned risk program or joint underwriting association operates at losses which the state makes the ultimate responsibility of program members.

## VI. CONCLUSION

The MMIP is inefficient and runs counter to the principles which have been developed in interpreting Sections 1 and 2 of the Sherman Act. It should be addressed through legislation which carefully considers the MMIP's economic impact, and which recognizes the rights of the member-owners of admitted carriers

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<sup>391</sup> *See id.*

upon whom the burden of the MMIP has been imposed.

### Appendix

Figure 1: Graph of supply and demand for an individual medical malpractice insurer in the voluntary market, assuming no responsibility for residual market business and no regulation of premiums.

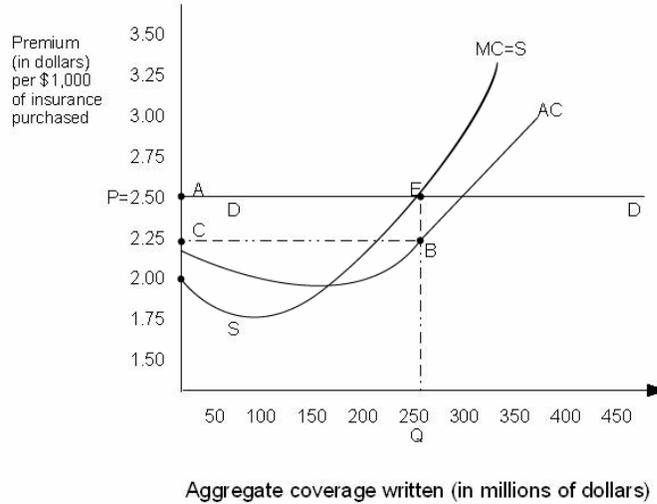
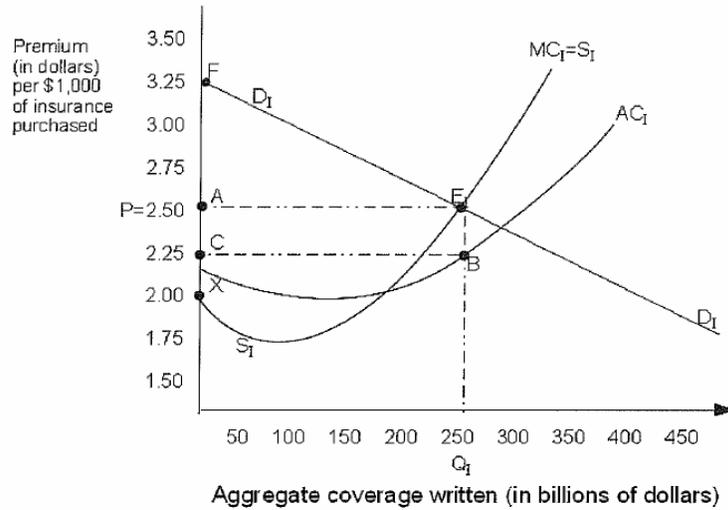


Figure 2: Graph of supply and demand for entire medical malpractice insurance industry in the voluntary market, assuming no responsibility for residual market business and no regulation of premiums.



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Figure 3: Graph of supply and demand for entire residual market, assuming legal requirement that carriers provide insurance and do so at a specified premium, and legal or practical requirement that healthcare providers obtain insurance.

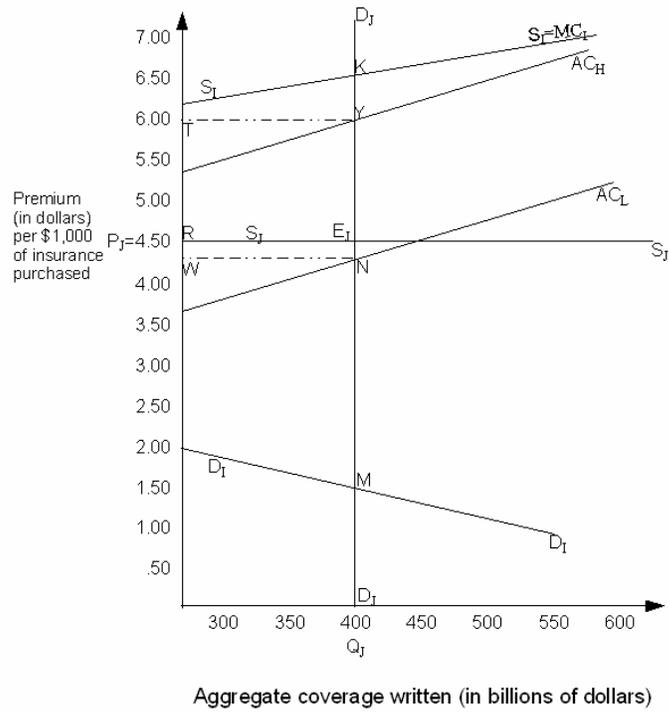


Figure 4: Graph comparing equilibria in voluntary market under conditions of perfect competition and of monopoly, assuming no responsibility for residual market business and no regulation of premiums.

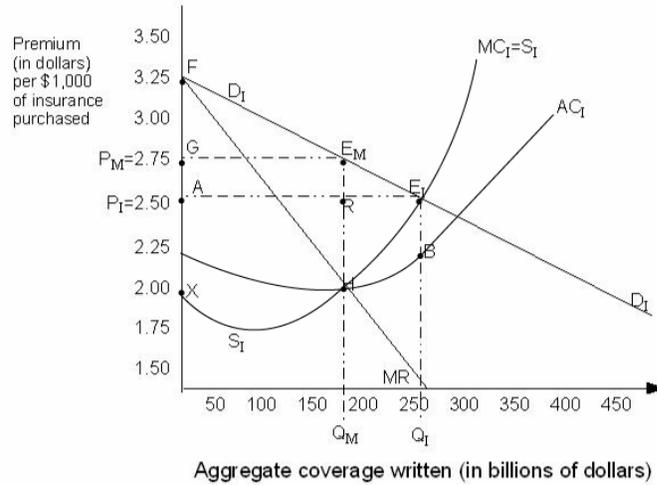


Figure 5: Graph showing effects in voluntary market of imposition of MMIP losses on voluntary market medical malpractice insurers, both under conditions in which premiums are regulated and in which they are not.

