

The Regulation of Insurance Claim Practices

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Insurance claim practices determine the extent to which insurers will or will not honor their promises. This Article describes the failure in the market for claim practices, the failure of the regulatory responses to that failure, and the ways in which litigation can provide a partial corrective. The Article explains why the market fails to guarantee fair claim practices, how market forces might be improved, and why, even with improvements, market forces alone are not enough. It then describes claim practices regulation by state insurance departments, argues that regulation in most cases is insufficient, and suggests improvements in state regulation. Finally, the Article concludes that private litigation, in addition to redressing individual harm, serves a necessary regulatory function in promoting fair claim practices, and it describes the substantive law and processes that are needed to perform that function.

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INTRODUCTION

The paradigm of insurance distribution in the United States is the private market,¹ and insurance in general and insurance claim practices in particular are prime examples of the use of regulation to facilitate and supplement the market. In his foundational article on insurance regulation, Spencer Kimball stated, “The major objective of insurance regulation is to facilitate the successful operation of the insurance enterprise itself.”² But a hoary aphorism of insurance law states that insurance is imbued with a public interest, justifying the intervention of legislatures, administrators, and courts to supplement and correct the operation of the market and to serve nonmarket goals variously described as “important social objectives”³ or “egalitarian or distributional concerns.”⁴

This Article describes the failure in the market for claim practices, the failure of the regulatory responses to that failure, and the ways in which litigation can provide a partial corrective. Market failure is endemic to the market for claim practices because of information asymmetries, agency problems, and the risk of opportunism by insurers. The response to these failures by state insurance regulators could include improvements in the market, intervention in disputes about claims, and focused or broad-ranging enforcement actions, but the response has generally been inadequate to the task. Private litigation, both coverage litigation and claim practices litigation—generally known as “bad faith”—also serves a regulatory function. For the regulation of claim practices, litigation is superior in concept and certainly in practice to administrative regulation. The Article concludes by describing the desirable contours of the law and litigation of claim practices to best fulfill its regulatory role.

1. Mammoth exceptions exist, of course—Social Security, Medicare, the National Flood Insurance Program, state insurers of last resort, and more—but for most insurance the market is the usual form of distribution.

2. Spencer L. Kimball, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471, 477 (1961).

3. ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 63 (5th ed. 2012).

4. TOM BAKER & KYLE D. LOGUE, *INSURANCE LAW AND POLICY* 580 (3d ed. 2013).

I. MARKET FAILURES IN CLAIM PRACTICES

The regulation of claim practices, like most other forms of market conduct regulation, primarily serves to facilitate the operation of the insurance market and to remedy its imperfections. The function of the claim process is to fulfill the insurer's promises and the insured's legitimate expectations of coverage.⁵ Therefore, the first step in determining the proper scope of the regulation of claim practices is defining the imperfections of and limitations in the market that may hinder the process in fulfilling its function.

Market failures with respect to claim practices are of three kinds. First, insurance consumers do not possess adequate information to assess the relative quality of insurers' claim practices, so there is not an effective market mechanism for influencing that quality. Second, the claim process is a strong example of an agency relationship, in which the insurer has freedom to act in a way that will affect the insured, but the insured has limited capacity to monitor the insurer's behavior. Third, and in some respects a combination of the first two, insurers have the ability and incentive to act opportunistically at the point of claims.

A. Information Problems

Consumers need information for competitive markets to work well.⁶ In choosing among insurance policies and insurers, a potential insured ideally would have access to and would consider information about the insurer's financial condition, the price of the policy, its terms, and the insurer's record of servicing policyholders, including the quality of the claim process. Currently, and with some variation among lines of insurance and among jurisdictions, the market provides adequate information only on price. Personal-lines property/casualty insurance is sold largely on the basis of price, and information about the cost of insurance is easily available. Consumers can obtain quotes from different insurance companies, increasingly through web tools as well as more traditional sources.⁷

Comparing policy terms is more difficult. Insurers usually provide summaries of some policy terms to shoppers but refuse to provide the actual policy language until after the policy has been purchased. Regulators in some states publish summaries of key policy provisions or the standard policies of leading companies online, but even then consumers require diligence and expertise to discover and parse the relative merits of policy terms.

5. Issues of unfair discrimination or distributional concerns arise in the claim process only incidentally. Tom Baker & Karen McElrath, *Insurance Claims Discrimination*, in *INSURANCE REDLINING: DISINVESTMENT, REINVESTMENT, AND THE EVOLVING ROLE OF FINANCIAL INSTITUTIONS* 141 (Gregory D. Squires ed. 1997).

6. STEPHEN G. BREYER ET AL., *ADMINISTRATIVE LAW AND REGULATORY POLICY* 6 (7th ed. 2011); JERRY & RICHMOND, *supra* note 3, at 62.

7. Some regulators even have facilitated the process by providing price comparison tools online. *Auto Insurance Premium Comparisons*, CONSUMER AFF. & BUS. REG., <http://www.mass.gov/ocabr/insurance/vehicle/auto-insurance/auto-insurance-premium-comparisons.html> [<https://perma.cc/8YCE-7MWP>] (last visited Feb. 17, 2016).

Assessing the financial stability of insurance companies is both a collective action problem and an information problem, and regulation has substituted for market information to address these problems. Information about the financial stability of insurance companies is a public good that benefits all insureds but is in the interest of no single insured to generate, and measuring financial stability requires a degree of expertise that few insureds possess. The solution principally has been through regulatory barriers to entry as well as ongoing supervision and required reporting of the financial condition of companies, supplemented by private reporting services.

Claim practices is the area in which the market has completely failed to provide adequate information to consumers (and, as is explained in Part II, regulators have largely failed to supplement the market as well). When choosing among insurers, insurance consumers have no means of evaluating and comparing claim practices—which insurer is more likely to pay promptly, fully, or at all for which type of claims?

The sole theme in providing potential policyholders with information about claims practices is promoting a vague sense of security. For example, two of the most famous slogans in American advertising history emphasize insurance companies' promise to provide security: Allstate's "You're in Good Hands with Allstate" and the image of cradling hands,⁸ and State Farm's reassuring jingle "Like a good neighbor, State Farm is there."⁹ Advertising indirectly evokes the claim process, but it always has been institutional rather than factual, aimed at providing a perception of security unsupported by actual information about a company's claim practices.

At this late date in the provision of information through advertising, it would be difficult for a company to benefit from providing information on claim practices. The data are not publicly available to document any claims, so the only plausible effort would be to mirror the institutional advertising of other firms in building or reinforcing a reputation for quality.

Indeed, advertising the quality of claim practices is potentially dangerous, which may help explain the absence of such an emphasis. Insurance is sold as a measure of security. Promoting the possibility that security will be denied in the event of a claim, even by a company's competitors, could diminish consumers' belief in security and therefore diminish effective demand for all insurance.

A related factor is the unlikelihood of consumers successfully processing

8. See, e.g., *You're in Good Hands with Allstate* (Allstate television broadcast advertisement 1950); Boots's Commercials, *Allstate Insurance Commercial (1986)*, YOUTUBE (Aug. 13, 2007), <https://www.youtube.com/watch?v=PWw600H7bg0>; Mark Miller, *Old Allstate Ad: 1950s Allstate*, YOUTUBE (Mar. 16, 2008), <https://www.youtube.com/watch?v=69aMq4HiaZc>.

9. See, e.g., *Like a Good Neighbor, State Farm is There* (State Farm television broadcast advertisement 1971); CommercialsUSA, *State Farm "Like a Good Neighbor" Jingle Ad— "Can I Get a Hot Tub?!"*, YOUTUBE (July 1, 2010), <https://www.youtube.com/watch?v=OB6r2Wi0E98>; State Farm Insurance, *The State Farm® Legacy—Like a Good Neighbor*, YOUTUBE (Apr. 7, 2011), <https://www.youtube.com/watch?v=-9aS2JZkoQ4>; State Farm Insurance, *Like a Good Neighbor, State Farm is There.*®, YOUTUBE (Feb. 8, 2011), <https://www.youtube.com/watch?v=YaaHevxxvA>.

information about claim practices. Consumers often tend to discount risk, especially low probability, nonsalient risks, even if the potential loss is substantial.¹⁰ Even though one buys insurance to reduce the consequences of a potential risk, a consumer is likely to undervalue possible negative consequences, such as the occurrence of a loss and the possibility that a company will fail to pay in the event of a loss.

Nor are consumers likely to have sufficient experience of their own with claim practices to assess the quality of a company's performance. Most insureds never suffer a loss, few insureds suffer more than one, and even fewer suffer a substantial loss. Even including the experience of acquaintances, consumers do not have an adequate base of experience to assess a company's claim practices, much less to compare it to a competitor's practices.

Moreover, even if a loss occurs and the claim process does not fully compensate the insured, the information inequality between a company and its policyholder produces situations in which the policyholder may not be able to evaluate adequately the company's performance in the claim process. If a policyholder does not receive all that he or she expects in terms of payment or service during the claim process, the policyholder must identify the shortfall as the fault of the company, rather than take it as simply an unfortunate event.¹¹ Because of the policyholder's lack of expertise in understanding the insurance policy, its interpretation, and the technical aspects of the damages and its consequences, he or she is likely to accept the insurer's explanation for the limits on coverage as correct even if it is not.

Therefore, the market has produced little data that consumers can use on the relative performance of different insurers in the claim process, and it is unlikely ever to do so.¹²

B. Agency Problems

The second type of market failure in claim practices stems from the agency relationship inherent in insurance. In an agency relationship, each party may have different incentives and each may have access to different information, and these differences may affect their performance. That creates monitoring problems because one party who is subject to the other's discretion either needs to incur

10. BREYER ET AL., *supra* note 6, at 6–7; Daniel Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389, 1422 (2007).

11. See William L.F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming, Claiming . . .*, 15 LAW & SOC'Y REV. 631 (1981).

12. Nor are there effective intermediaries who generate or analyze data to provide shorthand forms of guidance for consumers. Partly, this is the result of the failure of the market to produce data; if there are no data to be evaluated, intermediaries cannot serve that filtering function. Partly, it is a collective action problem. Consumer Reports periodically surveys its members about their experience with insurance, including claim practices, but such surveys are necessarily limited in scope. Some websites seek to provide the information, but their data resources and reach are limited. See, e.g., VALCHOICE, <https://www.valchoice.com> [<https://perma.cc/HTM6-QSKB>] (last visited Feb. 17, 2016).

costs in monitoring the performance or takes the risk of a disadvantageous performance.

The agency problem is particularly acute in the insurance claim process. The insurer's duties with respect to a claim are vague, and the policyholder is poorly situated to monitor its performance of those duties.

Ex ante, the details of the company's obligation are not specified in the policy. A typical HO-3 homeowners policy, for example, only requires the company to pay claims within sixty days of agreement or adjudication and to participate in appraisal; otherwise, it delineates no duties concerning processing of a claim.¹³ The homeowner, by contrast, is subject to eight specified duties, including prompt notice, cooperation in investigation, and submission of proof of loss.¹⁴ Indeed, it would be hard to specify the insurer's duties because they necessarily rest on vague concepts such as promptness and reasonableness. As expressed in the Model Unfair Claims Settlement Practices Act, for example, a company must "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies."¹⁵ Even when a statute appears to narrowly specify a duty, the specification is usually qualified by a vague term.¹⁶

Ex post, the insured has no effective means of monitoring the company's performance in handling the claim. The vagueness of the company's defined responsibly and the substantial advantage in information and expertise that the insurer possesses creates an inherent difficulty in monitoring the performance.

More fundamentally, perhaps, the insurance contract presents distinctive agency problems because it combines sequential performance with the lack of substitute performances. The insured renders its entire performance first—paying the premiums. In the event of a loss, the insured cannot withhold its performance to provide an incentive for the company to fully perform its own obligation in the claim process. In a typical contract, if one party fails to perform, the other party can procure an adequate substitute performance, sue for any added cost, and, at least in concept, be made whole by the provision of damages. Insurance is different, however, as no insurer will sell insurance to compensate for a loss that has already occurred.¹⁷ A legal remedy limited to the recovery of the benefits of

13. INS. SERVS. OFFICE, INC., HOMEOWNERS 3—SPECIAL FORM, at 15 (1999), http://www.iii.org/sites/default/files/docs/pdf/HO3_sample.pdf [<https://perma.cc/3GDY-N57V>].

14. *Id.* at 13.

15. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4.C (Nat'l Ass'n of Ins. Comm'rs 1997).

16. In Tennessee, for example, an insurer is subject to a statutory penalty if it fails to pay a claim within sixty days of a demand by the policyholder, but only if "the refusal to pay the loss was not in good faith." TENN. CODE ANN. § 56-7-105 (West, Westlaw through 2016 2d. Reg. Sess.); *see also* GA. CODE ANN. § 33-4-6 (2012); LA. REV. STAT. ANN. § 22:1892 (2012).

17. "[A] breach in the employment context does not place the employee in the same economic dilemma that an insured faces when an insurer in bad faith refuses to pay a claim or to accept a settlement offer within policy limits. When an insurer takes such actions, the insured cannot turn to the marketplace to find another insurance company willing to pay for the loss already incurred." *Foley v. Interactive Data Corp.*, 765 P.2d 373, 396 (Cal. 1988).

the policy is also insufficient because it fails to fulfill the promise of security. That remedy does not give the insured the promised benefits until the litigation is concluded, perhaps years later, during which time the insured is likely to have suffered financial and emotional hardship and therefore to have lost the security and peace of mind for which he contracted.¹⁸

C. *Opportunism*

The third type of market failure, which is an extreme version of the agency problem, is the incentive and ability of an insurer to act opportunistically at the point of claim. In the context of economic relationships, opportunism is the practice of exploiting circumstances for selfish advantage without regard for prior commitment, or, in the colorful language of transaction-cost economics, “self-interest seeking with guile.”¹⁹ A party in a relationship invests costs and limits its freedom of action in return for commitments from its contracting partner. In some circumstances, the partner can take advantage of the sunk costs and limited freedom of action by dishonoring its commitments, particularly where strong controls on such behavior are lacking.

The ability to act opportunistically is inherent in the claim process. One form of opportunism rests on deceptive marketing: an insurer may properly deny a claim because it is not covered by the policy, but the insured’s expectations are still disappointed because the insurer marketed the policy on the basis of a perception of broader coverage or at least did not adequately disclose the policy’s limitations.²⁰ A second form entails a violation of the insurer’s obligation under the policy, in which the insurer wrongfully delays payment of the claim or denies a valid claim in whole or part. In both cases, the fact that the insurer’s claim performance is subsequent to the payment of the premium, is only vaguely defined in the policy, and is not subject to effective monitoring by the insured presents a significant potential for opportunism.

Opportunism is advantage-seeking behavior, and the advantage to the insurer is increased profit. Claim payments are an insurance company’s largest expense, so reducing payments has the greatest potential impact on a company’s bottom line. Delay in payments also is potentially beneficial because a company invests premium dollars until they must be paid out.

The extent to which insurers act opportunistically is hotly contested. Insurers and industry representatives acknowledge that occasional mistakes are made but

18. “Although the insured is not without remedies if he disagrees with the insurer, the very invocation of those remedies detracts significantly from the protection or security which was the object of the transaction.” *Rawlings v. Apodaca*, 726 P.2d 565, 570 (Ariz. 1986).

19. Oliver E. Williamson, *Opportunism and Its Critics*, 14 *MANAGERIAL & DECISION ECON.* 97, 97 (1993).

20. The potentially wrongful behavior here is at the front end of the insurance relationship, in the marketing of the policy. The remedies for this sort of opportunism include regulation of policy terms and greater mandated disclosure. Because the claim process plays only a supportive role in this type of opportunism, it is not the focus of this Article.

deny that there is systematic abuse. Industry critics argue in turn that companies have increasingly viewed the claim process as a profit center.²¹ What this debate certainly does is sharpen the questions about the regulation of claim practices. The purpose of regulation is to provide incentives and controls to further proper behavior in the claim process. Different incentives and controls are appropriate to correct occasional deficiencies—whether due to simple error or individual rogue adjusters—and systemic deficiencies that follow from institutional opportunism.

The market provides limited checks on opportunism in the claim process. In lines in which the market as a whole is relatively stable, such as auto insurance, retention is important, especially because the cost of acquiring a customer may be so large that customers will not produce a profit for the company until their third or fourth year of tenure.²² A bad claim experience may encourage an insured to switch carriers if the insured is able adequately to evaluate the company's performance in the claim process and identify the shortfall as the fault of the company, rather than take it as simply an unfortunate event.

With respect to consumers as a whole, however, claim practices are not a major determinant of satisfaction or purchasing behavior. A company that delays paying claims or denies valid claims in whole or part conceivably could suffer a negative reputational effect, and reputation is an important element in consumer purchases of insurance. But claims satisfaction is not the most significant factor in overall satisfaction, particularly relative to price and among younger customers, the largest-growing segment of the market.²³

II. FAILURES IN ADMINISTRATIVE REGULATION OF CLAIM PRACTICES

The presence of market failures means that market forces alone cannot ensure that insurance companies deliver satisfactory claim practices. The system of insurance regulation recognizes this fact and regulates claim practices in a number of ways. First, some regulation aims to improve the operation of the market for claim practices. Most of this type of regulation is directed at information problems that disadvantage potential insureds; some of it corrects policy terms that are particularly likely to cause problematic claim practices. Second, some regulation is more direct, setting standards for claim practices and enforcing those standards through administrative means.

21. *See generally* JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 56–120 (2010) (discussing changes to insurance companies' approaches to the claims process).

22. J.D. POWER & ASSOCS., STATE FARM AND GEICO CASE STUDIES: USING SEGMENTATION TO UNCOVER PROFITABLE CUSTOMER RETENTION OPPORTUNITIES 4 (2009), <http://images.dealer.com/jdpa/pdf/09-US-PersonalInsRetention-MD.pdf> [<https://perma.cc/QBP8-SHJN>].

23. J.D. Power reports, for example, that of those auto policyholders who changed companies, 15.4% went to GEICO, even though GEICO only has a 7% market share. Of course, GEICO's primary selling point is price. J.D. POWER & ASSOCS., 2012 U.S. AUTO INSURANCE STUDY: MANAGEMENT DISCUSSION 2 (2012), http://img.en25.com/Web/JDPower/2012_AIS_MD.pdf [<https://perma.cc/WRW9-6E4Y>].

The current system of administrative regulation of claim practices standards is sound in concept. However, what is sound in concept is not realized in practice. Administrative regulation currently does not achieve enough regulatory intervention in the market to ensure that insurers engage in an optimal level of observance of claim practices standards. Indeed, as constituted at present, it cannot.

A. The Failure to Improve the Market for Claim Practices

Because the market is the baseline for the insurance mechanism, one potential approach to improving claim practices is improving the operation of the market, with particular attention to market defects that tend to produce problematic claim practices. A principal defect that regulatory efforts could address is the lack of information with which potential insureds can evaluate the relative quality of insurers' claim practices so they can more effectively shop for insurance and, in the long term, create market pressure to improve claim practices. But regulators have made only very modest efforts to improve the information on claim practices available to consumers.²⁴

The most widely available source of information is consumer complaint data reported by state regulators.²⁵ The National Association of Insurance Commissioners (NAIC) collects the information from the states on its Consumer Information Source website, allowing consumers to search for complaint data on individual companies.²⁶

When consumers complain, their most common complaints are about improper claim practices. Nationally, of all complaints filed with insurance departments, delays in processing claims account for twenty-one percent of the complaints, claim denials for sixteen percent, and unsatisfactory settlements or offers to settle for ten percent.²⁷

The information about consumer complaints is incomplete and inexact; at its best, it can only help in making rough identifications of outlier companies. The strength of the data depends on consumer identification of wrongful behavior and taking the necessary steps to report that behavior. Because many insurance departments have limited or no authority to intervene in a policyholder's dispute with an insurer, the policyholder has little incentive to report.

Daniel Schwarcz accurately characterizes the presentation of consumer

24. See Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. 394, 414–20 (2014).

25. See J. ROBERT HUNTER, CONSUMER FED'N OF AM., STATE INSURANCE DEPARTMENT WEBSITES: A CONSUMER ASSESSMENT (2008), http://www.consumerfed.org/pdfs/state_insurance_websites.pdf [http://web.archive.org/web/20090323193247/http://www.consumerfed.org/pdfs/state_insurance_websites.pdf].

26. *Consumer Information Source*, NAT'L ASS'N OF INS. COMM'RS, <https://eapps.naic.org/cis/> [<https://perma.cc/ZT4N-SSDM>] (last visited Feb. 17, 2016).

27. NAT'L ASS'N OF INS. COMM'RS, REASONS WHY CLOSED CONFIRMED CONSUMER COMPLAINTS WERE REPORTED AS OF JUNE 30, 2014 (2015), https://eapps.naic.org/documents/cis_aggregate_complaints_by_reason_codes.pdf [<https://perma.cc/9GLH-9UAT>].

complaint data as “overlapping, confusing, and ambiguous.”²⁸ The states and the NAIC define categories that are impenetrable: There are “complaints” by consumers that are different than mere “inquiries.” Some complaints are “confirmed” by the department and others are “justified” or just “closed.” Sometimes the company takes “corrective action” and sometimes there are “other outcomes.” With these definitions, the published data are of limited usefulness to consumers.

The NAIC provides a template for data that could provide useful information. The Market Conduct Annual Statement (MCAS) provides a uniform reporting system for companies with respect to claims performance.²⁹ Companies separately report annuity policies (for which there are no relevant claim practice issues), life, homeowners, private passenger auto, and long-term care policies. In homeowners insurance, for example, companies report information including:

- Number of claims opened during the period
- Number of claims closed during the period, with payment
- Number of claims closed during the period, without payment
- Median days to final payment
- Number of claims closed with payment within zero to thirty days, thirty-one to sixty days, and so on
- Number of claims closed without payment within zero to thirty days, thirty-one to sixty days, and so on
- Number of suits opened during the period
- Number of suits closed during the period³⁰

After companies report the data, the NAIC aggregates it and produces “[s]corecards . . . to show the jurisdiction-wide ratio and the distribution of ratios for all companies filing an MCAS in a given jurisdiction.”³¹ The data and the scorecards serve two functions. They provide a source for regulators to determine where regulatory activity such as market conduct examinations might be most advantageously deployed, and they enable companies to “gain a better understanding of where they fit in the insurance marketplace and what opportunities may exist to improve their performance in a jurisdiction by comparing their jurisdiction-specific ratios to the scorecard for that jurisdiction.”³²

As originally proposed by the NAIC’s market conduct committee, the data from the MCAS also would provide more information to consumers on which to

28. Daniel Schwarcz, *Redesigning Consumer Dispute Resolution: A Case Study of the British and American Approaches to Insurance Claims Conflict*, 83 TUL. L. REV. 735, 756 (2009); see also Schwarcz, *supra* note 24, at 416–18.

29. NAIC Market Conduct Annual Statement, NAT’L ASS’N OF INS. COMM’RS, http://www.naic.org/mcas_2013.htm [<https://perma.cc/PRU9-PEQH>] (last visited Feb. 18, 2016). The MCAS also collects underwriting information.

30. *Id.*

31. *Id.*

32. *Id.*

select an insurer. The industry reaction was strongly negative.³³ As a result, the law in most states permits insurance departments to share the information with the NAIC only on the condition that it be kept confidential, so the public will not have access to it.³⁴

The data collected by the MCAS could be made available to the public and even could be expanded. More detail could be provided as to type of claim. For suits filed, additional information could be included such as how much the policyholder or accident victim claimed, how much the eventual settlement or jury verdict was, and how much the company was assessed in interest, attorney's fees, and penalties. Even expanded in this way, the data in the MCAS would not provide a perfect picture of claim practices. Because different insurers have different market segments, for example, data are not wholly comparable from one company to another. Information breeds information, however, and if claim practices developed as a significant factor in the market for policies, companies would be pressed to explain differences and even improve the reporting system itself.

Most consumers surely would not refer to such data when shopping for insurance, but the publication might have two salutary effects. First, it would provide a quantitative basis for competition in claim practices that might encourage the best performers to use the data in advertising. An insurer able to promote itself as the company most likely to pay a claim promptly or having only half as many policyholders forced to litigate claims might have a significant marketplace advantage. Second, intermediaries such as Consumer Reports or United Policyholders could compile and publicize indices of claim practices quality that would provide the information to consumers in a highly accessible form.

The theoretical underpinning of markets is that competition breeds quality, and currently the lack of a market for claim practices means that insurers are not required to compete for quality in claim practices. In the absence of regulatory intervention, no market is likely to develop, and regulatory intervention at an effective level has not occurred and is not likely to do so.

B. *The Failure of Administrative Enforcement of Claim Practices Standards*

The administrative regulation of insurance takes many forms: licensing of insurers and providers, control over policy forms and premium rates, and setting financial requirements, among others. The regulation of claim practices involves setting claim practices standards and then enforcing those standards.

33. See Jim Connolly, *NAIC Insurer Conduct Data Scheme Riles Insurers*, PROPERTY CASUALTY 360° (Sept. 25, 2008), <http://www.propertycasualty360.com/2008/09/25/naic-insurer-conduct-data-scheme-riles-insurers> [https://perma.cc/Z6YW-62RY].

34. See Daniel Schwarcz, *Differential Compensation and the "Race to the Bottom" in Consumer Insurance Markets*, 15 CONN. INS. L.J. 723, 734–35, 745 (2009); Schwarcz, *supra* note 24, at 415–16. The National Conference of Insurance Legislators' Proposed Market Conduct Annual Statement Model Act section 8 provides for the confidentiality of MCAS data.

Currently there are numerous claim practices standards, some mandated by statute or administrative rule and others from common law. The NAIC's Model Unfair Claims Settlement Practices Act, some version of which has been adopted in nearly every state, contains many standards, some general,³⁵ some specific,³⁶ and some in between.³⁷ Other statutes also set standards: for example, many states have enacted statutes that require payment of claims within specified time periods,³⁸ and others have enacted statutes that more generally prohibit a company to "unreasonably delay or deny payment of a claim,"³⁹ with unreasonableness defined when "the insurer delayed or denied authorizing payment of a covered benefit without a reasonable basis for that action."⁴⁰ Some statutory standards are focused on potentially problematic elements of the claim process: California, for example, requires that the policyholder be furnished on request a copy of all claim-related documents⁴¹ and prohibits insurance companies from paying adjusters any part of their compensation based on the amount for which they settle claims.⁴²

Setting standards for claim practices by itself may contribute to adherence to those standards by insurers. Setting the standards clarifies expectations about behavior, and insurers' institutional cultures may adopt the standards as internal norms. But that effect is limited. The basic principle of government regulation is that more is required. Outside entities, either regulators or private litigants or both, must have the incentive and mechanisms to enforce the standards, and the sanctions and remedies available to them must be sufficient to induce compliance by insurers.

The NAIC's Market Regulation Handbook identifies a "continuum of regulatory responses" for the analysis and regulation of market conduct.⁴³ The

35. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4.C (NAT'L ASS'N OF INS. COMM'RS 1997) [hereinafter UNFAIR CLAIMS SETTLEMENT PRACTICES ACT] (an insurer must "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.").

36. *Id.* § 4.M ("[Insurers must] provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use.").

37. *Id.* § 4.K ("Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form.").

38. *E.g.*, GA. CODE ANN. § 33-4-6 (West 2012); LA. REV. STAT. ANN. § 22:1892 (2012); MICH. COMP. LAWS ANN. § 500.2006 (West 2012); TENN. CODE ANN. § 56-7-105 (West 2012).

39. COLO. REV. STAT. ANN. § 10-3-1115 (West 2012); *see also* LA. REV. STAT. ANN. § 22:1973 ("The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.").

40. COLO. REV. STAT. ANN. § 10-3-1115; LA. REV. STAT. ANN. § 22:1973 ("The insurer has an affirmative duty to adjust claims fairly and promptly and to make a reasonable effort to settle claims with the insured or the claimant, or both. Any insurer who breaches these duties shall be liable for any damages sustained as a result of the breach.").

41. CAL. INS. CODE § 2071 (West 2003).

42. *See, e.g., id.* § 816; N.J. ADMIN. CODE § 11:2-17.8 (2012).

43. 1 NAT'L ASS'N OF INS. COMM'RS, MARKET REGULATION HANDBOOK 2011, at 11 (2012); *see also* Sharon Tennyson, *State Regulation and Consumer Protection in the Insurance Industry* 9–10

elements of the continuum are (1) contact with the regulated entity, (2) market conduct examinations (MCEs), (3) enforcement actions, and (4) closure.⁴⁴ Each of these elements may take several forms. Contact with the regulated entity includes interrogatories, interviews with the company, contact with other stakeholders, targeted information gathering, policy and procedure reviews, reviews of self-audit and self-review documents, and review of voluntary compliance programs.⁴⁵ MCEs may take the form of “desk examinations” of a company’s documents or on-site reviews.⁴⁶ Enforcement actions range from an agreement for a voluntary compliance plan through ongoing monitoring and self-audit to fines or even revocation of the insurer’s license.⁴⁷ Closure may include determining that no further action is needed; communicating the insurance department’s position; providing education, communication, or notices to insurers; ongoing, nonstructured monitoring; and requesting legislative or regulatory rule changes.⁴⁸

Along this continuum of claim-practice regulation, three elements are most important: the handling of consumer complaints, market conduct examinations, and enforcement actions.⁴⁹

1. Handling Consumer Complaints

Every state insurance regulator receives and processes in some ways questions and complaints from policyholders about their insurers.⁵⁰ This mechanism has the potential to enforce claim practices standards, although the effect is at best indirect and the potential is seldom realized.

When a policyholder files a complaint with an insurance department, typically the department separates complaints from simple inquiries and, if the former, determines if it has jurisdiction. Then the complaint is sent to the insurer for its response. Upon receiving the response, a department employee may discuss the response with the insurer and consumer in an attempt to reach a common understanding or voluntary resolution of the complaint. In all but a few jurisdictions, the department lacks the authority to authoritatively resolve the complaint and may in any event refrain from doing so to avoid taking a formal

(Networks Fin. Inst. Policy Brief No. 2008-PB-03, 2008), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1106172.

44. 1 NAT’L ASS’N OF INS. COMM’RS, *supra* note 43, at 13.

45. *Id.* at 13–16.

46. *Id.* at 16–17.

47. *Id.* at 17–19.

48. *Id.* at 19–21.

49. In addition to these principal types of regulation, regulators sometimes mandate alternative dispute resolution such as mediation for claim disputes; such processes may have an incidental effect of encouraging adherence to claim practices standards.

50. See Schwarcz, *supra* note 28, at 750; William C. Whitford & Spencer L. Kimball, *Why Process Consumer Complaints? A Case Study of the Office of the Commissioner of Insurance of Wisconsin*, 1974 WIS. L. REV. 639, 646 (1974). The inquiry and complaint process involves other issues as well, such as those concerning premiums and nonrenewal.

regulatory action.⁵¹

The processing of consumer inquiries and complaints serves three functions for insurance regulators.⁵² First, and the most obvious, is the resolution of disputes between insurers and their policyholders, particularly small value disputes. Second, disputes provide regulators with information about failures to adhere to claim practices standards, either by individual companies or in types of situations, and that information may spur other regulatory action. Third, the process has an affective function—for the department itself by generating goodwill, as it appears to be helpful, and for insurers by legitimizing claim denials or potentially contentious claim practices.

Given the variety of practices across the jurisdictions, it may be hard to reach general conclusions about regulators' relative weighting of these objectives and their success in achieving them. The existence of the complaint process may itself contribute to the dispute resolution function and to an extent the affective function. Referring consumer complaints to an insurer may spur company review of the underlying matter, particularly review by a decision maker not involved in the initial determination, that may result in a change of position in some number of cases.⁵³ This is particularly true for low-value cases or complaints brought by less sophisticated consumers; in those cases any means of dispute resolution is likely to be better than nothing.

Nevertheless, as a structural matter there is reason to doubt the efficacy of the complaint mechanism in enforcing claim practices standards. The caseloads of employees who process complaints often preclude extensive involvement. One survey reports that in fifteen states complaint handlers have caseloads of 600 cases or more, and in seven states of 1000 or more.⁵⁴ The result of such overload is predictable: nearly half of the states are unable to process all the consumer complaints they receive.⁵⁵ Regulators often refuse to address complaints in which there is an unresolved legal or factual issue, which certainly constitute a large portion of the complaints, both because such cases are resource intensive and because departments often consider the resolution of such issues beyond their authority. If the complaints are serious, they may warrant litigation and regulators then defer investigation.⁵⁶ As a matter of law and practice, the regulator's role is

51. Schwarcz, *supra* note 28, at 753.

52. Whitford & Kimball, *supra* note 50, at 670.

53. *Id.* at 675.

54. Schwarcz, *supra* note 28, at 757.

55. *Id.* at 756–57. Because of industry influence, the NAIC historically also has limited funds to devote to market conduct issues. See Scot J. Paltrow, *The Converted: How Insurance Firms Beat Back an Effort for Stricter Controls*, WALL ST. J., Feb. 5, 1998, at A1.

56. The focus of the dispute-resolution process is low-value complaints. For example, the California insurance department asks on its complaint form if the complainant is represented by a lawyer and states that if litigation is ongoing or pending, “If yes, we may defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of insurance law by the insurer that you or your attorney are willing to provide.” STATE OF CAL. DEP’T OF INS., CSD-001-P, REQUEST FOR ASSISTANCE (RFA) (2014),

less about adjudication and more a form of alternative dispute resolution. Most departments lack the statutory authority to compel a resolution of the case by the insurer, so its employees act as an intermediary, making inquiries of the insurer, perhaps offering independent views on the merits of the case and attempting to achieve a voluntary resolution. The employees are not powerless in this process because the threat of regulatory action, however attenuated, is always present. Ultimately, however, the resolution of the complaint rests on the insurer agreeing to it.⁵⁷ Therefore, even though department employees may refer to claim practices standards when they do seek resolution of complaints,⁵⁸ their ability to enforce the standards is limited. Nor are complaints likely to be a significant factor in identifying broad regulatory problems: less than one-half of one percent of complaints are referred to a department's market conduct division for consideration of a broader regulatory issue.⁵⁹

2. Market-Conduct Examinations

Market-conduct examinations can be directed at a number of areas, including marketing and sales, underwriting and rating, and producer licensing as well as claim practices. The guiding philosophy of market-conduct examinations was stated in the NAIC's first Market Conduct Surveillance Handbook:

Since it is inevitable that all companies will, on occasion, make errors that result in unfair treatment of policyholders, market conduct surveillance must be selective. It can only be effective if it focuses on general business practices as opposed to instances of treatment of policyholders or claimants, which may be infrequent or unintentional.

. . . [A] company engag[es] in a general business practice [when]:

1. The underlying cause of the problem, regardless of its frequency, can be traced to a company policy or regularly followed procedure as distinguished from an unintentional error.
2. The frequency of the problem—e.g., the percentage of auto policies incorrectly rated—is significantly greater for the company than the standard determined acceptable.⁶⁰

While solvency regulation and rate regulation historically have been the areas of greatest focus for insurance regulators, efforts have been made in recent decades to improve market-conduct regulation, including but not limited to the regulation of claim practices. In the early 1970s the NAIC engaged McKinsey & Co. to investigate and make recommendations on systems for analyzing and

<http://www.insurance.ca.gov/01-consumers/101-help/upload/CSD001RFA20151224A.pdf> [<https://perma.cc/28KD-SF7U>].

57. Schwarcz, *supra* note 28, at 755–59.

58. See Whitford & Kimball, *supra* note 50, at 678.

59. Schwarcz, *supra* note 28, at 753.

60. II. *Rationale and History of Market Conduct Surveillance*, NAT'L CONFERENCE OF INS. LEGISLATORS, <http://www.ncoil.org/policy/ii-history.html> [<https://perma.cc/5Z29-EFSF>] (last visited Feb. 20, 2016) (underlining in original).

improving financial surveillance of insurers and market conduct.⁶¹ Its recommendations contributed to the development of a coordinated but voluntary system for the collection of consumer-complaint data and the drafting of the NAIC's first Market Conduct Surveillance Handbook in 1974.

Despite the NAIC's efforts at reform, progress was seen to be slow.⁶² In 2003, the federal General Accounting Office found that market analysis and on-site examinations were used inconsistently, resulting in gaps in regulation in some instances and duplication in others.⁶³ Since then, two trends in MCEs have been reported. First, the NAIC continued its efforts at reform, particularly by inaugurating new systems for the collection of market conduct data.⁶⁴ Second, regulators have relied less on MCEs in recent years. Between 2003 and 2005, for example, the total number of all examinations dropped by eighteen percent; on-site, single-tate, targeted examinations fell by thirty percent, and lengthy examinations fell by a third and high-cost examinations by two-thirds.⁶⁵

Despite these efforts, the state-based system with national but nonbinding coordination has produced substantial complaints by insurers that market conduct examinations are expensive, duplicative, and wasteful. The Federal Insurance Office's report and recommendation on regulatory reform noted that:

Market conduct regulation has been the focus of significant criticism by industry and third-party commentators. The principal reasons are that state regulators often fail to adequately coordinate market conduct examinations, resulting in multiple examinations for the same or similar sets of issues, with all the attendant burdens and inefficiency.⁶⁶

Robert Klein, one of the most widely published scholars of insurance regulation,

61. Robert W. Klein & James W. Schact, *An Assessment of Insurance Market Conduct Surveillance*, 20 J. INS. REG. 51, 61 (2001); *II. Rationale and History of Market Conduct Surveillance*, *supra* note 60. Ironically, McKinsey would play a major role in redesigning insurance company claim practices to augment company profits.

62. U.S. GEN. ACCOUNTING OFFICE, GAO-03-433, INSURANCE REGULATION: COMMON STANDARDS AND IMPROVED COORDINATION NEEDED TO STRENGTHEN MARKET REGULATION 3-4 (2003).

63. *See id.* at 18.

64. For example, NAIC sponsors the Internet-State Interface Technology Enhancement, known by its acronym I-Site. I-Site contains data on examinations, investigations, and complaints supplied by state regulators and insurers' quarterly and annual financial statements, permitting regulators to assess market conduct issues across the jurisdictions. The effectiveness of I-Site is limited by the data supplied to it by individual regulators, and under-reporting or inconsistent reporting can be a problem. CAN. COUNCIL OF INS. REGULATORS, RISK-BASED MARKET REGULATION: A SURVEY OF APPROACHES 6 (2004). The NAIC also supports the Market Conduct Annual Statement, which collects and reports data on a variety of issues including claim practices, with company-level data made available to regulators and insurers and industry-level data by state made available to the public. The MCAS also produces reports on "outliers" among "nationally significant companies" with regard to underwriting and claims handling, which may require special attention.

65. News Release, Nat'l Assoc. of Ins. Comm'rs, Surveys Indicate Progress Toward Market Regulation Reforms (June 13, 2006) (on file with author).

66. FED. INS. OFFICE, HOW TO MODERNIZE AND IMPROVE THE SYSTEM OF INSURANCE REGULATION IN THE UNITED STATES 53 (2013).

concur and comments that MCEs disserve the public as well as insurers: “Currently, the states subject insurers to extensive, duplicative and costly examinations that focus too much on minor errors and too little on major patterns of abuse. In other words, regulators ‘miss the forest for the trees.’”⁶⁷

Individual states’ experiences of MCEs are highly variable.⁶⁸ Without a broad study of market conduct examinations in all states and across states, generalizations like those above are hard to document. That study has not been done,⁶⁹ and to the extent that the NAIC collects and collates data, it is not available to the public. As a possibly representative example of what one might describe as the ordinary use of MCEs, consider a snapshot of the New Jersey experience. The New Jersey Department of Banking and Insurance reports having conducted fifty-four market conduct examinations over the past nine years, with a high of nine concluded in one year and a low of three.⁷⁰ A probably typical example is an MCE of Esurance Insurance Company of New Jersey.⁷¹ The examination was an on-site examination conducted under the standards prescribed in the NAIC handbook. The examiners purported to “check[] for compliance with all applicable statutes and regulations that govern timeliness requirements in settling first and third party claims. The examiners conducted specific reviews placing emphasis on” the state’s adoption of the Unfair Claims Settlement Practices Act and other relevant statutes.⁷² They detected error ratios of twenty-three percent in paid claims and nine percent in denied claims.⁷³ The errors found principally were failing to pay within the legal time limits without obtaining an extension; also noted were failure to pay interest or sales tax due and failure to give required notices. These errors fairly can be described as systemic—delaying or underpaying claims in one out of four paid claims and one out of eleven denied. Nevertheless, no enforcement action was taken. Instead, the department ordered and the company agreed that the company “has taken or will take

67. Robert W. Klein, *Principles for Insurance Regulation: An Evaluation of Current Practices and Potential Reforms*, 37 GENEVA PAPERS ON RISK & INS. 175, 195 (2012).

68. FED. INS. OFFICE, *supra* note 66, at 53.

69. Tom Baker, *Qualitative and Quantitative Research on Tort Law Topics: A Comment on Helland & Klick and Kritzer*, 1 J. TORT L., no. 3, art. 4, 2007, at 4, 5. There are no significant law review articles about market-conduct regulation, no significant insurance-treatise descriptions, and, apart from the report commissioned by the NAIC, no systematic empirical research (at least that I have found). Knowledgeable insurance-industry insiders regularly complain to me that market-conduct exams are an expensive, paper driven, and mindless process that punishes insurance companies for minor mistakes while completely ignoring real problems. I am in no position to evaluate these complaints, but the alleged failure of market-conduct examiners to uncover the apparently massive UNUM/Provident disability insurance fraud provides some support for it.

70. See generally *Market Conduct Examination Reports*, STATE OF N.J. DEP’T OF BANKING & INS., http://www.state.nj.us/dobi/division_consumers/insurance/marketconductexams.htm [<https://perma.cc/A8TU-XACM>].

71. STATE OF N.J. DEP’T OF BANKING & INS., MARKET CONDUCT EXAMINATION OF ESURANCE INS. CO. OF NEW JERSEY (2012), http://www.state.nj.us/dobi/division_consumers/insurance/mcexams/esuranceadoprpt1.pdf [<https://perma.cc/8AXF-Y39M>].

72. *Id.* at 4.

73. *Id.* at 4–5.

corrective measures” and the department would reexamine the company within two years.⁷⁴

Timeliness and the required notices are important. But the MCE’s modest focus on “timeliness” (modest because the systemic errors were not regarded as serious enough to penalize Esurance) ignores many other statutory requirements—for example, those that prohibit:

- c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; [and]
- g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.⁷⁵

In Klein’s metaphor, the New Jersey experience suggests that too often MCEs focus on the trees rather than the forest, and not particularly tall trees at that.

Less ordinary but significant is the use of MCEs following high-profile events or spurred by other outside forces. The California Insurance Commissioner performed a market conduct examination of State Farm’s response to the 1994 Northridge earthquake,⁷⁶ and the Mississippi Insurance Department examined the company’s response to Hurricane Katrina claims.⁷⁷ Several high-profile MCEs also have been precipitated by litigation. For example, a market-conduct examination by the North Dakota Department of Insurance examined the employee-incentive policies of Farmers Insurance and concluded that Farmers set goals for adjusters that were “arbitrary and unfair to policyholders and claimants.”⁷⁸ A multistate market-conduct examination of Allstate’s use of Colossus, an expert system for evaluating general damages in auto personal injury claims, concluded in 2010 that the use of the system had not led to “systemic underpayment of . . . claims” but that Allstate needed to “enhanc[e] its management oversight of Colossus to ensure that it adheres to established criteria and a uniform methodology in selecting claims to be used to ‘tune’ or modify the

74. Esurance Ins. Co. of N.J., Order No. E12-68 (N.J. Dep’t of Banking & Ins. May 31, 2012) (consent order).

75. Unfair Claims Settlement Practices, N.J. STAT. ANN. § 17B:30-13.1 (West 2012).

76. CAL. DEP’T OF INS., MARKET CONDUCT EXAMINATION REPORT OF STATE FARM FIRE AND CASUALTY COMPANY (NAIC # 25143) AND STATE FARM GENERAL INSURANCE COMPANY (NAIC #25151) (1998), <http://mail.consumerwatchdog.org/insurance/rp/rp000620.pdf> [<https://perma.cc/2L3E-CNDS>].

77. MISS. DEP’T OF INS., REPORT OF THE SPECIAL TARGET EXAMINATION (KATRINA HOMEOWNER CLAIMS) OF STATE FARM INSURANCE COMPANIES (SPECIFICALLY STATE FARM FIRE & CASUALTY COMPANY) (2008), http://www.ins-compliance.com/images/inscomp/PDFs/2008/1103_MS_State_Farm_MC_Exam_Report.pdf [<https://perma.cc/UE6L-N5H8>].

78. N.D. INS. DEP’T, MARKET CONDUCT EXAMINATION REPORT: FARMERS INSURANCE EXCHANGE 3 (2007).

software to reflect recently settled claims.”⁷⁹ Each of these followed high-profile litigation about the subjects of the examination.

Market conduct examinations can be and in some cases are effective administrative tools for regulating claim practices. But experience suggests that their use has been intermittently and not always effectively focused on claim practices because of resources and a limited focus, as well as because of the broader issues discussed in Section II.C below.

3. *Enforcement Actions*

In every jurisdiction, insurance regulators have the authority to directly enforce claim practices standards through penalties for violations of the standards and through cease and desist orders.⁸⁰ The NAIC’s Model Act provides that when a commissioner has “reasonable cause to believe that an insurer . . . is engaging in any unfair claims practice” as defined by the statute, the commissioner “shall” issue a notice and conduct a hearing.⁸¹ Upon a finding of a violation, the commissioner issues a cease and desist order and “may, at the commissioner’s discretion” impose monetary penalties or even, in the extreme, revoke the insurer’s license.

Under the Model Act and many statutes, penalties are tiered. First, higher penalties are imposed for violations committed “flagrantly and in conscious disregard” of the statute.⁸² Under the Model Act, for example, the specified penalty is not more than \$1,000 per violation, or \$25,000 per flagrant and conscious violation.⁸³ Second, penalties are subject to an aggregate limit of \$100,000 for ordinary violations or \$250,000 for flagrant violations. Jurisdictions have adopted different versions of these penalties. Connecticut, for example, has modest penalties of \$5,000 per violation and \$50,000 in the aggregate per six-month period for ordinary violations and \$25,000 per/\$250,000 aggregate for violations of which the offender knew or should have known.⁸⁴ Others are more dramatic; Illinois, for instance, has a penalty up to \$250,000 for a single violation

79. News Release, N.Y. State Ins. Dep’t, Allstate Agrees to \$10 Million Regulatory Settlement over Bodily Injury Claim Handling Processes (Oct. 18, 2010), <http://www.dfs.ny.gov/insurance/press/p1010181.htm> [<https://perma.cc/7ZCS-VW6S>].

80. See generally Steven Plitt & Christie L. Kriegsfeld, *The Punitive Damages Lottery Chase Is Over: Is There a Regulatory Alternative to the Tort of Common Law Bad Faith and Does It Provide an Alternative Deterrent?*, 37 ARIZ. ST. L.J. 1221 (2005); Steven Plitt, *Regulating Insurance Company Claim Handling Practices: Rethinking the Unthinkable (Abandonment of the Common Law Tort of Bad Faith)*, 29 NO. 1 INS. LITIG. REP. 5 (2007).

81. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 5 (NAT’L ASS’N OF INS. COMM’RS 1997). Although the statute is directive and not discretionary (“shall,” not “may”), the vagueness of the reasonable-cause standard and the lack of a means of enforcing the requirement raise the possibility that regulators may not observe the requirements of the statute in practice and may fail to initiate enforcement proceedings in all circumstances when there is reasonable cause to do so. No studies of this issue have been reported.

82. *Id.* § 6(A).

83. *Id.*

84. CONN. GEN. STAT. ANN. § 38a-817 (2015).

with no aggregate cap.⁸⁵

A few states provide guidance on determining the scale of penalties to be imposed. For example:

In determining the penalty imposed under (d) and (e) of this section, the director shall consider the amount of loss or harm caused by the violation and the amount of benefit derived by the person by reason of the violation and may consider other factors, including the seriousness of the violation, the promptness and completeness of remedial action, whether the violation was a single act or a trade practice, and deterrence of the violator or others.⁸⁶

Or:

The Division of Insurance . . . shall consider all pertinent facts and circumstances to determine the severity and appropriateness of action to be taken . . . including but not limited to, the following:

1. The magnitude of the harm to the claimant or insured;
2. Any actions by the insured, claimant, or insurer that mitigate or exacerbate the impact of the violation;
3. Actions of the claimant or insured which impeded the insurer in processing or settling the claim;
4. Actions of the insurer which increase the detriment to the claimant or insured. The director need not show a general business practice in taking administrative action for these violations.⁸⁷

There is an important qualification to even the largest penalties. The Model Act specifies a variety of unfair practices, but those practices constitute statutory violations only if they are committed “flagrantly and in conscious disregard” of the Act or “with such frequency to indicate a general business practice to engage in that type of conduct.”⁸⁸ The great majority of statutes include the requirement that prohibited acts constitute a violation only if committed “with such frequency as to indicate a general business practice” or similar language.⁸⁹ Therefore, single violations, occasional violations, or even repeated violations that do not rise to the level of “a general business practice” are not really violations at all.

Thus the enforcement mechanisms are limited in two significant ways. First, an insurer may violate the statute but the violation may not subject it to an enforcement proceeding unless the violation is a regular and repeated practice or is flagrant and intentional; the regulators lack the authority to sanction serious violations that are merely reckless or occasional. Under a more robust regulatory

85. 215 ILL. COMP. STAT. 5/154.8 (2015).

86. ALASKA STAT. § 21.36.910 (2014).

87. S.D. CODIFIED LAWS § 58-33-68 (2015).

88. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 3 (NAT’L ASS’N OF INS. COMM’RS 1997).

89. *Id.* § 3(B). Section 3(A) offers a variation prohibits violating the statute “flagrantly and in conscious disregard” of the law. *Id.* § 3(A). For a general discussion, see Plitt & Kriegsfield, *supra* note 80, at 1248–50.

enforcement system, factors such as regularity and intent would go to the extent of the penalty, not the presence of a violation. Second, the statutory penalties available in many jurisdictions are exceedingly small. Individual penalties in the thousands of dollars and aggregate limits in the hundreds of thousands of dollars are unlikely to provide a substantial deterrent to insurers with premium income in the tens or hundreds of millions of dollars.⁹⁰

Even in those jurisdictions with significant penalties available, their use in claim practices cases is arguably insufficient. As with market-conduct examinations, a national survey of enforcement actions is needed to demonstrate the full scope of administrative enforcement of claim practices standards. But again, one state's experience may be a useful example. During 2013 the Insurance Division of the New Jersey Department of Banking and Insurance issued 123 consent orders, final orders, and orders to show cause.⁹¹ Of these, 118 were directed at insurance agents, public adjusters, bail bondsmen, and the like; only three were directed at insurers.⁹² Two of the actions against insurers were for selling health-benefit plans that did not comply with the law, and only one concerned claim practices; Aetna Health was fined \$850,000 for improperly delaying and denying claims and misinforming consumers.⁹³

C. *Why Administrative Regulation Has Failed*

The failure of administrative regulation to substantially improve the market for claim practices or to improve claim practices through direct enforcement presents a paradox: insurance may be the most highly regulated industry in the United States, but regulators have not performed very well in this area. In fact, insurance regulators do very well in ensuring the solvency of companies, reasonably well in controlling the rates companies charge, and not at all well in regulating insurers' market conduct, including their claim practices.⁹⁴ Many factors

90. A third limitation is that penalties are never imposed on individual officers or agents of the company, as they are imposed on individual licensees and, more to the point, on insurance consumers and care providers in cases of insurance fraud. Many states have enacted statutes that require companies to report to regulators whenever they have "reason to believe" that a "fraudulent insurance act" has been committed. *E.g.*, N.Y. PENAL LAW § 176.05 (McKinney 2015). The statutes apply only to false statements made by applicants for insurance, policyholders, victims who present claims to companies, doctors who treat those victims, and the lawyers who represent those victims. However, the statutes do not apply to false statements made by employees of insurers to policyholders or others. *See* Aviva Abramovsky, *An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards*, 98 J. CRIM. L. & CRIMINOLOGY 363 (2008).

91. *See generally* 2013 Insurance Enforcement Activity, STATE N.J. DEPT BANKING & INS., http://www.state.nj.us/dobi/division_insurance/insfines13.htm [<https://perma.cc/R2TM-TVNE>] (last visited Feb. 18, 2016).

92. *See id.*

93. *See id.*

94. The hypothetical offered by Kyle Logue captures the insurance-claim practices setting very well: "[t]hink of a regulatory agency that has a large budget for safety research, but that has a relatively paltry enforcement budget (and little stomach for fining the heck out of non-compliers), such that any regulated scofflaw's prospect of being sanctioned by the agency is fairly small." Kyle D. Logue, *Coordinating Sanctions in Tort*, 31 CARDOZO L. REV. 2313, 2342 (2010).

produce these results, but a plausible hypothesis is that insurance regulation is most effective where the public interest and industry interests align and least effective where those interests conflict.⁹⁵ In solvency regulation, regulators protect the public against financially insecure insurers while solving a collective action problem for insurers. Insolvency often results from collecting premiums that are too low or taking risks that are too great, and if one insurer does that, others must race to the bottom in order to compete. Even insurers that are able to resist are disadvantaged because the failure of one company diminishes the public's faith in all insurance companies and reduces the demand for all insurers' products. Where there is the strongest conflict between the public interest and industry interests, regulation is weaker and less effective, and surely the conflict is strongest in the regulation of claim practices.⁹⁶

This hypothesis suggests that what is in play in market-conduct regulation is a form of regulatory capture.⁹⁷ Susan Randall comments that "the problem of capture as it exists in other regulatory contexts is minimal when compared to the problem in the insurance industry."⁹⁸ There is certainly sufficient evidence for that proposition. The revolving door between regulators and industry swings frequently.⁹⁹ The industry is a major campaign donor at the state and federal level. Influence also comes from organizations, and the insurance industry teems with organizations that generate research and public-relations materials that shape the thinking of regulators¹⁰⁰ and "govern governance."¹⁰¹ Industry influence is magnified by the unusual structure of insurance regulation in which an industry dominated by huge, national and multinational corporations is regulated in fifty state capitals with coordination done by the public-private NAIC, which has its own issues with industry influence.¹⁰² And insurance issues tend to be complex

95. For a survey of theories of regulation as applied to the insurance industry, see KENNETH J. MEIER, *THE POLITICAL ECONOMY OF REGULATION: THE CASE OF INSURANCE* 18–32, 137–66 (1988). Meier identifies as operational variables in regulation the resources of industry groups, consumer groups, regulatory bureaucrats, and political elites. *Id.* at 138–41.

96. And in between the results are varied, almost random.

97. "Regulatory capture is the result or process by which regulation, in law or application, is consistently or repeatedly directed away from the public interest and toward the interests of the regulated industry, by the intent and action of the industry itself." Daniel Carpenter & David A. Moss, *Introduction to PREVENTING REGULATORY CAPTURE* 1, 13 (Daniel Carpenter & David A. Moss eds., 2014) (emphasis in original).

98. See Susan Randall, *Insurance Regulation in the United States: Regulatory Federalism and the National Association of Insurance Commissioners*, 26 FLA. ST. U. L. REV. 625, 639 (1999).

99. Four-fifths of the recent presidents of the NAIC have gone on to work for the industry. A study of all state insurance commissioners serving over a seventeen-year period found that half went into the insurance industry after leaving office. Martin F. Grace & Richard D. Philips, *Regulator Performance, Regulatory Environment, and Outcomes: An Examination of Insurance Regulator Career Incentives on State Insurance Markets*, 32 J. BANKING & FIN. 116 (2008).

100. See James Kwak, *Incentives and Ideology*, 27 HARV. L. REV. FORUM 253 (2014) (ideological capture).

101. RICHARD V. ERICSON ET AL., *INSURANCE AS GOVERNANCE* 151 (2003).

102. See Randall, *supra* note 98, at 629.

and of low public visibility, except when sparked by major events such as Hurricane Katrina or Superstorm Sandy.¹⁰³

Insurance-industry capture of regulation provides a good example of the nuances of contemporary approaches to the understanding of capture.¹⁰⁴

First, the early literature on regulatory capture focused on attempts by a regulated industry to obtain favorable regulations from an administrative agency that had primary responsibility for regulating the industry, such as the Interstate Commerce Commission and the railroad industry. But capture more accurately includes both statutory and regulatory capture—influencing legislation and also rulemaking and enforcement under that legislation.¹⁰⁵

The limits of the effective regulation of claim practices are both statutory and administrative. In most states, for example, regulators are barred by statute from making public data from the MCAS on an individual company basis, data that could be used to improve the market for claim practices.¹⁰⁶ And where regulators have the statutory authority to publish claims data, they fail to do so.

Second, capture scholarship commonly has focused on industry efforts to obtain favorable regulation. But capture may also be “corrosive,” in which the industry “push[es] the regulatory process in a ‘weaker’ direction . . . with the aim of reducing costly rules and enforcement actions that reduce firm profits.”¹⁰⁷

Claim-practices regulation inherently favors insurance consumers over insurers, but capture guarantees that the tilt is not too great. The modest enforcement penalties available in most states and the even more modest efforts at actual enforcement in claim practices cases demonstrate that nominally proconsumer regulation can be corroded.

III. LITIGATION AS REGULATION

In a classic article on the choice between regulation and litigation as vehicles for optimizing social behavior, Steven Shavell commented that:

[N]either tort liability nor regulation could uniformly dominate the other as a solution to the problem of controlling risks, but also that they should not be viewed as mutually exclusive solutions to it. A complete solution to the problem of the control of risk evidently should involve the joint

103. MEIER, *supra* note 95, at 30–31 (emphasizing the influence on regulation of salience—an issue “characterized by intense conflict of a broad scope”—and complexity).

104. See Carpenter & Moss, *supra* note 97, at 9 (“Perhaps the deepest problem with much of the research on regulatory capture is . . . its lack of nuance in describing how and to what degree capture works in particular settings.”). For a review of the literature, see PREVENTING REGULATORY CAPTURE, *supra* note 97, at 23–172.

105. Daniel Carpenter, *Detecting and Measuring Capture*, in PREVENTING REGULATORY CAPTURE, *supra* note 97, at 57, 58–60.

106. See *supra* notes 33–34 and accompanying text.

107. Daniel Carpenter, *Corrosive Capture? The Dueling Forces of Autonomy and Industry Influence in FDA Pharmaceutical Regulation*, in PREVENTING REGULATORY CAPTURE, *supra* note 97, at 152, 154; Carpenter & Moss, *supra* note 97, at 16.

use of liability and regulation¹⁰⁸

The same holds true for the problem of controlling the risk that insurers will violate claim practices standards. The market fails to adequately control that risk, so regulation is needed. Administrative regulation would not be completely effective in theory and is largely ineffective in practice. Therefore, private litigation is needed to serve a regulatory function as well.¹⁰⁹

The relative weight given to regulation and litigation in particular contexts depends on a variety of factors. Solvency regulation has long been a primary focus of regulators. Insurance commissioners erect strict barriers to insurers' entry into insurance markets and rigorously police capital requirements, reserves, and the like on an ongoing basis. As a result, the insolvency of insurers that plagued earlier generations is rare today. Moreover, litigation is unlikely to be an effective remedy for insolvency as it does not provide ongoing supervision but only occurs after the fact, when the occurrence of insolvency itself prevents an effective recovery in litigation. Therefore, litigation by private parties has a minimal role to play in ensuring solvency.

Where the actions of insurers are less rigorously policed initially, leading to regulatory underenforcement, however, there is a greater need for litigation as a supplement to administrative regulation. Claim practices is such an area.¹¹⁰ And litigation about claim practices, unlike litigation about insolvency, can contribute substantially to regulation.

A. *The Advantages of Litigation as Regulation*

There are three reasons that litigation can play an important role in the regulation of claim practices: information, cost, and remedy.

The first reason relates to the superior knowledge and incentives available to private plaintiffs as compared to regulators. Where an area is ongoing and highly complex, requiring extensive data gathering and study, for example, regulators are in a better position to acquire and assess the information needed to define and administer regulation. On the other hand, where transactions are remote from regulators, discrete, and of low visibility, private parties engaged in or affected by the transactions are in a better position to recognize and process information

108. Steven Shavell, *Liability for Harm Versus Regulation for Safety*, 13 J. LEGAL STUD. 357, 365 (1984); see also Logue, *supra* note 94. See generally REGULATION THROUGH LITIGATION (W. Kip Viscusi ed., 2002).

109. Abraham calls litigation of this type "forward-looking" because it deals with both past and continuing actions. Kenneth S. Abraham, *The Insurance Effects of Regulation by Litigation*, in REGULATION THROUGH LITIGATION, *supra* note 108, at 212, 231. Political conservatives and industry advocates often decry both administrative regulation and regulation through litigation. The position of Friedrich Hayek, a principal intellectual forerunner of modern conservatism, was clearer, opposing centralized administration but recognizing the need for regulation through liability rules. See Samuel Issacharoff, *Regulating After the Fact*, 56 DEPAUL L. REV. 375, 383 (2007).

110. "Ex post accountability is the prerequisite for ex ante liberalization. Without ex post mechanisms, the American experiment in deregulation becomes a free-wheeling descent into nonregulation." Issacharoff, *supra* note 109, at 385.

about the subject.¹¹¹

For claim practices, policyholders are in a better position than regulators to be informed about insurers' departure from standards and to use that information in litigation. That is true even though an insurer's actions on an individual claim typically are the product of a system in place for the resolution of many claims because the system is only instantiated on a case-by-case basis. This is a paradigmatic instance in which private parties have superior knowledge compared to administrators because "the alleged wrongdoing is fairly concrete and aimed directly at or knowingly suffered by private individuals."¹¹²

Related are the different incentives presented to private parties and to regulators. At their worst regulators may be subject to capture, and at their best they may be burdened with many issues and have inadequate resources to meet them. As long as litigation provides an effective and efficient remedy, private plaintiffs have the incentive to pursue litigation with regulatory effects.¹¹³

The second reason is that the administrative costs of properly regulating claims practices would be prohibitive.¹¹⁴ The promulgation of claim practices standards through statute and regulations is a relatively low-cost activity, because the standards are general and reflect widely accepted norms. The enforcement of those standards, however, would require much more extensive resources. Market-conduct examinations are sometimes routine but, under NAIC standards, may be triggered by factors such as an excess of consumer complaints. Conducting an examination focused on the substance of claims, as through closed file reviews, would be very expensive, as would the continued monitoring required to assure that deficiencies identified in the examination are corrected.

Litigation about claims practices is not cheap. But it has two financial advantages over administrative enforcement. First, the expense is only triggered when there is a plausible basis for believing that the standards have been violated—that is, a policyholder and her lawyer together have made a determination that the policyholder may have a claim that justifies the expense of litigation.¹¹⁵ Second, at least part of the expense is ameliorated because the inquiry is initially focused on a particular case, even though it may broaden to evaluate institutional practices.

A related point is the advantage of litigation in developing claim practices standards. Many of the standards as stated in statute, rule, or decision are necessarily general; litigation enables courts to apply claim practices standards in

111. Shavell, *supra* note 108, at 359–61.

112. J. Maria Glover, *The Structural Role of Private Enforcement Mechanisms in Public Law*, 53 WM. & MARY L. REV. 1137, 1181 (2012).

113. What has been described as "the eagerness of entrepreneurially motivated private actors," Issacharoff, *supra* note 109 at 383, or "those parties who have sufficient incentives to operationalize that information through enforcement," Glover, *supra* note 112, at 1178.

114. Shavell, *supra* note 108, at 363–64.

115. See Steven Shavell, *A Fundamental Enforcement Cost Advantage of the Negligence Rule Over Regulation*, 42 J. LEGAL STUD. 275 (2013).

individual cases and to develop a more complete and more refined body of law.

The third reason is that in addition to serving a regulatory function, litigation also serves important purposes that are not well served by direct administrative regulation. Most obviously, litigation provides recompense to those who have been injured by claim practices violations. It also serves the public value of private participation in the regulatory process, as it “frees individuals from total dependence on collective bureaucratic remedies and gives them a personal role and stake in the administration of justice.”¹¹⁶

B. Coverage Litigation as Regulation

Litigation about ordinary insurance coverage disputes revolves around the interpretation and application of the terms of the insurance policy.¹¹⁷ But there is a sense in which this ordinary litigation is regulatory as well.

In a typical coverage case, the court begins with the relevant policy language. If the court does not find an unambiguous application of the language to the facts of the case, the court resorts to a variety of interpretive doctrines to resolve the issue. Policy language is interpreted against the company as its drafter. Grants of coverage are interpreted broadly and exclusions narrowly. The reasonable expectations of the policyholder are given weight.

As a formal matter, interpretation doctrines look to the moment of contract formation. A term is construed against the insurer-drafter because at the time the contract was made, it had control of the language and could have resolved any ambiguity, presumably in its own favor. If the insurer-drafter did not do so, the fault is its own, and the insured should not suffer the consequences. Similarly, the insured at the moment of formation had reasonable expectations about coverage under the policy, created by representations of the insurer and its agents or more general understandings about the allocation of risks under the policy. If the insurer creates policy language that is inconsistent with the insured’s expectations, it has the obligation to clarify the situation or bear the adverse consequences.

In commercial contracts generally, these doctrines apply by focusing on the moment of formation.¹¹⁸ In the insurance context, however, especially in consumer cases, the market failures inherent in insurance give them quite a different cast, a cast that courts sometimes recognize explicitly but more often use implicitly. All of these issues arise only at the point of claim, of course. The problems of asymmetric information, agency, and opportunism yield a situation in which the actions an insurer takes in drafting the contract provide the vehicles for action at the point of claim. An insurer drafts policy language knowing that the language is not subject to negotiation and that the insured is unlikely to read or understand it. The insurer also knows that at the point of claim, it will have

116. Richard B. Stewart, *Crisis in Tort Law?: The Institutional Perspective*, 54 U. CHI. L. REV. 184, 198 (1987).

117. And sometimes allied doctrines such as waiver and estoppel.

118. Or subsequent events, in the cases of waiver and estoppel.

considerable discretion in evaluating the claim, the insured is likely to be necessitous of resolution, and it will be time-consuming and expensive for the insured to dispute the insurer's interpretation of the contract or evaluation of the claim. In light of these factors, the interpretive doctrines are not only about ascertaining meaning by looking back to the drafting process but also about correcting the inherent imbalance in the claim process.

The difficulty of regulating insurer conduct in this way is summed up in Karl Llewellyn's aphorism that "[c]overt tools are never reliable tools."¹¹⁹ Covert tools invite attempts at redrafting and provide insufficient guidance for the future.

[S]ince they do not face the issue, they fail to accumulate either experience or authority in the needed direction: that of marking out for any given type of transaction what the *minimum decencies* are which a court will insist upon as essential to an enforceable bargain of a given type, or as being inherent in a bargain of that type.¹²⁰

For Llewellyn the "given type of transaction" referred to the type of contract; the problem with interpretation as a covert tool is even more pronounced when the issue is another step removed from formation, namely defining the "minimum decencies" of claim practices.

C. Claim Practices Litigation as Regulation

Regulation requires standards to which a regulated entity must adhere, a mechanism for applying those standards, and a means of enforcing adherence to the standards or of making violations of them sufficiently costly to deter such violations. In order for claim practices litigation to best serve a regulatory function, therefore, what is required is a liability rule that reflects proper claim practices standards and that is capable of being operationalized effectively and efficiently, a correlative damage rule that provides adequate incentives for plaintiffs and achieves an appropriate level of deterrence for insurers, sufficient visibility of the rule, and a remedy for potential plaintiffs.

The focus of this Article is first-party insurance, but litigation surrounding a liability insurer's duty to settle illustrates how these requirements can be met effectively. A typical liability insurance policy by its terms creates a duty of the insurer to defend claims against the insured and reserves to the insurer the right to settle litigation. Even though the policy does not do so, courts uniformly hold that the obligation of good faith limits the insurer's discretion in settlement, creating a duty to make reasonable settlement decisions.¹²¹ The courts adopt various tests to define the limit—good faith and fair dealing, due care, reasonableness, equal consideration to the insured's interests—but "the differences among them are

119. K.N. Llewellyn, Book Review, 52 HARV. L. REV. 700, 703 (1939) (reviewing O. PRAUSNITZ, *THE STANDARDIZATION OF COMMERCIAL CONTRACTS IN ENGLISH AND CONTINENTAL LAW* (1937)).

120. *Id.*

121. JERRY & RICHMOND, *supra* note 3, at 832–49.

subtle”¹²² and they coalesce around a standard of whether an insurer that bore sole financial responsibility for the judgment would have accepted the plaintiff’s offer to settle.¹²³ As applied, the standard provides a substantial guide for insurer’s behavior. In litigation the standard requires evidence of the kind presented in the underlying trial and expert evaluation of that evidence, so the litigation can be expensive. But as a practical matter, most cases settle, reducing the costs of litigation.¹²⁴

Although the duty to settle arises out of contract, the bad-faith action often is characterized as lying in tort, not contract. The principal advantage to this characterization is the more expansive damages available, including damages not subject to the limitations on consequential damages in contract law and in some cases punitive damages. Jerry and Richmond summarize the advantages of this characterization, all of which relate to its effectiveness as a remedy for the violation of claim practices standards.

First, the extra damages recoverable in tort can help compensate the insured’s attorney, and thus help give the insured a full remedy for the insurer’s breach of the duty to settle, unimpaired by the transaction costs of securing the remedy. Second, without the availability of tort remedies, plaintiffs’ lawyers will be reluctant to represent insureds, and it is unlikely that the insureds would find representations of a quality routinely available to insurers. Third, unless the insurer is liable for extracontractual damages, it has little incentive to perform its contract obligations. If the most that contract will award is the cost of performing the contract obligations, insurers will refuse to perform at all in some of the cases, knowing that some insured will not take the time or trouble to pursue the contract remedies.¹²⁵

In short, the duty to settle is implemented through a litigation system that provides adequate incentives for all parties and compensation to the insured. Because of the breadth of the system, the development of a bar that makes extensive use of the system makes it almost certain that policyholders will become aware of the system and will be able to implement it. The duty to settle therefore provides a model for the ways in which the regulatory purposes of litigation can be achieved.

1. *Claim Practices Standards*

In first-party insurance cases, there are numerous legal formulations of claim practices standards, some mandated by statute and implementing regulations, others from common law. The most common statutory standards reside in enactments of the NAIC’s Model Unfair Claims Settlement Practices Act, some

122. *Id.* at 836.

123. PRINCIPLES OF THE LAW OF LIABILITY INSURANCE § 27(2) (Tentative Draft No. 2, 2014).

124. BAKER & LOGUE, *supra* note 4, at 511.

125. JERRY & RICHMOND, *supra* note 3, at 839–40.

version of which has been adopted in nearly every state.¹²⁶ Those standards do not always constitute a liability rule enforceable through private litigation; some statutes create a private right of action, most do not, and some courts use the statutory standard, directly or indirectly, as defining the content of an insurer's enforceable obligation. The statutory standards often are supplemented by more specific regulations.¹²⁷

Judicial standards are most commonly set within the body of law known generally but inexactly as "bad faith."¹²⁸ About a half-dozen states use some variation of the *Gruenberg v. Aetna Insurance Co.* standard of reasonableness, or acting with proper cause.¹²⁹ A much larger group of states has adopted some version of the "fairly debatable" rule: "To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim."¹³⁰

I have argued elsewhere that the fairly debatable rule does not accurately reflect the common-law origins of the contractual obligation of good faith on which it is based, nor does it honor the nature of the insurance relation.¹³¹ For present purposes, three factors are especially important.

First, the nature of the insurance relation is one in which the insured purchases security and not just contractual rights. The fairly debatable rule fails to honor this relation. In effect, it includes in the policy a term that renders the insurer immune from full damages in the event of a negligent coverage decision or an improper claim practice unless the insurer acted with the intent to harm the policyholder's interests or in reckless disregard of them. This limitation is absurd; no company would sell and no consumer would buy a policy that contained such a provision.

Second, the problems of asymmetric information, agency, and opportunism that plague the market for claim practices also are salient here. A strong standard is necessary to substitute for the insured's inability to define and monitor the insurer's behavior at the point of claim.

Third, the fairly debatable rule fails to provide adequate incentives to enforce standards. From the insured's perspective, it is much too difficult to establish a violation of standards under the rule. In New Jersey, for example, the Supreme Court adopted the fairly debatable rule in *Pickett v. Lloyd's* in 1993.¹³² In the two decades since, only about fifty-five cases involved an adjudicated claim under

126. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT (NAT'L ASS'N OF INS. COMM'RS 1997).

127. *See, e.g.*, UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES MODEL REGULATION (NAT'L ASS'N INS. OF COMM'RS 1997).

128. *See* Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL & INS. PRAC. L.J. 693 (2012).

129. *See* *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973).

130. *Anderson v. Cont'l Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978).

131. *See generally* Feinman, *supra* note 128.

132. *Pickett v. Lloyd's*, 621 A.2d 445, 454 (N.J. 1993).

Pickett; only five of those survived summary judgment, and only *Pickett* itself involved a claim that was successful before a jury.¹³³

Therefore, the appropriate liability rule is that an insurer must promptly, fairly, and objectively process, investigate, evaluate, and resolve the claim. This rule can be given further content by legislative and administrative standards and judicial application. For example, the rule requires an insurer to reasonably investigate a claim.¹³⁴ The duty to investigate requires the insurer to seek evidence that potentially supports a claim, not just evidence that favors a denial,¹³⁵ including even bases for coverage beyond those advanced by the insured.¹³⁶ It includes the responsibility to use the insurer's own resources to investigate rather than simply relying on its insured or others, to interview witnesses or others with relevant information,¹³⁷ to search for and consider evidence contrary to its own interests,¹³⁸ to attempt to resolve apparent conflicts with the insured,¹³⁹ to consider alternative explanations,¹⁴⁰ to use competent personnel to investigate,¹⁴¹ and to use experts who are independent, objective, and unbiased.¹⁴²

2. Remedies

The lack of effective remedies for violations of claim practices standards renders the standards ineffective; the insured would not be compensated for the injury incurred and the company would not have a financial incentive to observe the standards if damages are limited to the amount owed under the policy.

The damages rule should be the correlative of the liability rule. If the policyholder litigates to enforce the company's obligations under the policy, its initial remedy is to receive the benefits to which it was expressly entitled: payment of the claim. That remedy is insufficient to fully protect the policyholder's interest. The policyholder may suffer consequential economic loss from the failure to receive, whether in a timely manner or at all, the benefits owed under the

133. H. Richard Chattmann & Aaron H. Gould, *Revisiting Pickett v. Lloyds: A Survey, Assessment, and Practice Pointers Regarding New Jersey First-Party Insurance Bad Faith Law*, N.J. LAW., Aug. 2012, at 16.

134. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4(C) (NAT'L ASS'N INS. COMM'RS 1997); see *Wilson v. 21st Century Ins. Co.*, 171 P.3d 1082, 1088 (Cal. 2007).

135. See *Bernstein v. Travelers Ins. Co.*, 447 F. Supp. 2d 1100, 1112 (N.D. Cal. 2006); *Wilson*, 171 P.3d at 1087; *Egan v. Mut. of Omaha Ins. Co.*, 620 P.2d 141, 145 (Cal. 1979); STEVEN PLITT ET. AL., COUCH ON INSURANCE, § 207:25 (3d ed. 2011). This conforms to industry standards. See DORIS HOOPES, THE CLAIMS ENVIRONMENT 10.7 (2d ed. 2000) ("Claims representatives should investigate in an unbiased way, pursuing all relevant evidence, especially that which establishes the legitimacy of a claim.").

136. *Jordan v. Allstate Ins. Co.*, 56 Cal. Rptr. 3d 312, 319 (Cal. Ct. App. 2007).

137. *Estate of Parker ex rel. Parker v. AIG Life Ins.*, 317 F. Supp. 2d 1167, 1174 (C.D. Cal. 2004).

138. *Jordan*, 56 Cal. Rptr. 3d at 320.

139. *State Farm Fire & Cas. Co. v. Simmons*, 963 S.W.2d 42, 46–47 (Tex. 1998).

140. *Hensley v. Shelter Mut. Ins. Co.*, 210 S.W.3d 455, 468–69 (Mo. Ct. App. 2007).

141. See PLITT ET. AL., *supra* note 135, § 207:25; see also WILLIAM T. BARKER & RONALD D. KENT, NEW APPLEMAN INSURANCE BAD FAITH LITIGATION § 4.06 (2d ed. 2014).

142. *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 995 (9th Cir. 2001).

policy.¹⁴³ This loss may include a variety of types of harm, depending on the type of insurance and the particular facts, and it includes the expense incurred in pursuing the claim as a result of the company's breach of its obligation to process the claim reasonably. Because of the special nature of insurance policies, the American rule on attorney's fees and the rule of limited expectation damages should not be applied to deny recovery for litigation expenses.¹⁴⁴ Particularly in personal lines situations, where peace of mind is part of what is being purchased with the policy, the insured also may suffer compensable emotional harm.

Payment under the policy alone also is an insufficient disincentive to the insurance company's temptation to behave opportunistically. By delaying or denying payment to the policyholder, the company increases its own profits at the expense of its policyholder. If the company is liable only for the amount it owed under the policy, the only check on opportunism is the reputational effect of unreasonable claim practices, which works notoriously poorly in the insurance market. Indeed, many policyholders who are denied what they are owed will not pursue either their claims under the policy or the claim practices cause of action, providing further incentive for the company to act unreasonably. Accordingly, damages beyond the policy limits, including punitive damages in appropriate cases,¹⁴⁵ are necessary to reinforce the standard of reasonableness.

3. *The Conduct of Regulatory Claim Practices Litigation*

For claim practices litigation to serve a regulatory function, the liability rule and damage rule need to be operationalized effectively and efficiently. Currently, claim practices litigation often has a significant problem in that respect: it is protracted and expensive. Partly, this is due to the usual need in complex cases to conduct extensive discovery and retain experts.¹⁴⁶ Partly, according to policyholder advocates, it may be due to insurers' strategy of denying claims and delaying litigation in order to pressure policyholders to settle and to reap investment profits on delayed payments.¹⁴⁷

Much of the time and expense of claim practices litigation is unavoidable in a litigation system with extensive discovery and, at least potentially, jury trials. Even

143. *E.g.*, *Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y.*, 886 N.E.2d 127 (N.Y. 2008); *Panasia Estates, Inc. v. Hudson Ins. Co.*, 886 N.E.2d 135 (N.Y. 2008).

144. *E.g.*, *Brandt v. Superior Court*, 693 P.2d 796, 798–99 (Cal. 1985); *White v. W. Title Ins. Co.*, 710 P.2d 309, 320 (Cal. 1985). The California courts point out that the recovery of attorney's fees in such cases is not a violation of the American rule against the award of attorney's fees. Instead, the fees and litigation expenses are damages that flow from the insurance company's breach of its good-faith obligation. *Brandt*, 693 P.2d at 798. *See generally* DENNIS J. WALL, *LITIGATION AND PREVENTION OF INSURER BAD FAITH* § 13:17 (3d ed. 2011).

145. *E.g.*, *Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P.2d 334, 347–48 (Haw. 1996); *Anderson v. Cont'l Ins. Co.*, 271 N.W.2d 368, 379 (Wis. 1978); *see* WALL, *supra* note 144, § 13.15. Another appropriate disincentive is interest on the amount owed at a rate higher than the statutory rate. *E.g.*, ME. REV. STAT. ANN. tit. 24-A, § 2436 (2013); 42 PA. CONS. STAT. § 8371 (2012).

146. Charles Miller, *The Scope of Expert Testimony in Insurance Bad Faith Cases: Can the Expert Testify on the Meaning of the Policy?*, 15 CONN. INS. L.J. 211, 216–17 (2008).

147. *See* FEINMAN, *supra* note 21.

though most cases settle, they do so only after many of these costs already have been incurred. This Article's initial discussion of the regulatory function of claim practices litigation is not the place to fully explore alternatives, but two points merit further exploration.

First, much of the time and expense of this litigation is about the scope of discovery. Routinizing discovery would reduce this litigation, which is collateral to the main issues in the cases, and therefore would reduce delay and expense. For example, an insurer could be required to produce the complete claims file, all relevant claims manuals, claims committee notes and procedures, and the like.

Second, many of the allegations of violations of claim practices standards concern not the individual actions of rogue adjusters but systematic practices throughout the company. Discovery of information about these practices is relevant to a large number of cases, but its disclosure is often barred by blanket confidentiality agreements or umbrella protective orders. Such agreements and orders are appropriate to protect trade secrets, but, when overbroad, they simply impose additional costs on future plaintiffs. For that reason, and because disclosure serves the public interest, such orders should be discouraged.

D. The Effects of Regulatory Litigation

A regulatory approach to claim practices litigation obviously has an immediate impact in individual cases brought by policyholders. A strong liability rule with significant remedies increases the ability of policyholders to enforce insurers' obligations, producing more successful litigation and settlements. But defining litigation as regulatory requires a greater impact than simply affecting the resolution of individual disputes. Regulatory litigation, strong or weak, has a systemic impact on insurers' behavior.

Regulatory litigation affects the incentives of insurers, which in turn affects their behavior in the large run of cases that do not result in litigation. As with any class of potential defendants, insurers measure their potential liability costs against the costs and benefits of compliance or violation, discounting the amount of potential liability by the probability that suits for violations will be brought. The regulatory function of litigation is better served as insurers' potential liability increases as the liability rule, remedies, and probability of suit become stronger. In the absence of effective regulatory litigation, compliance with claim-practice standards is determined by the market and by administrative regulation, which as described above is inadequate to accomplish the task.

These effects are obvious. However, there is an additional important, interactive process among the elements of insurers' calculations. Strengthening the liability rule and remedies causes an increase in the probability of litigation in the short term because it increases the potential value of litigation to policyholders. The long term, systemic effect of the strengthening is more important and iterative in that it contributes to the development of a policyholder bar. The presence of such a bar is a prerequisite to effective regulatory litigation, a prerequisite that is filled once economic incentives are created from the stronger

liability rule and remedies. This specialized bar is available to potential clients—indeed, it recruits potential clients—and it can make the investment necessary to pursue actions and develop the degree of expertise needed to combat the comparable expertise on the insurers’ side. Much of this process is furthered by the development of creation of networks and organizations of lawyers. An obvious illustration is the development of a plaintiffs’ personal injury bar and its professional organizations that were spurred by, and then contributed to, the expansion of tort law through the mid-twentieth century. In the insurance arena, anecdotally the policyholder insurance bar seems to be broader and stronger in states with more effective law and remedies for bad faith than in other states.

Because discovery in claim practices cases can be extensive, including discovery with respect to systematic violations of claim practices, litigation also serves a regulatory function in producing information that exposes insurer practices to scrutiny and potentially reframes the discussion about claim practices and the need to address violations. This information-producing function is highly important in spurring further litigation, administrative and legislative action, and public awareness.¹⁴⁸ The controversy about the use by many insurers of Colossus, an expert system for estimating general damages, illustrates the intertwined loops that begin with discovery in litigation, produce more litigation, transform ordinary litigation into regulatory litigation, and spur administrative action. Colossus can produce consistency across claims, but it also can be abused to underpay claims through limiting the data input to the system, through “tuning” in converting the Colossus severity point report into a dollar figure, and through treating its estimate as binding rather than a guide for adjusters’ judgments.¹⁴⁹ Instances of misuse of Colossus became apparent only through discovery in litigation.¹⁵⁰ Ultimately, the issue became of such visibility that it resulted in a Multistate Market Conduct examination of Allstate’s use of the system; the Regulatory Agreement that concluded the MCE noted two class actions as the source of information.¹⁵¹ Although the regulators purported to find no systematic underpayment of claims, they did find widespread inconsistencies in the tuning of the program and required Allstate to alter its use of Colossus.

The impact of regulatory litigation is demonstrated by empirical research on the effect of different standards for determining bad faith and different damages available for violations of claim practices. Claims are resolved more quickly; according to one study, claims are thirteen percent more likely to close in a given

148. See Eric Helland & Jonathan Klick, *The Tradeoffs Between Regulation and Litigation: Evidence from Insurance Class Actions*, 1 J. TORT L., no. 3, art. 2, Oct. 2007, at 1.

149. On Colossus, see FEINMAN, *supra* note 21, at 113–20; and R. Bonnett, *The Use of Colossus to Measure the General Damages of a Personal Injury Claim Demonstrates Good Faith Claim Handling*, 53 CLEV. ST. L. REV. 107 (2006).

150. E.g., Declaration of Thomas J. Corridan, *Dougherty v. AMCO Ins. Co.*, No. C07-01140 MHP, 2008 WL 2563225 (N.D. Cal. June 23, 2008) (No. 307CV01140), 2008 WL 2556603.

151. Order Approving Settlement Agreement, *Allstate Indemnity Co.* No. INS-2010-00212, 2010 WL 4020127, at *3.

period with considerable benefits to insurance consumers.¹⁵² Claims also are less likely to be paid below the amount of economic losses claimed,¹⁵³ and claim payouts for both economic and noneconomic damages are likely to be higher with the former showing a greater increase.¹⁵⁴ Finally, and perhaps most strikingly, the benefit of regulatory litigation accrues more to claimants unrepresented by counsel than to those with lawyers by a factor of ten.¹⁵⁵

CONCLUSION

The market for insurance works well in some respects. In all lines of insurance, prospective policyholders have an abundance of information to compare prices. Because the market does not always work so well, the insurance industry is highly regulated, and much of the regulation is highly successful. During the financial crisis that began in 2008, only a handful of insurers became insolvent, a success attributable to effective solvency regulation.

But the success of the market and of the regulation of market failures has not been uniform. There is no effective market for quality in claim practices, and regulators have not provided adequate controls. The market could be improved and administrative regulation could be strengthened. Even if that happens, litigation has an essential role to play in regulating claim practices.

152. Danial Asmat & Sharon Tennyson, *Do Multiple Damages Awards Succeed in Relieving Strain on the Legal System? Evidence from Tort Law in the Auto Insurance Industry* (Univ. of Mich. Ross Sch. of Bus., Working Paper, 2011).

153. Danial P. Asmat & Sharon Tennyson, *Does the Threat of Insurer Liability for "Bad Faith" Affect Insurance Settlements?*, 81 J. RISK & INS. 1 (2014); Mark J. Browne et al., *The Effect of Bad-Faith Laws on First-Party Insurance Claims Decisions*, 33 J. LEGAL STUD. 355 (2004).

154. Browne et al., *supra* note 154 at 383–84, 386.

155. *Id.* at 385.

