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The Tradeoffs between Regulation and Litigation: Evidence from Insurance Class Actions

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The Tradeoffs between Regulation and Litigation: Evidence from Insurance Class Actions*

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Abstract

Law and economics scholars generally view regulation and litigation as substitutes in the task of deterring potentially harmful conduct. Existing normative models suggest that the desirable mix of regulation and litigation will depend on a number of variables, but all largely agree that, on the margin, optimality requires that as public regulation increases, private litigation should decline and vice versa. To investigate whether this condition holds, we examine the factors that affect plaintiffs attorneys' decisions about where and when to file class actions using a unique dataset covering the class action experience of 130 insurance companies during the period 1992 to 2002. We find no evidence to support the proposition that public regulation and private litigation function as substitute channels to deter harmful behavior. In fact, we find some evidence that litigation and regulation tend to piggy-back on each other at least in the insurance industry. More important in the attorneys' filing decisions is whether or not cases regarding the same general allegation and cases filed in the same state have been successful in the past.

KEYWORDS: tort law, law and economics, regulation, litigation

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INTRODUCTION

Perhaps no other single feature of the U.S. civil justice system generates such a fervent emotional reaction from stakeholders and commentators as class action litigation. Both positive and negative anecdotes are circulated by players on both sides of the system, generating a seemingly endless stream of examples of class actions' benefits as well as horror stories of their abuse. Both sides agree, however, that the procedural device has essentially become an instrument for changing public policy.

Class actions function in a way similar to regulation. What is unclear is how the two systems fit together. Specifically, if class actions and regulation substitute for each other in the deterrence of harmful activities, then we can best view class actions not as a procedural device designed to facilitate individual litigation but as one part of the larger structure of administrative regulation. As a second best solution, in cases where regulators lack information or enforcement resources, class actions have the potential to play a role in an optimal regulatory design.

The cause for concern lies in the fact that class actions may effectively be duplicative of regulation, and vice versa, in many contexts. Anecdotally, there are class action cases which deal with exactly the same issues as regulators but do so in ways that either contradict regulators' decisions or sanction essentially the same action twice, generating concern over excessive deterrence. As with so many aspects of the civil litigation system, there is a dearth of empirical analysis and even underlying data tend not to be available to examine whether these anecdotes are illustrative or deceptive with regard to how class action litigation fits into the general regulatory structure in practice.¹ However, as demonstrated in the normative models of regulation, the ability to design the optimal regulatory structure hinges on this question.

In this study we examine the regulation and litigation interaction. Specifically we estimate the role of state regulatory agency performance in the plaintiffs attorney's decision where and when to file an insurance class action. Presumably, if litigation and regulation are substitutes, we should find less of a role for litigation in those states that aggressively regulate their insurers. All other things equal, if more stringent regulatory activity deters harmful conduct, plaintiffs attorneys will not find it particularly profitable to litigate over harms in states already devoting substantial resources to regulating insurers.

Using a unique dataset covering the class action experience of 130 insurance companies over the period 1992-2002, we investigate the effect of variables capturing the extent of a state's insurance regulation on the likelihood that an

¹ On the lack of high quality data in this area, see Eric Helland et al., *Torturing the Data*, 19 J. ECON. PERSP. 207 (2005). For a series of interesting case studies on the relationship between litigation and regulation see W. KIP VISCUSI, AEI-BROOKINGS JOINT CENTER FOR REG. STUD., REGULATION THROUGH LITIGATION (2002).

insurer faces a class action regarding a given allegation in that state. Cutting against the proposition that litigation and regulation substitute for each other, we do not find that aggressive regulation lowers the likelihood an insurer will face a class action. In fact, we find some evidence that regulation and litigation compound each other with a more aggressive regulatory regime being associated with a higher likelihood of facing class action litigation. Additionally, we find that past success in class actions covering the same general allegation and past success of class actions in the given state are strong positive predictors of whether an insurer is likely to face a class action regarding that allegation or in that state.

In Part I, we review the normative economic models of the interaction between litigation and regulation. In Part II, we describe the dataset we use to explore this interaction. Part III provides details about our empirical model, including a discussion of our regulation variables, as well as other controls in the model. Part IV discusses our results, and Part V highlights the limitations of our analysis as well as describing the extensions we are currently working on.

I. THE ROLE OF LITIGATION IN REGULATION

The rationale for regulation and litigation both arise out of a market failure. Specifically in the case of insurance markets the justification of insurance regulation is typically the inadequacy of consumer information about what they are actually purchasing. Attempts to recover damages resulting from the harmful actions of insurance companies typically make similar allegations. For example, original equipment manufacturer (OEM) cases, which alleged that non-OEM parts used to repair collision damage were inferior to OEM parts, dealt with issues that had been extensively considered by regulatory agencies in many of the same states in which the litigation occurred.

Although the subject of the substitutability of litigation and regulation was raised in Tullock's early text on law and economics² and a formal model is provided in Wittman,³ Shavell,⁴ provides the seminal treatment of this interaction as a mechanism design problem. In the Shavell framework, four general factors determine the optimal mix of private litigation and public regulation in the deterrence problem: 1) relative quality of information regarding the benefits of the harm-producing activity, costs of harm, and likelihood of harm; 2) the likelihood that the cost of harm exceeds the assets of the entity generating the harm; 3) the

² See, e.g., GORDON TULLOCK, *THE LOGIC OF THE LAW* 125 (1971).

³ Donald Wittman, *Prior Regulation Versus Post Liability: The Choice Between Input and Output Monitoring*, 6 J. LEGAL STUD. 193 (1977).

⁴ Steven Shavell, *A Model of the Optimal Use of Liability and Safety Regulation*, 15 RAND J. ECON. 271 (1984), and Steven Shavell, *Liability for Harm Versus Regulation of Safety*, 13 J. LEGAL STUD. 357 (1984).

likelihood that a private party will not pursue litigation in the event harm occurs; and 4) relative administrative costs of litigation and regulation.

As Shavell describes and explicitly models these various factors, the concerns about information and administrative costs will generally push in favor of litigation, while the possibility that a defendant will escape judgment in some circumstances due to plaintiffs not pursuing their cases (e.g., cases in which harm only becomes apparent far in the future, at which time litigation will become more difficult as evidence deteriorates, etc.) or because the defendant's assets are insufficient to cover the harm it causes suggest an advantage of regulation. Specifically, a social planner needs to consider that care under a pure liability system diverges from the socially optimal level of care for two reasons: 1) because the likelihood of being sued when harm occurs is less than one, the individually rational level of care taken will be lower than the social optimum at every level of expected harm with the gap increasing as the likelihood of suit declines; and 2) beyond some level of expected harm, the tortfeasor becomes judgment proof and will not increase care even if it is socially optimal to do so.

Shavell deduces the optimal level of regulation in the case where both regulation and liability are used to deter harm. He shows that optimality requires that the level of regulation be set such that the marginal cost of additional care induced by the regulation equals the expected reduction in harm, resulting from the additional care.

More to the point, as the regulatory standard is raised, the social planner needs to compare: 1) the gain created by inducing some individuals to undertake socially beneficial levels of care that they otherwise would not have taken because of the possibility they would not have been sued even in the event they cause harm with 2) the loss generated by forcing some individuals to undertake care that is not cost justified from a social standpoint. The gain from increasing the regulatory standard is decreasing as the likelihood of litigation (in the event of harm) increases because the gap between the socially efficient and the individually rational level of care goes to zero as the likelihood of litigation goes to one in the range where the judgment proof problem is not a concern. The loss from regulation inducing too much care is invariant to the level of litigation. Thus, in the case where both litigation and regulation are used to deter harm, optimality requires that as the level of regulation increases, the likelihood of litigation must decrease on the margin and vice versa, all other things equal.⁵ In

⁵ The same thing would be true if liability exposure increases because awards go up (e.g., if plaintiffs are compensated by some multiple of harm where the multiple can be greater than one). Shavell does not consider this possibility in his model but it is a trivial extension. The point here is that as expected liability increases either due to an increase in the likelihood of litigation or an increase in the expected judgment, the gains from increasing regulation decline.

effect, efficiency implies that regulation and litigation should be substitute means to deter harm on the margin.⁶

In the specific case of the insurance industry Shavell's model would seem to imply that litigation that is "forward looking (i.e. that seeks to change future behavior such as using non-OEM parts, is more efficiently handled by local regulators who can weight the relative cost and benefits of new or altered regulation).⁷ For example, in the case of OEM parts, the tradeoff is presumably higher insurance premiums versus more expensive but potentially safer auto repairs.⁸ Contrast this with a case alleging that a company failed to end automatic deductions from victims' checking accounts when the policy ended. While this practice is banned by all states, recovering damages given that harm has occurred, and providing the proper deterrence to prevent future harm, may well be less costly for a court than a regulatory agency since the victims (or the class attorney) have every incentive to identify themselves to the court. Obviously a number of possible cases fall somewhere in between.

It is also worth pointing out that the tradeoff between regulation and class actions need not be motivated by efficiency. Two other factors are frequently cited in the literature. The first is preemption. To the extent that regulations form a floor for safety regulation courts will have fewer cases the more stringent the regulation. Alternatively regulatory capture, in which better organized business interests control the local regulatory agency to the detriment of efficient enforcement of consumer protection laws litigation provides a necessary backstop.⁹

Nevertheless, whichever model of regulation and litigation interaction is more predictive in the real world, if regulation and litigation are effective in inducing care (detering harm), we should find this same substitution effect. That is, as the level of care mandated by regulations increases or as regulators become more fastidious in their enforcement, which is tantamount to an increase in the effective mandated level of care, there should be less of a role for litigation.

⁶ It should be noted that Shavell's model is normative (i.e., describes what would be desirable if efficiency is the criterion used to evaluate a system), while not necessarily being descriptive of reality.

⁷ Kenneth S. Abraham, *The Insurance Effects of Regulation by Litigation*, in REGULATION THROUGH LITIGATION 212 (W. Kip Viscusi ed., 2002).

⁸ See Victor Schwartz & Leah Lorber, *State Farm v. Avery: State Court Regulation Through Litigation Has Gone Too Far*, 33 CONN. L. REV. 1215 (2001).

⁹ Alan Schwartz, *Statutory Interpretation, Capture and Tort Law: The Regulatory Compliance Defense*, 2 AM. L. & ECON. REV. 1 (2000).

II. DATA

To investigate whether litigation and regulation are substitutes, we use a unique data source covering the experience of insurance companies with class action litigation. The dataset, described more completely in Pace,¹⁰ focuses on class actions against firms in the insurance industry, reporting on the characteristics and outcomes of nearly 750 cases brought against insurers over a ten year period. The information was gathered through a survey that concentrated on larger insurance companies in the property-casualty, life, and health markets.

The data consist of 988 case-level surveys from 130 insurance companies, describing 748 distinct cases that were open at least one point during the period of 1992 to 2002. The data contain information on cases filed between 1984 and 2002. The surveys asked the responding companies to describe, for each such case in which they were a named defendant, the courts of filing and disposition, the names of other defendants in the case, whether there were also similar cases filed earlier or in other jurisdictions, the lines of insurance involved, the key allegations of the plaintiffs, key statutes involved, whether the issue of regulatory jurisdiction (i.e., whether a regulatory agency should have primary jurisdiction in the matter) was raised by any of the parties, the description of the actual or putative class, the geographical scope of the actual or putative class, the outcome of any certification process, the manner in which the case was resolved, and the details of any settlement or trial verdict for the plaintiffs.

The data on regulatory stringency come from the National Association of Insurance Commissioners (NAIC) which collects data on insurance commissions. This data is contained in the “Insurance Department Resources Report” which according to the NAIC website “Provides an in-depth look at the resources of the 55 insurance departments.” The data are available electronically for 2004 and in hard copy for previous years.

Specifically we examine the impact of the resources (measured by total staff and budgets adjusted by the number of insurers overseen by the regulator) and activities (measured by the number of market conduct exams¹¹ completed and by the fines levied adjusted by the number of insurers covered by the agency) of the state insurance commissions on the likelihood that an insurer faces a class action in a given state. Ideally we would like information on regulatory activity specific to the line or allegation but the data provided by the NAIC is not disaggregated by line.

¹⁰ NICHOLAS M. PACE ET AL., RAND, INSURANCE CLASS ACTIONS IN THE UNITED STATES (2006).

¹¹ Market conduct exams generally monitor insurers’ marketing and advertising practices, as well as the way insurers handle claims and provide other services to their customers. These are the kinds of issues that will generally form the central issue in insurance class actions, so this metric of regulatory activity forms a nice parallel to the tort context.

III. MODEL

Implicitly we follow Shavell's model of harm generation. We presume that the probability that a company commits a wrongful act is determined by the level of regulation. The likelihood of litigation is determined by the prevalence of harm as well as the likelihood that litigation will be successful. Thus, regulation affects the observed number of class actions filed by determining the number of harms available to be litigated.

To examine the substitutability of regulation and litigation using the data described above, in principle, we wish to estimate the reduced form equation:

$$\Pr(\text{Case Filed}_{isat}) = \beta \cdot \text{Regulation}_{st} + \Theta \chi + \delta_i + \lambda_s + \varphi_a + \tau_t$$

where i indicates the insurance company, s denotes a state in which it offers insurance, a indicates a given general allegation (allegations are described in the appendix), and t denotes the year. Since allegations are linked to specific lines in our data we cannot independently identify the impact of offering a line of insurance from the allegation fixed effect. Our primary interest is in the effect of the regulatory resources and activities variables described above which include the number of market conduct exams initiated in the state per the number of firms offering insurance in the state, the number of market conduct examiners employed by the state per the number of insurers, insurance commission budget divided by the number of insurers writing policies in the state, and the dollar amount of fines levied per firm.¹²

To increase the precision of our estimates of the effects of the regulatory variables, we also control for a number of factors that might influence whether a plaintiffs lawyer will file a particular case in a particular state in the χ vector. These variables include the proportion of cases removed to federal court in a given state during the given year and the proportion of cases removed in a given allegation in a given year. Presumably this measure gives some indication of how likely it is the lawyer's case will remain in the court he filed it in. We also include the proportion of class actions certified in a given state-year and allegation-year to provide some sense of how favorably the class action mechanism is treated within a given state or allegation category.

To control for the lawyer's expectation of success we also include the proportion of cases dropped by the plaintiff in each state-year and allegation-year combination. Along the same lines, we include the proportion of cases in which there was an approved settlement for each state-year and allegation-year

¹² For our primary regressions, we actually include these variables in their log forms to mitigate any scale effects arising from idiosyncratic differences across states.

combination, as well as similar variables for the proportion of cases in which there was a plaintiffs' recovery at trial.¹³

We also control for the firm-level and state-level characteristics described in Table 1. Lastly, all regressions include time-invariant state and allegation fixed effects as well as year fixed effects that are common across all states and allegations. Summary statistics are available in Table 1.

One issue with the empirical approach represented in the equation above is that the size of the risk set is very large since it encompasses all companies who offered a line of insurance by state and the allegations that have arisen against that line of insurance in the sample period.¹⁴ To avoid this problem, instead of estimating probit models where the dependent variable takes the value of 1 if the insurer faced a class action regarding allegation a in line l in state s during year t and zero otherwise, we instead analyze the fraction of insurers offering line l in state s during year t that faced a class action over allegation a by time t .

Since our primary variables of interest are at the state-year level this should cause no special issues in estimation and we cluster the standard errors on state and year. Specifically we estimate the model

$$\%claim_{s,t} = \beta \cdot Regulation_{s,t} + \Theta\chi + \lambda_s + \varphi_a + \tau_t$$

where $\%claim_{s,t}$ is the proportion of companies with an allegation a made against them in state s by time t .

One difficulty with this dependent variable is that it is bound by zero and one; hence the effect of liability exposure, or any independent variable, cannot be constant throughout the range of the independent variables. The usual solution to this problem is to estimate the model using the logistic transformation. This is problematic in our case as it requires deleting values of zero or one. These observations may be particularly important as the limiting case is that none (or all) of the firms in the risk set have had a case filed against them. For this reason, we estimate the model using the general non-linear model as outlined in Papke and Wooldridge.¹⁵

¹³ To capture the recent history of the courts in these regards, we use four year moving averages for these variables, though the results do not change appreciably if the window is lengthened or shortened.

¹⁴ Thus the number of observations can be as large as 10,465,000 (130 companies, 50 states, 70 lines of insurance and 23 allegations) observations. In reality, not every company offers every line, not every line has litigation and the resulting number of observations is under one million. This may still be too large for estimation at which point the data can be collapsed into company, state, allegation if we are willing to assume that the specific line sued carries no additional information beyond the allegation.

¹⁵ Leslie Papke & Jeffery Wooldridge, *Econometric Methods for Fractional Response Variables with an Application to 401(k) Plan Participation Rates*, 11 J. APPLIED ECONOMETRICS 618 (1996).

IV. RESULTS

We present the results of our regressions in Table 2. In general, we find no systematically negative relationship between the level or intensity of regulation and the likelihood of class action litigation. None of the regulatory variables consistently generates a negative coefficient which would imply that the likelihood of being sued decreases as regulatory scrutiny increases. In only one specification does any regulatory variable generate a negative coefficient, and it is not statistically significant.

On the other hand, the coefficient on the number of market conduct examiners per insurer is positive and it is statistically significant in every specification. The number of market exams per insurer likewise generates uniformly positive coefficients, though none is statistically significant at the 5 percent level.¹⁶ The same is true of the fines per insurer variable which consistently generates a positive, though not statistically significant, coefficient.

What we do find, in general, is that the likelihood of facing a suit appears to be predicted by general indicators of a suit's success in the given state or in a given allegation category. For example, states in which relatively more class actions lead to a recovery for the plaintiff class appear to be more attractive places to file a class action. Specifically, we find a positive and statistically significant relationship between the likelihood an insurer will face a class action and the fraction of class actions in a given state that lead to a plaintiff recovery at trial. There are indications that other proxies for plaintiff success have a positive relationship with the likelihood an insurer will face a class action in a given state and/or with respect to a given allegation, though these effects are not statistically significant at the 5 percent level.¹⁷

In Table 3, we examine a slightly different dependent variable. In this case, we focus on the likelihood of facing a class action regarding the insurer's activities in a given state, as opposed to having a class action filed in a particular state. For some of the cases in the dataset, the class action was not filed in the state where the plaintiffs resided. Since the effect of regulation is presumably strongest in the state where the transactions are taking place, it is important to

¹⁶ In addition to examining the specification in which we include both market conduct examiners and agency budget, we also examine specifications in which only one of these variables is included to mitigate the possibility that one largely picks up the effect of the other since labor costs are likely to be a large portion of an agency's budget. As is evident in Table 2, the sign, magnitude, and statistical significance of the examiner coefficient is not affected by whether or not agency budget is included.

¹⁷ For example, there appears to be a large (in magnitude) negative relationship between filing and how frequently cases regarding a given allegation are removed to federal court, presumably indicating that plaintiffs' attorneys general prefer to keep their cases in state court. Also, allegations with high rates of plaintiffs recovering at trial are associated with a higher likelihood an insurer will face a suit.

determine whether the state of residence/state of filing distinction is the cause of us not finding a substitution effect between regulation and litigation.

In this set of regressions, once again, we find no statistically significant negative relationship between any of the regulatory variables and the likelihood of facing a class action regarding business in a particular state. We do, however, find a positive relationship between the number of market conduct exams per insurer and the likelihood of facing a class action. This effect is statistically significant at the 5 percent level.

As an additional robustness check, we examine the same sets of regressions using only data from 1995-2002. It is clear from the dataset that insurers were more complete in their survey responses for later years with response rates becoming quite high in 1995 and later. To make sure the incompleteness of earlier years is not driving our results, we present these partial time period regressions in Table 4. It is apparent that our results are substantively similar to the results with the full sample.

These results suggest, contrary to the prescriptions of Shavell's normative model that regulation and class action litigation, at least in the insurance market, do not function as substitutes.¹⁸ We find no evidence that the likelihood of facing litigation declines as regulatory enforcement increases. In fact, we uncover some evidence of a piggy-backing effect in which either litigation follows regulatory enforcement or vice versa. This result makes sense in a world in which litigation and regulation decisions are not made by a selfless social planner but rather by self-interested individuals. Presumably, lawyers see profit opportunities in cases of wrong-doing uncovered by regulators and/or regulators have an incentive to act when litigators uncover something under their purview, perhaps for public relations reasons. Further, it is also largely unsurprising that lawyers would exploit general signals regarding how hospitable a court will be to a claim or how favorably courts in general treat specific allegations when deciding where and when to file a class action.

V. THE EXAMPLE OF OEM PARTS

The regulatory and litigation experience of insurers with respect to OEM parts may be illustrative though we have no way of knowing how far this experience generalizes across other allegations within the industry. Despite the existence of extensive regulatory action reaffirming insurers' decisions to use of non-OEM parts, litigation against insurers over this issue continued.

There are approximately 30,000 automobile accidents in the US each day. In many cases repairs to damaged vehicles can be made at less expense using parts that are not produced by the original equipment manufacturer (OEM). These non-

¹⁸ This is also generally consistent with the case studies contained in Viscusi, *supra* note 1.

OEM or aftermarket parts had been the subject of long legislative battle in which OEM manufacturers tried to convince state legislatures to ban the practice of using non-OEM parts.¹⁹ Their efforts were unsuccessful and no legislative ban was enacted.

This is not to say that OEM parts are not regulated. According to the GAO, forty states have enacted some form of legislation governing the use of OEM parts. Of these states 36 states require companies identify aftermarket crash part used in the repair. A warranty is required by 27 states and 23 states require a manufacturer's ID for tracking purposes on any OEM parts. Although regulated, every state insurance commission and consumer product safety commission in the US allowed the practice and two states, Massachusetts and Hawaii, required it.²⁰

Although non-OEM parts are less expensive and by providing competition have lowered the price of OEM parts there was considerable debate about safety. There was also considerable study of the issue much of it at the behest of regulators. The outcome of these studies generally found that non-OEM parts differ only cosmetically from OEM parts and created little or no safety risk. For example, the Insurance Institute for Highway Safety found that except for hoods there was no safety difference between OEM and non-OEM parts. Whether or not one agrees with the regulators' decisions on OEM parts, it is hard to argue that the issue had not been evaluated and that regulators and legislators had not reached a consensus favoring the regulated use of non-OEM parts.

In many ways, the case of *State Farm v. Avery* sought to reverse the regulatory consensus in favor of OEM parts. Although the facts of the case are complex and remain controversial, the important feature of the case for evaluating the tradeoff between regulation and class actions is the plaintiffs' allegation that non-OEM parts were in fact unsafe and hence that State Farm breached its contract with policy holders by specifying the use of aftermarket parts on repair estimates. Testimony in the case, some of it from collision repairers rather than safety experts, alleged that non-OEM parts are inferior to OEM parts and create a safety risk. The suit, on behalf of policy holders in 48 states, a class estimated to be 4.7 million people, was decided in Williamson County, Illinois. The class was awarded \$1.2 billion, which was reduced to \$1 billion on appeal. In 2005, the Illinois Supreme Court overturned judgment against State Farm. The Court unanimously ruled that the class should not have been certified because it was too broad and that the plaintiffs failed to demonstrate either a breach of contract or consumer fraud.

Regardless of the actual safety of non-OEM parts, the *Avery* case is an example of regulatory agencies and class action litigation both examining the

¹⁹ Schwartz and Lorber, *supra* note 7.

²⁰ GAO, MOTOR VEHICLE SAFETY: NHTSA'S ABILITY TO DETECT AND RECALL DEFECTIVE REPLACEMENT CRASH PARTS IS LIMITED, GAO DOC. NO. 01-215 (2001).

same underlying issue and coming to contradictory conclusions. That is, litigation and regulation were not playing the substitute roles envisioned in the Shavell model. States had extensively legislated on the issue and although they had imposed limits on the practice, all had allowed the use of non-OEM parts. The effect of the *Avery* case, at least until it was overturned, was to cause a number of insurance companies to switch to OEM parts.

VI. LIMITATIONS

There are a number of limitations in our present analysis of how class action litigation and regulation interact. Contrary to the interpretation we provide above, it could be the case that both litigation and regulation increase together as underlying harm levels increase for exogenous reasons. That is, as suggested by Shavell, litigation and regulation could be substitutes on the margin, but we fail to find this because underlying activity levels (or their attendant costs) are changing differentially across states over time causing both litigation and regulation to move in the same direction on average, while still maintaining substitutability on the margin. Effectively, in this case, our results would suffer from an omitted variables bias. We are in the process of investigating this possibility through an instrumental variables analysis using state budget changes in non-regulatory areas to model a state's choice of regulatory intensity. This approach will allow us to estimate the relationship between regulation and litigation independent of any changes in underlying activity levels.

We also lack precision in the sense that our regulatory variables are gross measures of regulation. That is, while regulatory intensity may be high in general, the focus of the regulatory activity may be in very different areas than those that lead to class action litigation. While our litigation data is allegation (and line) specific, our regulatory data is aggregated at the industry level. To explore this possibility, we plan to look at survey data from state insurance commissioners detailing the areas of regulation where they focus most of their resources to determine whether there is a disconnect between our regulation variables and the effect we purport to be estimating.

CONCLUSION

Law and economics scholars generally view litigation (especially class action litigation) and regulation as substitutable mechanisms to induce appropriate care levels when activities have the potential to generate harm. As spelled out by Shavell, on the margin, socially optimal policy requires that as regulation increases litigation should decrease.

Using a uniquely large and detailed dataset of insurance class actions we examine whether or not there is a tradeoff between regulation and litigation in practice. We find no evidence to suggest that there is. Instead, we find some

evidence that plaintiff's lawyers and regulators piggy-back off of each other perhaps leading to levels of care that exceed the socially optimal level. More work is necessary to rule out the possibility that exogenous variation in underlying harm levels is driving the positive correlation between regulation and litigation.

Table 1
Summary Statistics

Variable	Description	Source	Mean	SD
Dependent Variable in "Filing State" Regressions	% of firms in "risk set" with a case filed against them in given state	RAND	.0175	.0712
Dependent Variable in "Plaintiffs' State" Regressions	% of firms in "risk set" with a case filed against them on behalf of residents of given state	RAND	.0004	.0092
Market Conduct Exams per Ins.	Number of market conduct exams per insurance firm in the state	NAIC	.0242	.0359
Market Conduct Examiners per Ins.	Number of market conduct examiners per insurance firm in the state	NAIC	.1043	.1644
Agency Budget per Ins.	Agency budget (\$100,000) per insurance firm in the state	NAIC	.0046	.0095
Fines per Ins.	Fines (\$100,000) per insurance firm in the state	NAIC	.0054	.0101
% Out of State	% of the risk set that is chartered outside of the state	RAND	.9732	.0619
% Fed. Court (Allegation-Year)	4-year moving average of the % of the allegation type filed in Federal court	RAND	.0162	.0530
% State Court (Allegation-Year)	4-year moving average of the % of the allegation type filed in state court	RAND	.0426	.1244
% State Court (State-Year)	4-year moving average of the % of cases filed in this state's courts	RAND	.0966	.2537
% Removed (Allegation-Year)	4-year moving average of the % of the allegation type removed to federal court	RAND	.0109	.0398
% Removed (State-Year)	4-year moving average of the % of the this state's cases removed to federal court	RAND	.0239	.1107
% Certified (Allegation-Year)	4-year moving average of the % of the allegation type in which the class is certified	RAND	.0113	.0457
% Certified (State-Year)	4-year moving average of the % of the state's certification rate	RAND	.0238	.1210
% w/ P Recovery (Allegation-Year)	4-year moving average of the % of the allegation type in which plaintiffs recover damages	RAND	.0151	.0538

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% w/ P Recovery (State-Year)	4-year moving average of the state's rate of plaintiff recovery	RAND	.0279	.1269
% Settled (Allegation-Year)	4-year moving average of the allegation types settlement rate	RAND	.0079	.0392
% Settled (State-Year)	4-year moving average of the state's settlement rate	RAND	.0164	.1015
% Dropped (Allegation-Year)	4-year moving average of the allegation type's unilateral drop rate	RAND	.0271	.0830
% Dropped (State-Year)	4-year moving average of the state's unilateral drop rate	RAND	.0413	.1481
% Multistate (Allegation-Year)	4-year moving average of the allegation type's rate of multi-state (between 2-49) classes	RAND	.0035	.0250
% Multistate (State-Year)	4-year moving average of the state's rate of multi-state (between 2-49) classes	RAND	.0026	.0285
% Nationwide (Allegation-Year)	4-year moving average of the allegation type's rate of nation-wide classes	RAND	.0680	.1354
% Nationwide (State-Year)	4-year moving average of the state's rate of nation-wide classes	RAND	.0064	.0560
% Regulatory Involvement (Allegation-Year)	4-year moving average of the allegation type's rate of regulator involvement on behalf of defendants	RAND	.0510	.1265
% Regulatory Involvement (State-Year)	4-year moving average of the state's rate of regulator involvement on behalf of defendants	RAND	.0197	.1063

Rand: See Pace, *supra* note 13.

NAIC: National Association of Insurance Commissioners, *Insurance Department Resources Report*

Note: Data cover the period 1992-2002

Table 2
Likelihood of Facing Class Action: Filing State
(Standard Errors in Parentheses)

ln(Market Conduct Exams per Ins.)	0.121 (0.110)	0.197* (0.113)	0.120 (0.107)
ln(Market Conduct Examiners per Ins.)	0.760*** (0.179)	--	0.759*** (0.173)
ln(Agency Budget per Ins.)	-0.016 (0.491)	0.289 (0.499)	--
ln(Fines per Insurer)	0.034 (0.123)	0.085 (0.132)	0.034 (0.123)
% Out of State	-9.459*** (1.865)	-9.478*** (1.790)	-9.459*** (1.865)
% Fed. Court (Allegation-Year)	1.002 (1.245)	0.657 (1.219)	1.001 (1.249)
% State Court (Allegation-Year)	4.209***	4.073***	4.212***

	(1.046)	(1.061)	(1.029)
% State Court (State-Year)	2.398***	2.407***	2.397***
	(0.664)	(0.668)	(0.666)
% Removed (Allegation-Year)	-3.851	-3.798	-3.851
	(2.715)	(2.683)	(2.713)
% Removed (State-Year)	0.656	0.554	0.656
	(0.708)	(0.702)	(0.708)
% Certified (Allegation-Year)	-7.140	-7.420	-7.140
	(4.642)	(4.673)	(4.645)
% Certified (State-Year)	0.377	-0.027	0.373
	(1.012)	(0.964)	(0.967)
% w/ P Recovery (Allegation-Year)	2.447	2.999	2.444
	(2.059)	(2.046)	(2.073)
% w/ P Recovery (State-Year)	2.754***	3.399***	2.752***
	(1.059)	(1.125)	(1.041)
% Settled (Allegation-Year)	4.475	5.508	4.476
	(4.345)	(4.296)	(4.338)
% Settled (State-Year)	-3.851**	-4.068**	-3.843**
	(1.628)	(1.653)	(1.553)
% Dropped (Allegation-Year)	0.482	0.294	0.483
	(1.634)	(1.613)	(1.641)
% Dropped (State-Year)	-0.214	-0.314	-0.213
	(0.624)	(0.650)	(0.626)
% Multistate (Allegation-Year)	4.949	5.114*	4.946
	(3.054)	(2.940)	(3.054)
% Multistate (State-Year)	-1.222	-0.753	-1.231
	(1.450)	(1.417)	(1.451)
% Nationwide (Allegation-Year)	-3.205**	-3.435**	-3.205**
	(1.489)	(1.484)	(1.488)
% Nationwide (State-Year)	-3.214**	-3.211**	-3.210**
	(1.357)	(1.332)	(1.360)
Pro-Defense Brief in Line	-4.185**	-4.034**	-4.188**
	(1.634)	(1.620)	(1.639)
Pro-Defense Brief in State	1.881	2.068	1.876
	(0.791)	(0.767)	(0.808)
State Effects	Yes	Yes	Yes
Year Effects	Yes	Yes	Yes
Allegation Effects	Yes	Yes	Yes
Observations	15,255	15,309	15,255

Note: Data cover the period 1992-2002.

*p<0.10; **p<0.05; ***p<0.01

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Table 3
Likelihood of Facing Class Action: Plaintiffs' State
(Standard Errors in Parentheses)

	(4)	(5)	(6)
	Pending Claims	Pending Claims	Pending Claims
ln(Market Conduct Exams per Ins.)	0.01504** (0.00642)	0.01402** (0.00621)	0.01506** (0.00648)
ln(Market Conduct Examiners per Ins.)	-0.00138 (0.01182)	-0.00071 (0.01174)	
ln(Agency Budget per Ins.)	-0.02860 (0.02499)		-0.02876 (0.02474)
ln(Fines per Insurer)	0.01579 (0.01155)	0.01573 (0.01159)	0.01559 (0.01154)
% State Court (Allegation-Year)	-0.29415 (0.45806)	-0.29456 (0.45808)	-0.29633 (0.45864)
% Fed. Court (Allegation-Year)	-0.13381 (1.28456)	-0.13271 (1.28096)	-0.11514 (1.27846)
% State Court (State-Year)	-0.15428 (1.33858)	-0.15351 (1.33861)	-0.14263 (1.32952)
% of all cases filed in this State	-0.39844 (0.28330)	-0.40197 (0.28176)	-0.39049 (0.28235)
% Removed (Allegation-Year)	-2.10868 (1.73005)	-2.10746 (1.73085)	-2.09267 (1.72623)
% Removed (State-Year)	0.19241 (0.22354)	0.19256 (0.22342)	0.18178 (0.22279)
% Certified (Allegation-Year)	3.42099 (2.86311)	3.41446 (2.86552)	3.46841 (2.81966)
% Certified (State-Year)	1.39809*** (0.43178)	1.39002*** (0.43112)	1.40361*** (0.43002)
% w/ P Recovery (Allegation-Year)	-0.02273 (1.48865)	-0.02998 (1.48562)	-0.07976 (1.48056)
% w/ P Recovery (State-Year)	0.60758 (0.41366)	0.60819 (0.41335)	0.60354 (0.41312)
% Settled (Allegation-Year)	-2.93722 (3.21842)	-2.91473 (3.21495)	-2.96065 (3.17678)
% Settled (State-Year)	-1.41463** (0.65551)	-1.40291** (0.65547)	-1.41966** (0.65447)
% Dropped (Allegation-Year)	1.24835 (1.85269)	1.25060 (1.85262)	1.20887 (1.84201)
% Dropped (State-Year)	0.56430** (0.28093)	0.56728** (0.28035)	0.57821** (0.28045)
% Multistate (Allegation-Year)	-2.50816 (2.17207)	-2.49145 (2.16933)	-2.54712 (2.14782)
% Multistate (State-Year)	-0.17542 (0.81946)	-0.18514 (0.81885)	-0.17840 (0.81942)

% Nationwide (Allegation-Year)	1.17937*** (0.25575)	1.17943*** (0.25575)	1.16518*** (0.25550)
% Nationwide (State-Year)	-0.15243 (0.46279)	-0.14421 (0.46086)	-0.16608 (0.46254)
Pro-Defense Brief in Line	3.20354*** (0.26051)	3.20345*** (0.26055)	3.20828*** (0.26017)
Pro-Defense Brief in State	0.01294 (0.06721)	0.00920 (0.06718)	0.01313 (0.06729)
State Effects	Yes	Yes	Yes
Year Effects	Yes	Yes	Yes
Allegation Effects	Yes	Yes	Yes
Observations	15255	15255	15309

Note: Regressions include all the variables from Table 2. Data cover period 1992-2002.
*p<0.10; **p<0.05; ***p<0.01

Table 4
Likelihood of Facing Class Action: 1995-2002
(Standard Errors in Parentheses)

	Filing State	Plaintiffs' State
ln(Market Conduct Exams per Ins.)	0.231* (0.133)	0.018** (0.008)
ln(Market Conduct Examiners per Ins.)	1.095*** (0.222)	0.008 (0.016)
ln(Agency Budget per Ins.)	-0.047 (0.666)	-0.014 (0.025)
ln(Fines per Insurer)	-0.014 (0.128)	0.015 (0.013)
State Effects	Yes	Yes
Year Effects	Yes	Yes
Allegation Effects	Yes	Yes
Observations	12,015	12,015

Note: Regressions include all the variables from Table 2.
*p<0.10; **p<0.05; ***p<0.01

APPENDIX: DESCRIPTION OF ALLEGATIONS

ANNUITIES:

- i) Failed to disclose payments made to annuity provider by mutual fund companies.
- ii) Failed to fully inform prospective and current policyholders about withdrawal penalty for transferring or switching policies.
- iii) Failed to inform when variable contracts purchased in tax-deferred plans provided no additional benefit to the customer.
- iv) Failed to register annuities as securities.
- v) Failure to disclose possibility of lower return in different market conditions.
- vi) Falsely represented that assets could be transferred among funds offered in the contracts without charge.

<ul style="list-style-type: none"> vii) Made changes to interest rate used for payments that did not reflect market conditions as promised. viii) Misrepresented annuity contract interest rate adjustments conditions. ix) Misrepresented the riskiness of annuities as an investment. x) Misrepresenting that tax benefits in tax-deferred plans are only available if they are funded with an annuity contract. xi) Replaced original mutual funds included in annuities with inferior funds. xii) Represented annuities as a type of insurance product. xiii) Sold 403(b) retirement plans improperly as debt-consolidation plans. xiv) Sold 403(b) retirement plans that were defective in tax consequences. xv) Unauthorized replacement of existing annuities with new contract. xvi) Unnecessary placement of tax-deferred annuities into tax-deferred retirement plans.
<p>AUTO (1st PARTY) - Increased Value Issues: Deducted portion of payments for vehicle repair based on alleged betterment in value of vehicle from upgraded parts or repairs.</p>
<p>AUTO (1st PARTY) - Diminished Value Issues: Failed to reimburse policyholders for the diminished value of repaired vehicles.</p>
<p>AUTO (1st PARTY) - OEM Issues</p> <ul style="list-style-type: none"> i) Conspired with other insurers to manipulate the price of auto physical damage coverage with the use of aftermarket parts. ii) Created Certified Automotive Parts Association (CAPA) to conceal flaws in aftermarket parts. iii) Failed to disclose the use of aftermarket parts for repairs rather than using original equipment manufacturer parts. iv) Failed to pass along savings realized by the use of aftermarket parts for repairs rather than using OEM parts to policyholders. v) Specified aftermarket parts for repairs rather than using OEM parts, resulting in diminished value and safety issues.
<p>b) AUTO (1st PARTY) - Other Issues</p> <ul style="list-style-type: none"> i) Failed to obtain salvage title after totaling vehicles. ii) Failed to reimburse deductibles paid on claims where other driver was at fault. iii) Systematically omitted payment for certain necessary types of safety-related repairs. iv) Systematically referred policyholders to auto repair shops that use substandard replacement parts and repair methods. v) Used valuation software package designed to produce offers for automobile total loss at less than fair market value.
<p>c) AUTO (VARIOUS)</p> <ul style="list-style-type: none"> i) Calculated premiums in manner not consistent with state law. ii) Continued to charge higher premiums for drivers with prior accidents even though law required removal of the surcharge. iii) Improperly surcharged or denied discounts to drivers whose prior coverage was a non-standard insurance policy. iv) Included "owned but not insured" exclusion in policies without a corresponding premium adjustment. v) Marketed multiple types of policies at different premium levels but with no difference in coverage or benefits.

<p>vi) Over billed regular policyholders by setting improperly high profit margin in order to subsidize high risk customer pool.</p>
<p>AUTO (LIABILITY) - 3rd Party Claimants</p> <ul style="list-style-type: none"> i) Discouraged claimants from seeking counsel. ii) Unfairly \ deceptively handled claims. iii) Unnecessarily delay in payment of concluded settlements without including interest payments.
<p>AUTO (PIP\MEDPAY) - Health Care Providers</p> <ul style="list-style-type: none"> i) Made inappropriate fee reductions on claims submitted under PIP coverage. ii) Provided cash incentives to claims reviewers who would deny or limit tests and treatments. iii) Used cost-based criteria to review claims.
<p>AUTO (PIP\MEDPAY) – Policyholders</p> <ul style="list-style-type: none"> i) Failed to disclose practice of paying only bills at a fixed percentile of local "usual and customary" charges. ii) Systematic denial of claims for MRI payments. iii) Systematic reduction of PIP benefits through bill review computer program. iv) Systematically refused to reimburse on "reasonable and customary" grounds without investigating particular merits of the claim. v) Used medical file review firms with unqualified, non-medical reviewers making claims decisions. vi) Used valuation software package designed to produce offers for personal injury claims at less than full and fair value.
<p>AUTO (UM/UIM) - 3rd Party Claimants: Threatened uninsured motorists with loss of license in order to obtain reimbursement.</p>
<p>AUTO (UM/UIM) - Policyholders</p> <ul style="list-style-type: none"> i) Charged for multi-car "stack" coverage when actually only one car. ii) Failed to pay uninsured/underinsured motorist claims on vehicles based on an unenforceable "other-owned auto exclusion". iii) Sought reimbursement from uninsured motorists in a way that prevented insureds from pursuing own claims.
<p>COMMERCIAL GENERAL LIABILITY - 3rd Party Claimants: Inappropriate inducement to accept low settlement amounts while handling asbestos claims.</p>
<p>CREDIT LIFE</p> <ul style="list-style-type: none"> i) Calculated premiums on total amount financed plus all future interest rather than on unpaid principal only. ii) Induced borrowers to purchase optional credit insurance products unknowingly. iii) Sold policies not approved by state regulators. iv) Sold policies without required federal Truth in Lending disclosures
<p>Credit Report Issues</p> <ul style="list-style-type: none"> i) Declined to offer installment plan due to adverse credit report. ii) Declined to renew policy due to adverse credit report. iii) Denied coverage solely based on adverse credit report. iv) Discriminated against minorities due to systematic use of credit reports in underwriting. v) Failed to disclose adverse credit report that resulted in denial of insurance, rate

<p>increase, or coverage change.</p> <ul style="list-style-type: none"> vi) Failed to disclose any use of or request for credit report. vii) Failed to notify of receipt of adverse credit report even if not used. viii) Improperly used credit histories when calculating premiums. ix) Increased rates based on adverse credit report. x) Ordered credit report without legally permissible purpose.
<p>DISABILITY: Created inappropriate financial incentives to employees to routinely deny claims.</p> <p>Systematically cancelled long-term disability policies for patients with cancer, heart disease, and other high value claims.</p>
<p>HEALTH - Members</p> <ul style="list-style-type: none"> i) Calculated premiums based on higher "usual and prevailing" provider fees though actually paid Medicare maximums. ii) Cancellation of "guaranteed renewable" policies when substantial claims filed. iii) Charged improper premiums for replacement coverage. iv) Claimed to be non-profit association health service providers when in fact for-profit insurance companies. v) Collected deductible and co-payments calculated on original billing rather than on negotiated, discounted rate. vi) Discriminated against women by limiting or excluding coverage of prescription contraceptives. vii) Enforcing illegal arbitration clauses. viii) Failed to comply with small group pooling laws. ix) Failed to disclose full impact of arbitration clauses. x) Failed to disclose to members how benefit and coverage decisions are made. xi) Failed to disclose to members how providers are compensated. xii) Failed to notify former policyholders of conversion rights after termination. xiii) Failed to provide members with proper appeals process. xiv) Failed to provide notice of adverse health care decisions. xv) Failed to refund or rebate to members tobacco settlement money obtained for costs expended for their health care. xvi) Failed to reimbursement members for out-of-pocket expenses for alternative care despite legal requirement to do so. xvii) Failed to warn customers of financial compensation incentive program for providers to limit treatment or tests. xviii) Falsely represented that providers, and not administrators, would direct medical care. xix) Forced enrollment into Medicare in violation of Secondary Payer Act. xx) Issued cancer supplement replacement policies that were more expensive and contained reduced benefits. xxi) Offered only inferior policies at higher rates after canceling "guaranteed renewable" policies when substantial claims filed. xxii) Pressured providers and patients to accept generic versions of drug that are not as safe and effective as brand name versions. xxiii) Pursued subrogation recovery efforts so as to interfere with members rights to settle personal injury claims. xxiv) Pursued subrogation recovery efforts without legal basis for doing so. xxv) Systematically denied members lead poison testing. xxvi) Systematically reduced payments for necessary anesthesia services.

- xxvii) Terminated depositor medical insurance without adequate warning.
- xxviii) Used "tier rating" with premium price hikes greater for ill policyholders than healthy ones.
- xxix) Used renewal rating methodology in violation of law.
- xxx) Used utilization-management guidelines as a substitute for decision-making by doctors.
- xxxi) Violated fiduciary obligations with interchange programs and negotiation of formulary rebates \ discounts from drug manufacturers.
- xxxii) Violated non-profit status by failure to keep premiums in line.
- xxxiii) Violated non-profit status by failure to provide coverage to high risk or low income population.
- xxxiv) Violated non-profit status by large surplus growth.

HEALTH – Providers

- i) Arbitrarily changed provider reimbursement rates.
- ii) Attempted to fix prices paid to providers for services in violation of antitrust laws.
- iii) Delayed payments unnecessarily without paying interest on valid claims.
- iv) Disregarded medically necessary criteria in making coverage and treatment decisions.
- v) Divided up market in conspiracy with other plans to dictate prices and terms in violation of antitrust laws.
- vi) Entered into illegal capitation arrangements.
- vii) Failed to adequately explain to providers how the reimbursement fee schedule was designed and how it operates.
- viii) Failed to maintain accurate books and records resulting in improper payments to providers.
- ix) Failed to maintain consistent medical utilization/quality management and administration of covered services.
- x) Failed to make increased reimbursement payments when the treatment required extra time and resources.
- xi) Inappropriately used cost-based criteria to review claims.
- xii) Interfered with providers' relationships with patients by arbitrarily denying or delaying authorizations and/or payments.
- xiii) Made treatment and payment decisions based in part on prior history of provider's actions and charges.
- xiv) Paid financial incentives and performance bonuses to review staff to limit patient care costs.
- xv) Paid out-of-network providers less than billed charges.
- xvi) Performed industry wide boycott of certain medical services.
- xvii) Reimbursed fees to providers at levels lower than true prevailing rates.
- xviii) Reimbursed providers based on the frequency of which they order a particular test or treatment.
- xix) Sent Explanation of Benefit notices to members that appeared to suggest providers' charges exceeded usual and customary rates.
- xx) Systematically refused to pay for treatments by falsely claiming no referral from primary care physician.
- xxi) Used claim review software to "bundle", drop, and "downcode" claim codes submitted by providers without justification.
- xxii) Violated state prompt-payments laws.

LIFE

- i) Attempted to recoup funds based on changing economic conditions unrelated to expected mortality experience.
- ii) Began a deceptive voluntary exchange program designed to terminate policies with prohibited cost of insurance increases.
- iii) Claimed premiums would "vanish" over time.
- iv) Collected premiums for the period prior to the delivery of the policy and/or prior to coverage start.
- v) Continued to collect additional premiums for "child rider" after cut-off age for coverage.
- vi) Discriminated against disabled by excluding applicants with health problems without evidence of negative effect on life expectancy.
- vii) Discriminated based on race by targeting small-face-value policies with benefits less than total premium payments to minorities.
- viii) Discriminated based on race by targeting policies with higher prices, no cash accumulation, or fewer benefits to minorities.
- ix) Discriminated by setting premium levels based on race.
- x) Failed to accurately disclose impact of demutualization on existing policyholders.
- xi) Failed to disclose early withdrawal penalties.
- xii) Failed to disclose that money paid would be used to pay charges and fees and would not earn any interest or investment income.
- xiii) Failed to inform term life policyholders of right to convert during last year of conversion period.
- xiv) Failed to notify policyholder's employer and end automatic payroll deductions for premiums when policy canceled.
- xv) Failed to observe the guaranteed features of term life policies.
- xvi) Failed to pay persistency bonus for continuing to keep the policy in force as promised.
- xvii) Failed to register as an investment company when investing its assets primarily in other securities.
- xviii) Failed to register as an investment company when issuing securities in the form of variable insurance products.
- xix) Failed to register variable life policies as securities under state Blue Sky laws.
- xx) Improperly characterized variable life policies as mutual fund investments.
- xxi) Improperly charged excess costs of insurance, expenses and admin. fees in violation of contract and marketing materials.
- xxii) Improperly charged policies with costs and other fees including deferred acquisitions cost tax.
- xxiii) Increased cost of insurance charges on whole life in order to induce policyholders to surrender policies or allow to lapse.
- xxiv) Increased premiums, reduced benefits, or terminated coverage after group life policyholders retired.
- xxv) Made dividend payments at less than the contractually required amount.
- xxvi) Mislead prospective buyer about the company's shaky financial condition.
- xxvii) Misrepresented policy performance projections.
- xxviii) Misrepresented the benefits from and suitability of "rolling over" some or all of an existing life insurance policy's cash value.
- xxix) Misrepresented the cash value and/or benefits a policyholder would realize under a policy.
- xxx) Provided misleading advice to "churn" existing policies with new ones and

<p>obtain transaction fees.</p> <p>xxxix) Provided misleading advice to "churn" existing policies with new ones with higher premiums and/or reduced benefits.</p> <p>xxxixii) Provided misleading advice that implied policy was a "high interest retirement savings vehicles" and not insurance.</p> <p>xxxixiii) Set monthly premiums which were not, and could never be, sufficient to pay current policy cost or to meet forecasts.</p> <p>xxxixiv) Sold higher priced policies, rather than less expensive ones with the same coverage, because commissions were higher.</p> <p>xxxixv) Sold life policies to existing Medigap customers without consent or knowledge and/or as "health" coverage.</p> <p>xxxixvi) Sold life policies to non-US residents that were actually "securities" in violation of state Blue Sky laws.</p> <p>xxxixvii) Unfairly allocated portfolio yields to universal life policies.</p>
<p>LONG TERM CARE: Failed to disclose that premiums could increase.</p>
<p>Modal Issues</p> <p>i) Failed to comply with Truth in Lending Act requirements for financed portion of the annual premiums paid on a periodic basis.</p> <p>ii) Failed to disclose annual percentage rate and finance charges incurred when paying premiums periodically rather than annually.</p> <p>iii) Imposed premium finance service charges in violation of state law.</p>
<p>Other Issues</p> <p>i) Denied claims based on policy exclusions that are legally unenforceable because they are not tied to specific premium discounts.</p> <p>ii) Failed to pay claims stemming from the Jewish or Armenian Holocausts.</p> <p>iii) Failed to pay interest on delays in paying liability settlements.</p> <p>Received the benefit of broker fees improperly charged by independent agents.</p>
<p>Other Issues</p> <p>i) Denied claims based on policy exclusions that are legally unenforceable because they are not tied to specific premium discounts.</p> <p>ii) Failed to pay claims stemming from the Jewish or Armenian Holocausts.</p> <p>iii) Failed to pay interest on delays in paying liability settlements.</p> <p>Received the benefit of broker fees improperly charged by independent agents.</p>
<p>PROPERTY</p> <p>i) Charged a "management fee" in order to illegally increase premiums.</p> <p>ii) Discriminated based on race by refusing to insure or only offering policies with fewer benefits in particular geographic areas.</p> <p>iii) Discriminated based on race by refusing to insure older homes or only offering policies with fewer benefits to minorities.</p> <p>iv) Failed to provide allowance for general contractor's overhead and profit when paying for repairs with multiple trade specialists.</p> <p>v) Paid reduced benefits when homeowners do own repairs.</p> <p>vi) Provided poor customer service, delayed responding to inquiries, and generally mishandling claims.</p> <p>vii) Systematically denied supplemental claims on the basis of a time bar even though additional damage recently discovered</p> <p>viii) Systematically estimated damage at lower than actual cost of repair.</p> <p>ix) Used "survey" sent to policyholders following disaster to later deny claims and/or as a waiver of rights.</p>

<ul style="list-style-type: none"> x) Used unqualified estimators, adjusters, contractors, or engineers for damage evaluation. xi) Wrongly limited coverage for water or mold damage.
<p>STRUCTURED SETTLEMENTS: Failed to disclose rebate of portion of the commission paid to annuity broker. Represented structured settlements as partial assignments when in fact full assignments.</p>
<p>WORKERS' COMPENSATION</p> <ul style="list-style-type: none"> i) Administered experience readjustments unfairly. ii) Conspired to charge unduly high fees on businesses placed in assigned risk pool. iii) Conspired to fix prices in violation of antitrust laws. iv) Conspired to overload assigned risk pool. v) Conspired with the National Council on Compensation Insurance to charge more than approved by state Board of Insurance. vi) Failed to pay applicable insurance taxes. vii) Failed to warn or protect insured entities' employees of asbestos danger at covered facility. viii) Inflated in-house counsel bills to insureds w/ negative impact on loss histories for reimbursement dividends and future rates. ix) Inflated in-house counsel bills to self-insureds for services in order to generate increased income. x) Misreported medical-legal expenses to Rating Bureau as claim costs rather than general expenses to inflate experience modifiers. xi) Overcharged customers in order to inflate surplus and reserves to later engage in predatory price wars and reduce competition. xii) Passed on excessive servicing carrier fees to policyholders in the form of higher rates.

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