

# REVIEW OF INSURANCE POLITICS

## **Symposium on Regulatory Class Action Litigation**

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### **A Former Regulator's Perspective**

*Lawrence H. Mirel*

### **Ending Judicial Usurpation of Insurance Regulatory Authority**

*Robert Detlefsen*

### **The Critical Role of Insurance Class Actions**

*D.J. Powers*

## **Articles**

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### **Sarbanes-Oxley for Non-Public Insurers**

*Tom Finnell*

### **Sarbanes-Oxley, the Model Audit Rule, and the Perils of Overregulation**

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### **Limiting UM/UIM Coverage to Injuries Sustained by Insureds**

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*Joe Thesing and David B. Reddick*

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### NAMIC Headquarters

3601 Vincennes Road  
P.O. Box 68700  
Indianapolis, IN 46268  
(317) 875-5250  
(800) 33-NAMIC  
Fax: (317) 879-8408

### NAMIC

#### Federal Affairs Office

122 C Street, N.W.  
Suite 540  
Washington, D.C. 20001  
(202) 628-1558  
Fax: (202) 628-1601

[www.namic.org](http://www.namic.org)

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## Editor's Overview

*Politics is the study of who gets what, when, and how.*

– Harold Lasswell (1935)

*The rule of law ... is preferable to that of any individual. On the same principle, even if it be better for certain individuals to govern, they should be made only guardians and ministers of the law.*

– Aristotle, *Politics* (circa 335 B.C.)

It is well known that insurance is among the most thoroughly regulated industries in the United States. Less appreciated is the broad scope of insurance politics, a category that extends beyond conventional modes of statutory regulation to include all forms of governmental decision-making that determine “who gets what, when, and how” in the realm of risk allocation and insurance. The familiar products of insurance politics – laws that directly pertain to the business of insurance, enacted by state legislatures and administered by state insurance departments – are augmented, and sometimes eclipsed, by sundry decisions of state and federal courts; Congress and the executive branch; quasi-regulatory and legislative bodies such as the National Association of Insurance Commissioners (NAIC) and the National Conference of Insurance Legislators (NCOIL); and, in states that allow ballot initiatives, the voters themselves. In sum, the enterprise of insurance is affected by a wide variety of political actors and institutions – often profoundly so.

The volume you hold in your hands is the inaugural edition of a new publication that seeks to illuminate the intersection of politics and insurance. The importance of this phenomenon cannot be overstated, for no commercial enterprise is as indispensable to the functioning of a modern society as insurance. Any doubts to the contrary were surely erased by the Sept. 11 terrorist attacks and the devastating hurricanes of 2004 and 2005.

The social and economic importance of insurance no doubt accounts for the often conflicting agendas of those who would seek to use the instruments of politics to influence the nature and purpose of insurance. One such conflict is explored in this volume's first offering: a symposium that examines the type of class action lawsuit in which plaintiff attorneys seek to alter existing insurance regulatory regimes, sometimes in direct contravention of the expressed will of legislators and regulators. The topic is introduced by former District of Columbia Insurance Commissioner Lawrence Mirel, who acknowledges his own “well-deserved reputation as a critic of the use of class action litigation as a regulatory tool.” To Mirel, the issue is “not whether the statutory regulators or the courts should have the final word on insurance disputes, but rather what

role each should play in the process of achieving justice.” He suggests that the regulatory system is “perverted” when a class action lawsuit against a regulated entity is filed before the appropriate regulator has had a chance to review and adjudicate the dispute.

My own essay argues that class action litigation tends to produce regulatory outcomes that are contrary to the public interest, mainly because courts are singularly ill-equipped to make sweeping policy decisions. In contrast to decision-making by statutory regulators, the class action mechanism is characterized by a lack of subject expertise and public accountability on the part of both judges and jurors; the adversarial nature of legal proceedings; the dominant role of truth-manipulating lawyers motivated by personal reward and self-interest; and not least, the violation of democratic values and constitutional norms that judicial usurpation of regulatory authority represents.

To say that D.J. Powers is unpersuaded by this argument would be a gross understatement. Powers argues that insurance departments cannot be trusted to protect the interests of consumers in regulatory disputes, primarily because most states’ commissioners are co-opted by the industry they are charged with regulating. Regulators, he suggests, are corrupted by insurance companies in part because they depend on insurers for campaign contributions (in states with elected commissioners), and also because they hope to secure lucrative employment in the industry when they leave office. Even when regulators try to do the right thing, their departments’ meager resources are no match for the high-powered, deep-pocketed insurance industry. Hence, if not for the altruistic labors of private class-action attorneys, insurers would be free to exploit consumers – perhaps, one imagines, by charging risk-based premiums, for example.

Separate contributions by Tom Finnell and Gary Strohm critically examine one of the insurance world’s most heated political controversies of the past year: whether elements of the federal Sarbanes-Oxley (SOX) corporate governance and accounting statute should be applied to non-public insurance companies. Finnell, who performed a cost-benefit analysis of the NAIC-driven proposal last year, presents data and marshals evidence that challenge the wisdom of forcing non-public insurers to adhere to standards that were intended by Congress to protect shareholders of public corporations and create transparency for corporate investors. Strohm identifies several unintended negative consequences that would likely flow from the NAIC’s proposed SOX law, should states choose to enact it. These include the disproportionate adverse impact the law would have on small to medium-size insurers; the potential for broader application of the law than originally envisioned; and overzealous enforcement made possible by the discretion the law affords to regulators.

Distinguishing statutory language from legislative intent is a challenge often confronted by courts. Paul Tetrault shows how the challenge arises in the context of state laws that define the purpose and function of automobile insurance policies that provide coverage for accidents caused by uninsured or underinsured motorists (UM/UIM coverage). Courts in no fewer than 20 states have addressed this “narrow, yet important question,” with decidedly mixed results. Interestingly, Tetrault finds that in many cases, the relevant statutory language is overbroad, in the sense that it would require insurers to pay claims for injuries suffered by an individual who is not the insured but who is related to the insured. The difficulty this poses for insurers, observes Tetrault, is “that they have no way of measuring and assessing their exposure to the risk” presented by non-insureds. Interestingly, Tetrault finds that courts sensitive to this problem must sometimes adopt an “activist” approach to statutory construction, because adherence to “strict construction” would yield outcomes that are “if not absurd, as some judges have suggested, at least unwise.” Judicial activism, it turns out, is not always a bad thing.

Regardless of their judicial philosophy or mode of legal reasoning, judges in South Dakota could soon face severe punishment if they render decisions that prove to be unpopular. That is the startling prospect raised by a citizen initiative that has qualified for the 2005 statewide ballot in South Dakota. Styled by its proponents as the “Judicial Accountability Initiative Law” – or J.A.I.L. – its central conceit is that “when judges ... abuse their power, the People are obliged – t is their duty – to correct that injury, for the benefit of themselves and their posterity.” While the public’s antipathy toward judicial imperialism is understandable, Joe Thesing and David Reddick caution against empowering citizen tribunals to penalize judges whose only offense may be following the law instead of yielding to popular passion. It’s a safe bet that America’s Founding Fathers would not approve of the J.A.I.L.er’s assault on the rule of law. Nor would Aristotle, who inspired the Founders, and whose words appear in the epigraph above.

Robert Detlefsen

## A Former Regulator's Perspective

By  
Lawrence H. Mirel

Far too little attention has been paid to the impact of large-scale class action litigation on the ability of state insurance regulators to carry out their statutory responsibilities. The two articles that follow go a long way toward illuminating the issue. Anyone interested in how best to achieve fairness and efficiency in the regulation of the business of insurance should be grateful to Robert Detlefsen and D. J. Powers for their thorough and thoughtful presentations of the two sides in this important public policy debate.

I make no claim to impartiality. I have a well-deserved reputation as a critic of the use of class action litigation as a regulatory tool. But it is important to see the question at issue in the proper light. No one is claiming that the courts should have no role in resolving insurance disputes, or that individuals or groups of individuals should be denied access to the courts. The class action mechanism, which is designed to improve court efficiency and to provide remedies when many persons have suffered identical or similar injuries that are too small to warrant individual actions, has a proper role in our system of justice. Like any other judicial or regulatory process, however, it can be abused.

The question to ask is how the insurance-buying public can best be protected against improper or illegal actions by insurers and their agents? What procedure, or combination of procedures, will produce the fairest outcomes in the most efficient manner? The issue is not whether the statutory regulators or the courts should have the final word on insurance disputes, but rather what role each should play in the process of achieving justice.

There is no doubt that courts are the best place to resolve disputes among litigants. It is likewise clear that administrative agencies, carrying out public policy mandates established by elected legislators, are in a better position than courts to view and balance all interests involved in a regulatory issue and to be concerned about the overall operation of the industry being regulated. Where a legislature has established a set of administrative rules designed to protect the public, and a regulator has been appointed by the Governor, or elected by the people, to apply those rules, courts should defer to that process at least until such time as it is clear that the process has failed to work or has produced an inequitable result. All states and the Federal Government have Administrative Procedure Acts that allow a decision by a regulator to be challenged in court by an aggrieved or unsatisfied party. The APA typically requires the courts to grant

due deference to the expertise of the regulatory agency but not to be bound by regulatory decisions that are clearly improper or unfair.

When a class action suit is filed against a regulated entity, however, before the statutory regulator has had an opportunity to review and attempt to resolve the dispute, the system is being perverted. That perversion is compounded when the class consists of people living in various jurisdictions, where separate regulators are charged with applying different laws that may require or allow quite different outcomes. Whatever shortcomings there are in the regulatory system, that system exists for a reason and should be allowed to work before a dispute is taken to court. That is why the recent Texas law, cited by Dr. Detlefsen, is such a valuable model. It does not deprive a court of jurisdiction; it simply requires the court to determine if an administrative agency has authority over the dispute, and if so to require that the plaintiff exhaust the administrative remedy before seeking relief in the courts. That seems to me quite a sensible idea, fairly balancing the rights of litigants and the mechanism created by the elected legislature to ensure overall fairness in the system.

Judicial remedies should not be seen as an alternative to regulatory action, or vice versa. Both have a proper role in our system of justice. More work needs to be done to define the parameters of each and to ensure that they work together to provide the best protection to the public in the most efficient matter. The papers by Robert Detlefsen and J.D. Powers are important documents in providing understanding of the issue. They should be read by regulators, legislators and judges, as well as anyone concerned about the proper regulation of insurance.

# Ending Judicial Usurpation of Insurance Regulatory Authority: The Problem of Class Action Litigation Involving Jurisdiction of State Insurance Departments

By  
Robert Detlefsen, Ph.D.

## Executive Summary

In a growing number of class action lawsuits against insurers, plaintiff attorneys seek not only to win large monetary awards, but also to regulate insurers' behavior in the marketplace and manage their relations with consumers. Such "regulatory class actions" threaten basic principles of republican democracy. The doctrine of the separation of powers that is embedded in the U.S. Constitution and the constitution of every state assigns legislative authority expressly to legislatures, while the power to implement legislation through regulation is assigned to administrative agencies in the executive branch. When undertaken by agencies such as state insurance departments, regulatory decision-making is generally transparent and subject to public comment and petition. Regulatory class actions, on the other hand, empower private attorneys with personal agendas to serve as de facto regulators.

Recognizing the threat to democratic principles and public accountability posed by regulatory class actions, the Texas Legislature in 2003 enacted comprehensive class action reform legislation that contains a specific provision designed to ensure that regulatory authority statutorily invested in administrative agencies will not be usurped by courts through regulatory class actions. As a result, Texas courts are now required by law to consider whether the claims advanced by plaintiffs in proposed class actions are within the jurisdiction of state administrative agencies. If they are, the law requires the court to refrain from certifying the class.

Such a law is necessary because class action lawsuits are remarkably ill suited as forums for addressing regulatory issues. The overall effect of judicial usurpations of insurance regulatory authority is to subvert and destabilize the regulation of insurance, thus adding to the cost and decreasing the availability of insurance products. States can remedy this problem by enacting legislation modeled after Texas's "administrative process" requirement. Such a law will ensure that

professional competence, procedural fairness and public accountability are the hallmarks of insurance regulation.

## Introduction

For better or worse, the United States has developed the most politically active court system in the world. The nation was not even a half-century old when Alexis de Tocqueville famously observed that “scarcely any political question arises in the United States that is not resolved, sooner or later, into a judicial question.”<sup>1</sup> Today, Tocqueville’s insight has particular relevance to insurance regulation; indeed, in recent years it seems that scarcely any important *insurance regulatory question* arises in the United States that is not eventually transformed into a judicial question. The trend is most noticeable in the increasing number of class action lawsuits in which plaintiff attorneys seek not only to extract large monetary awards from insurers, but also to regulate their behavior in the marketplace and manage their relations with consumers.

As a mode of regulation, however, “regulatory class actions” have proven undesirable for a variety of reasons. The fact that they are initiated and carried out by private litigants, together with their potential to impose high costs and penalties on defendants, means that opportunists and ideologues can use regulatory class actions as tools for extortion and self-dealing, as well as to institute dubious (and decidedly non-democratic) “reforms” of existing regulatory regimes. Moreover, regulatory class actions rely for their policy judgments on amateur, one-time decision makers – civil jurors – who are not required to explain their decisions, and who are not accountable to the larger public that must live with the policy implications of their verdicts. Jurors are expected to render policy decisions based on their mostly passive involvement in an adversarial process dominated by partisan lawyers and presided over by judges who often lack substantive expertise in the matters under dispute. As a result, regulatory class actions generate high levels of unpredictability, inefficiency and unfairness.

More fundamentally, regulatory class actions threaten basic principles of republican democracy. The doctrine of the separation of powers that is embedded in the U.S. Constitution and the constitution of every state assigns legislative authority expressly to legislatures, not courts. Federal and state laws are enacted by legislators who are elected by the people, directly accountable to the people and subject to a limited term of office. The power to implement legislation is assigned to administrative agencies in the executive branch, which is presided over by a democratically elected governor or president. Most of what agencies do, like regulatory decision-making, is ultimately transparent and subject to public comment and petition. Regulatory class actions, on the

other hand, empower private attorneys with personal agendas to act as de facto regulators. As Lawrence Schonbrun observes:

The class action suit is not regulation in the sense of big, inefficient bureaucracy. Rather, it is the deputation of the nation's lawyers as "bounty hunters" to sue whomever they can legally assert has engaged in conduct injurious to large groups of individuals. In practice, it amounts to the lawyers suing whomever they believe vulnerable to a settlement and capable of paying large attorneys' fees.<sup>2</sup>

### **Returning Regulatory Authority to the Regulators: The Texas Solution**

Recognizing the threat to democratic principles and public accountability posed by regulatory class actions, the Texas Legislature in 2003 enacted comprehensive class action reform legislation that contains a specific provision designed to ensure that regulatory authority statutorily vested in administrative agencies will not be usurped by courts through regulatory class actions.<sup>3</sup> As a result, Texas courts are now required by law to consider whether the claims advanced by plaintiffs in proposed class actions are within the jurisdiction of state administrative agencies. If they are, the law requires the court to refrain from certifying the class. The essence of Texas's "administrative process" requirement is reflected in the following draft language, which this article proposes as a model for other states to consider:

Before hearing or deciding a motion to certify a class action, the court shall hear and rule on all pending motions asserting lack of jurisdiction because an agency of this state has exclusive or primary jurisdiction over the action or a part of the action, or asserting that a party has failed to exhaust administrative remedies. The ruling of the court shall be reflected in a written order. If a motion provided for in this Act is denied and a class is subsequently certified, a person may obtain appellate review of the order denying the motion as part of an appeal of the order certifying the class action.

While Texas was the first state to adopt a statutory administrative process requirement to curtail the growth of regulatory class actions, the idea for such a measure did not originate with the Texas Legislature. Indeed, an administrative process requirement was proposed as part of a model class action reform act developed by the American Legislative Exchange Council (ALEC) in 2000. In an article endorsing the ALEC proposal, attorney John Beisner cites judicial rulings in which courts decided on their own to deny class certifications because

administrative agencies were better situated than courts to resolve the matters in dispute.<sup>4</sup>

For example, in 1980 the U.S. Court of Appeals for the Ninth Circuit upheld a trial court's denial of class certification for a group of former military personnel seeking to recover a retroactive pay increase. Noting that the plaintiffs' claims were the subject of "ongoing administrative procedures," the appellate court observed that "any claims paid through the class action procedures would be reduced by the costs of the suit and attorneys' fees that plaintiffs sought."<sup>5</sup> In other words, assuming their case had merit, the members of the proposed class would fare better if their claims were resolved on an individual basis by the appropriate administrative agency, rather than through the costly and inefficient class action mechanism. Leaving no doubt as to the likely motivation behind the proposed class action, the court added, "The district court and this court cannot be unaware of the fact that the principal beneficiaries of the class action would be plaintiffs' attorneys."<sup>6</sup>

Such judicial deference is unusual, however. For the most part, trial courts continue to decide class certification issues without regard as to whether the issues presented might be better addressed by administrative proceedings. For that reason – as the Texas Legislature recognized – courts must be required by statute to defer to administrative agencies with jurisdictional authority over the subject of a proposed class action.

## **Regulatory Dispute Resolution: The Relative Merits of Agencies and Courts**

Not every regulatory class action concerns a dispute that lies within the jurisdiction of an existing executive branch agency. To a certain extent, class actions arise from an absence of institutions that can effectively channel contending parties and groups into less expensive and more efficient ways of resolving disputes. Government efforts to create such institutions have tended to be rare and unsuccessful. In the 1970s, for example, a bankruptcy reform commission established by Congress recommended that routine bankruptcy cases be diverted from federal courts into a newly created administrative agency, which, the commission believed, would be able to process them more efficiently and cost-effectively. The proposed reform bill, however, was opposed by a politically diverse coalition that included the American Bankers Association, the National Consumer Finance Association, the Department of Justice, organized labor and congressional leaders of both parties, all of whom expressed misgivings about creating a "new federal bureaucracy."<sup>7</sup>

Such apprehensions are understandable when the proposed reform would transfer adjudicatory and regulatory authority to a bureaucratic entity that does not yet exist but which, once established, would be directed from Washington under federal auspices. Americans are the heirs of a political tradition that is mistrustful of centralized bureaucratic authority, preferring instead to fragment authority among a variety of state and local institutions of government. But that does not mean that policymakers, interest group representatives and ordinary citizens should not welcome alternatives to regulatory litigation that make use of existing state-based administrative agencies. Arguably among the most experienced and professional of these are the insurance departments that exist in every American state, territory and the District of Columbia.

### *Regulatory Dispute Resolution and State Insurance Departments*

Most state insurance departments are established by statute, as is the office of insurance commissioner, which leads the department. Most commissioners are appointed by the governor, sometimes with the advice and consent of the state legislature or one of its chambers, and normally serve at the governor's pleasure. In a dozen states, however, insurance commissioners are directly elected by voters.

The basic mission of insurance commissioners is to execute the provisions of state law that regulate the insurance business, such as licensing and examination requirements. Insurance commissioners are typically granted broad statutory authority to promulgate rules and regulations, and to conduct hearings and render decisions in disputes over matters pertaining to the state's insurance laws. In Illinois, for example, the director of insurance is empowered "to conduct such examinations, investigations and hearings in addition to those specifically provided for, as may be necessary and proper for the efficient administration of the insurance laws of this State."<sup>8</sup>

This authority is usually circumscribed by the provisions of a state Administrative Procedures Act (APA), which generally requires that proposed rules be published and made available to the public; that public hearings be held before any rules are adopted; and that hearings be conducted according to basic constitutional norms of procedural fairness and efficiency.<sup>9</sup> For example, the APA (or in some states the insurance code itself) will typically require insurance departments to give prior notice of hearings and allow interested parties to testify, present evidence and cross-examine witnesses. Matters that are commonly the subject of insurance department hearings include license and revocation proceedings, rate filings, takeovers of domestic insurers and alleged instances of unfair trade or claims practices.<sup>10</sup>

In general, states place considerable emphasis on ensuring that insurance administrators have substantive expertise in the field of insurance, with statutes often requiring that regulators be selected on the basis of their “knowledge of the insurance industry.”<sup>11</sup> As Peter Bisbecos and Victor Schwartz observe, the expertise that regulators bring to their positions is enhanced through regular interactions with insurers, consumers and other interested parties.<sup>12</sup> In contrast to civil litigation, the defining characteristics of adjudicatory and regulatory proceedings conducted by state insurance departments are public accountability, expertise, efficiency, balancing of competing interests and attention to the economic and social consequences of their decisions.

Of course, no regulatory system is perfect. In particular, a system in which authority is dispersed among more than 50 separate jurisdictions, each with its own enforcement apparatus, will likely display individual variations in efficacy, transparency, procedural fairness and public accountability. The sources of insurance department dysfunction, when it occurs, are similar to those that afflict many other government bureaucracies. An insurance department may suffer from inadequate staffing and budgets. Civil service rules, while useful in combating political patronage and cronyism, may have the effect of protecting incompetent or underperforming staff. A department may be led by a politically ambitious commissioner who seeks to curry favor with voters by zealously pursuing a populist, anti-industry agenda.

Ignoring this latter tendency, some *soi-disant* consumer advocates and class action attorneys argue that, in fact, most regulators are little more than shells for the industry they are charged with regulating. The evidence for this canard consists mostly of anecdotes about regulators who took jobs in the insurance industry after leaving office. The implication is that regulators use their authority to ingratiate themselves with insurance companies, with the expectation that eventually they will be rewarded with a lucrative industry position.

As a general proposition, the notion that regulators are inherently biased in favor of the insurance industry is almost certainly wrong. In the first place, the record shows that regulators pursue a variety of career paths after leaving office. While some have gone on to work for insurance companies and trade associations, others have become governors, members of Congress, consumer activists, lawyers, academics and consultants (some of whom specialize in testifying as expert witnesses in lawsuits against insurers).

Second, nearly a quarter of the nation’s insurance commissioners are chosen directly by voters, who presumably would be loath to elect and re-elect regulators who are biased against them as consumers. In states where commissioners are appointed, few governors would jeopardize their own electability by installing an insurance commissioner who was widely perceived as “anti-consumer” and

“pro-industry.” Appointed commissioners are at least indirectly accountable to the voting public, in contrast to class action attorneys who are often not even accountable to their putative clients.<sup>13</sup>

Third, inasmuch as insurance is one of the most heavily regulated industries in the United States, it stands to reason that the type of individual who self-selects into the role of insurance regulator is someone who agrees with the fundamental premise of contemporary insurance regulation – that consumers benefit from aggressive government supervision of such matters as pricing, coverage terms and market conduct. Finally, even if it were true that regulators are biased in favor of insurers and against consumers, it hardly follows that the insurance regulatory function should be turned over to private lawyers and judges. In a democracy, the proper response to regulatory dysfunction is regulatory reform, undertaken by democratically elected lawmakers and public officials.

### *Regulatory Dispute Resolution and Civil Litigation*

Compared to administrative proceedings conducted by regulators, civil jury trials are remarkably ill suited as forums for addressing regulatory issues. Unlike administrative proceedings, civil trials are costly and time-consuming, in part because of lengthy jury selection procedures and the need to resolve disputes over what evidence and arguments must be suppressed to avoid misleading amateur decision makers.<sup>14</sup> Unlike professional regulators in administrative proceedings, civil jurors do not have access to written summaries of the issues and evidence in advance of the trial; hence, the whole story of the dispute must be presented to them orally, increasing the likelihood that complex information will be misunderstood or ignored. Whereas regulators in administrative hearings are free to engage advocates and witnesses at any point in the proceeding, civil jurors are not allowed to comment during trial to indicate that they are confused or satisfied on a certain point.<sup>15</sup>

The jury system entrusts judgment to a randomly chosen group of individuals who are not told about the applicable rules of law until after the trial is over, nor instructed how similar cases have been decided by other juries. Unlike regulators who preside over administrative hearings, jurors are not required to explain and justify their decisions, making it difficult for the parties and others affected by the policy implications of their decisions to understand why the jury acted as it did, or how to avoid accusations of wrongdoing in the future.

What is more, numerous experiments confirm law professor George Priest’s observation that the typical civil jury trial is an “an engine of inconsistency.”<sup>16</sup> In one study, researchers affiliated with the University of Chicago Jury Project asked judges who had presided over jury trials how they would have decided

the case had it been a bench trial. In 79 percent of the cases, the judge agreed with the jury.<sup>17</sup> That may appear encouraging until one considers that it is impossible to tell in advance whether any particular jury will be the one in five that behaves capriciously. Referring to two asbestos cases over which he presided, a Philadelphia judge commented: “Two men had similar physical problems. They each had pleural thickening and some shortness of breath. In the case involving the man who counsel believed to be the sicker of the two, the jury awarded \$15,000. For the other plaintiff, the jury awarded \$1.2 million. These results make this litigation more like roulette than jurisprudence.”<sup>18</sup>

Another study compared verdicts by different juries in three series of cases. One sequence of cases concerned claims of harm from the morning sickness drug, Bendectin; the second sequence of cases involved an alleged defect in Audi automobiles; and the third sequence of cases involved an assortment of several other allegedly dangerous products. In each of the case sequences, most juries found either that the product in question was not defective or that the product was not responsible for the plaintiffs’ injuries. However, in each sequence there was at least one jury that, hearing the same evidence as the juries that found no liability, decided otherwise and awarded massive compensatory and punitive damages. Although the defendants prevailed in the overwhelming majority of cases, the average award was in the millions of dollars.<sup>19</sup>

The inconsistent results of jury trials may have less to do with jurors and juries per se than with the dominant role played by the parties’ lawyers. Information on causation is provided by dueling, lawyer-coached expert witnesses, who typically present different kinds of scientific or technical evidence at widely separated points in the trial. Trial lawyers’ cross-examination of witnesses is designed more to obfuscate and generate contradictions than to inform, leaving many jurors bewildered and confused.<sup>20</sup>

In part because of their unpredictable outcomes and high cost, jury trials do not occur in 95 percent of civil lawsuits.<sup>21</sup> Instead, information gathered in pretrial discovery becomes the basis for a settlement. Yet compared to administrative proceedings, the pretrial discovery and negotiation process is costly, inefficient and slow. U.S. Court of Appeals Judge Ralph K. Winter, a member of the federal courts’ Advisory Committee on Civil Rules, discloses that “in private conversations with lawyers and judges, I find precious few ready to argue that pretrial discovery involves less than considerable to enormous waste.” He notes that the Advisory Committee found that a “no-stone-left-unturned ... philosophy of discovery governs much litigation and imposes costs, usually without corresponding benefits.” Moreover, “discovery is sometimes used as a club against the other party solely to increase the adversary’s expenses.”<sup>22</sup> As if to illustrate Judge Winter’s point, a *New York Times* profile of legendary class action

attorneys William Lerach and Melvyn Weiss offered the following synopsis of the tactics that made them successful litigators:

Mr. Lerach played the bad cop, taking on defendants frontally and battering them with threats, insults and a raft of legal filings. He regularly courted the media, both to raise his own profile and to shine an embarrassing spotlight on defendants in an effort to persuade them to settle rather than litigate. Mr. Weiss, though comfortable in the guise of good cop, still wasn't above leaking information to the press or issuing threats himself. But he usually preferred to negotiate behind the scenes, promising to save defendants from unnecessary ignominy.<sup>23</sup>

If they insist on a jury trial, American litigants must endure extraordinary delays. In 1988, the average civil case tried in the Circuit Court of Cook County, Illinois, had been filed more than six years earlier.<sup>24</sup> While delays are not that great in every jurisdiction, the trend in most is toward ever-lengthier delays. In 1942, the median time between filing and trial of a civil case in Los Angeles was 4.2 months; that figure grew to 19 months by 1962 and 41.5 months (almost three-and-a-half years) by 1982.<sup>25</sup> In 1987, the median time from filing to jury trial was more than three years in Detroit and almost five years in Providence, R.I.<sup>26</sup>

Commenting on this state of affairs, law professor Albert Alschuler concludes: "The civil trial is on its deathbed, or close to it, because our trial system has become unworkable. The American trial has been bludgeoned by lengthy delays, high attorneys' fees, discovery wars, satellite hearings, judicial settlement conferences, and the world's most extensive collection of cumbersome procedures. Few litigants can afford the cost of either the pretrial journey or the trial itself."<sup>27</sup>

As problematic as jury trials are, the alternative that the court system offers – negotiation between lawyers based on pretrial discovery – is hardly an improvement, given the prominent role played by non-legal factors such as cost and delay, and the parties' relative ability to sustain them. Moreover, precisely because so few cases actually go to trial – and because those that do produce widely divergent outcomes – trial lawyers who engage in settlement negotiations have little empirical basis for predicting a case's likely outcome at trial. In one experiment, five experienced New York trial lawyers were asked to read the files and estimate the recovery value of 59 settled cases. Forty percent of the actual recoveries were less than two-thirds the amount the experts predicted; the median recovery was only about 75 percent of the experts' estimates. What this says is that the legal system is so unpredictable that even experienced trial lawyers are unable to predict the outcome of jury trials. As one lawyer candidly stated in an academic survey of attorneys:

I started out as a plaintiffs' trial attorney with a strong belief in the jury system. ... I don't believe that anymore. I think ... it behooves you to do anything possible to avoid it. ... You can go through all the different systems, whether it be family law through divorce, product claims, malpractice claims, securities litigation, you know, virtually every category of major litigation. ... Is it predictable, reliable in terms of a rule? Are the transaction costs reasonable in terms of a result? Does it provide guidance for the future? Not a single one of these systems would even get a passing grade.<sup>28</sup>

### *Generalist Judges and Abusive Lawyering*

Nearly every state has specialized courts for family issues, juveniles and small claims, while the federal system operates special courts for bankruptcy and patent appeals. However, most civil lawsuits – including regulatory class actions – are presided over by “generalist” judges. In contrast to insurance regulators, whose exclusive purview is insurance law and regulation, a judge who hears a case involving insurance regulation may never have heard an insurance-related case before. He or she must rely on the litigants' attorneys to point out the relevant statutes, precedents, facts and arguments. Encouraged by an activist judicial culture, the generalist judge is more likely than a professional regulator to rely on his personal values to reach a result that he thinks is just.<sup>29</sup> In contrast to professional regulators, who are required by the laws of most states to be experts in their fields, state judges typically come to the bench after prior careers as practicing lawyers, prosecutors or political activists.<sup>30</sup> Not surprisingly, attorneys often tell their clients that the legal outcome of a case depends on which judge ends up hearing it.

Regulators are guided by professional norms that emphasize thorough fact-finding, objective analysis and careful consideration of the public interest. The tactics used by lawyers in high-stakes litigation, on the other hand, are often intended to obscure facts while adding to the economic burdens of litigation as a way of forcing their adversaries to agree to a settlement. A survey of Chicago lawyers revealed that more than 80 percent of them had deliberately abused discovery tools in at least 40 percent of their cases – for example, by sending huge numbers of documents to opponents in hopes of both unnecessarily adding to their workload and obscuring crucial information.<sup>31</sup> Such strategies are hardly conducive to informed regulatory decision-making. Nor, for that matter, is the tendency of class action attorneys to pursue outcomes that primarily benefit themselves, rather than their putative clients. As law professor John C. Coffee observes, “The modern class action ... has long been a context in which opportunistic behavior has been common and high agency costs have prevailed. Settlements have all too frequently advanced only the interest of plaintiffs' attorneys, not those of class members.”<sup>32</sup>

## The Insurance Regulatory Class Action: Three Illustrative Cases

The tendency of class action litigation to subvert and destabilize the process of insurance regulation has been amply demonstrated in recent years. Here are three examples, each of which illustrates a particular failing of insurance regulatory class actions:

### *Administrative Error and Attorney Self-Dealing: The Premium Double-Rounding Cases*

In 1995, a lawyer-driven dispute over the proper method for calculating auto insurance premiums in Texas led to the simultaneous filing of a pair of class action lawsuits against two of the state's largest auto insurers on behalf of more than 4.4 million policyholders.<sup>33</sup> In Texas, insurance companies writing private passenger motor vehicle policies are required to round off premiums to whole dollars. This much is clear from the *Texas Automobile Rules and Rating Manual*, which directs insurers to "Round the premium for each peril, coverage and exposure for which a separate premium is calculated, to the nearest whole dollar. Round a premium involving \$.50 or over to the next higher whole dollar: e.g. 100.50 = 101.00, but 100.49 = 100."<sup>34</sup> When applied to premiums on an annual basis, the "whole-dollar rounding" rule was considered fair because its effect over the long run would be neutral: that is, about half the premiums would be rounded up and about half would be rounded down. The Texas Department of Insurance (TDI) also prescribed a pro-rata method for determining how premiums should be calculated for terms of less than a year.

The rating manual, however, did not explicitly indicate whether the whole-dollar rounding method should be used to calculate semiannual, monthly or quarterly premium payments. Two insurers, Allstate and Farmers, assumed that the rule applied to *all* premium charges, so for policies of less than a year's duration, they performed the rounding process twice, once when the annual premium was calculated and again after making the pro-rata computation for a six-month or shorter term. It turned out, however, that by "double-rounding" in this way, an insurer could collect an extra dollar on 25 percent of all six-month policies, because rounding twice a year (once for each six-month period) results in upward rounding 75 percent of the time rather than 50 percent of the time. Because rounding was done for each *individual coverage* type (e.g., liability, uninsured motorist, medical payments, collision, etc.) in the calculation of a total auto policy premium, the attorneys who brought the suit claimed that on a per-motor-vehicle basis, the *average* consumer would be overcharged about \$3 per year. Given that the defendants' combined sales accounted for three out of every 10 Texas auto insurance policies, and given the plaintiffs' theory that the insurers

had been double-rounding for 10 years, the litigation, when brought as a class action, was thought to be worth more than \$100 million.<sup>35</sup>

The original petition accused the insurers of breach of contract for failing to charge the lawful rate for private passenger motor vehicle insurance policies; later, the plaintiffs added an additional cause of action under the Texas Deceptive Trade Practices Act (DTPA). Under the DTPA, the plaintiffs were able to seek treble damages in addition to recovery of the \$100 million in alleged overcharges.

The class action attorneys made these charges in spite of the fact the insurers had been assured repeatedly by the TDI that they were following the law. The defendants produced correspondence from 1985 between Allstate and a TDI employee who indicated that the company was required to round both the annual and six-month premiums; a 1981 letter from the TDI flatly stated:

Rule 9 provides that a policy may be issued for a six month period at 50 percent of the annual rates or premiums. This office has consistently ruled that the annual premium is figured in the normal fashion, rounded to the nearest dollar (.50 or over). Then a 6 month policy would be figured at 50 percent of the annual rounded premium, and then rounded again.<sup>36</sup>

The plaintiffs responded to this letter simply by asserting that it was incorrect and had no official standing. “It’s no defense to the violation of law that they got bum advice from a bureaucrat,” said lead plaintiff attorney John Cracken in one news article.<sup>37</sup> The plaintiffs also brushed aside the TDI’s exclusive authority to regulate premiums. According to Texas law, the “[State] Board [of Insurance] shall have the sole and exclusive power and authority and it shall be its duty to determine, fix, and promulgate just, reasonable and adequate rates of premium.”<sup>38</sup> The TDI is further authorized to issue uniform rules: “The State Board of Insurance may prescribe, promulgate, adopt, approve, amend, or repeal the standard and uniform manual rules, rating plan ... for motor vehicle insurance ... under the procedures specified in this article.”<sup>39</sup>

Having dismissed the possibility that the TDI might have some actual authority over the matter at hand, the plaintiff attorneys began searching the state for the ideal trial venue. They found it in Crystal City, a tiny town in sparsely populated Zavala County, located on the Mexican border in southwest Texas. Though it contains less than 1 percent of all Texas automobile policyholders, Zavala County is one of the poorest counties in the state, and had a reputation for being so “plaintiff-friendly” that railroads reportedly had torn up their tracks there in order to prevent lawsuits.<sup>40</sup>

To file the suit in Zavala County, the plaintiff attorneys first needed to locate and recruit Allstate and Farmers automobile policyholders who lived there. Eventually they succeeded, but the hunt for plaintiffs caused some in the media to ask if the litigation was lawyer-driven. In response, plaintiff attorney Cracken offered a ringing defense of “entrepreneurial litigation”:

Entrepreneurial litigation is litigation where the trial lawyer discovers a massive wrong and spends a lot of time and money righting that wrong for a 25 percent to 30 percent share of the total recovery. . . Entrepreneurial litigation is vital to society because in the absence of it, companies who do business with millions of consumers can tweak the math in calculating consumers’ bills and build a huge cache of illegal cash. . . *It ensures that someone is looking over the shoulder of big business as they deal with millions of consumers.*<sup>41</sup> (Emphasis added.)

The premise behind this conceit is that regulatory enforcement agencies such as the TDI are either non-existent or ineffectual. In fact, the TDI conducted a rigorous investigation soon after the case was filed. Nearly a full month before the scheduled date of the class certification hearing, the insurance commissioner issued a press release that set forth his analysis of the double-rounding controversy and announced his decision not to pursue punitive action against the insurers:

“The existing rounding rules are confusing and unclear, particularly with respect to car insurance,” [Commissioner Elton] Bomer said. “Information has now come to my attention that before 1991, former TDI Auto Section staff managers and technicians consistently advised companies to double-round. TDI staff today believes, as I do, that single rounding is the only correct procedure. However, this interpretation in favor of single rounding never has been communicated to the industry. The current rounding rules were not amended, and staff acknowledges that questions about them simply have not arisen in recent years. It would be unfair, therefore, for the Department to take enforcement against any company for double rounding.”<sup>42</sup>

The TDI did not let matters rest there, however. It continued to pursue its regulatory mission, despite the trial court’s decision to certify the class, and despite the Texas Supreme Court’s rejection of the defendants’ argument that the matter should be resolved by the TDI rather than the courts. While the defendants awaited a decision on their appeal of the class certification ruling, the TDI held public hearings on a clarified rounding rule, which led to the formal adoption of single-rounding rules for auto insurance that would take effect

November 1, 1996.<sup>43</sup> Moreover, TDI disclosed that the defendants had entered into an agreement with the department to refund or credit all overages from double-rounding charged on or after the date of the press release that announced Bomer's initial findings. The agreement also restated Bomer's position that for nearly 20 years before 1991, the agency had interpreted the rules in a manner consistent with double-rounding and that the insurers could reasonably have relied upon this advice.<sup>44</sup>

When the defendants' appeal of the class certification ruling was denied, the case moved into the inevitable settlement phase. Notwithstanding the TDI's finding that the insurers had operated in accordance with TDI instructions, the insurers were understandably concerned about the possibility of a "monster" verdict from Zavala County jurors, especially in the wake of an aggressive media campaign that had been mounted by the plaintiffs' attorneys.<sup>45</sup>

The parties eventually agreed to a settlement plan that called for the insurers to make available \$35.7 million to the 4,401,817 members of the plaintiff class.<sup>46</sup> The settlement agreement estimated a net recovery to each class member of \$5.57. Class members who were current or recent policyholders (and for whom current mailing addresses were, therefore, available) would be mailed a check in that amount. However, more than 60 percent of the class members had not been active policyholders of either of the two insurers for more than 10 years. Because they lacked current mailing addresses for these individuals, the settlement called for the insurers to notify this group of nearly 2.9 million former policyholders by placing quarter-page advertisements in two consecutive Sunday editions of the 20 largest Texas daily newspapers.<sup>47</sup>

The ads gave instructions on how to obtain and submit a claim form in order to receive a check for \$5.57. By the time the payout period expired six months later, the two insurers had received fewer than 350 claim forms, resulting in a payout of less than \$2,000.<sup>48</sup> Thus, most of those eligible to collect the meager per-claimant payout never bothered to do so, and most of the money allocated to class members was never disbursed.

The plaintiffs' attorneys, however, calculated their fee based on the total amount that the settlement made available to class members – \$35.7 million. According to the terms of the settlement, their fee was to be 28.99 percent of that sum, or \$10,349,430. To that they added \$1,612,407 in costs. Incredibly, the plaintiffs' attorneys argued that their fee was reasonable because, in addition to the recovery they obtained for their "clients" (most of whom never collected), the litigation had prompted the TDI to amend its regulations to clearly forbid double-rounding. The plaintiffs estimated this benefit to have been worth \$31 million, based on their assumption that the defendants would have continued double-rounding on those class members who were still active policyholders for

the next decade. Thus, the plaintiffs' attorneys declared, the benefit to the class was not merely \$35.7 million, but more than \$71 million.<sup>49</sup>

This exercise in self-justification implies that the TDI willfully ignored the double-rounding issue, and finally took action only when confronted by adverse publicity generated by the lawsuit. But in fact, no insurance consumer had ever complained to the TDI about double-rounding, and there is no evidence the TDI was aware of the problem. There are no grounds for believing the TDI would have failed to take corrective action once the problem was brought to light, irrespective of whether the class action had been allowed to proceed.

If, when the lawsuit was filed as a class action, the Texas courts had been operating under the administrative process requirement that is in effect today, the matter could have been swiftly and equitably resolved by the TDI, without the self-aggrandizing intervention of class action attorneys. It is true that the TDI's eventual decision not to hold the insurers responsible for what the agency acknowledged was its own error did not result in the policyholders being fully reimbursed for past overcharges. However, as we have seen, not only were the amounts in question trivial, but under the circumstances it was never realistic to think the class action mechanism was capable of providing an appropriate remedy to the majority of class members. Instead, the clear purpose and effect of the litigation was simply to enrich the plaintiffs' attorneys at the insurers' expense.

### *Creating a Monopoly by Judicial Fiat: The Automobile Replacement Parts Case*

The double-rounding cases demonstrate how regulatory class actions can be used to exploit technical ambiguities in the administration of insurance regulation, to the almost exclusive benefit of the plaintiff attorneys who bring suit. Aside from the financial windfall that accrued to a handful of lawyers, the double-rounding cases achieved nothing from a regulatory standpoint that could not have been accomplished more efficiently had the matter been referred to the state insurance department. However, a different scenario was played out in *Avery v. State Farm*,<sup>50</sup> a 1999 Illinois case that concerned the common insurance industry practice of specifying the use of generic brand "aftermarket" collision repair parts in lieu of original equipment manufacturer (OEM) parts for insured auto repairs.

In *Avery*, plaintiff attorneys persuaded an Illinois trial court effectively to prohibit this practice nationwide, despite the fact that it had been carefully examined by Congress and the legislatures of all 50 states. Throughout the 1970s and '80s, automakers had lobbied to protect their dominance of the replacement

part market by urging legislation to prevent insurers from using less costly generic versions of OEM parts. Dozens of bills were introduced, rules proposed and hearings held. In the end, Congress and the legislatures and insurance regulators of every state declined to prohibit the use of generic parts. Indeed, because insurers' use of non-OEM parts generates market competition that helps reduce claim costs, thus leading to lower premiums for consumers, two states – Massachusetts and Hawaii – passed laws *requiring* insurers to use generic parts.

None of this mattered in the world of the regulatory class action. Plaintiff attorneys were able to designate some five million current and former State Farm auto insurance policyholders from throughout the United States as an aggrieved class, on whose behalf they filed a complaint alleging that State Farm had defrauded its policyholders by specifying generic crash replacement parts for insured auto repairs – even though the policy agreement clearly stated that generic parts could be used. There was no evidence to suggest that generic parts were categorically inferior to OEM parts, as the plaintiff attorneys had claimed, nor had any of the plaintiffs suffered economic or personal injury. Indeed, the class contained members who had never had generic parts installed in their vehicles.

After being rebuffed by courts in several states, the plaintiff attorneys eventually found a circuit court judge in rural Marion, Ill., who was willing to certify the class. At trial, the judge refused to admit evidence showing that the use of generic parts results in substantial savings for policyholders – a key consideration of the legislators and regulators who had previously examined the issue. The jury responded by ordering State Farm to hand over \$1.2 billion. Of this, \$600 million was for punitive damages, which was supposed to “send a message” to other potential wrongdoers to change their behavior.

The message to State Farm and every other auto insurer was, “If you want to avoid getting sued and losing hundreds of millions of dollars, use only replacement parts made by the automakers.” The verdict caused not only State Farm, but also Nationwide, Travelers, MetLife and other insurers to stop specifying the use of generic auto parts.<sup>51</sup> The Marion judge and jury succeeded in creating a highly lucrative monopoly for the automakers in what was becoming an increasingly competitive market – in direct contravention of the considered judgments of lawmakers in Congress and every state legislature.

Eventually, after nearly six years of appellate litigation, the Illinois Supreme Court reversed the trial court verdict, declaring in August 2005 that “it was an abuse of discretion for the circuit court to certify plaintiffs’ breach of contract claim as a class action.”<sup>52</sup> The case should never have been certified, the Supreme Court explained, because of glaring differences among members of the plaintiff class with regard to such fundamental matters as the language in their policy

agreements and whether they actually had non-OEM parts installed in their vehicles.

Given the time and money devoted to achieving this result, the Supreme Court decision was something of a Pyrrhic victory for State Farm and its policyholders. But consider: If a Texas-type administrative process rule had been in effect when the case was filed in 1997, the circuit court would have been obliged to consider whether the Illinois Division of Insurance should decide the generic parts issue before certifying the class. If the circuit court somehow fabricated a rationale for denying jurisdiction to the insurance department, its decision could have been appealed immediately. Eight years of litigation that cost State Farm policyholders millions of dollars would have been avoided,<sup>53</sup> and the six-year interregnum during which competition was essentially eliminated from the replacement auto parts market would never have occurred.

The trial court that decided the *Avery* case was, like courts in general, ill equipped to consider the policy implications of its intervention into the insurance regulatory process. None of the actors responsible for the decision – not the jury, nor the judge, nor the attorneys – were in any way accountable to the millions of motorists whose auto insurance premiums would be affected by their judgment. An insurance commissioner, by contrast, would have had a strong incentive to consider the interest of the larger public in the generic parts controversy. Whether directly elected or appointed by a democratically elected governor, insurance commissioners have a duty not only to protect consumers from allegedly fraudulent and unfair business practices, but also to keep insurance coverage affordable by maintaining a competitive marketplace for insurance-related goods and services.

### *Credit-Based Insurance Scoring: The Next Target of Regulatory Class Actions?*

One of the more contentious issues confronting state legislatures and insurance departments in recent years concerns insurers' use of consumer credit scores to partly determine whether an auto or homeowners policy should be issued, and at what price. As they seek to determine the appropriate regulatory approach to credit-based insurance scoring, legislators and regulators must weigh a variety of competing interests and arguments.

For example, some critics of "insurance scoring," as the practice is known, maintain that credit scores are sometimes based on inaccurate reporting data and that they fail to account for mitigating circumstances that ought to be considered when evaluating an individual's financial stability. Insurers, on the other hand, point to several credible studies that demonstrate conclusively that an individual's experience managing credit is a strong predictor of whether he or

she will file a claim for automobile or homeowners insurance, and the potential size of losses.<sup>54</sup> Some critics seem willing to concede the existence of a statistical correlation between credit scores and insurance risk, but regard the correlation as somehow invalid because insurers, in their view, have not satisfactorily explained the reason for the correlation. Insurers reply that the reason is immaterial; what matters is that credit-based insurance scoring improves risk assessment. That, in turn, helps reduce the extent of cross-subsidization among risk classes, which lowers the cost of insurance for low-risk individuals and increases the availability of coverage.

By the end of 2003, no fewer than 39 states had considered legislation to regulate insurance scoring, and in 2004 more than 40 bills were introduced in 27 states. Many of these bills were based on a model act developed by the National Conference of Insurance Legislators (NCOIL) in November 2002.<sup>55</sup> The NCOIL approach permits insurers to use credit-based insurance scores as an underwriting and rating tool in most instances, but prohibits their use as the “sole basis” for denying, canceling or non-renewing a policy, or for increasing rates.

In the absence of legislation that would prohibit class certification in cases where an agency has jurisdiction over the matter in dispute, it is conceivable that courts will soon begin supplanting legislators and regulators in determining how laws governing insurers’ use of credit information should be interpreted and enforced. A pending class action filed in Illinois in 2002 provides a cautionary tale. Plaintiffs in *Hoffman v. State Farm Mutual Automobile Insurance Company*<sup>56</sup> allege that State Farm violated the “sole use” provision of the Illinois insurance code by refusing to issue or renew policies solely because of a credit report – even though the insurer cited other factors for its decision, such as a negative claim history. Remarkably, the plaintiffs acknowledge that other negative rating factors were considered by State Farm, but insist that these merely served as a “pretext” for taking action based solely on a credit report.<sup>57</sup> A class certification hearing was scheduled for June 27, 2005.<sup>58</sup>

Whatever the outcome of the *Hoffman* case, the plaintiffs’ “pretext” argument could be easily transported to courts in any of the growing number of states with insurance scoring laws based on the NCOIL model. As we have seen, it is virtually impossible to predict how any particular jury in any particular jurisdiction would rule on such a matter – which is one reason why regulatory class actions are such poor mechanisms for settling disputes over public policy issues. It may seem bizarre to suggest that an insurer’s adherence to a law was simply a ruse that allowed it to violate that same law. However, given what occurred in the non-OEM parts class action, it is not difficult to imagine the “pretext” argument – or another that is no less implausible – leading to a jury verdict that would upset the

careful efforts of legislators and regulators to craft a policy on insurance scoring that serves the public interest.

### **Private Agendas vs. the Public Interest**

Unlike regulators, private class action attorneys are free to ignore legislative mandates and the broader public interest because they are accountable only to themselves. Yet, plaintiff attorneys often cite their lack of public accountability as a virtue, in contrast to government regulators, whom they chide for not being sufficiently “activist.” Defending the *Avery* decision in a press interview, attorney David A.P. Brower insisted that “[t]he insurance commissioners in Illinois didn’t do anything about [insurers’ use of generic parts], and I don’t know if any insurance commissioner has done anything about the OEM parts cases.” Far from failing to “do anything,” the insurance commissioners in Illinois and other states had followed the will of their respective legislatures. “I think regulators, insurance commissioners, the Securities and Exchange Commission, the consumer affairs departments of the states are very busy,” Brower continued. “And they have political agendas, and in some cases they have people they have to answer to.”<sup>59</sup> Those “people,” it should be noted, are the citizens’ representatives – democratically elected governors, presidents and legislators.

Do class action attorneys have agendas? William Lerach, a leading practitioner, answers thusly: “We’re no angels. We’re driven by the profit motive just like everyone else. I make more money in one month sometimes than my father made in his entire life.” Adds Lerach’s erstwhile partner, Melvyn Weiss: “Am I in it for the money? Yes.”<sup>60</sup>

### **Why Judicial Deference to Administrative Authority Should be Statutorily Mandated**

It is important to emphasize that the voluntary deference to administrative authority displayed in the federal rulings described earlier in this article is unrepresentative of the dominant mindset among judges and other legal elites. Instead of acknowledging the inappropriateness of regulatory class action litigation, the culture of the modern American legal profession encourages judges and lawyers to serve as *de facto* regulators.

The only way to ensure that class action lawyers and judges will defer to administrative authority is to impose deference by statute. Mandatory deference is necessary because – unlike their counterparts in other democratic nations – American lawyers, judges and law professors have created a body of legal ethics that exhorts courts to act as policymaking and regulatory bodies, rather than as mere adjudicators of disputes between private litigants. American lawyers’

codes of ethics endorse zealous advocacy of clients' causes without regard to the interests of justice in the particular case or to broader social concerns.<sup>61</sup> Their professional norms encourage them to advance unprecedented legal claims, coach witnesses and attempt to wear down their opponents through burdensome pretrial discovery.

Regulatory class actions are the product of an activist legal ideology that is vigorously disseminated by legal elites and accepted by large segments of the legal profession. Reflecting their belief that courts should serve as policymaking bodies, American legal scholars tend to speak of law not as a logically coherent set of neutral principles and rules, but as a set of tools for achieving better government.<sup>62</sup> According to law professors P.S. Atiyah and Robert S. Summers, "American law schools have been the source of the dominant general theory of law in America ... 'instrumentalism' ... [which] conceives of law essentially as a pragmatic instrument of social improvement."<sup>63</sup> Thus, observes political scientist Robert Kagan, "the language of the American law school classroom is the language of policy analysis. Law reviews bristle with arguments for new legal rights, not for legal stability. American legal scholars tend to celebrate those American judges who feel authorized or even obligated to 'do justice' when the other bodies of government have 'failed' to take action against social problems."<sup>64</sup> In such a milieu, it is naïve to suppose that many judges will voluntarily decline to certify a class in favor of allowing an administrative agency to assume jurisdiction. It is not simply hubris or vanity that prevents them from doing so, but a professional culture that regards courts and litigation as superior instruments of public policymaking.

## Conclusion

Experience shows that modern class action litigation is a deeply flawed mechanism for resolving disputes between private parties. In cases where the defendant is an insurance company and the object of the suit is to alter the regulatory regime under which the insurer operates, the excessive cost, inefficiency and unfairness of the class action system can produce results that are detrimental not just to the named parties, but to society as a whole. The overall effect of judicial usurpations of insurance regulatory authority is to subvert and destabilize the regulation of insurance, thus adding to the cost and decreasing the availability of insurance products.

States can remedy this problem by enacting legislation that would require trial courts to refrain from certifying a proposed class action if the claims at issue are within the jurisdiction of a state administrative agency, such as an insurance department. Such a law will help ensure that professional competence, procedural fairness and public accountability are the hallmarks of insurance regulation.

## Endnotes

1. Alexis de Tocqueville, *Democracy in America*, Vol. 1 (Knopf, 1945), p. 290.
2. Lawrence Schonbrun, "The Class Action Con Game," *Regulation*, Fall 1997, pp. 50–51.
3. Texas H.B. 4, Sec. 26.051, reads as follows:  
STATE AGENCY WITH EXCLUSIVE OR PRIMARY JURISDICTION.  
(a) Before hearing or deciding a motion to certify a class action, a trial court must hear and rule on all pending pleas to the jurisdiction asserting that an agency of this state has exclusive or primary jurisdiction of the action or a part of the action, or asserting that a party has failed to exhaust administrative remedies. The court's ruling must be reflected in a written order.  
(b) If a plea to the jurisdiction described by Subsection (a) is denied and a class is subsequently certified, a person may, as part of an appeal of the order certifying the class action, obtain appellate review of the order denying the plea to the jurisdiction.  
(c) This section does not alter or abrogate a person's right to appeal or pursue an original proceeding in an appellate court in regard to a trial court's order granting or denying a plea to the jurisdiction if the right exists under statutory or common law in effect at the time review is sought.
4. John Beisner, "Discussion of the Class Action Improvements Act," *Disorder in the Court: A Guide for State Legislators* (American Legislative Exchange Council, 2003), pp. 53-55.
5. *Pattillo v. Schlesinger*, 625 F.2d 262 (9th Cir. 1980), at 265.
6. *Ibid.*
7. Jeb Barnes, "Bankrupt Bargain? Bankruptcy Reform and the Politics of Adversarial Legalism," *Journal of Law & Politics*, Vol. 13 (1997), p. 893.
8. 215 Ill. Comp. Stat. 5/401 (c).
9. Peter M. Lencsis, *Insurance Regulation in the United States: An Overview for Business and Government* (Quorum Books, 1997), p. 15.
10. *Ibid.*
11. See, e.g., Ind. Code § 27-1-1-2.
12. Peter A. Bisbecos and Victor E. Schwartz, "The Damaging Effect of Regulation of Insurance by the Courts," National Association of Mutual Insurance Companies, 2002, p. 10.
13. This phenomenon was openly acknowledged by renowned class action attorney William Lerach, who declared in a 1993 interview, "I have the greatest practice of law in the world. I have no clients." *Forbes*, Oct. 11, 1993.
14. Walter Olson, "The Jury Selection Ordeal," *Wall Street Journal*, Dec. 7, 1994, p. A19.
15. John C. Reitz, "Why We Probably Cannot Adopt the German Advantage in Civil Procedure," *Iowa Law Review*, Vol. 75 (1990), p. 989.
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# The Critical Role of Insurance Class Actions

By  
D.J. Powers, J.D.

## Introduction

Insurance has long been recognized as a business affected with the public interest.<sup>1</sup> Not only is insurance an economic necessity, in many cases the state or federal government requires consumers to purchase it. Drivers must purchase auto insurance, homebuyers with mortgages must purchase homeowners insurance and employers in almost every state must purchase workers' compensation insurance. Thus, not only does the government have the power to ensure that insurers comply with the law, it has the *duty* to do so.<sup>2</sup> This article will show the critical role insurance class actions fill in realizing that public policy goal.

Regulation is one method of making insurers follow the law, but it cannot do the job alone. The structure of the regulatory system creates a strong regulatory bias in favor of insurers, and the repeated failures of regulators across the country to protect consumers from illegal practices confirm this fundamental problem. To realize the public policy goal of making insurers follow the law, consumers need alternative protections. The insurance class action serves that role.

The first section of this paper will analyze the structure of the insurance regulatory system and show why it is profoundly biased in favor of insurers and against consumers. Those structural flaws include:

- Decision makers who mostly come from the insurance industry before serving and return to the industry after serving.
- Decision makers who receive information from only one side – the insurer's side.
- A system where the consumer is not allowed to participate or lacks the resources to participate in the decision-making process.
- A system that does not provide a realistic way for consumers to hire the attorneys and experts they need to present their side.
- A system that allows insurers to easily out-resource the agency.
- A system where the decision maker meets *ex parte* with the insurer to hear their side and even resolve the dispute without any consumer or public participation.

This section will also show how the insurance class action provides the appropriate remedy for those problems.

The second section of this paper will apply this analysis to the Texas double-rounding class action.<sup>3</sup> That case represents an excellent example of the critical role of the insurance class action. In that case, the class action attorneys discovered that the insurers were overcharging consumers by tens of millions of dollars. The regulator *agreed that the companies were violating the law*. Moreover, one of the two insurance company defendants admitted that the practice resulted in overcharges. Yet, after intense *ex parte* lobbying by the insurers, the commissioner failed to make them pay back the overcharges to consumers. The class action filled the void left by the regulator's failures to identify the illegal conduct and to obtain refunds for consumers.

### **Insurers Want to Resolve Disputes in the Agency Because They Know the Regulatory System Is Deeply Biased in Their Favor**

The structure of insurance regulation creates the bias in favor of the regulated industry. This paper is not a criticism of regulators or individual agency employees, most of whom are hard-working and dedicated employees. Instead, the analysis recognizes that the system is imperfect, and that this imperfection almost always favors insurers. Examples of regulatory failures to enforce the law abound.<sup>4</sup>

While insurers already know they will pay less of what they owe when a regulator decides the dispute than when a court does, at least one regulator felt the need to let other class action defendants in on this trick-of-the-trade. A Houston attorney sued several rental car companies in a class action for selling insurance without a license.<sup>5</sup> When the insurance regulator learned of the case, his staff sent a letter to the rental car companies encouraging them to make a deal with the regulator. The agency explained that with the regulator the companies would only have to pay an "amount of restitution that is a small fraction of the amount" owed under the law.<sup>6</sup> The companies jumped at the opportunity and the regulator followed through on his word. The deal he cut allowed the companies to pay back only a small portion of what they owed, but receive a waiver of liability.<sup>7</sup>

There are numerous ways in which the structure of the regulatory system is biased in favor of insurers. This paper will not be able to discuss all of them. However, an analysis of some of the key structural components of the regulatory system, along with a comparison to the structure of the insurance class action, reveals there is a critical role for the insurance class action in the overall public policy goal of making insurers follow the law.

### *The Decision Maker*

The primary argument insurers make against insurance class actions is that the regulator is better equipped to resolve the dispute than a judge.<sup>8</sup> For a variety of reasons, a judge is more impartial and as skilled, if not more skilled, in fairly and equitably resolving the dispute.

Resolution of the insurance class action complaint is a judicial function, not a legislative function. The very premise of the insurers' argument that the regulator is better equipped to resolve the dispute than a judge is erroneous. By simply labeling the class action as a "regulatory class action," they claim that a court's exercise of jurisdiction over the case violates the separation of powers doctrine because, they allege, the judge is engaging in regulation. But in making that argument, insurers ignore the fact that adjudicating the class action dispute is a *judicial* function, not a regulatory function.

The issue in an insurance class action is to interpret and enforce *existing law*. That is quintessentially a judicial function. The very core of the judicial function is to *adjudicate claims* for violations of existing law. Since 1803, it has been clear that an American court's role is to determine whether a defendant broke the law:

It is emphatically the province and duty of the judicial department to say what the law is.<sup>9</sup>

Insurance class actions determine whether the insurer broke or is breaking existing law, so the court's exercise of jurisdiction does not violate the separation of powers doctrine. The court exercises a classic judicial function: Declare what the law is and then enforce that law.

This is not to say that regulators do not have a role in enforcing the law. They do. However, that role is to punish wrongdoers, not resolve disputes between parties. This is the commissioner's quasi-criminal disciplinary power. It provides the commissioner with the power to revoke a license if a company has violated a statute or agency rule. In lieu of the cancellation or revocation, the commissioner may, in his or her discretion, order restitution.<sup>10</sup> However, just as the criminal prosecution of a defendant does not resolve the civil dispute between the defendant and the victim when the criminal court orders restitution, the regulator's disciplinary action against an insurance company cannot resolve the civil dispute between the insurer and the consumer.

Courts have correctly recognized the fundamental distinction between judicial functions and regulatory functions. They rightfully rule that a court is the proper forum for determining whether a charge or practice is legal:

[I]t is the proper province of the courts to declare whether an insurance charge comports with the law; such a declaration is not judicial ratemaking.<sup>11</sup>

Once that fundamental error in the insurer's argument is revealed, their entire case for prohibiting insurance class actions fails.

Regulators are far more likely to be biased than judges. The structure of the regulatory system ensures regulators will, in all but rare cases, be biased in favor of insurers. Several factors contribute to that bias. Of course, not every factor applies to every regulator. However, the overall bias in favor of insurers is undeniable. As the *Chicago Tribune* recently recognized, state regulators, other than in California, rarely take on insurance companies.<sup>12</sup>

First, regulators frequently come from the insurance industry and bring with them the industry's point of view. The background of just a few of the state insurance regulators at the time of this writing includes:

- Kentucky: 34 years in the insurance industry.<sup>13</sup>
- Missouri: More than 40 years in the insurance industry.<sup>14</sup>
- Oklahoma: 25 years in the insurance industry.<sup>15</sup>
- South Carolina: 18 years in the insurance industry.<sup>16</sup>
- South Dakota: 25 years in the insurance industry.<sup>17</sup>

There are a variety of causes for this. Some states require that the commissioner have knowledge of or experience in the insurance industry.<sup>18</sup> Such a requirement makes it highly likely that the commissioner will come from the insurance industry. In addition, many commissioners are appointed by the governor with consent of the legislature. The insurance lobby has tremendous political clout with governors and legislators. According to the *National Underwriter*, the insurance industry is the sixth largest political contributor in the country.<sup>19</sup> Insurers frequently exercise that clout not only to push one of their own for appointment, but also to oppose outsiders. As a result, insurance regulators frequently come from the insurance industry, and bring with them the industry's viewpoint.

The recent selection of the insurance regulator in Missouri illustrates the problem. The governor appointed a five-person selection committee to select the new commissioner, and packed the committee with insurer representatives.<sup>20</sup> The five committee members were the president of an insurance agency, the chief lobbyist for Blue Cross/Blue Shield, the chief lobbyist for the state medical association, an insurance company lobbyist and a doctor who worked on the governor's campaign.<sup>21</sup> Not surprisingly, the governor appointed a person with more than 40 years in the insurance industry.<sup>22</sup>

Second, regulators realize that their most likely future employment is with the insurance industry, so they have a personal incentive not to alienate insurers. Indeed, regulators often obtain lucrative deals within the insurance industry when they leave. Many regulators take jobs lobbying for insurers or working in insurance companies. Just a few recent examples include:

- The former South Carolina regulator took a job with one of the largest insurer trade associations in the country.<sup>23</sup>
- The former District of Columbia regulator took a job lobbying for insurers.<sup>24</sup>
- The former Illinois regulator took a job lobbying for insurers.<sup>25</sup>
- The former New York regulator took a job lobbying for insurers.<sup>26</sup>
- The former Texas regulator is making hundreds of thousands of dollars a year lobbying for insurers.<sup>27</sup>

Third, regulators with political aspirations do not want to alienate insurers because they offer a deep well of future contributions. Insurers are huge contributors to political candidates of both parties.<sup>28</sup> A shrewd regulator knows that if insurers cannot trust him or her to rule for the industry today, then they will not trust him or her with a contribution in the future.

Fourth, insurers constantly lobby regulators *ex parte* and, therefore, can easily color the regulator's view. Insurers spend enormous amounts of money and resources to lobby regulators on a daily basis. They spare no expense in bringing their economic, lobbying and political clout to bear on agency decisions. In contrast, regulators rarely hear from consumers or their representatives. Take a look at an insurance regulator's schedule; you will see that the overwhelming percentage of the commissioner's meeting time is with industry representatives and that a fraction is spent with consumers or consumer representatives.

U.S. Sen. Bill Nelson, D-Fla., a former insurance commissioner himself, recognized the fundamental bias in the state regulatory system. He decried the situation as an inherent conflict of interest in which state commissioners often come to office from the insurance industry, stay in the job for a short time and then return to the industry.<sup>29</sup> That pattern has been repeated over and over again throughout the country.

While examples of the problem Sen. Nelson identified abound, the recent move of the South Carolina director of insurance (and then-president of the National Association of Insurance Commissioners) to becoming the chief executive officer of the Property Casualty Insurers Association of America (PCI), one of the largest insurance trade associations in the country, demonstrates the problem. Before becoming commissioner, he was the chief executive of a property and casualty insurance company.<sup>30</sup> As commissioner and president of NAIC, he

was one of the most vocal proponents of personal lines deregulation, which happened to be at the top of PCI's list of goals.<sup>31</sup> Apparently, he was negotiating his new job at the same time he was still serving as director of insurance and president of the NAIC.<sup>32</sup> Shockingly, he defended his move on the basis that he saw his new role as a continuation of his efforts as the director of insurance.<sup>33</sup>

Judges, on the other hand, rarely have any of these built-in biases. Judges come from a wide variety of backgrounds. A few may come from an insurance industry background, but that is a small exception to the rule. Judges have myriad job opportunities after they leave the bench, and many do not plan to leave the bench until retirement, so they have no personal interest preventing them from ruling against insurers. Judges rarely need future political contributions from insurers, so that pressure is nearly nonexistent. Finally, neither side can lobby the judge, particularly in an *ex parte* situation.

Of course, there are certainly regulators who do a better job than others in overcoming these pressures. However, it would clearly be better to have a decision maker who does not have to overcome personal interests and biases to reach a decision. Particularly in a case with substantial stakes, like a class action, it is better to have a judge resolve the dispute between consumers and the insurer, rather than the regulator.

Even an unbiased regulator lacks the resources necessary to reach a balanced decision. A third problem with the structure of the regulatory system is that the input to the regulator is overwhelmingly from the industry's perspective. Insurance company personnel and lobbyists routinely contact the regulator to provide information, perspective and analysis, and to prod regulators to act favorably to the insurers. Even when the regulator wants to reach a balanced decision, he or she cannot do so without the arguments and data necessary to understand both sides. There are rarely lobbyists for consumers to provide that input, and never any that can match the resources of the industry. Most regulators do not have the time or resources to obtain information on every issue on their own, so they often must render decisions based only on information from one side of a disputed issue – the insurer's side.

The agency staff does not make up for this imbalance of input. Regulators' budgets never reach the amounts necessary to match the resources that insurers bring to bear on them. In addition, agency staff frequently, although not always, suffer from the same bias pressures as the regulator. Staff members also learn that it is far more difficult for an employee to disagree with the insurance company than to agree with the insurance company position. When the staffer takes the insurer's side, no one complains. But if the staffer opposes the insurer, the staffer risks complaints to his or her superiors by the insurer. It is in the staff member's personal interests to remain non-controversial by not opposing insurers.

The class action, on the other hand, is a far superior model for matching the input from both sides to the decision maker. Insurers maintain their ability to present their input – albeit not in an *ex parte* manner – but now consumers have someone with the resources and the incentive to provide the decision maker with consumers’ input, information, perspective and analysis. When comparing the two possible forums for resolving the dispute, one in which the sides have relatively equal resources and one in which one side has substantially more resources than the other, the need for the class action becomes obvious.

Regulators are not more qualified to resolve insurance class action disputes than judges. Insurers claim that regulators must be experts in insurance regulation, as opposed to judges who may not have any experience in regulation or insurance. There is no theoretical or factual evidence to support this assertion. Judges are as qualified, and often more qualified, to resolve insurance class action disputes than regulators.

First and foremost, the relevant expertise needed to resolve the dispute is judicial, not regulatory. As shown above, insurers base their argument on the faulty premise that the decision as to whether an insurer broke or is breaking *existing law* is a regulatory issue. It is a *judicial* issue. As such, judges are well-qualified for that role; it is their essential role in our governmental framework.

Second, the insurers’ argument that a regulator must be an expert in insurance is simply false. Many states have no requirement regarding expertise in insurance. Others provide a meaningless requirement. For instance, Texas provides a circular qualification: The required “qualification” is that the commissioner must be “qualified in the field of insurance and insurance regulation.”<sup>34</sup> California also provides a circular requirement that a person is qualified if he or she is qualified: “The commissioner shall be a person competent and fully qualified to perform the duties of the office.”<sup>35</sup> Stricter requirements are not appropriate, because they would narrow the field of candidates to almost only insurance company employees. But the fact remains that the allegations that regulators have more expertise to resolve insurance disputes than judges is plainly false.

Third, insurance regulators often lack a legal background, as states do not require that regulators be attorneys. Thus, regulators often lack the essential skills necessary for deciding a hotly contested legal dispute, like experience in the interpretation of statutes, rules and contracts, or balancing the evidence, or any of the many other important skills that lawyers possess.

Fourth, even when a statute requires insurance experience, there is no guarantee the experience is related to the dispute in the class action. For instance, a commissioner may qualify by having sold health insurance policies for 20 years. That regulator will have no greater expertise than a judge, and probably much

less expertise, in determining whether a charge by a property and casualty insurer complies with a statute.

Indeed, the insurers' argument really seeks to deny consumers the right to have disinterested judges and juries hear *any* dispute between an insurance company and its consumer. There is no basis for arguing that a judge is fit to decide whether an insurer broke the law when only one consumer was harmed, but not when a class of consumers was harmed. A judge can interpret the law equally well whether there is one plaintiff or a class of plaintiffs, and nothing about regulators makes them more qualified to decide disputes based on how many consumers the insurer harmed. Each argument put forth for the elimination of insurance class actions would apply equally to individual actions against insurers. Thus, the insurers' argument is not really against class actions; it is about the elimination of the right of the judicial branch to resolve disputes between consumers and insurers.

*Consumers' Right to Participate Is Far Greater In the  
Class Action Context Than In a Regulatory Proceeding*

A second major problem with regulatory adjudication of the dispute is that consumers lack standing to participate. While the consumer has the right to file a complaint, the regulator, just like a prosecutor in a criminal prosecution, takes full control over the case. The consumer has no way to force the regulator to take action, to make particular arguments or make a reasonable settlement. Instead, the regulator has complete control. Moreover, even if a consumer wanted to intervene in the disciplinary action, he or she would lack standing to do so.

The Texas rental-car case mentioned above illustrates how a consumer lacks standing. After the filing of the class action, and the subsequent letter from the agency that the rental car companies could obtain a complete waiver of liability by paying a "small fraction" of what they owed, the companies all smartly agreed to have the agency commence a disciplinary action. They then settled the case on terms that were favorable to the companies.<sup>36</sup> The injured consumers attempted to participate in that regulatory action, but the agency and courts held that consumers lacked standing to participate in the regulatory action.<sup>37</sup> Like a criminal proceeding, the regulatory enforcement action cannot resolve the rights of the parties. That is what the courts do.

The rental-car case presents a stark contrast to the rights of consumers in the class action context. In a class action, consumers have the absolute right to contest the settlement and present arguments and evidence to convince the judge to reject the settlement.<sup>38</sup> In the regulatory context, however, consumers have no right to present arguments or evidence, or otherwise oppose the class-wide settlement.<sup>39</sup>

Consumers are at a fundamental disadvantage if disputes are resolved by the regulator and not a court, for they will not have legal standing to participate in the process. Once a settlement is made, they will lack standing to challenge the reasonableness of the settlement. Thus, the insurance class action is critical for providing due process rights to consumers.

*There Is a Tremendous Imbalance of Resources in Favor of Insurers in Regulatory Adjudication, While Resources are Far More Balanced in the Class Action Context*

A third problem with resolving disputes at the agency, rather than in court, is the tremendous imbalance of resources in regulatory adjudications. Insurers' resources greatly exceed those of consumers and the regulator when the claim is adjudicated at the agency. Conversely, resources are relatively balanced in the insurance class action.

Consumers have virtually no resources to participate in regulatory adjudications, but have sufficient resources in a class action. Consumers, not the regulator, are the real parties in interest in the dispute. Consumers will be financially affected by the outcome. Consumers' rights are being determined. Thus, the fairest system for resolving a dispute between an insurer and a consumer is a system wherein both sides have relatively equal resources. The class action meets that criteria; regulatory adjudication does not.

In the regulatory arena, several obstacles prevent consumers from effectively participating. First, an individual consumer has a small amount of money at stake. In an overcharge or unfair discrimination case, for instance, most consumers will have damages below \$500, and often under \$100. Thus, it is economically infeasible for them to hire an attorney and experts to advocate their side of the dispute. Second, the administrative process does not provide a method for consumers to pool their resources. There is no mechanism to have similarly situated consumers band together to share the costs of litigation. Third, there is no mechanism for consumers to recoup their attorney and expert witness fees in the regulatory arena. Fourth, much of the lobbying of the regulator occurs long before the dispute ever arises. Insurers lobby the regulator regularly to build a relationship with the regulator that will pay off when a dispute arises. Individual consumers lack the resources for such lobbying, even if they somehow knew beforehand that they would have a dispute with the insurer in the future.

Although these issues prevent consumers from participating in the regulatory proceeding, insurers fully participate, and do so with comparatively unlimited resources. The insurer has a large amount of money at stake because its relationship with all of its consumers will be decided. In addition, insurers can

simply recoup their litigation fees in rates. Finally, their years of lobbying the regulator often pays off when a contested issue reaches the regulator.

One of the most imbalanced aspects of the regulatory system is that of the staff advisory opinion. Here is how it works: When an insurer identifies a practice that it fears might be challenged in the future, it seeks “guidance” from agency staff members. Once they find a staff member that agrees with their position, they ask the staff member to write a letter confirming that position. This entire process is conducted *ex parte* without any public notice or opportunity for the public to participate. Later, when a dispute arises over the practice, the insurer pulls out the letter and cries, “But the agency *required* us to do it this way!”

This enormous imbalance of resources at the agency stands in stark contrast to the balance of resources in a class action. In the class action, consumers are able to pool their resources so that they can match the legal and expert witness resources that the insurer brings to bear. Pre- and post-litigation lobbying of the judge is essentially non-existent, and has relatively little effect if it does occur. Finally, judges will appropriately dismiss letters from staff members – even from regulators – that were not issued through a proper and public process.<sup>40</sup>

In agency adjudications, insurers easily out-resource the regulator. The regulator serves an important role, but the regulator cannot fill the void of resources to protect consumers’ interests. The regulator has no financial stake in the outcome of the dispute, so does not share a sufficient financial interest with the consumer to represent the consumer’s interests. Moreover, the regulator’s duty is to balance the interests of all concerned – insurers, consumers and the public. Just as insurers need to present their side, despite the duty of the regulator to balance the interests of all parties, so, too, consumers need an advocate on their side. It is a simple equation: If there is an advocate plus a regulator on one side, there needs to be an equally funded advocate plus a regulator on the other side. The regulatory system tips the scales of justice to the insurers, because there is a regulator looking out for both sides, but an advocate only on one side.

A simple example illustrates how the regulator cannot adequately represent the consumers’ interests. Assume the insurer violated the law and overcharged 25 percent of its consumers. However, the company is also having financial problems and, if forced to refund the overcharges, it risks being unable to pay its claims, many of which will exceed the state’s guaranty association protection. The regulator will then have to balance the rights of 1) the overcharged consumers; 2) the company; 3) the insureds who will have claims filed against them; 4) the future claimants; 5) the guaranty association; and 6) other insurers, and ultimately consumers, who contribute to that guaranty fund. The overcharged consumers are entitled to be represented by someone with only their interests, just as the insurance company is represented by someone with only its interests. Moreover, the overcharged consumers are entitled to have their rights

determined by someone who will not ignore their rights based on those other considerations.

Even if the regulator could sufficiently represent the consumers' interests, the regulator lacks sufficient resources to even come close to matching the insurance company's resources. Regulators are faced with limited budgets, and they simply cannot match the hundreds of thousands of dollars of attorney and expert fees that insurers bring to these disputes. Nor can the agency match the experience and expertise of the insurers' attorneys and experts. While insurers typically engage several attorneys with decades of successful litigation experience, for instance, regulators usually can assign only one staff attorney to the case, a staff attorney who typically is already overburdened with other cases. And the regulator's pay scale means that in most cases that attorney will be substantially less experienced than the insurer's attorneys. Moreover, the staff attorney faces all of the same bias pressures that the regulator faces, discussed above, with the added incentive to settle cases as quickly as possible to reduce his or her workload. Thus, it is exceedingly rare to find a case where the regulator has anywhere near the resources necessary to match the insurance company's resources in a regulatory adjudication.

*The Class Action Process Is Open;  
The Regulatory Process Is Not*

Another major problem with adjudicating class action controversies at the agency is the lack of an open process. Regulatory disputes are almost always resolved *ex parte*. The regulator or regulator's staff meets with the company and they eventually reach a settlement without any public input. The rental-car case is an excellent example. The regulator did not hold any public hearings to take public input on the case or the settlement. Indeed, the one consumer who tried to participate in the process was denied the right to participate.<sup>41</sup> The opportunity to "opt out" of the regulatory settlement is no remedy, because doing so means the consumer loses the only way to afford the fight – by joining with all other similarly situated consumers.

In the class action, conversely, consumers have an absolute right to participate and *ex parte* contacts with the judge are strictly prohibited. Once a proposed settlement is reached, affected consumers are given notice and the opportunity to be heard on whether the settlement is fair.<sup>42</sup> The openness of the class action process stands in stark contrast to the closed nature of the regulatory adjudication.

## The Double-Rounding Class Action Illustrates the Need for Insurance Class Actions

The favorite “whipping boy” for the industry and its apologists is the double-rounding class action.<sup>43</sup> Insurers like to tout that case as their prime example for eliminating insurance class actions. However, once one gets beyond the industry’s rhetoric, it becomes clear that class actions like the double-rounding case are essential for making insurers follow the law.

In a nutshell, the facts of that case are as follows:

1. The Texas Department of Insurance rules for calculating premiums, as interpreted by the regulator and agency staff, required insurers to round *only once* in calculating the premium for each coverage.<sup>44</sup>
2. The Farmers and Allstate insurance companies rounded *twice* in their calculation.<sup>4</sup>
3. Single rounding was revenue neutral, but double-rounding resulted in extra premium.<sup>46</sup> Allstate admitted that using double rounding would result in “an overcharge.”<sup>47</sup>
4. No other major auto insurer in the state double-rounded.<sup>48</sup> The insurance commissioner wrote that “[Allstate] and Farmers are the only major insurers in the State of Texas who use double rounding. I believe this to be wrong. *This is not fair to those consumers* who pay a different premium.”<sup>49</sup> (Emphasis added.)
5. The net effect of double-rounding was that Farmers and Allstate collected tens of millions of dollars more in premiums than if they had single-rounded.<sup>50</sup>
6. The regulator failed to discover the illegal practice.<sup>51</sup>
7. The regulator failed to order the companies to refund the illegal overcharges, despite his agreement that double-rounding was “not fair” to the consumers.<sup>52</sup>
8. The class action, while not perfect, resulted in consumers actually receiving some refunds of the illegal charges.<sup>53</sup>

Would consumers have fared better if they received more restitution? Absolutely, but the regulator was directly responsible for weakening the plaintiffs’ chances and causing the lower recovery.<sup>54</sup> Short of full restitution, however, consumers were better off with the partial restitution of the class action than with the complete lack of restitution of the regulator.

The bottom line is that the class action, not regulation, achieved the public policy goal of having insurers follow the law. The availability of the insurance class action 1) identified an illegal practice that the regulator missed; and 2) provided restitution of illegal overcharges that the regulator agreed were unfairly and

illegally collected from consumers. Moreover, the regulatory solution created an incentive for insurers to break the law, whereas the class action creates a *disincentive* to break the law. Thus, the double-rounding class action is a prime example of why courts should continue to decide insurance class actions.

### *This Was a Judicial Function*

Resolution of the double-rounding dispute was a standard judicial function, as opposed to a regulatory function. The sole issue in the case was whether Farmers and Allstate were violating *the existing rules* for calculating premiums. Regulatory rules in Texas have the force and effect of a statute,<sup>55</sup> so the issue was a purely legal question of interpretation. The plaintiffs did not seek in the suit to affect what any *future* rule should be. Thus, the case clearly called for a judicial decision, not a regulatory decision.<sup>56</sup>

Indeed, three separate Texas courts rejected the insurers' argument that the dispute was a regulatory dispute that should be decided by the regulator, not a court. The trial judge initially rejected the insurers' argument.<sup>57</sup> The companies then sought relief from the San Antonio Court of Appeals, but that court also rejected the argument.<sup>58</sup> Finally, the companies presented the argument to the Texas Supreme Court, but that court also rejected the argument that the regulator should resolve the dispute.<sup>59</sup>

### *The Regulator Was Not More Qualified Than a Judge to Decide the Dispute*

The regulator, Elton Bomer, was a well-respected insurance commissioner and deserved that reputation. His lack of ties to the insurance industry before his appointment as commissioner stands out in comparison to most commissioners. Nevertheless, nothing about his skills or background made him more qualified to decide the dispute than a district judge.

Commissioner Bomer was not a licensed attorney and apparently lacked legal training or experience. The primary issue in the case was one of legal interpretation, and he did not bring any skills in that regard that a district judge lacked. Indeed, a district judge, having been trained as a lawyer, would likely possess far more skills and experience in that regard. There were no specialized insurance facts at issue – the only factual issue was whether the agency had given the companies permission to double-round. However, Commissioner Bomer had no personal knowledge of that, and relied instead on a review of old agency documents. A district court could just as easily perform that function.

We will never know the extent to which the prospects of future employment in the industry played in Commissioner Bomer's decisions, consciously or

unconsciously. That potential, however, does color the legitimacy of the regulatory process. While the author believes that future employment did not weigh in Commissioner Bomer's decision in that case, the fact is that Commissioner Bomer went on to lobby for insurance companies after he left the agency and is making hundreds of thousands of dollars doing that.<sup>60</sup> The message that sends to current regulators is obvious.

### *Consumers Had No Right to Participate*

Consumers had no legal right to participate in the commissioner's adjudication of the dispute with Farmers and Allstate.<sup>61</sup> Conversely, consumers had the right to participate in the class action.<sup>62</sup> Thus, the choice becomes: Should the parties' rights be determined in a forum in which only the insurer, and not the consumer, has the right to notice and participation, or should the parties' rights be decided in a forum where both sides have the right to notice and participation? While insurers advocate for an unfair advantage with the regulatory resolution, because it is in their financial interest, there is no theoretical or public policy justification for such a blatant violation of consumers' due process rights.

### *The Resources of the Two Sides Would Have Been Imbalanced Without the Class Action*

Even if consumers had the right to participate in the regulatory adjudication, however, they would be hopelessly without resources. Consumers in that case had less than \$100 at stake on an individual basis. It would not be economically feasible, and for most consumers it would not be economically possible, for a consumer to pay for the attorneys and experts needed to protect the consumer's interests at the agency.<sup>63</sup> Nor is there any way for consumers to realistically pool their resources in the agency proceeding. On the other hand, the insurers brought an army of lawyers and law firms to advocate for their side at the agency. Regulatory adjudication would be a tremendously unjust system for resolving the parties' dispute.

Conversely, the class action provided the perfect mechanism for consumers to participate by pooling their resources to hire top attorneys and experts to match the resources of the insurance companies.<sup>64</sup> Indeed, to make it clear to the companies that they would not be able to out-resource the consumers, the class action lawyers created a \$4 million "war chest" to fund the litigation and added that they would spend an additional \$1 million if necessary.<sup>65</sup> There was no doubt the insurers would not win the class action by outspending consumers.

The double-rounding case also illustrates the problem of staff memos, as described above. The insurers were faced with the sworn testimony of the head of the agency's automobile section and the written position of the commissioner

himself that the rules prohibited double-rounding. Allstate's defense was an allegation that the agency had told them many years earlier to double-round. There are numerous problems with their argument.

First and foremost, whether the overcharge was the result of fraud or honest mistake should not matter: Either way, the companies were not entitled to keep the illegally obtained overcharges. When I catch my child with his hand in the cookie jar before dinner, I make him put the cookies back, whether he made a conscious decision to disobey my rule or made an innocent mistake. Similarly, whether Farmers and Allstate consciously tried to overcharge consumers or did so out of an honest mistake should not matter; they should give the extra premium back to the consumers from whom they illegally took it.

Second, allowing an informal staff member's opinion to have any bearing on the dispute is a gross denial of consumers' due process rights. Consumers were given no notice of or opportunity to participate in this staff member's decision. Texas has a mandatory procedure for modifying the regulator's rule,<sup>66</sup> and insurers know that a staff member lacks the power to modify the rule on his own. Allowing a staff memo like this to alter the rights of the parties is the antithesis of due process.

Third, the staff member's opinion directly conflicted with the conclusion of every single regulator who opined on the issue. The regulator and the head of the agency's automobile insurance department stated that double-rounding was illegal.<sup>67</sup> Moreover, a line of *former* Texas regulators also said that the rules prohibited double-rounding.<sup>68</sup>

Fourth, Allstate's reliance on the staff member's opinion is suspect. Did Allstate get a different answer from other staff members and wait to get the letter until they found a staff member who would permit double-rounding? We will never know. What we do know is that Allstate recognized that they would be collecting an "overcharge" by double-rounding.<sup>69</sup> So, if they were acting in good faith, why did they not go to that staff member's superiors to correct his error? Allstate routinely goes to regulatory superiors when an insurance department staff member's decision is against their financial interest. If they were truly acting in good faith, they would have gone to the staff member's superiors, even when the erroneous decision was in their financial interest.

Finally, the companies themselves proved that their decision to double-round had nothing to do with the agency's instructions. On May 7, 1996, Commissioner Bomer wrote them a letter explaining that the rules prohibited double-rounding and instructed them to stop.<sup>70</sup> They refused to stop double-rounding.<sup>71</sup> Thus, they demonstrated that their actions were *not* motivated by a desire to comply with the regulator's requests.

### *The Process Was Closed to Consumers and the Public*

The double-rounding case also illustrates the difference in openness between the class action and the regulatory adjudication. In the class action, of course, the file and all hearings are open to the public, consumers have the option to intervene with or without their own attorney, notice to consumers is required and consumers have the opportunity to participate in the decision of whether to approve the settlement.<sup>72</sup>

Consumers were not entitled to, and did not receive, any of those basic rights in the regulator's resolution of the double-rounding dispute. Instead, the regulator in the double-rounding case issued his "resolution" after *ex parte* lobbying by the insurers and without notice to the affected consumers or an opportunity to be heard. There was nothing open or transparent about the regulatory process.

### *The Regulator Sent the Wrong Message to the Industry*

The importance of the class action is not only to ensure that the defendant insurance company follows the particular law at issue. The class action also provides an economic incentive to the defendant and all other insurers to follow *all insurance laws* in the future. Consider the two messages to insurers.

The first message is from the regulator: If you break the law, you will not need to return your ill-gotten gains. Or, as the agency explained in the rental car case, if you break the law, we will only make you pay a small fraction of what you owe.<sup>73</sup> The regulator has given insurers an economic incentive to break the law! The bottom line to Farmers and Allstate under the regulator's resolution was to keep more money by breaking the law than by following the law. Rather than provide an incentive for those insurers and others to follow insurance laws in the future, the regulator provided an incentive for them to violate those laws.

The second message is from the class action: If you break the law, you will be hit with a class action suit wherein consumers with sufficient resources will seek not only complete restitution, but also punitive and exemplary damages. Here, the message to insurers is quite different. Indeed, insurers' deep distaste for insurance class actions proves that they provide an excellent disincentive to an insurer that contemplates engaging in a practice that violates the law. As to future conduct by insurers, the insurance class action again served an important role in filling the void left by the regulator's failure.

## **Conclusion**

Regulation has failed, repeatedly, to achieve the public policy goal of having insurance companies follow the law. The insurance class action is critical in

the efforts to reach that public policy goal by 1) identifying illegal practices; 2) requiring insurers to pay the damages they caused to consumers; and 3) creating an economic incentive for all companies to follow the law. In short, courts in insurance class actions do exactly what they should be doing: enforcing the rule of law.

## Endnotes

1. 43 AM. JUR. 2D INSURANCE § 24.
2. *Id.*
3. *Frailan Sendejo et al. v. Texas Farmers Ins. Co.*, No. 95-08-09165-CV, 365th District Court, Zavala County, Texas; *Armando Martinez et al. v. Allstate Ins. Co.*, No. 95-08-09169-CV, 365th District Court, Zavala County, Texas.
4. For instance, race-based premiums for life insurance were illegal for more than 30 years but continued to exist due to regulatory failures.
5. *Wall Street Journal/Texas Journal*, “Insurance Commissioner Ruffles Consumer Activists,” Feb. 18, 1998.
6. *Id.*
7. *Id.*
8. While in a rare case a jury will determine questions of fact, nearly every insurance class action is decided by a judge.
9. *Marbury v. Madison*, 1 Cranch 137, 177, 2 L.Ed. 60 (1803).
10. *See, e.g.*, TEX. INS. CODE § 82.051 et seq.
11. *Allstate Ins. Co. v. Fleming*, 2005 WL 1536228 (Tex. App. – Austin 2005).
12. *Chicago Tribune*, “Insurers’ Influence Strengthens, Many States Reluctant to Resist Industry Rate, Policy Trends,” Sept. 4, 2004.
13. *BestWire*, “Kentucky’s New Insurance Commissioner Earns Post Via Web, Not Politics,” Aug. 11, 2004.
14. *BestWire*, “New Missouri Governor Names Industry Veteran Commissioner,” Jan. 5, 2005.
15. *BestWire*, “Okla. Governor Says New Insurance Commissioner Will ‘Restore Integrity’ to Post,” Jan. 25, 2005.
16. *BestWire*, “Kitzman Named South Carolina Director of Insurance,” Feb. 3, 2005.
17. *BestWire*, “South Dakota Names New Insurance Director,” July 21, 2005.
18. *See, e.g.*, ARIZ. REV. STAT. 20-141 (C), requiring the regulator to be “well versed in insurance matters.”
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20. *Columbia Daily Tribune*, “Going Too Far, Blunt Stumbles With Insurance Appointment,” Jan. 24, 2005.
21. *Id.*
22. *BestWire*, “New Missouri Governor Names Industry Veteran Commissioner,” Jan. 5, 2005.

23. *National Underwriter*, “Ex-NAIC Chief Defends New Industry Role,” Aug. 19, 2004.
24. *BestWire*, “D.C. Commissioner Mirel Points to Successes as He Steps Down,” Aug. 17, 2005.
25. *BestWire*, “Dykema Gossett Announces Addition of Former Acting Illinois Insurance Regulator to Staff,” Aug. 23, 2005.
26. *BestWire*, “N.Y. Regulator Serio’s Departure Leads Him to Post at Lobbying Firm,” Jan. 20, 2005.
27. [www.ethics.state.tx.us/tedd/lobcon2005a.htm](http://www.ethics.state.tx.us/tedd/lobcon2005a.htm).
28. *National Underwriter*, “Insurance Industry Gives,” March 26, 2004.
29. *Daily News*, CALIFORNIA, Oct. 23, 2003, B1.
30. *National Underwriter*, “Ex-NAIC Chief Defends New Industry Role,” Aug. 19, 2004.
31. *Id.*
32. *BestWire*, “Ernst Csiszar Steps Down as South Carolina Insurance Director to Head P/C Trade Association,” Aug. 19, 2004.
33. *National Underwriter*, “Ex-NAIC Chief Defends New Industry Role,” Aug. 19, 2004.
34. TEX. INS. CODE § 31.023 (2).
35. WEST’S ANN. CAL INS. CODE § 12901.
36. *Wall Street Journal/Texas Journal*, “Insurance Commissioner Ruffles Consumer Activists,” Feb. 18, 1998.
37. *Siebenmorgen v. Texas Department of Insurance*, 1999 WL 394621 (Tex. App. – Austin 1999).
38. *See e.g.*, FED. R. CIV. P. 23.
39. *Siebenmorgen*, *supra*.
40. *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212-13 (1988) (statements of agency’s attorney do not constitute agency action without evidence of formal adoption by the agency).
41. *Siebenmorgen v. Texas Department of Insurance*, 1999 WL 394621 (Tex. App. – Austin 1999).
42. *See e.g.*, FED. R. CIV. P. 23.
43. *Frailan Sendejo et al. v. Texas Farmers Ins. Co.*, No. 95-08-09165-CV, 365th District Court, Zavala County, Texas; *Armando Martinez et al. v. Allstate Ins. Co.*, No. 95-08-09169-CV, 365th District Court, Zavala County, Texas.
44. Deborah Hensler, et al., CLASS ACTION DILEMMAS: PURSUING PUBLIC GOALS FOR PRIVATE GAIN (RAND Institute for Civil Justice, 2000), p. 262, 266, 269 (hereafter “CLASS ACTION DILEMMAS”).
45. *Id.* 262.
46. *Id.* 258.
47. *Id.* 262.
48. *Id.* 269.
49. *Id.* 269.
50. *Id.* 274.
51. *Id.* 257.
52. *Id.* 268.

53. *Id.* 281.
54. *Id.* 272.
55. *Lewis v. Jacksonville Building & Loan Ass'n*, 540 S.W.2d 307, 310 (Tex. 1976).
56. *Great Northern Railway Co. v. Merchants Elevator Co.*, 259 U.S. 285, 291 (1922).
57. CLASS ACTION DILEMMAS, p. 284.
58. *Id.*
59. *Id.* 271.
60. [www.ethics.state.tx.us/tedd/lobcon2005a.htm](http://www.ethics.state.tx.us/tedd/lobcon2005a.htm).
61. *Siebenmorgen v. Texas Department of Insurance*, 1999 WL 394621 (Tex. App. – Austin 1999).
62. TEX. R. CIV. P. 42.
63. While the class action lawyers did advocate for the consumers at the agency in that case, their reason for doing so was to preserve the class action. If insurance class actions were not available, consumers would not have been represented.
64. CLASS ACTION DILEMMAS, p. 261 (identifying the impressive team the Plaintiffs' attorneys assembled).
65. *Id.* 261.
66. TEX. INS. CODE ART. 5.96.
67. CLASS ACTION DILEMMAS, p. 262, 266, 269.
68. *Id.* 262.
69. *Id.* 287 n. 36.
70. *Id.* 269.
71. *Id.* 269.
72. See generally, TEX. R. CIV. P. 42.
73. *Wall Street Journal/Texas Journal*, "Insurance Commissioner Ruffles Consumer Activists," Feb. 18, 1998.

# Sarbanes-Oxley for Non-Public Insurers: The Debate Continues

By  
Tom Finnell, CPA

## Introduction

At the Spring 2006 National Meeting of the NAIC that was held in Orlando Fla., a working group adopted a proposal to make changes to the NAIC's Model Audit Rule (MAR) that, in some respects, would cause the MAR to be more closely aligned with certain of the reforms addressed in the Sarbanes-Oxley Act of 2002 (SOX). The language that was finally adopted borrowed heavily from a version that had been brought forward by industry "Interested Parties" as an alternative to the working group's hotly debated April 2004 draft. Exhibits I and II compare the proposed MAR revisions that were passed by the working group to corresponding provisions of SOX.

Nonetheless, the debate over applying SOX-like provisions to non-public insurers will continue. For example, though the working group's ostensible goal is to further strengthen policyholder protections, its efforts have run counter to some actions by federal regulatory agencies and have even met with resistance by influential members of Congress:

- In August 2005, Rep. Michael Oxley (R-Ohio), Chairman of the House Committee on Financial Services and co-sponsor of SOX, and Rep. Richard Baker (R-La.), chairman of the Subcommittee on Capital Markets, Insurance and Government Sponsored Enterprises, addressed their concerns about the application of SOX to non-public companies directly to the NAIC. They affirmed that, "Congress deliberately made the decision to apply the law only to those companies registered with the [SEC]." They also stated that, "if the NAIC intends to extend SOX provisions beyond publicly traded companies, we strongly suggest that state insurance regulators carefully examine what additional protections policyholders will be afforded...and how to best balance those protections with the costs involved."
- In November 2005, the Federal Deposit Insurance Corporation amended its regulations to raise the asset-size threshold from \$500 million to \$1 billion for internal control assessments of its regulated banks by management and external auditors. For those banks that continue to meet the revised higher threshold, guidance was also issued to reconcile FDIC internal control reporting requirements with those of SOX.

- In December 2005, the SEC's Advisory Committee on Smaller Public Companies recommended that registrants with market capitalization of less than \$125 million be exempted from SOX's requirements for reporting on internal controls altogether, and that those with market caps between \$125 million and \$750 million be exempted from the requirement to hire an outside auditor to attest to the adequacy of their internal controls.

The purpose of this article is to highlight the key provisions that have been adopted by the working group and to analyze their potential implications, particularly with respect to non-public insurers. This article also covers key aspects of a cost-benefit analysis that was prepared on behalf of the National Association of Mutual Insurance Companies (NAMIC) and which became an integral part of the debate over the working group's proposal as it was being framed.

## Background

Members of the U.S. Congress had previously dabbled with piece-meal reforms of financial reporting for years, but interest largely waned until Nov. 8, 2001, when Enron disclosed that it had overstated its earnings by \$600 million. SOX was enacted on July 30, 2002, as a federal response to the increasing number and size of such financial reporting scandals.

State insurance regulators monitored SOX developments in 2002 and 2003 with a high degree of interest. With improvements in governance, auditor independence, internal controls and other areas forthcoming as part of SOX, they believed that solvency protection, at least for public insurers, would be improved.

The NAIC had previously created the NAIC/AICPA Working Group, a joint forum where regulators and representatives of the public accounting profession could meet periodically to discuss issues of common interest. It fell to this group, led by Douglas Stolte, deputy commissioner for the Virginia Bureau of Insurance, to monitor developments associated with the adoption of SOX. The working group soon observed that there were potential gaps in state insurance solvency regulation as compared to SOX in areas such as:

- Auditor independence
- Governance, particularly the role of the Audit Committee
- Reporting by management and by auditors on the effectiveness of internal controls

SOX§404 requires registrants to affirm management's responsibility for establishing and maintaining an adequate internal control structure and financial reporting procedures; to assess the effectiveness of their internal control structure

procedures for financial reporting; and to obtain an independent auditor's report to attest to, and report on, management's assertion. By contrast, the current MAR requires only that reportable conditions be communicated to the insurance department in writing within 60 days of filing of the audited financial statements.

By early 2004, the working group had released its first draft of proposed changes to the MAR. Industry representatives had significant concerns with that proposal, which were echoed in meetings during the ensuing 18-month period, including that:

- Regulators had not adequately made their case that SOX-like provisions at the state insurance level were necessary.
- Such requirements, which included provisions similar to SOX§404 requiring reports by management and auditors on effectiveness of internal controls, would be prohibitively expensive and burdensome.
- Smaller companies should be exempted.

It was clear from the outset that the thorniest issues with the working group's proposal involved reporting on internal controls. At that time, large public companies were struggling to comply with SOX§404 and the notion of a possibly conflicting requirement at the state insurance regulatory level caused them much concern. But the non-public insurers expressed the most concern, as the working group's proposal would cause them to go through the same internal control documentation, testing, reporting, and independent attestation process as SOX required for public companies, a burdensome requirement that many non-public insurers saw as unnecessary.

By April 2005, accelerated filers – those public companies with market capitalization in excess of \$75 million – had finally made it through their first year under SOX. Their Form 10Ks and proxy statements had been prepared and filed, and the opportunity was present to reflect on what was gained from the reforms at the federal level, and the costs. The SEC itself provided a forum for that through a “Roundtable Discussion on Implementation of Internal Control Reporting Provisions” which was held at the SEC's headquarters in Washington D.C. on April 13, 2005. “Plusses” of the SOX§404 compliance efforts as captured in the SEC's published notes from the meeting included the following:

- Stronger transparency, quality of financial statements.
- Improved governance; tone at the top is better and stronger.
- Management is more aware of the environment, of controls and responsibilities.
- Audit committees are stronger and more independent; auditors are more independent and communications between them is improved.
- Internal control processes are more formalized and centralized.

On the other hand, the SEC notes also detailed many “minuses,” including the following:

- Too much heavy-handed focus was placed by auditors on transaction level processes; a more balanced focus should have been applied overall, with more emphasis on entity-level controls.
- The SOX§404 documentation and testing processes should have been risk-based, not checklist driven.
- The application of high coverage ratios by auditors resulted in high implementation costs.
- High opportunity costs were incurred in that resources were diverted from other important activities.
- SOX§404 monopolized “mindshare,” – that is, management’s attention – which is a critical issue especially for smaller companies.
- While the PCAOB had developed guidance for auditors, practical implementation guidance was needed for registrants.
- Controls nonetheless can’t be relied upon to eliminate fraud, particularly where collusion involves senior management.

In ensuing months, the SEC promulgated additional guidance, and formed an Advisory Committee on Smaller Public Companies to assess the current regulatory system for smaller companies under the securities laws, including the impact of SOX.

### **Cost-Benefit Study Commissioned by NAMIC**

In June 2005, the results of a cost-benefit analysis commissioned by NAMIC of the proposed changes to the MAR relating to reporting on internal controls were shared with the working group. The analysis was based on a survey of NAMIC members’ anticipated costs, and also utilized secondary research at the industry level. Key findings of the analysis are described below.

#### *Characteristics of Property/Casualty Mutuals*

There are approximately 550 property/casualty mutuals or mutual company groups that collectively represent about one third of the property/casualty industry, measured both by legal entity count as well as by premiums and surplus. The vast majority of such entities are quite small in size, each writing less than \$25 million in premiums. On the other end of the spectrum; however, are a small number of industry giants. For example, four property/casualty mutual groups each write in excess of \$5 billion of premium: State Farm, Liberty Mutual, Nationwide, and American Family.

While the property/casualty mutual industry segment is not immune from solvency issues that impact the rest of the insurance industry, they have experienced less susceptibility to costly insolvencies. Unlike stock companies, mutuals don't have to reconcile the conflicting interests of shareholders and policyholders. Without the demands of shareholders for competitive returns on capital, mutuals generally enjoy lower leverage ratios than their stock company counterparts. It is considerations such as these that caused NAMIC to assert that §404-like provisions have no applicability in the mutual company environment. Rather, NAMIC has consistently asserted that such provisions had been designed specifically by the U.S. Congress to thwart the indiscretions in financial reporting that had increasingly plagued publicly-held companies over the years.

### *Why Non-Public Insurers Are Concerned About SOX §404*

The biggest concern of non-public insurers about the working group's proposal was its cost. By the spring of 2005, studies had been released by the Big-4 audit firms, by FEI, AMR Research, and others, citing industry first-year implementation costs in excess of \$5.5 billion in the aggregate, or more than \$4 million per company. Ironically, the problems that SOX intended to address were exemplified by specific company situations where collusion of senior management often appeared to exist. *As a result, and despite these significant sums being spent, there was the wide-spread belief by many – including the PCAOB and the SEC as stated at the April 13, 2005, Roundtable – that the resulting improvements in controls still could not be relied upon to prevent financial reporting problems where such collusion existed.*

### *Problems in Financial Reporting – Experiences of Public Companies*

Despite much hype in the press about companies such as Enron and WorldCom, much less had been said about the extent of financial reporting problems specifically involving insurers. Therefore, the NAMIC study addressed the need for additional reforms within the insurance industry. Specifically, we sought to determine whether significant problems existed within the industry that would be responsive to §404-like reforms for non-public insurers, and whether the benefits expected from the reforms would justify their cost. To that end, the NAMIC study examined enforcement actions taken by the SEC against insurers and the extent of restatements made by insurers in recent years – the same information considered by federal regulators and the U.S. Congress leading up to the adoption of SOX at the federal level.

The U.S. Government Accountability Office (GAO) had studied 919 restatements involving accounting irregularities by 845 public companies from Jan. 1, 1997, through June 30, 2002. An accounting irregularity was defined to include both errors and fraud. The number of such restatements rose each year, and the

number involving large companies (those in excess of \$10 billion in market cap) grew rapidly. The GAO observed that 10 percent of public registrants restated their financial statements at least once during the study period and that, on average, restatements caused a 10 percent drop in stock price, or about \$100 billion in market capitalization. The GAO also noted that “the pressures on executives and boards of *public companies* to grow profitably and raise market values, combined with compensation arrangements, can create ‘perverse incentives’ to manage earnings, disguise risks, and avoid transparency...” (emphasis added).

Digging deeper, the NAMIC study looked in more detail at the restatements listed in the GAO report, noting only 17 restatements that pertained to the insurance industry, which resulted in relatively minor reductions in equity in the aggregate (decrease of about 1 percent) and individually by company. Also, no trend was exhibited by line of business or by business segment to suggest the existence of any systemic risk, or risks that might have carry-over effect to the property/casualty mutual segment.

The NAMIC study also considered enforcement actions by the SEC against publicly-traded insurers. The COSO/Treadway Commission on Fraudulent Financial Reporting reviewed 204 financial reporting enforcement actions from 1987-1997. The report also noted that the CEO and/or the CFO were implicated in 83 percent of the cases.

Another study of enforcement actions was also conducted by the SEC pursuant to SOX §704, covering the five years preceding the adoption of SOX and areas most susceptible to fraud, inappropriate manipulation, or earnings management. The SEC studied 515 enforcement actions arising from 227 investigations related to 164 entities, half of which were charged with fraud. In 75 percent of the cases, charges were brought against a board chairman, CEO, president, CFO, COO, CAO, or vice president of finance – in other words, there was collusion of senior management. Only four insurance-related cases occurred during the study period.

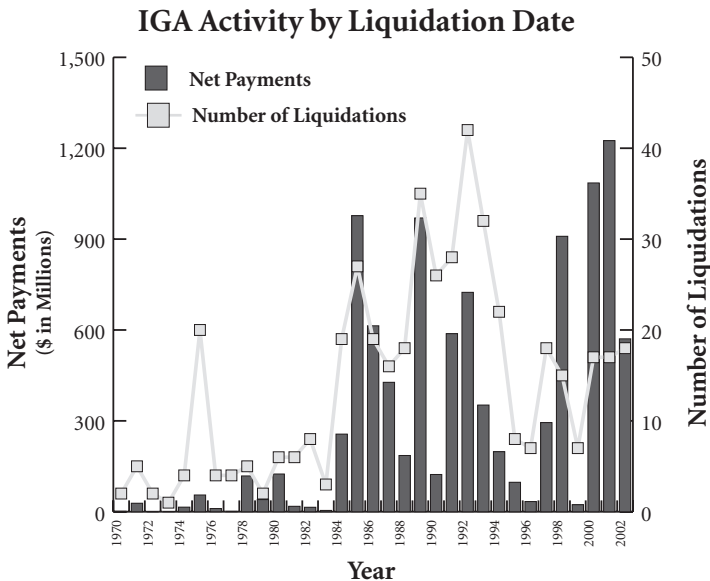
As the 1990s progressed, an increasing proportion of SEC enforcement actions related to technology-based companies. Stock pricing in those industry segments in particular became “irrationally exuberant” as a significant amount of the stock price valuation became based on non-financial measures. Many such companies at the time had little or no reported earnings to date, and precious little quantified data and tangible assets to support their stock valuations. That is quite different from the insurance segment. As a relatively mature industry, most insurers have years, if not decades, of experience and there is an enormous amount of industry data in a uniform format to support peer comparisons and other sophisticated financial analyses.

*Problems in Financial Reporting – Experiences of Insurers*

The NAMIC study also considered the insolvency experience of property/casualty insurers to determine if there was an apparent need for reforms, but also as insight into the potential benefits of those reforms. In other words, what is the current cost of insurance insolvencies, how much can that be reduced by additional reforms, and is that worth the cost of implementing those reforms?

In that regard, the NAMIC study considered studies on insolvencies made by A.M. Best covering the period from 1969-1990, and as updated in subsequent A.M. Best reports through 2004. On average, mutuals were 45 percent of the companies in the industry during that time frame, but comprised only 16 percent of the financially impaired companies in the A.M. Best study. A.M. Best noted that mutuals have not been as active in the more volatile commercial and casualty lines relative to other types of insurers, and that greater demands have been placed on managers of stock companies by shareholders to keep capital highly utilized, which can lead to greater degrees of underwriting leverage.

The insolvency cost data used in the NAMIC study included only the cost of claims covered by state insurance guaranty associations. Despite that limitation, the NAMIC study observed that the data is nonetheless sufficient to identify trends over time, to identify specific insurers that account for the largest share of guaranty fund costs, and as a means to provide insight into total costs. The following chart tracks payments by insurance guaranty associations (IGAs):

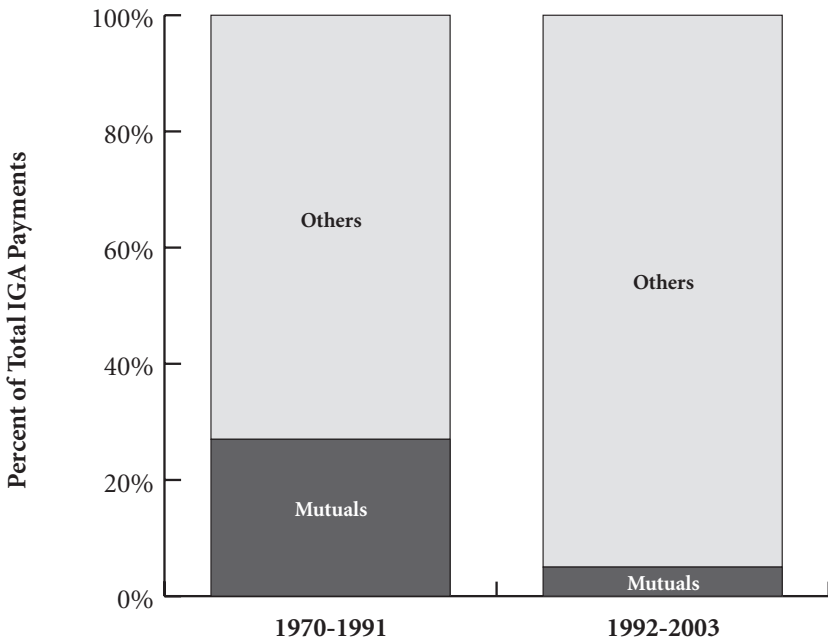


The above chart notes several “spikes” in property/casualty insolvency activity:

- A rise in the number of insolvencies in the mid-1970s with low dollar impact
- A rise in the number of insolvencies in the mid- to late 1980s that culminated in extensive payments of IGAs through 1990
- An increase in activity in 1992 prompted in part by Hurricane Andrew
- More recently, a relatively small number of very expensive insolvencies in the 1998-2000 timeframe

The NAMIC study dug deeper into the insolvency data, noting a clear trend in the composition of insolvency costs from 1992 forward as compared to periods prior to 1992, as shown in the following chart:

### Property and Casualty Experience – 1970-2003



As the chart portrays, property/casualty mutuals accounted for a significantly lower proportion of insolvency costs in the latter time frame relative to the earlier period. It was in the early 1990s that many significant regulatory reforms were enacted, including but not limited to enhanced audit rules, actuarial certifications, and the adoption of risk-based capital. Furthermore, the NAIC’s

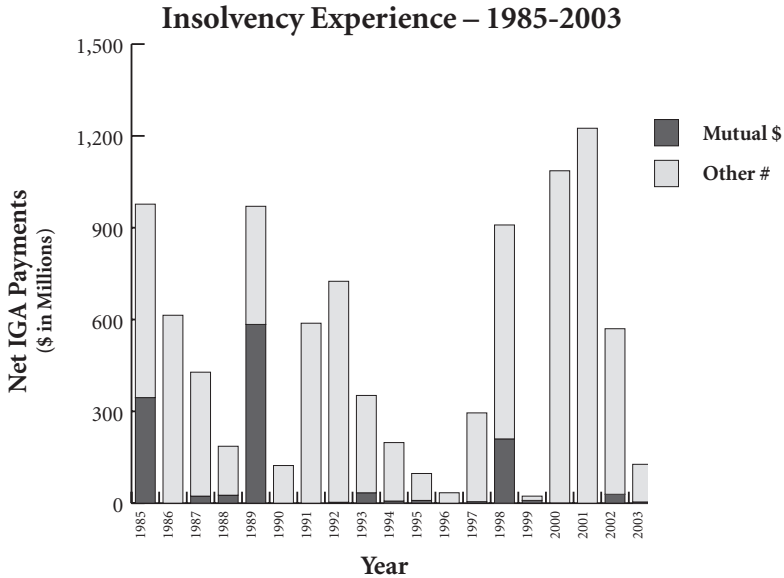
Financial Regulatory Standards were enacted in this time frame, resulting in greater uniformity in financial regulation nationally. It is apparent that property/casualty mutuals responded well to these reforms, suggesting that existing solvency regulation alone may be adequate for property/casualty mutuals.

Only 20 property/casualty insolvencies comprise more than 50 percent of total property/casualty insolvency costs through 2003; five of those top 20 are mutual companies. The seven largest property/casualty mutual insolvencies account for more than 80 percent of total mutual company insolvency costs through 2003, as follows:

Liquidation Date	Company Name	Net Payments	
		\$	%
1989	American Mutual Liability Insurance Company	324	21.0
1985	Ideal Mutual Insurance Company	291	18.8
1989	American Mutual Insurance Company	239	15.5
1998	PIE Mutual Insurance Company	181	11.7
1980	Cosmopolitan Mutual Insurance Company	117	7.6
1978	Consolidated Mutual Insurance	91	5.9
1985	Iowa National Mutual Insurance Company	49	3.2
		1,292	83.6
		253	16.4
		1,545	100.0

Interestingly, the chart shows that the only large mutual insolvency case since the 1980s is PIE Mutual, a situation in which collusion of senior management occurred and where a senior official at the domestic state insurance department was also implicated – a situation that internal controls alone would likely not be sufficiently reliable to prevent.

Comparing mutual v. stock property/casualty insurer insolvency costs over time yields the following chart:



As can be seen, since the 1980s, the only year that experienced any significant mutual company insolvency cost was 1998 when PIE Mutual was liquidated.

The conclusions reached by the NAMIC study in evaluating property/casualty insolvency data are:

- Mutual companies, particularly in recent years and over an extended time frame, remain an insignificant proportion of total property/casualty insolvency costs.
- Like most situations, there is an exception – PIE Mutual – but that situation clearly involved collusion by senior management and other factors that strongly suggest that internal controls could not have been relied upon to prevent its occurrence.
- Because mutual property/casualty insolvency costs are already so low, incremental improvements in internal controls will likely have an imperceptible impact on mutual insolvency costs; in other words, to improve controls, significant costs would be incurred, but there may not be a corresponding benefit to justify those costs.

### *Cost/Benefit Analysis*

To assess the potential cost impact on mutuals, the NAMIC study prepared a survey that was sent to NAMIC mutual company members with premiums in excess of \$25 million. The responses were analyzed, and results were extrapolated by company size category, as shown below:

Strata	Average Cost Per Company				(\$ in Millions)	
					Est. 2005	Est. 404
	Internal	External	Total	DW&AP	Mutual Premiums	Cost for Mutuals
\$1 billion >	\$10,108,500	\$3,450,000	\$13,558,500	0.183%	\$106,971	\$196
\$500-999 mm	814,429	955,714	1,770,143	0.239	12,155	29
\$250-499 mm	543,750	550,625	1,094,375	0.352	9,072	32
\$100-249 mm	302,786	285,667	588,452	0.364	7,293	27
\$25-99 mm	95,682	103,909	199,591	0.384	4,981	19
\$25 mm <					1,756	
					142,227	\$302

As can be seen above, the extrapolated estimated cost to NAMIC mutual company members exceeded \$300 million. On a percent of premium basis (referred to in the chart as DW&AP, for direct written and assumed premium), the cost to smaller companies is double that of the largest companies.

Respondents were asked to quantify the extent to which such implementation costs might change in the second year of compliance, yielding the following results:

Strata	Internal	External	Total
\$1 billion >	-45%	-10%	-36%
\$500-999 mm	-35%	-30%	-32%
\$250-499 mm	-35%	-48%	-41%
\$100-249 mm	-12%	-20%	-16%
\$25-99 mm	-14%	-15%	-14%

Generally, this chart shows a declining cost across most strata, but the extent of the decline decreases with company size. Thus, not only is the implementation cost more expensive for smaller companies measured as a percentage of premiums, but any second year cost-savings would also be proportionately less for smaller companies.

The survey also asked respondents to reply with employee headcount data, which is summarized below:

<b>Strata</b>	<b>Accounting &amp; Finance</b>	<b>Internal Audit</b>
\$1 billion >	404.0	104.3
\$500-999 mm	42.0	4.3
\$250-499 mm	14.9	2.4
\$100-249 mm	9.9	0.4
\$25-99 mm	5.4	0.3

Thus, for the smallest companies, there are fewer than six people on average who are involved in the financial function and internal audit combined. Even for companies up to \$500 million in premium, on average there are less than 20 individuals involved. This suggests that the burden to comply with internal control reporting requirements will be on the shoulders of a very small group of individuals. Much of the work would therefore have to be outsourced, which helps to explain why the estimated cost for smaller companies as a percentage of premiums would be much higher than for larger companies. It also calls into question the need for a COSO-like approach for companies with relatively few financial personnel on staff.

Given that \$300 million is the estimated first-year implementation cost for property/casualty mutual insurers to adopt the April 2004 version of the working group's proposal, the next question is to compare that with the corresponding benefits, which presumably would be a reduction in insolvency costs. However, the NAMIC study found that guaranty fund costs associated with the insolvency of property/casualty mutual companies from 1992-2003 aggregated, coincidentally, to about \$300 million. Two thirds of that was attributed to PIE Mutual, a situation that internal controls could not have been relied upon to prevent. Moreover, SOX compliance is not a one-time expense; there is an annual, continuing effort to maintain the documentation and testing effort in place and to report on effectiveness. Furthermore, the \$300 million of implementation cost is only for one segment of the industry – property/casualty mutual insurers. This suggests that the \$1 billion price tag for the entire industry that was put forward by others is probably in the ball park, and represents an amount that exceeds the aggregate current budgets of the various state insurance departments and the NAIC.

To put these findings in some perspective, it is helpful to consider the cost-benefit analysis that was calculated by the co-sponsors of SOX, Sen. Paul S. Sarbanes (D-Md.) and Rep. Michael G. Oxley. They noted that the benefit of SOX is the avoidance of the loss of market value – for example, the \$67 billion decline in market value for Enron, and the \$161 billion decline in WorldCom's

stock valuation. They concluded that the avoidance of such huge losses justify the cost of compliance, even for companies that have told them that they may each spend as much as \$300 million for first year implementation efforts alone.

By contrast, non-public insurers have no quantifiable measure that is comparable to market capitalization. They do not produce paper gains for shareholders, nor do they risk market losses. So, the loss of market value that can be avoided by non-public companies such as mutuals through a 404 compliance effort is zero. Thus, the NAMIC study focused instead on the actual costs of insolvency as the foundation for the cost-benefit analysis.

Based on the foregoing, the NAMIC cost-benefit study concluded that both the industry and regulators alike have a shared interest in insurance company solvency, and that a three-step evaluation should be undertaken in lieu of the NAIC's approach:

1. Study in detail the causes and effects of insurer insolvencies
2. Examine existing financial regulations/laws to determine shortcomings, if any
3. Develop targeted, cost-effective remedies to address identified weaknesses

NAMIC concluded that until this evaluation is complete, state regulators and legislators should reject proposals to apply investor-oriented protections to non-public companies, particularly through revisions in the NAIC's MAR. In the meantime, companies would, of course, be free to adopt provisions of the Act voluntarily, as indeed many have.

## Conclusion

In the few months that followed NAMIC's release of its cost-benefit analysis, the industry "Interested Parties" group presented and discussed with the working group proposed language as a substitute for the working group's April 2004 proposal. Based on factors derived from the original NAMIC study, the Interested Parties' proposal would result in first-year implementation costs to property/casualty mutuals that would range from \$80 million to \$88 million, a reduction from the \$300 million price tag of the working group's original proposal. The reduction in estimated cost was attributable to key changes as suggested by the industry "Interested Parties," which are summarized in Exhibit II:

- Raising the threshold to require internal control reporting from \$25 million to \$500 million of annual direct and assumed written premium.
- Eliminating the requirement for an independent audit of management's assertion on the effectiveness of internal controls

- Providing flexibility to management as to the framework or methodology to support their assessment of internal controls

In December 2005, the working group reached consensus on revised language largely based on the “Interested Parties” proposal, and voted to expose the collective revisions adopted by the Title II, III, and IV subgroups for public comment. In March 2006, the working group passed a motion to adopt the proposed revisions to the MAR with the following key recommendations:

- The Annual Statement Instructions for Annual Audited Financial Reports should not be changed for any of the proposed revisions, and states should be encouraged to adopt the revisions through specific legislative or regulatory action.
- The NAIC’s Financial Condition (E) Committee should expose the entire proposal for 45 days and then hold a public hearing to address any additional comments.

Exactly where the working group’s proposal will end up is unclear as of this writing, as its adoption of revised MAR language is not likely to squelch the debate. Ahead lies additional consideration by the NAIC leadership, and any resulting provisions would still have to be enacted by the individual state legislatures. A resolution passed by the National Conference of Insurance Legislators (NCOIL) in February 2006 assures that efforts to apply SOX-like provisions to non-public insurance companies will continue to be debated in state legislatures. Furthermore, some insurance industry representatives are reluctant to indicate their support for the proposal until the details of an “implementation guide” that is currently being drafted are also known.

Nonetheless, much work has been done, and many within the industry appear to be satisfied with the current version of proposal. However, some trade associations – including NAMIC – are not convinced. In its Jan. 31, 2006, comment letter to the working group, NAMIC indicated that it is not comfortable with the content of the proposed Title II and III changes, but will not object to them. However, with regard to the proposed Title IV changes as “now diluted in the alternate proposal,” NAMIC declared that “the internal control measures originally borrowed from the Act’s Section 404 are not defensible as rational and cost-effective state regulation of insurer solvency.”

## Sarbanes-Oxley, the Model Audit Rule, and the Perils of Overregulation

By  
Gary T. Strohm, CPA

The public was incensed – changes were needed to protect innocent investors! When Congress passed the Sarbanes-Oxley Act of 2002 (SOX), it did so to respond to several high-profile public company accounting meltdowns. They reacted in a swift, aggressive manner in order to restore confidence in the reliability of financial reporting of public entities. Two and a half years later, it is now evident that the legislation was neither perfectly drafted nor effectively implemented. Several delays have been granted to smaller filers, and additional guidance has been provided to internal accountants and external auditors whose over-reaction surpassed the initial intent of Congress in passing this Act.

As smaller public companies prepare for full compliance with SOX, they have seen many of their larger counterparts struggle with cost-effective implementation – many spending hundreds of millions of dollars. While there is a widespread belief that there are benefits, many question the value derived from the extensive effort expended, particularly related to the internal control documentation and testing component. Still, they have no choice, so they plod along trying to satisfy the Public Company Accounting Oversight Board (the body created by the Act to oversee accounting issues for public companies), their external auditors, and their shareholders.

Insurance regulators closely monitored what was transpiring at the public company level and saw enough similarities between shareholder and policyholder concerns to justify pressing for SOX-like changes for insurers. No specific major accounting scandals were cited in the insurer world. However, regulators believe that insurers should be held to the same or even greater degree of responsibility when it comes to corporate governance because of the public trust placed in them and their insurance products. This belief has led them to craft a new Model Audit Rule (MAR) that includes many of the same or similar provisions of SOX. The draft has been exposed for public comment and will likely continue to advance through the NAIC in 2006.

An interesting development worth watching relates to the recent tone of SEC commentary on the applicability of SOX to smaller public companies. Several SEC officials have expressed concerns that audit firms may be going too far in interpreting the regulations, and this may push the SEC to relax the requirements for internal control reviews for smaller companies. Wouldn't it be an ironic

development if ultimately some non-public insurers were held to higher corporate governance standards than their public counterparts?

The SOX-like provisions added to the MAR draft relate to Titles II, III, and IV of SOX. It is difficult to find much fault with the additions related to Titles II and III on Auditor Independence and Corporate Responsibility issues. In fact, many companies have already responded to suggested Title II and III changes by implementing prohibitions on non-audit services and strengthening audit committee activities and oversight. While there are arguments to be made for the efficacy of some of these improvements in corporate governance, particularly for smaller companies, the costs associated with implementing them are not nearly as overbearing as those required to implement Title IV requirements.

The Title IV provisions that are included in the draft MAR cause the most concern among non-public insurers. These provisions include primarily the development of a “Management’s Report of Internal Control over Financial Reporting.” The resistance relates to the extensive implementation costs to fully document internal controls and to develop this report compared to the modest benefits expected to be derived. The NAIC’s position continues to suggest that sufficient benefits exist and that the changes are absolutely necessary to complete the “quilt” of insurance regulation. It should be noted that the current “quilt” already includes a conservative statutory basis of accounting, risk-based capital requirements, periodic on-site regulatory examinations, external independent audits, actuarial opinion requirements, market conduct examinations, rating agency scrutiny, IRIS ratio analysis, and statutory limitations on investments, among other safety and security provisions.

As a public accounting firm serving mostly small to mid-size non-public insurance company clients, we note two perspectives that deserve additional consideration by the insurance industry, its regulators, and ultimately, state legislators who will be enacting these provisions.

First, most small to mid-size insurers oppose the insertion of most of the SOX provisions into their already highly regulated world via the MAR. While they acknowledge that some SOX provisions can improve corporate governance, they believe that consumers and the industry would benefit most from implementing SOX on a “best practices” basis. For many smaller insurers, adhering to the strictest interpretation of limitations on non-audit services from their independent accounting firms severely limits their options and flexibility in engaging service providers. As noted in a recent A.M. Best special report, *Insurance Auditors and Actuaries of North America*, there are a limited number of audit firms providing audit services to more than just one or two insurers.

Likewise, if these smaller insurers were to implement audit committees to the full extent contemplated in the draft MAR, they are going to face significant challenges in finding and retaining qualified individuals to serve effectively in this capacity. There is a limited pool of candidates with the requisite insurance knowledge; as demand for their services increases, so will the cost of retaining such individuals.

Changes in regulations for insurers often impact smaller insurers disproportionately. To emphasize this point, consider the effects of the initial implementation of the MAR which was adopted some 25 years ago. The MAR required most insurers to engage independent CPA firms to provide an audit of their financial statements. While an audit of a company that writes \$50 million in premium may cost \$XXX, the audit of a company that writes \$500 million is likely to cost much less than the proportionate equivalent of 10 times \$XXX.

Regulators may argue that they intend to allow for exemptions for smaller companies from the most onerous of the SOX-like provisions. For example, the exemption from the limitation on non-audit services provided by an insurer's external auditor can be requested if the insurer's direct and assumed premium writings are less than \$100 million. But that will ultimately be left up to the whims of state regulators and, based on commentary to date by various regulators, this exemption is only a guideline that may carry little weight in their state (e.g., one regulator suggested that he would resist giving this exemption to any insurer in his state). Such comments give cause for reflection regarding the permanence of other exemptions in the draft MAR – the exemption for smaller insurers from having to establish audit committees with a supermajority of independent members (insurers under \$100 million in premium) and the exemption from the requirement to prepare the report on the insurer's internal control over financial reporting (insurer's under \$500 million in premium).

While the current draft MAR (which includes much of the "Alternative Proposal" suggestions as advanced by the Interested Parties group, a group of involved industry representatives providing feedback to the NAIC/AICPA Working Group) includes all of these exemptions, how will they hold up to state-by-state interpretations? The thresholds for exemptions were raised high enough in this draft to get the majority of the trade groups to acquiesce, but will their acquiescence come back to haunt their membership as this new MAR moves through adoption in each respective state? (As we saw with the process for Codification of statutory accounting practices several years ago, numerous state differences were retained). In addition, how will these exemptions hold up to public scrutiny? If an insurer requests an exemption, will it appear as if they wish to avoid maintaining a good system of corporate governance? Only time will tell.

The second perspective that has not been well represented in previous discussions is the role of the independent CPA in serving small to mid-size insurers. While it is common for large insurers to have complex internal control structures that allow their independent auditors to test and rely on internal controls, that situation often does not exist for smaller insurers. Most have adequate, but not ideal, internal control situations. In these situations, potential weaknesses may be mitigated by executive or board member review. When a company has just three people in its finance area, this weakness (i.e. lack of segregation of duties) can only be remedied by this type of mitigating control or by adding staff. For many smaller insurers, the cost of additional staff may not be warranted for the benefits that are derived.

When external auditors face these situations, they are required to obtain an understanding of internal controls so they can adequately plan the audit process. Any control situations as described above are taken into account in devising the audit plan. Ultimately, if internal controls are not adequate, the auditor may be required to issue an internal control letter to the board of directors that states that the situation exists and that management has opted not to rectify the problem by hiring additional staff because the cost is prohibitive. The result can be a much more thorough, substantive audit focused more on the balance sheet of a company and less on the internal controls.

This point is significant if Title IV-type provisions are added for insurers, or if insurers feel compelled to follow them even if exempted because of market or regulatory pressures. Insurers will incur significant costs to strengthen internal controls and not necessarily have any better financial information to provide to regulators – lack of reliable financial information was cited by the NAIC as one of the main reasons for pushing so hard for the SOX-like provisions. The external audit firm has already designed an audit that allows them to opine that the financial statements are fairly stated in all material respects based on the internal controls that are present. Any improvements in controls may change the audit plan, but they would likely not change the ultimate deliverable from the original MAR (i.e. financial statements with an attestation by an independent CPA firm as to whether or not the financial statements are fairly stated).

In summary, insurance regulation and regulatory oversight have served the insurance industry very well throughout the years. Independent audits, as required by the original MAR, continue to play a vital role in the oversight mechanism, despite regulatory contentions that all these SOX-like changes are “absolutely necessary” to ensure that regulators are receiving accurate financial statements (an outright condemnation of the external audit process?). Regulatory changes such as these need to be implemented with diligence, keeping in mind the lessons learned from a rather hasty adoption and several subsequent

revisions of such rules at the public company level. There will be an undesirable outcome if regulators blindly follow the lead of public oversight adopting overly rigorous rules that offer little improvement in policyholder security and that add costs to the insurance product that will be borne by the consuming public. This is especially true if the SEC ultimately relaxes its requirements for smaller public companies.

We encourage legislators across the country to do their homework and stay abreast of the developments in the public company arena before they vote to adopt any changes that make for a more onerous regulatory environment for non-public insurers – keeping in mind that policyholders will ultimately bear the costs of this additional regulation.

## **Limiting UM/UIM Coverage to Injuries Sustained by Insureds: Reconciling Statutory Language with Overall Legislative Intent**

By  
**Paul Tetrault, J.D.**

The fundamental purpose of uninsured and underinsured motorist statutes is to provide some measure of protection for insureds who responsibly purchase insurance when they are involved in accidents with drivers who are either completely uninsured or have a low level of coverage. The statutes generally require insurers to provide coverage when an insured is entitled to recover from an uninsured or underinsured individual.<sup>1</sup> Usually, a claim for such coverage is based on an injury sustained by one who falls within the policy's definition of an insured, such as the named insured, the driver of the vehicle, or a passenger.

A sometimes vexing question arises when a policyholder asserts a claim for UM/UIM coverage that is not based on an injury sustained by the policyholder or any other insured but rather on an insured's right to recover for the wrongful death of a person, often a close relative who does not live with the named insured, who does not come within the policy's definition of an insured person.<sup>2</sup> For instance, an insured father whose daughter is killed by an uninsured motorist may assert a claim against his policy's UM coverage based on his right to recover for the wrongful death of his daughter. If the daughter did not live with the father and was therefore not a member of his household, she may not fall within the policy's definition of an "insured," so the claim would be based on a fatal injury sustained by one who was not an insured under the policy.

Such claims present a particular kind of problem for insurers, in that they have no way of measuring and assessing their exposure to the risk that the death of someone who is not an insured but who is related to an insured will result in a UM/UIM claim by the insured. Insurers asked by regulators about the potential impact of such claims expressed concern about the difficulty in rating the exposure, "saying that they would need a family tree from each applicant" in order to gauge the likelihood that an applicant would make such a claim.<sup>3</sup>

Courts in more than twenty states have ruled on this "narrow, yet important question," as the issue was described in a 2004 ruling by Maine's Supreme Judicial Court. The results are far from uniform, as courts in various states have come to contrary conclusions, but a clear majority position has emerged against coverage. Of the states that have addressed the issue, about seven have ruled for coverage.

In at least four of those states, the court decisions were subsequently superseded by corrective changes in the states' statutes.

The courts' decisions have differed to some extent due to the precise language of a given state's statute, but more particularly, due to the ways in which judges have viewed that language. In several recent cases, judges who have ruled or argued in favor of coverage have limited their consideration to the one operative phrase in the statutory language, while those who have concluded that the statutes should not be read to mandate coverage under this circumstance have taken a somewhat broader view, considering the relevant language within the context of the purpose and function of UM/UIM coverage. The split in opinion has resulted in those judges favoring coverage – based on a reading of statutory language that might be characterized as strict – accusing their judicial brethren voicing opposing views of engaging in judicial activism. The judges arguing against coverage, meanwhile, generally maintain that their view is consistent with the policy underlying UM/UIM statutes.

This very lively issue has caused a notable level of consternation for courts, frequently yielding reversals on various levels of appeal, split decisions, and strongly worded dissenting opinions. In Georgia, for instance, two judges issued a pointed dissent in *Atlanta Cas. Co. v. Gordon*, 266 Ga. App. 666 (2004) when the intermediate Court of Appeals reversed a lower court that had concluded the state's UM statute trumped a policy provision limiting coverage to injuries sustained by covered persons. The dissenting opinion accused the majority of adding its own view of what the legislature must have intended when it passed the statute instead of looking at the law's plain language. The dissenting opinion ultimately prevailed when the Court of Appeals decision was itself reversed in an extremely brief decision by the Georgia Supreme Court, at 279 Ga. 148 (2005). But unanimity was not had at that level either, as one of the Supreme Court justices dissented, saying he agreed with the "well-reasoned decision" of the Court of Appeals.

Similarly, when Maine's Supreme Judicial Court considered the issue in *Butterfield v. Norfolk & Dedham*, 860 A.2d 861 (2004), the majority came down in favor of coverage while two dissenting justices opined against it. Similarly, two justices dissented in *Gloe v. Iowa Mutual Insurance Co.*, 2005 S.D. 29 (2005), though in this case the dissenters favored coverage while a majority of the South Dakota Supreme Court ruled against mandated coverage.

This is not to say that unanimity, at least within a single court, is never attained. For instance, there were no dissenters in the case of *Eaquina v. Allstate Insurance Co.*, 2005 UT 78 (2005), where the Utah Supreme Court ruled that coverage was not required by statute.

A review of court decisions issued during the past two years shows that most judges who have argued for coverage, whether in a majority opinion or dissent, have done so by asserting adherence to the statutory language. The judges holding or arguing against coverage, on the other hand, have considered broader policy implications. They have asked whether requiring coverage under this circumstance makes any sense in the context of uninsured motorist law. The tendency for judicial policy considerations to weigh against coverage may provide some guidance for legislators considering how to respond to a judicial determination that coverage is mandated.

## Georgia

In *Atlanta Cas. Co. v. Gordon*, a decision that would be reversed on further appeal, the majority of the Georgia Appeals Court acknowledged that the language in the statute appeared to be clear on its face, but the judges could not bring themselves to believe the legislature intended to require insurance companies to pay damages for the death of a person who was not insured under the policy in question.

Quoting from previous case law, the Court pointed out that “[s]tatutes must be construed ... so as to square with common sense and sound reasoning,” and noted that the court’s duty is “to consider the results and consequences of any proposed construction and not so construe a statute as will result in unreasonable or absurd consequences not contemplated by the legislature.”

Again citing earlier case law, the Court noted that Georgia’s Uninsured Motorist Act was enacted “to require some provision for first-party insurance coverage to facilitate indemnification for injuries to a person who is legally entitled to recover damages from an uninsured motorist, and thereby to protect innocent victims from the negligence of irresponsible drivers.” The insured in the case did not suffer any injuries and was not the person the statute was designed to protect, the Court pointed out.<sup>4</sup> “Therefore, there is nothing in the above statement of the statute’s purpose which would support an interpretation that the legislature intended to compensate insureds for consequential damages arising from the death of a third party.”

Two judges dissented, referring to the majority opinion as “the activist interpretation of an unambiguous statute.” Addressing the fact that legislatures in other jurisdictions had seen fit to change their statutes following court decisions mandating coverage, the dissenting judges simply noted that Georgia’s legislature was fully capable of undertaking a similar course of action if it wanted to do so. The dissenters also suggested that looking to other jurisdictions was not instructive in part because other states’ statutes were worded differently.

Notably, the dissenters, whose position was ultimately fully endorsed by the state's Supreme Court, did not consider the wisdom or advisability of allowing recovery, but limited their analysis to the language of the statute, which they contended allowed an insured to recover from its uninsured motorist carrier for the death of a child who was not an insured under the policy.

## Maine

A similar distinction between the competing interpretations can be seen in the majority and dissenting opinions in the Maine Supreme Court's *Butterfield* decision, although the shoe was on the other foot, with the majority ruling for coverage and the dissenters arguing against it. The majority in *Butterfield* held that a policy provision limiting UM coverage to injuries sustained by an insured limitation was not valid because it conflicted with the state's uninsured motorist statute, which requires insurers to provide coverage "for the protection of persons insured thereunder *who are legally entitled to recover damages from owners or operators of uninsured, underinsured or hit-and-run motor vehicles ...*"

The Court focused on the italicized words and asserted its decision was determined by its holding in a case that addressed a similar point. While the majority in *Butterfield* believed that the UM statute had to be interpreted to require coverage in the situation presented, the dissenters asserted that the policy limitation "comports with our uninsured motorist statute, and is not contrary to our case law precedent," and pointed out that policy language limiting the scope of uninsured motorist coverage had been enforced by the Maine high court on several previous occasions.

The dissenters concluded that the limiting language was not only permissible, but also sensible. "Without the policy provision at issue in this case, Norfolk & Dedham could not accurately address the risk to which it is exposed in the uninsured motorist part of its policy, and on which it could base a reasonable premium," the dissenting opinion begins. "That provision limits the risks arising from injuries to a determinable number of persons, i.e. the named insureds under the policy and resident family members of the named insureds, and protects the insurer from risks that are unascertainable."

The dissenting opinion went on to refer to the policy limitation as "reasonable" and as "a common sense" provision. "The named insured limitation in its policy allows Norfolk & Dedham, as an insurer, to better ascertain its risk in calculating premiums to be paid for the coverage offered," the dissent pointed out. "The decision by the Court, when taken to its logical conclusion, means that an insurer offering uninsured motorist protection is prevented from restricting in *any* way the scope of coverage."

The dissenters thus went beyond the position that the provision is permissible under Maine law to point out that it should be so, because it makes sense, and that it would not make sense to not allow it. The majority opinion, in contrast, did not venture to address whether allowing the provision would represent good policy, but merely concluded that such a provision is not allowed under the statute as it exists.

Ultimately, a policy decision was made by the Maine Legislature in the 2006 legislative session when it passed corrective legislation specifying that insurers can limit UM coverage to injuries sustained by insureds.

### South Dakota

In ruling against coverage in *Gloe v. Iowa Mutual Insurance Co.*, the South Dakota Supreme Court focused on the public policy set forth in the state's UM/UIM laws, and "reiterate[d] that the purpose of these statutes is to protect the insured party who is injured in an accident."

The South Dakota Court pointed out that several of its cases "have noted that the purpose of UM/UIM coverage is to protect the *insured* party *who is injured* in an automobile accident by the negligence of an uninsured/underinsured motorist." [Emphasis in original.] The statute<sup>5</sup>, therefore, mandates coverage to provide such protection, according to the Court, which added that coverage is not mandated "for the consequential losses a wrongful death beneficiary incurs simply because that beneficiary has an auto policy and the decedent happens to be a relative for which the beneficiary is legally entitled to maintain a wrongful death action."

Thus, a majority of the justices decided in accord with "the clear majority of courts that have found no mandated UM or UIM coverage for the wrongful death of one not insured under the claimant's policy."

The majority in *Gloe* pointed out that allowing recovery results in an anomaly where the insured can recover when a relative dies but not when a relative sustains serious injury but does not die as a result. This is so because wrongful death statutes create a right of recovery when a close relative dies, but there is no corresponding right of recovery when a close relative is merely injured. After describing the anomaly, the Court concluded, "The legislature could not have intended that result."

This paradox was also noted in the *Gordon* case by the Georgia Appeals Court, which pointed out that the insured's right to recover for wrongful death is derivative of the decedent's right to recover, and if the decedent's son had not been killed but had only been injured, there would have been no right of

recovery under the father's policy. "There is no reason to reach a different result because the injuries were fatal," the Court asserted. However, as noted, the state's Supreme Court did not agree.

The dissenting opinion in *Gloe*, rather than looking at the overall purpose of the UM/UIM statute, zeroed in on the "plain meaning of the statutory language," asserting that the claimant "should be allowed to recover from his own underinsured coverage for the wrongful death of his parents."

The dissenters contended there is nothing illogical about the idea that the Legislature intended to allow recovery as sought and asserted there was no need to look to other jurisdictions because the language of the statute was not ambiguous.

## Utah

In *Eaquina v. Allstate*, 2005 UT 78 (2005), a woman asserted a UIM claim against her insurer after her adult son, who did not live with her, died from injuries sustained in an automobile accident. In doing so, she argued that Utah's UIM statute, stating that "underinsured motorist coverage provides coverage for covered persons who are legally entitled to recover damages from owners or operators of underinsured motor vehicles because of bodily injury, sickness, disease, or death," requires such coverage.

A unanimous Utah Supreme Court acknowledged a certain amount of "logical appeal" in the argument that the cited statutory language does not seem to allow insurers to restrict coverage. However, the Court asserted that such appeal persists only when the language is viewed in isolation. The argument's appeal apparently fades when viewed more broadly in the context of the entire UM statute, however, as the Court concluded that the statute does not require such coverage.

The *Eaquina* Court conducted a comprehensive review of the issue as handled by courts across the country, noting that the vast majority have ruled consistently with its holding, against coverage. And the Court pointed out that contrary decisions in three states – Ohio, Nebraska and Maryland – were subsequently corrected by legislation.

The Utah Court considered whether the limitation was permissible under the state's UM statute and concluded it was, and took note of the fact that allowing such a limitation makes sense from a public policy perspective. "An interpretation that would allow an insured to recover UIM benefits under her insurance policy for the death of a third party who is not covered under that policy would impose an unfair risk on insurance companies without

the attendant consideration in the form of a premium and, possibly, increase the cost of insurance for all consumers,” the Utah Court observed. “Such an interpretation would mandate an insurance company to provide UIM coverage to a wrongful death beneficiary simply because that beneficiary has an automobile insurance policy and the decedent happens to be a relative for which the beneficiary is legally entitled to maintain a wrongful death action. To judicially extend UIM coverage to include members of the family who are not residing with the insured would, in effect, require automobile insurance companies to insure any lineal descendant from whom an insured may inherit for hazards associated with the operation of vehicles.”

## Conclusion

A review of recent case law on this issue thus reveals two competing positions. The position for coverage is based on a reading of statutory language that can be characterized as strict, close, or narrow. The position against coverage is based on analysis of the overall purpose of UM/UIM laws together with consideration of whether allowing a limitation on coverage is reasonable as well as whether forbidding a limitation is unreasonable. (An exception to the dichotomy described is presented by the decision of the Court of Appeals of New Mexico in *State Farm v. Leubbers*, 119 P.3d 169 (2005). In *Leubbers*, the Court engaged in considerable consideration of policy issues and concluded that they weighed in favor of recovery. The decision has been appealed to the state’s supreme court for further review.)

The broader reading, while apparently having the advantage in common sense, is somewhat vulnerable to a charge of judicial activism. It is worth asking, however, whether the judges arguing against coverage have been somewhat forced into this often-maligned mode of statutory construction by deficient legislative drafting. In any case, it is important to point out that, where this matter is not an issue of constitutional interpretation, the courts do not have the final say no matter how activist they may seem. Rather, the state legislatures are free to respond to the judicial interpretations with whatever correction or clarification that may be warranted. And, as noted above, that is precisely what has happened, with legislatures in several states modifying their statutes to clarify that they do not provide coverage in these cases. The reported cases do not cite examples in which legislatures have changed statutes to provide coverage after a court has ruled against it.

In the legislature, it should be noted, the analysis is different from what goes on in a court. A judge may feel bound by what statutory language appears to indicate, even if that flies in the face of common sense and contradicts the overall intent of the statutory scheme. Legislators, of course, are able to consider policy

questions without such restraints, and enact statutory changes that are consistent with common sense. As the policy arguments advanced by several courts suggest, such an analysis should lead to the conclusion that the recovery sought in these cases is beyond the scope of the interest that UM/UIM statutes were enacted to protect; that limiting coverage to injuries sustained by an insured is reasonable; and that not allowing such limitation is, if not absurd, as some judges have suggested, at least unwise.

## Endnotes

1. For example, Maine's statute requires that all automobile liability insurance policies include coverage for "the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured, underinsured or hit-and-run motor vehicles, for bodily injury, sickness or disease, including death, resulting from the ownership, maintenance or use of such uninsured, underinsured or hit-and-run motor vehicle." 24-A M.R.S.A. § 2902(1). Georgia's statute states that the insurer is to pay "all sums which [the] insured shall be legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle." OCGA § 33--7—11 (a) (1).
2. State wrongful death statutes allow close relatives of decedents such as parents and children to recover in civil actions from those responsible for the death. These cases therefore usually involve situations in which the decedent is closely related to the insured, thus triggering the wrongful death statute, but is nevertheless not an "insured" as defined by the policy. Since most auto insurance policies include household members within the definition of "insured," the claims in these cases are often based on the death of a close family member who is not a member of the insured's household.
3. See *Report of the Bureau of Insurance to the Joint Standing Committee on Insurance and Financial Services on Uninsured Motorist Coverage and Butterfield v. Norfolk and Dedham Mutual Insurance Co.*, at [http://mainegov-images.informe.org/pfr/120\\_Legis/reports/ins\\_uninsured\\_motorists\\_2005.pdf](http://mainegov-images.informe.org/pfr/120_Legis/reports/ins_uninsured_motorists_2005.pdf).
4. The insured was the father of a minor who was struck and killed by an uninsured motorist. The minor was not living with his father and did not fall within the father's policy's definition of an "insured."
5. The South Dakota statute requires coverage "for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness, or disease, including death, resulting therefrom." SDCL 58--11—9.

## South Dakota Amendment Seeks Judicial Accountability, But at What Price?

By

Joe Thesing and David B. Reddick, Ph.D.

On Nov. 7, South Dakotans will go to the polls to choose their Gov. and 105 state legislators. They also will decide whether to retain the state's five Supreme Court judges and whether to re-elect the 38 Circuit Court judges running in nonpartisan races. But it will be Amendment E – a measure to remedy perceived wrongdoing by the judiciary – that is likely to capture the most attention and generate the strongest reactions among voters.

Amendment E is the brainchild of Ronald Branson, an ordained minister from California, who brought his largely Internet-based grassroots campaign to South Dakota in early 2005. He succeeded in convincing 46,800 residents to sign petitions in support of his Judicial Accountability Initiative Law (J.A.I.L.) amendment in order to have it placed on the ballot.

Branson's J.A.I.L. amendment builds from the premise that "the doctrine of judicial immunity has the potential to be greatly abused; that when judges do abuse their power, the People are obliged – it is their duty – to correct that injury, for the benefit of themselves and their posterity."

The amendment calls for creation of a 13-member Special Grand Jury composed of voters selected annually at random, who would hear complaints about judges and determine if indictments were warranted. If an indictment were issued, a 12-member special trial jury would be impaneled to hear the case against a judge and render a judgment. The special trial jury, not the special judge appointed to conduct the trial, would impose any penalty on the convicted judge. A judge receiving "three strikes" would be permanently removed from office.

However, if approved by South Dakota voters, the effect of Amendment E will be felt far beyond the state's court rooms. Amendment E would actually allow lawsuits against all South Dakota citizen boards, including county commissioners, school board members, planning and zoning board members, public utilities commissioners, and professional licensing boards, not to mentioned jurors, prosecutors, and, of course, judges.

As one would expect, the J.A.I.L. amendment has generated strong reactions among many South Dakotans, including 92 of the state's 105 legislators, who signed House Concurrent Resolution 1004 in early February. It urges "...all South Dakota voters to protect our citizen boards, to protect our system of justice, to protect economic development, to protect all our citizens from frivolous lawsuits that would be authorized by the Judicial Accountability Initiated Law, and to vote against Amendment E."

The “No on Amendment E” coalition has been formed to combat the initiative. This broad-based coalition of business, law enforcement, labor, legal, and insurance industry interests, including the National Association of Mutual Insurance Companies (NAMIC), will lead the charge to defeat Amendment E in November.

It should not be surprising that Branson and his J.A.I.L. amendment attracts support from voters who are frequently outraged by anecdotal accounts of seemingly unjust or wrongheaded judicial rulings. Every day, the mass media bombard us with stories about judges who issue opinions or make decisions contrary to laws enacted by state legislatures.

But the means Branson and his followers have chosen to attack judicial misdeeds will not achieve its intended purpose. Instead, as one South Dakota lawmaker aptly noted, “anarchy can be expected if it (the J.A.I.L. amendment) is passed by the people of South Dakota.” The doctrine of judicial immunity derives from our common understanding that an independent judiciary is essential to the functioning of a constitutional democracy. The rule of law, upon which constitutional democracy depends, demands that judges act as neutral arbiters of the law, without fear of reprisal from politicians or the public. By placing judges at the mercy of populist demagogues, the J.A.I.L. amendment would subvert the rule of law.

Implicit in Branson’s writings is the premise that judicial immunity is absolute, and that ordinary citizens have no recourse in addressing perceived judicial wrongdoing. However, that is simply not true. As in every other state, litigants in South Dakota may file an appeal of an adverse ruling in the appropriate appellate court. To protect against judicial malfeasance, a seven-member Judicial Qualifications Commission exists to review complaints brought by the public. Under the commission’s rules, disciplinary proceedings against a judge are confidential until the commission’s recommendation is filed with the State Supreme Court or the accused judge requests the matter be made public. The matter automatically becomes public if the disciplinary investigation derives from the conviction of a judge for a felony under state or federal law, or a crime of moral turpitude.

The practical idea behind the concept of judicial immunity is that it allows judges and citizen board members to perform their work without fear of harassment or liability for unpopular or unfavorable decisions. If the J.A.I.L. amendment were to become law, it would seriously undermine this concept, and threaten the integrity of the entire system of government. How many qualified people would want to be a judge or serve on a school board if doing so meant having to live with the constant fear that a complaint about a judicial act or board decision would result in a special grand jury investigation and possible indictment?

Finally, and perhaps most importantly, Supreme Court justices and Circuit Court judges are already accountable to South Dakota voters. In the case of the state’s five Supreme Court justices, voters have the opportunity every eight years to decide whether to retain them in office.

The 38 Circuit Court judges are subject to nonpartisan elections. In 2004, South Dakota voters were asked to consider a constitutional amendment to allow Circuit Court judges

to be retained like their Supreme Court counterparts, but voters defeated the measure by a 2 to 1 margin. On Nov. 7, all five Supreme Court justices and 38 Circuit Court Judges will face voters.

Whether Ronald Branson and his followers ultimately succeed in South Dakota remains an open question, but the fact that 24 other states have initiative provisions that could lead to measures such as this one being placed on their ballots should serve as a wake-up call to anyone who supports maintaining the independence of the current state judicial system.

## Notes On Contributors

**Robert Detlefsen, Ph.D.**, is director of public policy at the National Association of Mutual Insurance Companies (NAMIC). His articles and commentaries have appeared in numerous publications, including the *Journal of Insurance Regulation*, the *Risk Management and Insurance Review*, *National Review*, *The New Republic*, and *Reason*. He is the author of a book, *Civil Rights Under Reagan*, and has taught courses in American government, constitutional law, and political theory at several colleges and universities. Detlefsen is a graduate of the University of Massachusetts, Amherst, and holds a Ph.D. in political science from the University of California, Berkeley. He can be contacted at [rdetlefsen@namic.org](mailto:rdetlefsen@namic.org).

**Tom Finnell, CPA**, is managing director of Invotex Group ([www.invotexgroup.com](http://www.invotexgroup.com)), a full service financial and economic consulting firm that serves the business and legal communities, the insurance industry and governmental entities in matters involving disputes, investigations and examinations, financial analysis, reorganizations, and valuations. He was commissioned by NAMIC to evaluate the estimated costs and benefits to implement the then-proposed April 2004 proposal of the working group for reporting or internal controls. Finnell can be reached at [tfinnell@invotexgroup.com](mailto:tfinnell@invotexgroup.com).

**Lawrence Mirel, J.D.**, joined the Washington, D.C., law firm of Wiley Rein & Fielding as a partner in October 2005. For the previous six years he served as commissioner of Insurance, Securities and Banking for the District of Columbia. As a member of the National Association of Insurance Commissioners (NAIC), he was active in international insurance issues, setting up an International Regulatory Cooperation Working Group which provides training to non-U.S. insurance regulators. He also established the Class Action Litigation working group to explore the impact of such litigation on regulatory authority. He is a graduate of Oberlin College and Columbia Law School and has been an adjunct professor at the American University School of Law and the George Washington University School of Law. He can be contacted at [LMirel@wrf.com](mailto:LMirel@wrf.com).

**D.J. Powers, J.D.**, is an attorney in private practice. He formerly served as general counsel at the Texas Department of Insurance, and was the founder of the Center for Economic Justice, located in Austin, Texas. He can be contacted at [djpowers@swbell.net](mailto:djpowers@swbell.net).

**David B. Reddick, Ph.D.**, is senior state affairs manager at the National Association of Mutual Insurance Companies (NAMIC). He monitors legislative and regulatory issues in 10 southeastern states. Prior to joining NAMIC in 1999, he spent nearly five years as the government relations officer for a Wisconsin-based national health insurance carrier. He also worked five years with the Indiana Department of Insurance, the last two years as chief deputy commissioner. He is a former newspaper reporter and editor. Reddick holds master's and Ph.D. degrees from Michigan State University and a B.A. degree from the University of Windsor (Canada). He can be contacted at [dreddick@namic.org](mailto:dreddick@namic.org).

**Gary T. Strohm, CPA**, is managing partner of Strohm Ballweg, LLP, a CPA firm based in Madison, Wis. that specializes in serving insurance entities throughout the country. He actively follows the many issues affecting small to mid-size insurers through attendance at NAIC meetings, participation in NAMIC's Accounting Committee, and attendance at IASA and numerous other insurance industry groups. Strohm is a graduate of the University of Wisconsin, Whitewater, from which he received a BBA in Accounting. He can be contacted at [gstrohm@strohmballweg.com](mailto:gstrohm@strohmballweg.com).

**Paul Tetrault, J.D., ARM, AIM**, is northeast state affairs manager for the National Association of Mutual Insurance Companies (NAMIC). He served for many years as a writer and editor at *The Standard, New England's Insurance Weekly*. A graduate of Villanova University and Suffolk University Law School, Tetrault has earned the Associate in Risk Management and Associate in Management professional designations from the Insurance Institute of America. He served as a judicial law clerk for an associate justice of the Massachusetts Appeals Court and practiced law in the areas of litigation defense and insurance coverage. He can be contacted at [ptetrault@namic.org](mailto:ptetrault@namic.org).

**Joe Thesing** is north central state affairs manager for the National Association of Mutual Insurance Companies (NAMIC). He represents member companies before state legislatures and departments of insurance in ten states: Kansas, Michigan, Minnesota, Montana, Nebraska, North Dakota, Ohio, Pennsylvania, South Dakota and Wisconsin. Before joining NAMIC, Thesing served for three years as deputy director of legislative services at the Ohio School Boards Association and for five years as a program director and special assistant at the U.S. Department of Justice in Washington, D.C. He also served in a variety of positions at the Ohio Attorney General's Office from 1991 to 1994. Thesing holds a Bachelor's Degree in History from Ohio University. He can be contacted at [jthesing@namic.org](mailto:jthesing@namic.org).



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Mutual Insurance Companies  
3601 Vincennes Road  
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