Determining Bad Faith in Claims Handling Litigation: An All-Inclusive Approach

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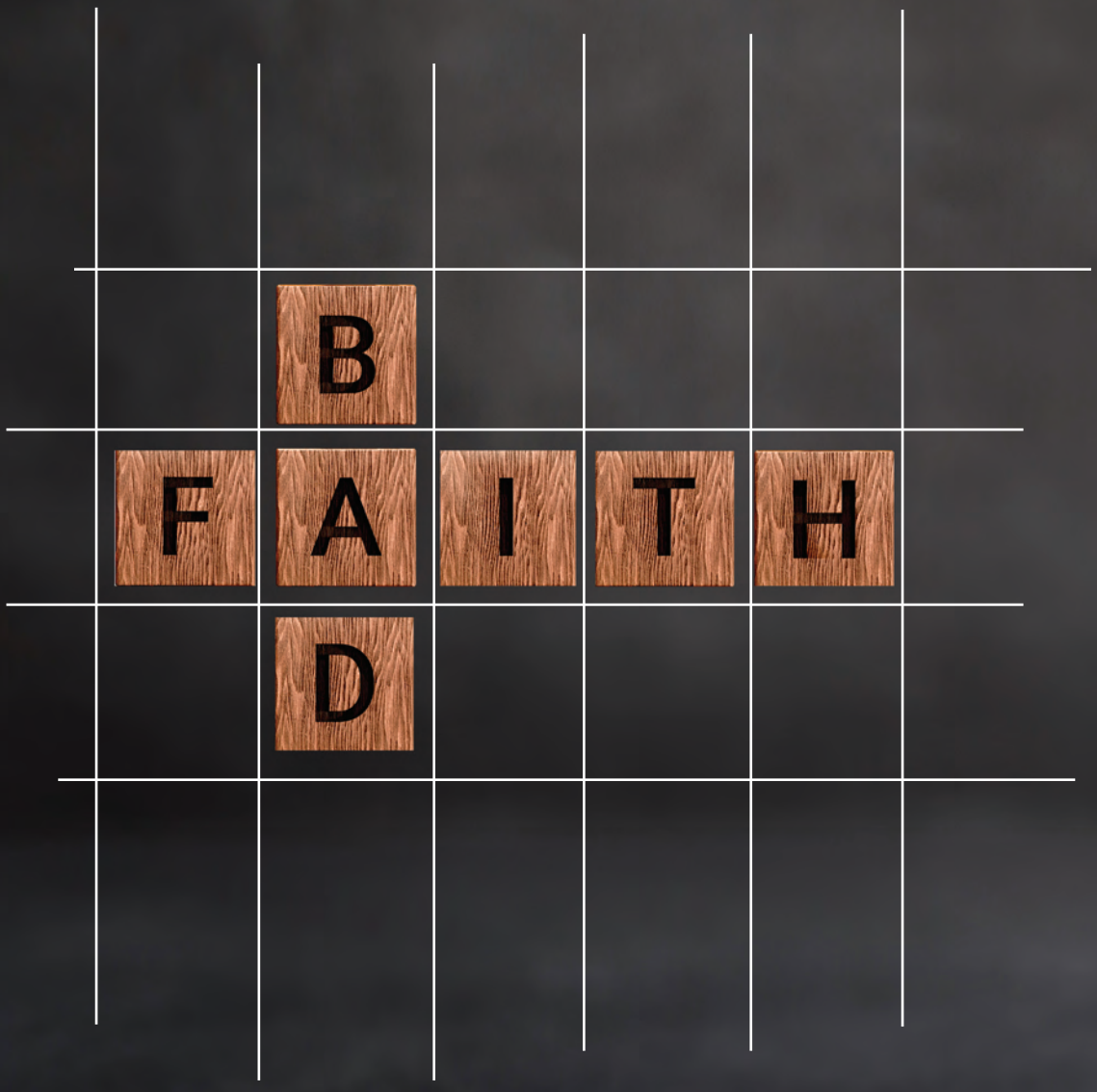


A court that concludes that an insurer acted in bad faith may have overlooked important factors. This article examines how attorneys and claims professionals can take a holistic approach, as opposed to a fragmentary approach, to potential bad faith on the part of an insurer to provide a supportable conclusion.

The 18th century economist and philosopher Edmund Burke is quoted as saying, ***"No power so effectually robs the mind of all its powers of acting and reasoning as fear."***

Regardless of your field of expertise—claims professional, defense counsel, plaintiff's attorney, or expert witness—this commentary probably resonates with you.

Insurers have survived a continuous onslaught of slings and arrows hurled by attorneys and policyholders seeking to clothe insurers in a shroud of greed, motivated only by their salacious desire to make money—classic irony, because this couldn't be further from the truth.

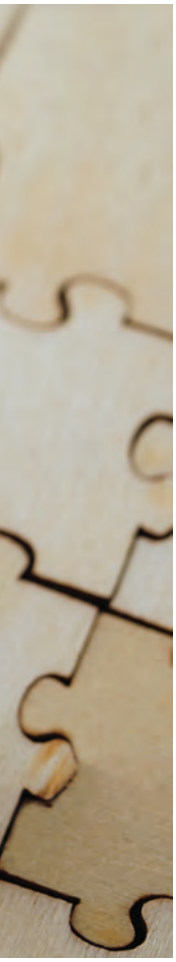
In nearly every state, insurers are charged with a duty of good faith and reasonable care in evaluating claims for settlement based on honesty and diligence. And most insurers adhere to this responsibility.

A corollary to this precept is that an insurer should never place its own financial interests above those of its policyholders. So, giving equal weight to its own interests and policyholders' interests is not evidence of good faith.

In today's litigious environment, which often involves large judgments, the mere suggestion of bad faith on the part of the insurer frequently, and unfortunately, causes the insurer to take a fear-induced approach to the allegation. Even when such allegations are factually strained, insurers often choose to settle bad-faith claims rather than litigate them, due to the possible outcomes.

Expectations of Claims Representatives

I was a neophyte claims adjuster for the Insurance Company of North America (INA) in 1968.[1] In addition to on-the-job training, several multipage manuals provided technical training.



INA's claims philosophy in 1968 was the same for an insurer then as it is today:

> *No claim can be known to have been properly concluded which has not been properly investigated. This is an irrefutable statement. The end result of every claims investigation is the payment of a sum of money or the denial of any payment whatsoever. Sometimes, on the basis of inadequate or improper investigation, the correct amount is paid or a claim is properly denied. This is a refutable statement. For unless there was an adequate and proper investigation, we do not really know if payment or the amount or denial was justified. Thus, we can positively state that a proper claim result cannot be assured without an adequate and complete investigation... Almost the entire effort in claims investigation can be summed up simply in three words: Get the facts.*[2]

Many insurers have compartmentalized and individualized tasks that were once handled by one claims professional by assigning them to sub-areas within claims departments. For example, an insurer may assign different individuals to tasks for auto physical damage, building damage, liability investigation, settlement negotiations, subrogation, and salvage.

Nonetheless, very little has changed regarding insurers' overall approach to claims, whether first- or third-party: Collect the facts, evaluate the claim, and pay it or deny it.

In a 2021 case, the Arizona Supreme Court stated this regarding the insurer's responsibility when handling a claim: [3]

> *To act reasonably, the insurer is obligated to conduct a full investigation into the claim. The Court has described the insurer's role as "an almost adjudicatory responsibility." To carry out this responsibility, the insurer "evaluates the claim, determines whether it falls within the coverage provided, assesses its monetary value, decides on its validity and passes on payment." The company may not refuse to pay the settlement simply because the settlement amount is at or near the policy limits. Rather, the insurer must fairly value the claim. The insurer may, however, discount considerations that matter only or mainly to the insured—for example, the insured's financial status, public image, and policy limits—in entering into settlement negotiations. The insurer may also choose not to consent to the settlement if it exceeds the insurer's reasonable determination of the value of the claim, including the merits of plaintiff's theory of liability, defenses to the claim, and any comparative fault. In turn, the court should sustain the insurer's determination if, under the totality of the circumstances, it protects the insured's benefit of the bargain, so that the insurer is not refusing, without justification, to pay a valid claim.*[4, 5]

In this situation, the claim could not be settled. The insurer made an offer that was lower than expected—an assertion of the insurer's failure to negotiate in good faith. And a bad-faith lawsuit will almost always follow a bad-faith claim.

Once litigation begins, the plaintiff's attorney usually requests, among other things, the claim file, claims committee meeting notes, and internal casualty claims manuals and uses them to ferret out the insurer's supposed bad-faith actions.

The modus operandi of most bad-faith experts is to treat claim file entries as a Jenga game.[6] For example, the claim file is like the vertical game tower, and the expert treats each distinctive entry as a separate, unconnected block; removes it; and sets it aside. The expert then highlights these entries in the claim file, ultimately weaving them into a noncontextual series of "facts" to support a bad-faith conclusion.

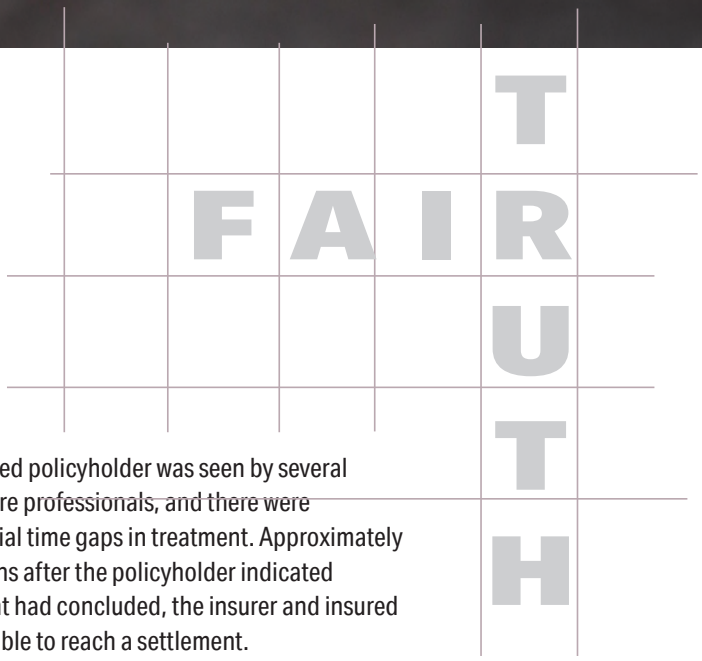
Real-World Examples

Consider this example of an insurer placing its own interests above a policyholder's:

> The insurer in this case recently entered the lawyers' professional liability market. In its haste, the insurer based its own applications and policy forms on the admitted filings of other carriers and Insurance Services Office, Inc. (ISO) and generally available public documents.

The policyholder was a law firm. Its policy appeared to be cobbled together, which created several ambiguities in policy language. However, the policy contained an appropriate retro endorsement.

At policy renewal, the law firm partner responded to application questions and denied that any



claims existed. After the policy was renewed, a claim against the law firm was presented.

The insurer intractably denied coverage and threatened a rescission action, forcing the law firm to file a declaratory action. The insurer's outside coverage counsel recommended that the insurer file a declaratory action, and the insurer demurred.

During deposition, the claims professional who denied the claim was asked, "Do you recall whether there were concerns with regard to filing a declaratory judgment action?"

The claims professional responded: "I think it was about expense. We don't want to spend the money."

The matter was settled to the policyholder's satisfaction.

The next example demonstrates the Jenga approach to determining bad faith:[7]

The policyholder was injured by an uninsured driver who failed to stop at a red traffic signal. The policyholder was taken by ambulance to a regional hospital and treated for several injuries, including concussion without loss of consciousness.

Although it was later determined that the policyholder had been using a handheld phone at the time of the occurrence, liability of the third-party driver was not challenged, and comparative negligence was not made an issue.

The claim was originally assigned to a property damage adjuster, with the property damage claim settled to the insured's satisfaction. Also, the policyholder's medical bills were paid to the policy's medical pay limit.

Because the third-party driver was uninsured at the time of the accident, approximately six months later, the insurer opened an uninsured motorists bodily injury (UMBI) claim on behalf of the insured and assigned it to several claims professionals.

The injured policyholder was seen by several healthcare professionals, and there were substantial time gaps in treatment. Approximately 11 months after the policyholder indicated treatment had concluded, the insurer and insured were unable to reach a settlement.

Thereafter, the insured began another series of treatments, which lasted an additional 20 months, again with substantial time gaps.

After obtaining all of the insured's medical records, the insurer made a settlement offer that the insured deemed too low. As a result, the insured hired counsel to litigate the value of the claim, and the plaintiff's counsel employed an expert to determine whether the insurer engaged in bad faith.

During the bad-faith litigation, the policyholder's insurer produced claims notes consisting of 95 pages and hundreds of individual entries. The plaintiff's expert had removed these Jenga blocks:[8]

- The insurer assigned a property damage adjuster to settle the property damage claim with the insured. The plaintiff's expert, ignoring the task assigned to this adjuster, denounced her and the insurer for failing to open a UMBI claim: "The claims representative handling appeared focused on the repairs relative to the insured's vehicle, but little if any UM [uninsured motorists] claim-related activities were documented. In fact, there is no documentation provided suggesting CR [claims representative] even opened the UM coverage, and nothing to indicate he was investigating the insured's injuries or treatment."
- The expert opined that because the UMBI claim was opened 193 days after the occurrence, which he concluded falls well below industry standards and is an extremely dangerous and unfair claims practice, the insurer was in bad faith in the handling of the UMBI claim.

- The UMBI claim was not ready for settlement for approximately 31 months due to substantial gaps in treatment and a lengthy delay (not caused by the insurer) in obtaining a complete set of medical records. The expert placed responsibility for this delay on the insurer because the expert could not find any claim log entry or logged activity seeking the medical records. The expert then opined that a lack of transactional evidence on the insurer's part was evidence of bad-faith claims handling, even though all medical invoices and reports were in the insurer's claim file before the insurer made an offer.
- The insurer considered certain medical treatments and bills too remote from the occurrence and not connected to the original injuries incurred, and the plaintiff's expert, who was not a doctor, determined that the insurer lacked any reasonable basis not to consider these medical bills, and thus opined that the insurer had acted in bad faith.
- The injured party's spouse, who was also a named insured on the policy, inquired about the diminished value of the policyholder's damaged vehicle. The adjuster reminded the policyholders that they had rejected uninsured property damage coverage. Although this exchange had nothing to do with the UM/UIM (underinsured motorists) injury claim, the plaintiff's expert concluded that the insurer had not provided a reasonable explanation for the lack of coverage. Therefore, the insurer acted in bad faith.

Many attorneys and their experts use this approach—cherry-picking, hyperbolizing, and uniting individual unconnected events—to support allegations of bad faith. However, it doesn't consider the insurer's and claims representatives' overall claims handling.

Because there is simply no such thing as a perfect claim file, sometimes the insurer's claims adjusting may support a conclusion that the insurer acted in bad faith. However, hindsight and perfection are not the standards that govern an insurer's actions. Reasonableness is.

The next example reviews a claim made by an umbrella insurer against a primary insurer for bad faith in an excess verdict matter:

> The adult claimant and her daughter were injured in a motor vehicle accident when another vehicle struck their vehicle from behind with such force that it was driven into the stopped vehicle in front of it. This caused the claimant's airbags to deploy and extensive damage to both the front and rear of the vehicle.
>
> The third-party's claim was assigned to a senior claims resolution specialist. The third party had auto policy limits of $250,000/$500,000 and an umbrella policy with a different insurer.
>
> The primary policy's adjuster displayed bias against the policyholders by undervaluing both claimants' claims and ignoring defense counsel's observations after depositions of both plaintiffs as well as the findings of the doctor who conducted an independent medical examination on behalf of the third-party insurer.

The senior claims resolution specialist continually updated the umbrella insurer, predicting that the claim value would not exceed the primary limits. The claimants' counsel made several demands for settlement, all well within the primary policy limits.

A trial resulted in an excess verdict of $700,000 for the claimant's daughter. The umbrella carrier instituted litigation that included a claim for bad-faith claims handling.

Very seldom is a smoking gun in a claims log. But after the daughter's deposition, wherein defense counsel concluded that she was not malingering and would make a good witness at trial, the primary insurer's senior claims resolution specialist made this entry:[9]

> So, the deposition of [the daughter]. I sure have a different conclusion from what I read. She's massively exaggerating her injuries and has been malingering for almost 3 years. She has knee pain from sitting too long? That's a new one. She bled through bandages onto her pants so frequently and so badly that her mother had to bring her pants to school? She had abrasions from the airbags. They're not going to bleed through anything. Her claims of massive bleeding are not supported by the ER records nor any kind of reasonable knowledge of abrasions. She wasn't even taken to the ER by ambulance, despite all this claimed bleeding. Hell, if what she claimed was happening actually happened, I would think her parents would have taken her back to the hospital because of the risk she was going to bleed to death. As if this entry was not sufficient, referring to the independent medical examination (IME) doctor's findings and diagnosis, and the deposition of the daughter: . . . but my reading of the report shows someone exaggerating her injuries well out of proportion to the evidence in the medical records. Despite no evident limitations in the medical reports, so far as school or work are concerned, she was often inconsolable during the depo.... These are just a few of the patently ridiculous claims she makes that aren't born (sic) out by any medical documentation or reasonable probability. I don't think she'll appear at all well before a . . . jury.

"Many attorneys and their experts use this approach—cherry-picking, hyperbolizing, and uniting individual unconnected events"

This entry demonstrates a subjective approach to the claim as well as a lack of professionalism by the claims

personnel. The primary insurer settled the umbrella policy insurer's bad-faith claim prior to trial.

When evaluating potential bad-faith claims adjusting, a comprehensive overview of the insurer's actions can provide a supportable conclusion. Therefore, attorneys and claims professionals should take a holistic approach when determining whether the insurer's actions demonstrate bad faith (or a lack of good faith).

What Is a Holistic Review?

To determine whether a bad-faith claim exists, attorneys and claims professionals should answer several questions:

- Was the claim handled in a professional manner? How was the policyholder treated?
- Was coverage confirmed?
- Are there any comments in the claim file that suggest bias on the part of the adjusting staff toward the claimant—whether first or third party—that influenced the staff's attitude?

- Was a full and complete investigation of the claim conducted? This includes obtaining important information, such as:
  - Statements of the parties and witnesses
  - Photographs of the scene of the occurrence and damage to the vehicles
  - All medical records, including invoices and narrative reports of treating healthcare providers
  - Verification of lost wages
  - An independent medical evaluation, if necessary
- If an attorney was involved, did the claim file include any negative comments regarding that attorney that were not fact based (that is, subjective versus objective comments)?
- Was communication between the insurer and claimant and the claimant's attorney appropriate?
- Were there any violations of the state's Unfair Claims Practices Act?[10]
- Did any claims personnel appear hostile toward the claimant or the claimant's attorney?
- Did the insurer's compartmentalization of responsibilities create any noticeable problem during the handling of the claim? Did any delay due to the compartmentalization affect handling of the claim?
- Were the claim file entries objective? Did the file include any subjective comments not supported by other information in the file that demonstrate a predisposition to undervalue or deny an otherwise clear liability claim?
- Was a computer model used to evaluate the claim? If so, how reliable is the computer model/software used within the insurance industry?
- When was any settlement demand made on behalf of the claimant?[11] Did the insurer have all documentation necessary to evaluate the claim?
- Was the demand for settlement made in an attempt to create a bad-faith situation?

- Did the claim valuation appear to be fair and reasonable?
- Were the company's internal guidelines followed?

When reviewing the claimant's expert's opinion, the opposing attorney and expert rebuttal witness should consider some additional questions:

- Did the expert cherry-pick claim file entries (that is, use the Jenga approach)?
- Did the expert hyperbolize the actions of the insurer? For example, "This is the worst action on the part of an insurer I have ever seen."
- Did the expert use improper characterizations of the insurer's actions? For example, claim bad faith for the insurer denying a claim when the insurer made an offer that was rejected.
- Did the expert appear to conclude that the insurer was guilty of bad faith before reviewing the entire file?
- Some experts who opine that an insurer acted in bad faith for the way a claim was handled may also advance opinions regarding the actions of insurer-appointed defense counsel. But appointed defense counsel represents the insured, not the insurer.

Generally this type of opinion is out of bounds and of little value, particularly if the expert is not an attorney. Even the most basic personal injury lawsuit is dynamic, and second-guessing litigation counsel's decisions cannot possibly take into account the nuances of litigation. ■

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1. Insurance Company of North America (INA) was the oldest stock insurance company in the United States, founded in Philadelphia in 1792. It was one of the largest American insurance companies of the 19th and 20th centuries before merging with Connecticut General Life to form CIGNA in 1982 and was acquired by ACE Limited (now Chubb Limited) in 1999.
2. Policyholders Service Division Training Program, INA, Training Guide–Volume IV, p. 3.
3. *Apollo Education Group v. National Union Fire Insurance Company of Pittsburgh*, 480 P.3d 1225 (AZ 2021).
4. All citations omitted in quote.
5. *Id*., 2021. The *Apollo* case involved a dispute between the insured, Apollo Education Group, and National Union Fire Insurance Company of Pittsburgh, Pennsylvania. The National Union Directors and Officers policy did not contain a contractual duty to defend; the insured defended itself if sued. Apollo settled a shareholder class action suit, which National Union refused to consent; the amount in controversy was $13.5 million. Apollo then brought an action against National Union for breach of contract and bad faith.
6. The Hasbro game of Jenga consists of 54 hardwood blocks that are stacked into a tower of three wooden blocks at right angles, ending with an 18-story tower. The object of Jenga is to remove one block at a time from the tower and then stack it on top. The last player to stack a block without making the tower fall wins the game.
7. The facts have, of necessity, been abbreviated.
8. Sentences in quotes are taken verbatim from the expert's report.
9. The following is the verbatim information provided to the insurer: "Overall [the daughter] will make a good witness. I believe the jury will be very sympathetic to her because of testimony that she still has scars on her legs and that she is self-conscious about them. In addition, she did not seem to over exaggerating (sic) her injuries or [be] malingering. In addition, I expect that the jury will be sympathetic to the fact that she is still having limitations because of knee."
10. Although most Unfair Claims Practices Act statutes generally do not provide a basis for a civil action against an insurer, they can be used to demonstrate the insurer's lack of attention to the claim.
11. Some plaintiffs' attorneys will make demands for settlement before the insurer has had an opportunity to fully investigate and evaluate the claim. When the insurer indicates it cannot consider a settlement before conducting an investigation, the attorney will claim bad faith. Fortunately, most courts see through this artifice.