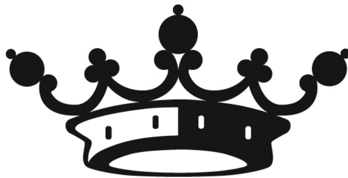
INSIDE THE MINDS

Minimizing Insurance Liability

Leading Lawyers on Navigating State and Federal Regulations, Evaluating Exposure, and Drafting Agreements



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Minimizing Liability by Understanding Key Risks and Implementing and Enforcing Best Practices

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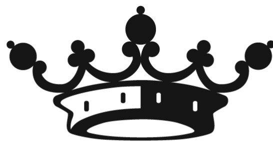

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Opening Statement

Every insurance company faces litigation as a cost of doing business. However, companies can minimize their losses from litigation through implementation of the "best practices" discussed herein and by monitoring and abiding by different states' laws. As discussed more fully below, there are a multitude of insurance laws and regulations that insurers must be abreast of and in compliance with for each of the fifty states. Insurers will face varying legal hurdles depending on the state in which they do business and which products they sell. Although some areas of concern, such as bad faith claims, are no longer as dangerous as they once were, new concerns such as problems associated with mergers/acquisitions and major medical health insurance are on the rise. The following discussion of "best practices" provides practical and generally applicable advice to assist insurers in limiting their liability to agents and insureds for a variety of issues.

A Broad Overview of Insurance Rules and Regulations

Most regulation of insurance takes place at the state level. As a result, the law of insurance lacks the uniformity that comes from broad federal regulation. It is important to realize that each state approaches insurance a little bit differently than the other states, so it impossible to give global answers to insurance questions. Each state has its own laws that insurance companies must abide by, and each state has a state Department of Insurance that creates rules and regulations with which the insurance companies in that state must comply. With the exception of a few federal laws, insurance law is a creature of the states.

Most of the federal laws in the insurance area pertain to privacy issues, including guidelines with respect to protecting medical records in the health care context. However, there is no single federal governing body for the insurance industry. This absence of a unifying federal regulatory scheme has not, however, led to a complete lack of uniformity among the states, largely due to the work of an organization called the National Association of Insurance Companies (NAIC). The NAIC publishes guidelines and standards with which it suggests insurance companies should comply. Oftentimes state regulations and rules comport with the guidelines

established by the NAIC. When a state follows a NAIC model rule, there is a wealth of explanatory materials produced by the NAIC to aid in interpreting the rules. It is important to remember, however, that states need not adopt NAIC rules and are not bound by NAIC interpretations.

Therefore, it can often be difficult for insurance companies to ensure that they comply with the many variations in state law with respect to certain policy requirements. As a result, even though an insurance policy may be standard in some respects, it might have some unique provisions in each state. Furthermore, even if a policy was previously approved by the state Department of Insurance, guidelines in that state can change and insurance companies must comply with the new guidelines. It can often be difficult for adjusters to remember to look at these state guidelines on a frequent basis, but an insurance company cannot simply rely upon the existing policy language when evaluating claims and hope to comply with the regulations of all the states all the time. For example, many states require that all policies give insureds a look period longer than the thirty- to ninety-day look periods commonly listed in most insurance agreements. In the context of health insurance, some states require that certain procedures or care for certain conditions be covered in all policies notwithstanding policy language to the contrary. It is important for insurance companies to realize that insurance regulations are generally not default rules that an insurance company can draft its policies to avoid. Instead, these regulations are mandatory rules that apply even if they conflict with clear language in the policy.

Some states are more rigid in enforcing their regulations than others are. In general, California is one of the more difficult states for insurance companies, agents, brokers, and their lawyers because of its more stringent guidelines, and because the Ninth Circuit is known to be stricter in upholding damage awards against insurers. Florida and Pennsylvania are also considered stringent states with tough guidelines for insurers. Of all theories under which insurance companies face liability, fraud remains the most difficult allegation to overcome largely because issues of fact make fraud cases improper for resolution on summary judgment. Also, the possibility of punitive damages in fraud cases makes plaintiffs and their counsel more likely to pursue a vigorous litigation strategy and makes it more difficult to assess the settlement value of a case.

While insurance laws are generally regulated by the state Departments of Insurance, oftentimes the attorneys general might get involved if they find troublesome activities, such as schemes to defraud insureds, theft, elder abuse, or schemes involving straw agents.

Risks Associated with Insurance Depends on the Type of Insurance Sold

An insurance company's exposure in insurance litigation varies greatly depending on what type of policies the company sells. On the one hand, life insurance policies are a fairly stable book of business, and they operate under a stable set of laws and regulations. On the other hand, soaring costs are causing the state rules and regulations pertaining to health policies and, in particular, long-term care policies, to change rapidly and unpredictably.

Health Insurance Liability Claims

Major medical health insurance is the type of insurance that has the greatest liability claims. When someone's major medical policy is at stake and benefits are denied, damage to the insured's health often results. Therefore, damages can be claimed not only for the denial but also for the person's inability to get treatment for their condition. This risk of consequential damages is especially present if the insured has cancer, payment is denied, and the insured cannot afford treatment.

The health insurance application itself plays the biggest role in minimizing liability for an insurer; therefore, it is important to examine the application and the questions it contains. A health insurance policy will often require a person to record their medical history, and in many cases, an insurance company can assess its risk on a policy based on whether certain aspects of the insured's medical history were accurately revealed. For example, smokers will need to pay a higher premium, and applicants who have had heart problems in the past will pay a higher premium or may not be able to get insurance. In any event, a good application and application procedures insulate a prospective insurer from litigation risks.

Long-Term Care Policies

Another type of policy that has shown to be dangerous for insurers in terms of liability is long-term care policies. Currently, Congress is investigating these policies due to the high rate of denials and payment complaints on the part of senior citizens. Many of these policies were sold when the medical care costs were lower and meeting these claims have become increasingly difficult for insurance companies, as the costs for home health care and nursing home care have skyrocketed, and premiums have not gone up as fast as the costs. Indeed, denying claims of the elderly insured can be more inflammatory for a company, especially one operating in a state such as Florida or Arizona, where elderly citizens live in higher concentrations. Although Congress has recognized the problems in long-term care insurance and has recently begun to regulate some aspects of the area, it has been a challenge to win approval for long-term care rate increases, even with proof of need. These rate increases are quite unpopular—largely because they affect seniors. These issues virtually guarantee that there will be more changes in this area.

Annuities

There has also been some major liability for insurance companies in the annuity context, depending on how the annuities are supposed to be paid and if there are fees involved in terminating the policy. In some instances, early termination by the insured results in prohibitively heavy fees and penalties. In addition, equity-indexed funds run the risk of underperforming if the stock market suffers. Consumers who fail to appreciate the terms of their annuities or the risk in the investment often turn to litigation if they face significant losses. As always, careful disclosure to potential customers can prevent a large amount of this litigation.

Evaluating Exposure

Evaluating an insurance company's exposure with respect to the policies it sells is the responsibility of the actuarial department. The primary goal of the actuarial department is to assess policies, look at claims experience on a certain block of business, and assess how that business will perform today and in the future. It is important to keep track of when a certain block of business is

getting significantly out of balance in terms of premiums coming in versus claims paid out. When this imbalance occurs, the actuarial department needs to be able to verify that any premium rate increase requests are justified. The state Department of Insurance must agree to any increase in premium rates, and it typically takes twelve to eighteen months to get an increase in place. Therefore, companies that follow best practices need to start analyzing and justifying any rate increase requests as soon as a particular block of business starts showing signs of imbalance.

With respect to a litigation, companies typically evaluate their potential exposure by asking outside counsel to review a case and assess whether it is dangerous or not. Of course, things can sometimes change during the discovery process, and companies have to be informed of those changes. Examples of changes about which a company should be made aware include any attempt to litigate as a class action, a claim that is amended from a garden-variety breach of contract claim to include a bad faith or fraud claim, and a transfer to a less-favorable forum.

Liability Concerns for Failure to Pay a Claim

For insureds, it is important to keep in mind that the most important features of an insurance contract are the fine language that most people never read—i.e., what does this policy pay, when does it pay, and how does it pay? Many of the policies that are sold are limited liability policies that might pay for a certain cancer, heart, or stroke risk as specifically defined in the policy. Other policies may be hospital confinement policies that are not major medical policies. Consumers often get confused about what their policy will pay, and they need to be aware that a policy only pays in the circumstances that are outlined in the policy.

Every insurer is faced with a situation where they have to decide whether a claim should or should not be paid. If it is a close call, companies should evaluate the amount of the claim, the jurisdiction in which the claim is pending, and whether the insured has made a formal complaint to a Department of Insurance or retained an attorney.

The primary liability concern in a failure to pay a claim is if an insurance company is found to have acted in bad faith. If bad faith is found, then a

jury may award exemplary damages, including punitive damages, in addition to the claim amount. Otherwise, the insurance company's exposure is generally limited to actual damages for a breach of contract, and actual damages are arguably the amount the company would have been responsible for had it paid the claim.

The courts are requiring more evidence to find bad faith in a claims denial case—indeed, a plaintiff is almost required to prove that the insurance company had information in its possession that said it should have paid a claim, but it did not. In most cases, if it is a close call as to whether a claim should be paid or not, the courts are ruling that there may have been a breach of contract but not bad faith, because the company had an arguable reason to deny the claim. A company's exposure to bad faith liability can be greatly reduced by constructing and adhering to sound claim review procedures. Following a proven process every time makes it very difficult for a company to be held liable for bad faith refusal to pay.

With respect to decisions regarding failure to pay and bad faith claims, changes are state-specific. In a large number of states, the courts are less willing to find instances of bad faith than they used to be. Where the difference between breach of contract and bad faith may have been treated as a question of degree in the past, courts have increasingly separated the concepts of breach of contract and the tort of bad faith into clearly different claims. The standards for proving breach of contract are stable and not onerous, but plaintiffs bringing a bad faith claim must prove that an insurer had enough evidence to pay a claim and yet denied it. While a broadly accepted test for what conduct rises to the level of bad faith has not gained acceptance, the conceptual shift toward viewing bad faith as a tort has created a recent trend away from findings of bad faith in insurance claim litigation, especially where the insurance company relies upon a reasonable interpretation of its policies. *See Shelter Mut. Ins. Co. v. Barton*, 822 So. 2d 849 (Ala. 2001) (holding that an insurer is liable for bad faith only where it either had no basis to refuse a claim under the insurance contract or it intentionally failed to determine if such a basis existed); *White v. American Cas. Ins. Co.*, 756 N.E.2d 1208 (Mass. App. Ct. 2001) (holding that an insurance company that relied upon plausible interpretation of insurance contract cannot ordinarily be held liable for unfair claims settlement practice). In light of this emerging trend, the best practice is for insurance

companies to focus on complying with their claims review procedures. Where these procedures are followed, it will be very difficult for a potential plaintiff to allege that the company acted in bad faith.

Dealing with Bad Agents

One difficult area for many insurance companies involves dealing with what is called a rogue or bad agent—an agent who purposefully fails to represent the company in the proper manner. Most contracts allow a company to terminate an agent for any reason with written notice, and most also contain a provision whereby a company can terminate an agent for certain listed causes.

However, some of the most dangerous litigation in this area occurs when a company decides that a bad agent's activities justify terminating the agent for cause and the agent sues the company for wrongful termination. Unfortunately, because the legal standard is so difficult for a company to meet when it comes to terminating an agent for cause, the insurance company will often find it difficult to have a court dismiss these types of lawsuits. As a result, these cases typically become long, protracted legal battles. Despite the challenges presented by litigating with terminated agents, a company that believes that an agent has been acting inconsistently with company policy has an obligation to dismiss them. Failing to terminate a bad agent exposes the company to much more risk in litigating with the agent's disgruntled or defrauded customers than forcing the issue with the bad agent.

Merger and Consolidation in the Industry Have Caused Issues As Well

Finally, it should be noted that there was a huge merger/acquisition movement within the industry a few years ago, and some insurance companies have had difficulty catching up with the blocks of business they purchased. Many companies are still trying to digest their acquisitions and learn how the newly acquired businesses work and how their claims are paid. For example, an insurer that bought two or three different companies may find that those companies have differing systems for servicing similar policies. In many cases, substantial computer conversions are required to get policies that were administered differently or on different systems to operate on the same system.

Moreover, when policy administration systems are incompatible, new problems arise on a go forward basis beyond the retrofit issues. Resolving these issues is important for companies that are trying to get all of their acquisitions serviced in the same way so that they can reduce their field force and create the synergies that motivated the acquisition.

Best Practices to Minimize Insurance Liability

Some insurance companies have tried to minimize liability by using independent contractors as agents. When agents are not employees, the company has an extra layer of legal protection that can reduce exposure for their actions. At best, this strategy has resulted in mixed success. Ultimately, most insurance companies are found liable for the acts of their independent contractor agents because the sale of the insurance policies benefits the insurance company and an agent's actions are usually within the scope of the authority granted by the insurance company. Accordingly, providing sales training for all agents, including independent contractors, is the best way for insurance companies to reduce their liability. Insurance companies can require independent contractors to agree to abide by guidelines set by the company, and provide training sessions on their products and best practices. The creation of independent agents has not proven to reduce an insurance company's potential liability without further training.

Serving the consumer efficiently also helps to reduce liability; in many cases, the insured gets upset where there is delay with respect to processing a claim, or in deciding what will or will not be paid. Fortunately, most insurance companies are striving to create a better and quicker claims review and payment process. For example, many insurers are trying to achieve a ten-day turnaround on claims payment, a goal that is requiring them to upgrade their systems and to train their claims adjusters to have quicker response times.

Insurance companies typically have had the greatest success in minimizing liability by implementing best practices, implementing better agent training and education, and by creating fraud divisions to seek out suspicious activities (such as the use of straw agents, a sudden increase in the number of applications from a particular agent or group of agents, or a high lapse rate) to deal with problem areas in a timely manner.

Five Key Steps

In order to minimize liability when selling an insurance contract, it is important to follow five key steps:

1. *Read and know the terms of the contract and train agents on how the contract works so that it can be explained to potential customers.*

Benefits: As previously noted, most lawsuits in this area arise when there is a misunderstanding with respect to what is claimed by one side or the other, and sometimes these misunderstandings arise simply because the agents did not take the time to learn about the policies they were selling. Independent contractors who sell insurance policies are not beholden to any one company because they sell policies for many different companies. These agents do not concentrate on one company or one type of policy and therefore they may have some confusion with respect to how certain policies work. Therefore, it is essential to provide better training of agents, including independent contractors, before they begin selling policies. They need to know exactly what it is they are selling.

It is important not to allow the agent's duties to overshadow the fact that the consumer also has responsibilities in this area. The insured will often look at a four- or five-page insurance contract and sign it without reading. The insured may think that he or she can simply rely on what they believe the agent said—but insurance law does not work that way. Indeed, in almost every state, there is a duty to read an insurance contract, and an insured is held to the contract language. Accordingly, consumers need to understand the importance of reading insurance contracts and asking questions.

2. *Record by tape or video all presentations to potential insureds.*

Benefits: In the event of a dispute with respect to an insurance transaction, if an insurance company has a video or audiotape of that transaction that it can play back, both the company and the insured can then know exactly what was said. Recording these transactions therefore serves the double purposes of reducing abuse by agents and reducing fraud claims by insureds. Relying on recordings removes the doubts and disputes that occur

from relying on faulty memories. Indeed, the most common sources of insurance litigation are disputes concerning what an agent told or failed to tell a consumer. A consumer may claim that an agent put down incorrect information on their application. He or she may claim to have informed the agent about a certain issue, but the agent said not to include it in the application. If a transaction has been recorded and a dispute later arises, it is possible to know exactly what was said. A company armed with this knowledge can avoid fraud claims by removing most "he-said, she-said" factual disputes.

3. *Upon delivery of the contract, explain the terms and any rescission rights the customer has.*

Benefits: People often mistakenly believe that having a policy ensures that a claim will be paid, no matter what. In light of this misunderstanding, it is important to have a discussion if certain conditions must be met before a policy claim will be paid. This practice can help to prevent any anger and frustration the insured may have later when something happens down the road and a claim cannot be paid.

With respect to rescission rights, after the policy is delivered and the consumer signs the delivery receipt, the agent is supposed to remind the consumer there is a thirty-, sixty-, or ninety-day right to review and, if the consumer desires, to terminate the policy. Therefore, this review period is the time to look over the policy and make sure that it meets the consumer's needs. A dissatisfied consumer can always request a return of any premiums paid at this early stage. Emphasizing this right to consumers lessens tensions that arise when consumers face coverage questions after a loss has occurred.

4. *Respond to questions by insureds in a timely manner.*

Benefits: Most insurance companies have a tracking system to ensure that the company adequately responds within a certain time period to any questions that a consumer may have. A key point in insurance litigation is if an insured has called the insurance company repeatedly in an attempt to receive clarification with respect to a claim and gets no response or a response that does not answer the question. In these instances, the insured may feel compelled to get legal representation. It is important that insurance

companies avoid this situation by having enough trained personnel in place to handle customer questions. An insurance company should also have checks and balances in place so that an inquiry moves up the ladder, and if an adjuster does not have the answer it should go to a supervisor, and then to the legal department, if necessary.

5. *Comply with the Terms of the Policy.*

Benefits: It is easy to forget that insurance contracts are individual contracts. When a dispute arises, an insurance company cannot rely on its business practices, its agents' training, or its most recent policy changes. The controlling document is the particular consumer's policy. The insurance company's success or failure in the litigation will be determined by its adherence to that one document.

This fact has two main implications for insurers. First, an insurance company should strive to achieve uniformity in its policies. Uniform policies make it easy to set up computer systems to process claims, easy to train agents to sell and answer questions about policies, and easy to determine which claims are covered and which are excluded. This uniformity is efficient and allows companies to focus on its core business instead of getting mired in the details of myriad individual policies.

Experience shows, however, that achieving uniformity is a tall order. Especially in light of the market consolidation trend in the insurance industry, companies provide insurance under many different policies with many different requirements. As a result, the second implication of the primacy of the individual policy is that insurers should train their employees and agents always to look at the particular policy language in question instead of relying on general impressions or the latest policies. An employee or agent who takes the time to read before speaking can avoid significant litigation exposure.

Achieving Success in Minimizing Liability

Insurance companies that have been most successful in minimizing their liability have a good claims paying procedure; a good training program for agents and field force with respect to how a policy operates; a

system in place to respond to questions in a timely manner; and a system for moving a complaint up the ladder so that it is addressed before an attorney gets involved.

The best compliance programs are those that are based at both the adjuster and the consumer level. A company needs to have adjusters who understand the company's policies and are in compliance with how they work; and at the consumer level, you need to have a sales force who correctly explains how your policies work, and who also explain the consumer's rights when they purchase those policies.

Final Thoughts: The Importance of Best Practices

One of the most important best practices to minimize liability in the insurance area is simply getting consumers to understand that they are going to be bound by the terms of their policy. Some companies have been proactive in this area by launching educational campaigns to get consumers to understand that they need to read their insurance policies. At the same time, companies should always remember that they too are bound by the same terms that bind their customers.

In this same vein, it is important for companies to be sure that they are paying claims and responding to questions in a timely and routine manner. Handling claims is a large part of the business of insurance and companies that want to avoid litigation must handle claims and inquiries effectively and efficiently.

Finally, one easy thing that most companies can do to reduce their litigation risk is to have agents start tape recording their actual sales. Such a simple practice could give companies a powerful weapon against frivolous suits and increase their ability to control and evaluate their agents' performance.

Minimizing litigation risks is not something that an insurance company can achieve by magic. Instead, the companies that do the best to minimize their exposure are the companies that remember to do a few basic things very well.

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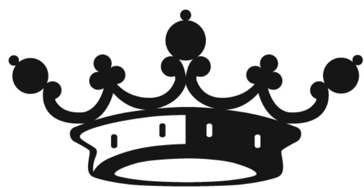

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