

What should worry all insurers?

First-party bad-faith lawsuits

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What should worry all insurers? The risks from plaintiffs' actions against insurers alleging first-party bad faith, including the extra-contractual and punitive damages sought.

Insurers should consider a comprehensive approach to managing the risk of facing a bad-faith claim. Their strategies should include steps taken before selling the policy, precautions when considering a claim under the policy, and carefully considered approaches when defending a lawsuit based on the policy.

Life, health and disability insurers should also separately consider preemption under the Employee Retirement Income Security Act of 1974, which can eliminate the risk of bad-faith claims for many policies.

Generally, insureds can assert first-party bad-faith claims or third-party bad-faith claims, which can be described as follows:

- **First-party bad faith:** The plaintiff alleges that the insurer refused to pay a claim without a reasonable basis or failed to investigate the claim properly.
- **Third-party bad faith:** The plaintiff alleges that the liability insurer did not reasonably defend or settle a claim against the insured within policy limits.

The focus here is on first-party bad faith, which can be asserted against all insurers. Third-party bad-faith claim issues are not addressed.

BEFORE THE POLICY IS SOLD

Before a policy is even sold, an insurer can take steps that reduce its bad-faith claims risks.

Goals and incentives

To minimize the risk of facing a bad-faith claim, insurers should make sure that a plaintiff's lawyer cannot characterize their internal goals, incentives, performance evaluations, or anything else as evidence that individuals who handle claims have a personal motive to deny them even when they should be paid.

Having an internal goal of processing a certain number of claims should not be a problem, especially if denying a claim takes more time than approving it. However, having an internal goal of

denying a minimum number or a minimum percentage of claims might be problematic.

A plaintiff's lawyer would welcome the opportunity to tell a jury that it must return a punitive damages award that is large enough to make the insurer change its internal goals or incentives.

Sales practices

Insurers should make sure they have good sales practices. As an initial consideration, good sales practices can reduce the risk of lawsuits based on alleged misrepresentations, which also usually seek extra-contractual damages, including punitive damages.

Furthermore, some lawsuits that allege a bad-faith claim begin with an insured's misunderstanding of what the policy covers based on how the policy was sold. In addition, many lawsuits that assert a bad-faith claim also include fraud claims.

By having objective criteria and limiting subjective judgment calls, insurers can limit the risk of facing bad-faith claims.

Moreover, having both fraud and bad-faith claims in the same lawsuit can magnify the risk that a jury will want to compensate the insured and to punish a "bad" insurer.

Policy language

Insurers should also make policy language as clear as possible, defining the events that trigger benefits and the amount of benefits by using criteria that are as objective as possible.

Many bad-faith claims arise from unclear policy language.

One might think that to assert a viable bad-faith claim, a plaintiff would have to be entitled to judgment as a matter of law on the contract claim. However, in many jurisdictions that is not the case. Instead, many courts submit the contract claim and the bad-faith claim to the jury together.

Other bad-faith claims can arise from judgment calls that the policy language leaves to those handling the claims.



For example, decisions about whether a condition was pre-existing, a death was accidental, or an individual is totally disabled all can have subjective aspects.

When feasible, insurers should consider having only objective criteria or, for claims decisions that require judgment calls, including objective criteria. By having objective criteria and limiting subjective judgment calls, insurers can limit the risk of facing bad-faith claims.

Arbitration

To minimize the risk of bad-faith claims, insurers may consider — for certain jurisdictions and for policies not funding an employee benefit plan governed by ERISA — having all policy-related claims resolved by arbitration. Some state insurance codes expressly allow arbitration; some expressly prohibit it; and many do not mention it.

Arbitration is commonly viewed as posing less risk of runaway awards based on emotion. But there are no guarantees in arbitration, just as there are none in other litigation. And if arbitration results in a runaway award, there are almost never any appeal rights.

Arbitration is supposed to be cheaper and quicker than other litigation, but it usually does not provide for early dismissal or dispositive motions. In some jurisdictions, it can be the best option, but it is not a panacea.

WHEN HANDLING A CLAIM

When considering a claim and before a lawsuit is filed, insurers should consider what steps it can take to prevent or minimize bad-faith claims.

Details describing good claims-handling practices vary by type of insurance, and a complete discussion is beyond the scope of this commentary. Some general guidelines and suggestions follow.

Good claims denials

While the standard varies by jurisdiction, bad-faith tort claims require a showing that the denial was not only wrong but also that the reason given was not reasonable or not debatable — or some other similar standard.

Insurers would not (or at least should not) deny claims for no reason or for a bad reason. In other words, they should have a good reason — based on policy language — for denying a claim.

Most likely, an insurer will have to defend a bad-faith claim based solely on the reasons for the denial given in the denial letter or other communication to the insured.

Insurers should write and send denial letters with all possible good reasons for denying a claim and explain those reasons in language that a typical juror can understand. If jurors cannot understand the reasons for a denial, they

probably are more likely to find the claim was denied in bad faith.

Good claims processing

Common sense makes it clear that insurers can minimize the risk of bad-faith claims by implementing good claims-processing practices.

In addition to having good claims-handling practices, insurers must be able to convince a jury that they have good claims-handling practices.

Putting aside the question of whether a claim should be paid, when handling a claim an insurer should recognize that every written word from it to the insured probably can be read to a jury.

Moreover, the insurer's internal communications, notes and relevant communications with third parties also can usually be read to the jury.

Insurers should write and send denial letters with all possible good reasons for denying a claim and explain those reasons in language that a typical juror can understand.

Even a delay in communicating, a lack of communication, or a lack of notes or other writings indicating that the claim was being handled promptly can usually be brought to the jury's attention.

Some may believe this sounds trite, but another way to express the same idea would be to say that, when handling a claim, an insurer should follow the golden rule: Treat others as you would wish to be treated.

Always be polite, cooperative and professional with insureds; handle the claims in a prompt, thorough and honest manner; and make sure these good claims-handling practices are documented. Then, an insurer can demonstrate to the jury how well the claim was handled.

Documenting good claims-handling

An insurer needs to document its good claims-handling practices so they can be proven in court.

Possible claims-handling documentation practices to consider include:

- Date-stamp materials and number pages when received.
- Keep good telephone notes or memos, including of no answers.
- Keep good notes or memos of all activity.
- Consult experts when appropriate.

- Provide experts with all facts and no opinions.
- Send or summarize any new information to the insured for response.
- Inform the insured in writing of what information the insurer reviewed.
- Invite the insured to submit any additional information.
- Follow up even when it is another's turn to respond.
- Add related emails to the claim file.
- Maintain records to avoid spoliation motions or arguments.
- Follow all written claim procedures or guidelines carefully.
- Do not write down speculation, opinion or gratuitous comments, such as, "Gee, maybe Bob should have..." "This lady cannot be telling the truth," or "I am so tired of her calling every day."
- Assume a jury will read all written notes, memos or other materials.

Bottom line: Do not handle a claim in a way a jury would not like; do not allow documents to be created that would allow a jury to be given the impression that the claim was not handled well; and create documents showing that the claim was handled well.

The ACA and health claims

Health claims must comply with the Affordable Care Act's Internal Claims and Appeals and External Processes Review. An April 15, 2016, slide presentation by the Centers for Medicare and Medicaid Services about the process can be found at <https://marketplace.cms.gov/technical-assistance-resources/internal-claims-and-appeals.pdf>.

The Department of Labor also has a website with related resources that help one understand the ACA's administrative claim review requirements. The website address is <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/internal-claims-and-appeals>.

As a practical matter, the ACA's claim requirements have almost eliminated bad-faith claims for ACA-covered health benefits.

The ACA requires external reviews to be independent. If an external review finds a claim to be payable, the insurer pays it. If the independent external review finds a claim is not payable, alleging bad faith would seem to be frivolous.

Unless an insurer uses a biased external reviewer, does not provide the appropriate information to the external reviewer,

or otherwise games the external review, the risk of bad-faith claims for ACA-covered health benefits probably is remote.

For non-ACA claims, an insurer might consider adopting concepts derived from the ACA's requirements.

For example, as reflected on a link above, the CMS has summarized the notice requirements for ACA-covered adverse health benefit determinations as follows:

- Describe reason(s) including specific plan provisions, scientific judgment used.
- Describe any additional information needed to improve or complete the claim.
- Provide sufficient information to identify claim.
- Provide notification of internal appeals and external review rights.
- Provide notification about health insurance consumer assistance or ombudsman office availability.
- Provide notification that Culturally & Linguistically Appropriate Services (CLAS) are available.

Always be polite, cooperative and professional with insureds; handle the claims in a prompt, thorough and honest manner; and make sure these good claims-handling practices are documented.

DOL claim regulation

For non-ERISA claims, insurers might consider adopting concepts from the DOL claim regulation, 29 C.F.R. § 2560.503-1.

While no reported cases commenting on this practice were found, plaintiffs' lawyers have used the DOL claim regulation at deposition to question witnesses as to why a non-ERISA claim was not handled in the same manner as an ERISA claim would have been handled.

While arguably not a proper opinion, one might see a plaintiff's claims-handling expert testify that the DOL claim regulation provides the minimum standard of care and an insurer in bad faith did not meet that standard.

WHEN A LAWSUIT IS FILED

After a plaintiff files a lawsuit asserting a bad-faith claim, an insurer should consider litigation strategies to prevail and to minimize the damages that might be recovered.

Appropriate steps include evaluating the forum, filing initial or other early venue and dispositive motions, limiting

discovery, conducting affirmative discovery, conducting witness interviews, preparing witnesses, retaining experts, limiting punitive damages, and settling.

The forum

At times, a change in forum can be outcome determinative: The judge or the jury pool might be the difference. Actions seeking a change in forum, such as those listed below, normally must be taken almost immediately:

- Remove to federal court based on ERISA preemption.
- Remove to federal court based on diversity.
- Move to transfer venue based on improper venue.
- Move to transfer venue based on forum non conveniens.
- Move to compel arbitration.

Opportunities for diversity removals to federal court at times arise as more information develops.

As to diversity removals, an insurer might consider arguing fraudulent joinder, moving to dismiss a non-diverse defendant, or conducting discovery to establish that a plaintiff seeks damages above the amount in controversy required for federal jurisdiction.

Initial or early motions

Initial Rule 12(b) motions or early-but-not-initial Rule 12(c) motions (judgment on the pleadings) or an early summary judgment motion might result in having a bad-faith claim dismissed before discovery.

A strategy to dismiss the bad-faith claim early might be particularly helpful. This is because it can limit the scope of discovery, thereby avoiding the risk that a plaintiff will develop evidence that will enable it to defeat a later summary judgment motion.

In some forums, even if the insurer cannot have the bad-faith claim dismissed, it may be able to have the court strike or dismiss the plaintiff's bad-faith pattern and practice allegations.

In some forums, however, the chances of having any early dispositive motions granted is remote and the most likely consequence of filing such a motion might be educating the plaintiff's lawyers on the facts, the law and the insurer's theory of the case.

Limiting plaintiff's discovery

Plaintiffs often seek discovery that some judges may allow and others may not. These include written claims procedures, training materials, arguably similar claim denials or approvals, complaints by other insureds, goals for claims-handling, payments, denials, incentive programs, performance evaluations, personnel files, statistics on

claim denials and approvals, reports or presentations for management, or communications with insurance-rating companies.

On the other hand, do not resist providing discovery of evidence that the insurer probably wants to use affirmatively, such as favorable claims statistics.

The extent to which the plaintiff's discovery is actually limited often turns on the predisposition and discretion of the judge.

Try to make the judge want to help the insurer. For example, affidavit evidence about the burdensomeness of responding or legal arguments about the irrelevance of requested discovery may help persuade the judge.

Consider being proactive during a scheduling or status conference or with a motion for a protective order. Do not just wait to respond to a plaintiff's motion to compel.

"An insurer's duty to defend does not depend on the technical legal cause of action asserted, but on the facts alleged or otherwise available to the insurer," the appellant says.

Discovery from plaintiff

An insurer should almost always take affirmative discovery from a plaintiff.

Many topics of discovery might be related to the policy and to a plaintiff's understanding of the policy coverage.

Formal and informal discovery might seek information about a plaintiff's other litigation or about other credibility issues (for example, criminal convictions).

If a plaintiff seeks mental distress damages, that may open the door to all types of discovery about medical treatment, activities and social media.

While insurers should be careful, making an insured look less sympathetic to a jury can help reduce the liability and damages risks.

Witness interviews

Insurers should interview key internal and any third-party witnesses early.

First, a lawyer representing an insurer should consider making it clear to an internal witness being interviewed that the lawyer represents the company and not the witness (an *Upjohn* warning).

If the internal witness has done something questionable, the lawyer will want to tell the client, the insurer.

An insurer should define what it wants to prove — its litigation objectives — and let witnesses know those objectives.

Memory is fallible, so an insurer should first and early interview and document the memories of its employees, its other agents and third parties.

Witnesses should be interviewed and prepared on who, what, when, where, why and how.

The interviewer should know the file well enough to ask tough questions, if appropriate, and not to accept answers at face value.

Witness preparation

Insurers should make sure their lawyers prepare each witness to be deposed or to testify at trial as they would for any other high-stakes lawsuit.

For example, having witnesses practice answering direct and cross questions — and even videotaping witnesses — should be considered.

Usually, a plaintiff's best bad-faith evidence will come from cross-examination of the insurer's witnesses.

Through those witnesses, plaintiffs' lawyers may attempt to portray the insurer as greedy, uncaring or a threat to the safety and security of society (the plaintiffs' "reptile theory").

Plaintiffs' lawyers' questions may attempt to have witnesses admit to "rules" that protect insureds.

For example, a series of questions may intend to establish that the primary rule for an individual handling a claim is to protect the insured from all the bad consequences flowing from not having the insured's claim paid.

Often, these may seem to be relatively innocuous questions seeking yes or no answers.

When preparing witnesses, have each witness:

- Know the insurer's story or talking points (e.g., the insurer considers claims fairly and pays almost all claims, but it should not pay claims that are not covered because doing so would undermine its ability to pay covered claims).
- Not agree with or adopt a plaintiff's terms like "rules" or "duty" or adopt a plaintiff's vague or overbroad statements.
- Answer questions with sentences (subject and verb) instead of one-word answers (e.g., "yes") that can be misunderstood.
- Practice answering safety and security questions.
- Be likeable and caring about the plaintiff and other insureds.

Expert witnesses

Expert witness use varies by jurisdiction.

Expert discovery also varies by jurisdiction and may further vary depending on whether the expert witness is a retained expert or an employee of the insurer.

If it is appropriate to retain an expert, a former insurance regulator might be a good choice.

Unless a plaintiff has a retained expert that an insurer needs to respond to with its own retained expert (i.e., it cannot respond with an in-house expert), an insurer rarely would want to use a retained expert.

Usually, an insurer wants a jury to perceive the insurer as having the expertise in-house to explain whatever needs to be explained.

Insurers should attempt to exclude a plaintiff's expert under the *Frye* or *Daubert* standard. A motion to exclude should focus on all or parts of opinions that are legal conclusions, define legal terms, turn on determinations of witness credibility, or opine on individuals' motivations or state of mind.

An insurer should consider having an in-house person as a witness to establish helpful facts, such as the total number of claims paid compared to the small number denied, the many steps taken to review a claim, how heavily regulated an insurer is, how many fraudulent claims are submitted, or other helpful facts.

Often, an insurer has an employee who can serve both as a quasi-expert or non-retained expert and as a 30(b)(6) deposition representative.

Whether such testimony is expert testimony depends on the testimony and the jurisdiction.

Punitive damages

Insurers need to develop case-specific strategies to minimize punitive damages.

Before planning what evidence to present at trial, the question of the bad-faith punitive damages available under state law and constitutionally permissible under *State Farm Mutual Insurance Co. v. Campbell*, 538 U.S. 408 (2003), warrants considerable research for each jurisdiction and fact situation.

Generally, punitive damages have been held to be constitutionally limited to a single-digit multiplier.

Mental distress damages are at times discussed as part of the damages that a jury can multiply, but some cases discuss whether mental distress damages have already been awarded as limiting the multiplier.

A tough call is whether to ask the court to bifurcate the case into contract and bad-faith phases.

Many courts will not do so. If the court does bifurcate, the evidence related to the bad-faith claim may be kept out

of the initial contract phase. But the risk of a high punitive damages award would seem greater if the jury decides the insurer was wrong before considering evidence regarding punitive damages.

Settlement

As a practical matter, perhaps even more than other kinds of high-stakes litigation, bad-faith cases seem to settle before trial.

Settling a case reasonably requires being ready to try the case if the other side is not reasonably negotiating a settlement.

Settlement considerations include:

- How dangerous the forum is for large jury verdicts, especially against insurers.
- The “heat” in the case from unfortunate evidence.
- The plaintiff as a sympathetic witness.
- An insurer’s witnesses’ ability to be likeable, to be credible, and to withstand cross examination.
- Other witnesses, if any.
- The legal arguments and facts related to mental distress and punitive damages.
- The dispositive legal arguments that might be made at summary judgment, after trial, and on appeal.

CONCLUSION

To avoid and defend bad-faith claims, insurers and lawyers representing insurers should consider a comprehensive approach, using strategies utilized in other high-stakes litigation and taking additional steps to specifically address bad-faith risks.

An insurer’s strategies should include steps to take before selling the policy, when considering a claim under the policy, and when defending against a lawsuit brought based on the policy.

With planning, an insurer should be able to minimize the risks of an adverse bad-faith verdict or to minimize the amount of damages beyond the policy benefits, making the litigation risks more manageable and more predictable.

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