

BAD FAITH IN THE HANDLING OF DISABILITY CLAIMS: IS IT REAL OR IMAGINED?

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Insurance carriers say that consumer lawyers cast too wide a net, hoping to catch some bad faith along the way. Their notion is that we rush to judgment, by claiming the tort of bad faith in most complaints for the termination or denial of disability benefits. Perhaps if carriers heeded our requests for claim files pre-litigation we could evaluate the existence of bad faith at that time, rather than waiting until discovery to do so.

Allow me to amplify the current state of bad faith law in the disability arena. This article first considers the groundbreaking cases of the last century, which taught us to enter the long corridor of bad faith litigation armed with supportive evidence to prove our claim. Then I consider the many new age cases which have brought in the high tide of disability bad faith law that is finally emerging on the shores. Rather than be caught in the undertow of motions for summary judgment on a bad faith count, litigators can prepare discovery to uncover the elements of bad faith conduct, and if it exists, be prepared to face summary adjudication on this most important facet of disability litigation.

An interesting article authored by a defense attorney and appearing in DRI Magazine in 1996 has been circulating for some time. It includes an interesting observation: “bad faith, as opposed to alleged bad faith is exceedingly rare” (so is a pear shaped diamond, but they too exist and are cultivated).

The author proposed some “advice” to reduce the vulnerability of the company to the allegations of bad faith. For instance, he maintained that the claim file should document the company’s desire to find out the true facts and demonstrate the company’s effort to fairly interpret policy language. I couldn’t agree more. It should be noted at the outset, that a reasonably conducted, but extensive investigation doesn’t necessarily mean that the carrier committed the tort of bad faith by being thorough. Yet evidence introduced in trials around the country demonstrate that company documents tell quite a different story than what the carriers would have their shareholders and policyholders believe. Many carriers have gravitated away from good faith and fair dealing, hypnotized by returning the “bad block” of disability business to profitability. For some, but not all carriers, claim *payment* centers have morphed into claim *management* centers, enabling the carriers to keep a tight fist around claim payments that are due and owing. Courts are being presented with more and more evidence of sinister motives which pave the way for substantial bad faith awards. As this occurs with more frequency, perhaps carriers will adjust their practices and resume handling claims in good faith, and deal fairly with the insureds who put their trust in the insurance company with each premium payment.

Consumers seek protection against calamity and purchase insurance to buy peace of mind and security. Egan v. Mutual of Omaha Ins. Com., 24 Cal. 3d 809, 819, 169 Cal.Rptr.691, 696 (Cal.1979); Mariscal v. Old Republic Ins. Co., 42 Cal.4th 1617, 1623, 50 Cal.Rptr.2d 224, 227 (Cal.Ct.App.1996). “The insurer has a duty to protect the insured’s interests as if it were its own, and it may not deny a claim without thoroughly investigating it.” Egan at 818-820, 169 Cal.Rptr. at 695-6; Mariscal, at 1623, 50 Cal.Rptr.2d at 227.

Bear in mind that each state’s laws define the ability to claim the tort of bad faith, and whether the case is to be submitted to judge or jury. Perhaps the most stringent standard from the plaintiff’s prospective is the “directed verdict rule,” under which a directed verdict is granted to the insurer on the grounds that the claim denial is fairly debatable as a matter of law, unless the insured can sustain his or her own directed verdict. Zilisch v. State Farm Auto. Ins. Co., 194 Ariz. 34, 38, 977 P.2d 134, 138 (Ariz.Ct.App.1998) vacated and remanded on other grounds by 196 Ariz. 234, 995 P.2d 276 (citing Stephen S. Ashley, Bad Faith Actions, Liability and Damages Section, 5:04 at 5-17 to 5-18 (2nd ed.1997)).

“What Is Bad Faith”: or, “Will I Know It When I See It?”

It appears to me that some insurance companies, especially those who handle disability claims, have forgotten the basic thread woven into all insurance contracts. Insurance companies have an “**obligation** to protect the interest of the insured.” Mariscal, at 1620, 50 Cal.Rptr.2d at 225. The insurance contract and the relationship it creates contains more than the company’s bare promise to pay certain claims when forced to do so; “implicit in the contract and the relationship is the insurer’s obligation to play fairly with the insured.” White v. Unigard Mut. Ins. Co., 112 Idaho 94, 98, 730 P.2d 1014, 1018 (1986). It certainly seems that over the past ten years the companies have forgotten and intentionally ignored that obligation. The tort of bad faith has its roots in the special duty of fair dealing and good faith owed by the insurer to its insured by virtue of the insurance contract. Gruenberg v. Aetna Insurance Co. 9 Cal. 3d 566, 108 Cal.Rptr. 480, 510 P.2d 1032 (1973)

Years after the birth of first party bad faith litigation, courts are recognizing that insurance companies have adopted widespread tactics and strategies to minimize payouts and maximize profits at a high price to its insured and the agreement to PROTECT him.

The insurer must conduct a neutral, detached investigation and exercise the same standard of care as if the insurer were exercising ordinary diligence in its own affairs. Stenger v. Provident Life & Accident Ins. Co. 121 F. Supp 2d 1238, (E.D. Wis. 2000) (citing Benke v. Mukwonago-Vernon Mutual Ins. Co. 110 Wis. 2d 356, 364-5 (Wis.Ct.App.1982)).

Certainly an insurer is entitled to investigate and evaluate claims to determine if a claim is to be paid. However, the company crosses the line from good faith claims handling to bad faith claims handling when they, “with knowledge or reckless disregard

for the wrongfulness of its actions, refuse to honor the insured's claim." Stenger v. Provident Life & Accident Ins. Co., 121 F. Supp.2d 1238, 1249 (E.D.Wi. 2000) (citing Anderson v. Continental Ins. Co., 85 Wis.2d 675, 271 N.W.2d 368 (1978)). In Stenger, the plaintiff survived a motion for summary judgment by providing evidence which suggested the carrier's bad faith conduct of totally disregarding any favorable evidence and its unwillingness to undertake any additional investigation once it possessed something that "could colorably be used to deny him benefits." See id. at 1250-1.

Most states hold that the plaintiff must show the absence of a reasonable basis for denying benefits of the policy in order to prove bad faith actions on the part of the disability carrier. Tarsio v. Provident Insurance Co. 108 F. Supp 2d 397, 400 (D. N.J. 2000) "To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying (the) benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim." Norcia v. Equitable Life Assurance Society of the U.S. 80 F. Supp 1047, 1053 (D. Ariz. 2000). "[W]hether a claim is 'fairly debatable' depends upon whether a reasonable insurer under the circumstances would have delayed or denied payment based upon the information available to it at the time of the delay or denial." Robinson v. State Farm Mutual Insurance Co., 2000 WL 1877745 at *3 (Idaho 2000). "Liability to a plaintiff who has made out a prima facie case for first party bad faith may be avoided by an insurer who can demonstrate the validity of the insured's claim was reasonably in dispute and therefore fairly debatable, or the delay was the result of an honest mistake." Id at *4.

The bad faith tort addresses the actions of major insurance companies, "bad men[,] . . . exploiting their superior cash reserves and skill as institutional litigants against a lone, disabled individual ...in order to delay for as long as possible having to pay the damages to which [the insured] is entitled." Norcia at 1048. The court acknowledged the need to address "the vast inequities" in bargaining power in such situations, and to potentially punish the offending company's actions with punitive damages for their behavior. See Id.

Some attorneys jump too readily into the bad faith arena without properly suiting up and soon, after discovery closes are faced with a motion for summary judgment on a bad faith allegation it cannot substantiate. Before taking the plunge, it would be helpful to review existing law, articles on bad faith, and even some sample jury charges on bad faith. For example, I came across the following charge from Wisconsin:

Wisconsin's Civil Jury Instructions 2761 "*Bad Faith by Insurance Company: Assured's Claim*" states:

- To prove bad faith against (insurance company) the (plaintiff) must establish that there was no reasonable basis for the insurance company's denying (plaintiff's) claim for benefits under (his/her) policy and that (insurance company) in denying the claim, either knew or recklessly failed to ascertain that the claim should have been paid.

- Bad faith on the part of an insurance company toward its insured is the absence of honest, intelligent action or consideration of its insured's claim.
- Bad faith exists, if upon an examination of the facts found by you, you are able to conclude that (defendant) had no reasonable basis for denying plaintiff's claim.
- In answering this question, you may consider whether plaintiff's claim was properly investigated and whether the results of this investigation were given a reasonable evaluation and review. If you find that (insurance company) either refused to consider the (plaintiff's) claim for damages, made no investigation, or conducted its investigation in such a way as to prevent it from learning the true facts upon which the (plaintiff's) claim is based, the insurance company can be found to have exercised bad faith. This is because you may infer from these facts a reckless disregard on the insurance company's part to learn that there was no reasonable basis for it to deny (plaintiff's) claim.
- If, on the other hand, you find that the insurance company, after conducting a thorough investigation of the facts and circumstances giving rise to the (plaintiff's) claim, reasonably concluded that the claim is debatable or questionable, then there is no bad faith even though it refused to pay the claim.

Marketing And Advertising And Its Part In The Bad Faith Analysis

Advertisements displayed by the disability carrier prey on the worries of middle class workers. Companies promise to restore incomes lost to disabilities, but break those promises daily. They tout the virtues of having the coverage that will protect you when you need income the most. An advertisement directed to professionals reads: *"without disability insurance, you're betting against the odds with the biggest asset you own- your ability to earn a living. And if your income were to stop tomorrow, how would you pay the bills? Or put the kids through school? Or maintain the lifestyle you've worked so hard to earn?"* Or another advertisement: *"Medical school probably covered everything except what to do for severe paralysis of the paycheck.... If you are 35 now, you have a 45% chance of becoming disabled before you reach age 65"*.

The courts across the nation have embraced the concept created by these marketing ploys and take them very seriously. Why would an individual pay money every quarter to a company to insure against a medical calamity, if he or she knew that the company would put on its battle gear every time a claim is filed and act as if it must guard its territory against an invasion by the money snatchers, those insureds who have the chutzpah to make a claim?

Brokers and agents, legitimately prospecting for commissions, target the healthy, wealthy and unwise money makers, so certain of their immortality and their ability to make a buck. Little do they know that their promises will never pay off when their clients need the benefits.

It stands to reason that the “very risks insured against presuppose that if and when a claim is made, the insured will be disabled and in strait financial circumstances and, therefore, particularly vulnerable to oppressive tactics on the part of an economically powerful entity”. Fletcher v. Western National Life Ins. Co. 10 Cal.App.3d 376, 404, 89 Cal.Rptr. 78 (Cal.Ct.App. 1970).

What is evidence of breaching the duty of good faith and fair dealing?

1. Failing to thoroughly investigate the claim and shifting the burden of investigation entirely on the insured.

The carrier has a duty to conduct a reasonable investigation of the claim and to pay benefits or deny coverage within a reasonable time. A carrier’s inactivity may be indicative of their failure to place its insured’s interests above their own, contrary to standard practice and good claims handling. “The insurer has a duty to protect the insured’s interests as if they were its own, and it may not deny a claim without thoroughly investigating it.” Mariscal at 1623, 50 Cal.Rptr. at 227.

2. Unreasonably delaying the payment of benefits when payments are due.

“An insurance company has a duty to pay a claim when it has acquired, through one means or another, sufficient evidence to establish the validity of the claim. It does not have the right to insist the claim be proved only through certain types of evidence. Nor does it exhibit good faith in denying a claim merely because an insured failed to dot the i’s or cross the t’s on a claim form or other submission. The issue is not whether the insurance company has received every item of information it requested from an insured. The question is not even whether the insurance company appears to have in its hands the exact type of information it prefers when deciding on a claim. Rather, the real question is whether there was enough evidence of whatever form and however acquired that it would be unreasonable for the insurance company to refuse to pay the claim.” McCormick v. Sentinel Life Ins. Co., 153 Cal.App.3d 1030, 1040, 200 Cal.Rptr. 732,741 (Cal.Ct.App. 1984).

When investigating a claim, an insurance company has a duty to diligently search for evidence that supports its insured’s claim. Mariscal v. Old Republic Ins. Co. 42 Cal.4th 1617, 1620, 50 Cal.Rptr.2d 224,225 (Cal.Ct.App. 1996) If it seeks to discover only evidence that defeats a claim, it holds its’ own interest above that of its insured, and breaches the covenant of good faith and fair dealing. An insurance company may not ignore evidence that supports coverage. Id at 1624.

3. Bad faith is supported when the insurer conducts an incomplete and slipshod investigation of the claim that prevents it from learning the true facts on which the plaintiff’s claim was based.

Despite claim handling guidelines that directed claim handlers to investigate both the insured's and the company's positions fully, the insurer failed to investigate the insured's case and "shifted the burden of investigating entirely to her." Ace v. Aetna Life Ins. Co., 139 F.3d 1241, 1249 n.24 (9th Cir. 1998), cert. denied, 525 U.S. 930, 119 S.Ct. 338 on remand 40 F.Supp.2d 1125 (D.Alaska 1999). Initially denying the insured's claim, the insurer only reviewed the material sent by the claimant, did not request additional medical information, and relied solely on an internal worksheet that provided an incomplete picture of the claimant's work demands, though more complete information was provided. *Id.* at 1244.

4. Failing to objectively evaluate the insured's claim

In Hughes v. Blue Cross of Northern California, the California Court of Appeals found that the "covenant of good faith and fair dealing . . . places the burden on the insurer to seek information relevant to the claim." 215 Cal.App.3d 832, 846, 263 Cal.Rptr. 850 (Cal.Ct.App. 1989). The court acknowledged that under different circumstances, the health insurer's medical consultant's failure to secure significant, medical documents may be attributable to institutional failure. *Id.* However, the court found that the insurer ". . . placed an undue burden of inquiry on the insured's physician," by not omitting any detail as to the consultant's grounds for denying coverage. *Id.* Further, the court noted that the failure to list the documents upon which the denial was based, "tended to assure that the [insurer's] staff's earlier failure to secure all relevant records would go undetected. *Id.*

5. Unreasonably failing to contact and speak with the insured's treating doctors can be evidence of bad faith conduct.

In Mariscal, the disability carrier never contacted the treating doctor or the witnesses of the accident and relied solely on its own *interpretation* of what the records meant. The insurer blamed its failure to contact the doctor on the so-called "universal truth" that doctors "are hard to reach by telephone," but the court rejected that defense and found that the failure to investigate evidences a breach of the duty of good faith and fair dealing. *Id.* at 1624, 50 Cal.Rptr.2d at 228. See also Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809, 169 Cal.Rptr. 691 (1979).

6. Failing to promptly investigate the claim, pay the claim, or seek or request the supporting information alleged to be missing

The California Court of Appeal noted that an insurer's duty to promptly investigate is particularly acute in cases involving credit disability insurance because failure to pay installments timely may result in repossession of the personal property, the very reason for which the policyholder sought protection. See McCormick v. Sentinel Life Ins. Co. 153 Cal.App.3d 1030, 1047-8, 200 Cal.Rptr. 732, 743 (Cal. Ct. App. 1984). In light of the fact that a telephone call to the treating doctor could have

resolved the omission and the failure to perform this simple task cost the insured its car, the court felt that inaction was evidence of bad faith. Id.

As most disability insurance contracts contain clauses absolving the insured of his or her duty to pay premiums while disabled and receiving benefits, an insurer's actions to compel the insured to continue to pay may evidence bad faith. If the carrier unreasonably delays its decision whether to pay a claim, AND thus forces the insured to continue to whittle away his or her savings by paying the premium, the insured is hit with a double whammy, all by the insurance carrier who is obligated to put the insured's interests before its own.

7. The insurer may not ignore evidence, which supports coverage; if it does so, it acts unreasonably toward insureds and breaches covenant of good faith and fair dealing.

See Mariscal v. Old Republic Ins. Co. 42 Cal.4th 1617, 1620, 50 Cal.Rptr.2d 224,225 (Cal.Ct.App. 1996)

8. Reserving rights only when it has a good faith belief in the existence of the rights asserted

Oftentimes, when the insurance carrier informs its policyholder of its decision to pay benefits, it includes a phrase, such as the following remark included in a recent letter I received on behalf of a client:

“based on our review, we are pleased to inform you that we are reversing the previous decision to deny benefits on your client's claim. However, please be advised that we have determined that further investigation is needed regarding his claim. Therefore, the above payments and any possible future payments, until we advise you otherwise, are being made under a Reservation of Rights.... we reserve our rights to ...seek repayment of the benefits that were made to you”.

An insurance company may not make the payment of disability benefits conditional if there is no good faith dispute about the insured's entitlement to the benefits. “A debt is as much an economic loss as the removal of payments, particularly where the debtor is disabled and without income to make repayment.” Sprague v. Equifax, Inc. 166 Cal. App. 3d 1012, 213 Cal. Rptr. 69 (Cal. Ct. App. 1985). Hence, it is my belief that the carrier should tell its insured exactly what “further investigation” is needed, so that when it is provided, he can insist on the removal of the reservation of rights and be free to use the benefit money.

Furthermore, though not an outright denial, perpetual delay may give rise to a bad faith claim in certain settings. “An insurance company cannot insulate itself from liability simply because rather than denying benefits it keeps a claims file on the shelf for months or years without ever formally denying it.” McCormick. supra at 1050,

200 Cal.Rptr. at 744. While it is better to pay with a reservation of rights while reasonable investigation is pending, it is not appropriate to keep such a reservation on a claim indefinitely, so that the insured's benefit money is tethered to the carrier's anchor.

9. Basing denial of the claim on an illegal standard for benefit eligibility. The company may not mislead an insured by merely quoting the language of the policy if it knows that the policy is at variance with the law.

There are many examples of this concept. For instance, if a policy contains a clause providing a more restrictive definition of total disability than that supported by case law, the carrier would have acted in bad faith, if it used the contractual terms in communicating the standards to the attending physician, rather than the legal definition. Moore v. American United Life Ins. Co., 150 Cal. App. 3d 610, 620, 197 Cal.Rptr. 878, 884 (Cal.Ct.App. 1984) Under the law, if an insured could perform sporadic tasks or give attention to simple or inconsequential details incident to the conduct of business, he still may be considered totally disabled. Id. at 626-7, 197 Cal.Rptr. at 888. But, if the attending physician is not given this information, his or her response about disability will be mistaken. Further, attending physicians and IME physicians should be informed that an ability to perform an occupation must not be on some remote island of make believe, but in the "real world employment marketplace" where the insured must be capable of working with reasonable continuity in his customary occupation. Moore at 630, 197 Cal.Rptr. at 890. A failure to consider these conflicts with prevailing legal definitions evidences bad faith. Id.

Another example is the "gainful occupation" clause. In Ace, the adjuster informed the insured that since he can work in a "gainful occupation", he was not disabled. 139 F.3d at 1244. However, the phrase "totally disabled from any gainful occupation" must not be applied literally, to insinuate that if the insured can hold any job in the world, he is no longer disabled. Instead, courts have insisted that the policy term "gainful occupation" must be applied to include consideration of the insured's prior salary history, as contrasted with a wage analysis of the occupations the carrier believes the insured is capable of based on his training, education and experience. Mossa v. Provident Life and Casualty Co. 1999 WL 74194 (E.D.N.Y.) See also Erreca v. Western States Life Ins. Co., 19 Cal.2d 388, 121 P.2d 689 (Cal. 1942). In fact, some newer policies include a clause indicating what percentage of prior wages is considered "gainful". The insured should not be given the impression that as long as he can work at something, he is no longer disabled.

A third example is when a clause in the contract states "the insured must be receiving care by a licensed physician appropriate for the disabling causing condition." This clause is found in the policy under the definition of "total disability". Companies have attempted to deny or terminate a claim because *it has* concluded that the insured is not receiving care which *they deem* appropriate for the condition and helping the insured regain function and return to work. The court in

Provident Life & Accident Ins. Co. v. Henry, 106 F. Supp. 2d 1002 (C.D.Cal. 2000) found that while the insured did not have to defer to the carrier's judgment as to what was appropriate for his condition, he was obligated to seek and accept appropriate treatment for the condition or risk being denied benefits. Expert testimony may have established whether surgery for carpal tunnel syndrome was the "appropriate care", but the case settled following the court's initial finding. To the contrary, the Court of Appeals in Morinelli decided that "appropriate care" *does not* require a qualitative evaluation of the care provided. In Morinelli, a diabetic was receiving care that his duly licensed doctors prescribed, but the carrier substituted its IME's opinion as the required type of treatment the insured must undergo in order to continue to qualify for benefits. The court determined that the second prong of the "totally disabled" definition does not entail an inquiry into whether the treatment met the standard of care. Hence the clause does not entitle the carrier to dictate the type of treatment the insured must have. The carrier was prevented from interpreting the policy language in such a way as to place an arbitrary restriction on the insured's right to select the type of treatment when no right to do so exists.

10. Imposing additional preconditions to coverage beyond those set forth in the policy

In Ace, the carrier rejected information presented by the insured as not constituting "objective medical evidence" of her total disability, and it informed her that she needed to produce objective medical evidence. 139 F.3d at 1245. In fact, the policy neither contained nor defined objective medical evidence. Id. Remarkably, the insurer's claim guidelines advised analysts to consider "subjective complaints of pain even in the absence of objective medical evidence," and provided an illustrative example of such a case. Id. at 1245.

This is also seen in Norcia, where the field representative informed the insured of the company's decision to terminate benefits, considered his occupation that of a retired/unemployed person, and stated "to qualify for benefits you have to be unable to perform the everyday activities of daily living." 80 F.Supp.2d at 1053. The Court called the field representative's homespun analysis "'pure poppycock', utterly bereft either of textual support in the language of the insurance contract or in the gloss placed on such language by any Arizona case." Id. at 1053.

11. Evidence of bad faith may exist if the insurer requires the insured to submit information not relevant to the claim and which the contract does not entitle them to obtain.

Watch out for instances when the company performs a fishing expedition, where the carrier casts a wide net over all information about the insured, hoping to catch some seductive data that causes the claim to spiral out of control, or the insured to backpedal.

12. The insurer must disclose the standard it applied in determining whether the insured is disabled.

An insurance company has a duty to pay a claim when it has acquired sufficient evidence to establish the validity of that claim. Ace at 1249. It does not have the right to insist the claim be proved only through certain types of evidence.

13. Bad faith may be established if the company adopts the IME's opinion as the basis upon which to deny or terminate benefits without subjecting it to reasonable evaluation and critical review.

An insurance company may not merely rely on the reports of its IME doctors without subjecting them to reasonable analysis. See Stenger, citing Anderson, at 692, and Fehring v. Republic Ins. Co. 118 Wis. 2d 299 (1984). Dr. Stenger suffered from severe psychiatric disorders, including bipolar affective disorder which had required extensive hospitalization and ongoing treatment. Despite extensive evidence of Dr. Stenger's disability, the carrier adopted the conclusions of its two IME doctors without determining whether their opinions were reasonable. The court found the carrier's one-dimensional approach supportive of a claim for bad faith, since the carrier evidently ignored mounds of medical evidence supporting disability in order to adopt the findings of IME doctors' whose opinions were not subjected to any critical evaluation.

14. Improper motivation.

For this element of bad faith, we look to cases other than disability cases for guidance. In White v. Continental General Insurance Co., the court held that the insured established a claim of bad faith based on evidence that the insurer had suffered severe financial losses and that post-claim underwriting allowed it to increase revenues by taking on new policyholders while decreasing expenditures by denying coverage when claims were submitted. 831 F.Supp. 1545 (D.Wyo. 1993). There was also evidence of a "bonus plan" which awarded those handling the claim points for performing certain actions on a claim, such as issuing denials, finding pre-existing conditions or identifying other misrepresentations that would allow the company to deny benefits. Id.

To borrow from a UIM case, Zilisch v. State Farm Mutual Automobile Insurance Co., the Arizona Supreme Court found that unreasonable behavior can be proven with evidence that the company set arbitrary goals for the reduction of claims paid and that the salaries and bonuses paid to claims representatives were influenced by how much representatives paid out on claims. 196 Ariz.234, 238, 995 P.2d 276, 280 (Ariz. 2000). The lower court, in evaluating the relevance of evidence of improper corporate financial motivation for terminating the claim, reasoned that "[s]ubjective motive is only important if the insurer fabricates evidence to create fair debatability or relies solely on contradicted facts, which it alone generates." Zilisch, 194 Ariz. 34,

40, 977 P.2d 134, 140 (Ariz.Ct.App. 1998), vacated and remanded on other grounds by, 196 Ariz. 234, 995 P.2d 276 (Ariz. 2000).

15. An insurer's unreasonable defense during litigation may evidence bad faith.

In Ingalls v. Paul Revere Life Ins. Group, the North Dakota Supreme Court's decision to permit plaintiff to develop evidence about Paul Revere's litigation strategies forced the defendant to call his own counsel as a witness. 561 N.W.2d 273, 280 n.4 (N.D. 1997).

Paul Revere attempted to rescind Mr. Ingall's policy for alleged misstatements in his application as to income, without doing an independent investigation of the income. See id. at 278-9. Since the court was faced with 'post claim underwriting'¹ issues and whether the company had sufficient evidence to justify its denial, including an allegation of fraud and misrepresentation in the complaint, the defense called its own counsel as a witness. See id. at 280 n.4.

Another element of bad faith committed by Paul Revere involved an offer of settlement made to the insured while he was lying in a hospital, with pressure being applied by the field adjuster who gave him one day to either accept or reject an offer. To make matters worse, the adjuster threatened to sue the insured if he didn't accept the offer or if he hired an attorney. Id. at 282-4. With these factors, the court upheld an award of exemplary damages in the amount of \$2,500,000.

16. Evidence of "post claim underwriting", which is looking for ways to challenge information in the application that would allow the company to rescind the policy can be used to support a claim for bad faith.

Reviewing the lower court's jury verdict, granting damages of \$500,000 for mental anguish stemming from the defendant's commission of the tort of bad faith, the North Dakota Supreme Court in Ingalls reasoned:

"An insurer's bad faith breach of its duties to an insured is likely to cause mental anguish: 'It is inconceivable that a layman, unaccustomed to the courtroom and fearful of the entire judicial process, who is also subjected to financial pressures from a refusal of the insurer to discharge its commitments, will not be subjected to stress the precise effects of which are difficult to measure in exact terms but which, nevertheless are present.'"

¹ Evidence of post claim underwriting can occur when an insurance company fails to do an adequate underwriting until after a claim is submitted and then denies the claim asserting that the insured is not entitled to coverage. Banks v. Paul Revere Life Ins. Co., 31 F.Supp.2d 82, 85 n.5 (D. Conn. 1998) (citing White v. Continental Gen. Ins. Co., 831 F.Supp. 1545, 1556 (D. Wyo. 1993)). Where an insured has developed a pattern of such widespread conduct, Connecticut's Unfair Insurance Practices Act (CUIPA) provides a statutory remedy. Id. (citing Conn. Gen. Stat. Section 38a-816(12)).

Ingalls at 283 (quoting 16A Hohn Alan Appleman and Jean Appleman, Insurance Law and Practice §8878.55 p.442 (Rev.Vol. 1981)).

17. The right of privacy has been defined as the right to be left alone, and the right to live one's life in seclusion without being subjected to unwarranted and undesired publicity. Violation of this right is a tort.

According to the Restatement, Second, Torts (1977) Section 652B :

One who intentionally intrudes, physically or otherwise, upon the solitude or seclusion of another or his private affairs or concerns, is subject to liability to the other for invasion of his privacy, if the intrusion would be highly offensive to a reasonable person. Trailing and shadowing the claimant could be the basis of an action against the insurer which authorized the surveillance. Recently in Hines v. UNUM, UNUM was found liable for bad faith in an ERISA setting when it “readily jumped to secretly videotape [the insured] without sufficient justification, failed to consider [the insured’s] medical evidence, and . . . extrapolated a change in restrictions and limitations based upon unrelated medical evidence.” 110 F.Supp.2d 458, 469 (W.D.Va. 2000). Incidentally, the insured’s treating doctor refused to review the videotape, because he concluded the tape would not be indicative of Hine’s day-to-day workplace activities and how those activities would be affected when she has the symptoms of her illness. Id. at 463. The damages for bad faith consisted on an award of reasonable counsel fees and costs. Id. at 469.

At least one Judge has voiced concern that unscrupulous conduct otherwise justifying a bad faith tort award would not be stopped until insurers administering disability plans felt the financial sting of a bad faith verdict, unfettered by the ERISA limitations. See Dishman v. UNUM, 1997 WL 906146 at *28-36 (C.D. Cal. May 9, 1997). Finding the fee-shifting reform insufficient to ward off further bad faith conduct, Judge Letts advocated the imposition of some “statutory or other legal deterrent,” though he considered “bad faith tort liability under state law [to be] so extreme and unpredictable that it would detrimentally disturb the ERISA balance.” See id.

STATUTORY GUIDELINES:

Are there statutory guidelines for the imposition of bad faith? Nearly all 50 states have statutes, which empower an insurance commissioner or some comparable official to penalize an insurer for unprofessional claims practices. In most instances, these statutes are derived from the model Unfair Claims Practices Act created by the National Association of Insurance Commissioners in 1970. In some jurisdictions, these statutes also give an insured a private right of action against the insurer.

For example, in Ingalls v. Paul Revere Life Ins. Group, the North Dakota Supreme Court upheld the trial court’s jury instruction that a violation of the state’s Prohibited Practices in Insurance Business Act may be evidence of bad faith. 561 N.W.2d at 281-2 (1997); See NDCC 26.1-04-03 (1999).

Similarly, violations of the Unfair Insurance Practices Act (“UIPA”), 40 Pa.S Section 1171.1 et seq. can be considered in determining whether an insurer acted in bad faith. MacFarland v. United States Fidelity & Guar. Co., 818 F. Supp, 108, 110 (E.D.Pa. 1993). Certaineed Corporation v. Federal Ins. Co. 913 F. Supp. 351 (E.D.Pa 1995) The UIPA includes the following unfair practices,

- i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
- ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.
- iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
- vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company’s liability under the policy has become reasonably clear.

40Pa.C.S.A.Section 1171.5(a)(10)(1982)

Punitive Damages: A Pattern of Practice

Courts throughout the country are beginning to grasp and react to what lawyers have been trying to prove for years, that some insurers, hungry for the premium dollar but slow to pay, have consciously transformed their claim departments from claim payment centers into profit centers. Those poorly underwritten risks, those uninvestigated insureds are haunting the insurers in the place it hurts the most, their pocketbook.

In evaluating a punitive damages award against General American in Arizona, Judge Sheldon reasoned:

“Based on the evidence presented at trial, the jury could reasonably have inferred that the Defendant engaged in outrageous claims practices in the handling of Plaintiff’s claim.

Moreover, the jury could have concluded based on the evidence that the Plaintiff was the victim of the corporate plan to eliminate claims similar to his. The Plaintiff argued at trial that the corporate plan went into effect after the corporation determined that its reserves for the long-term disability policies had caused it to err to the extent of causing potential losses in the range of forty to sixty million dollars for the company. After the plan was instituted, the corporation noted continuing increases in its profit margins and, as noted by Plaintiffs, the increase in profitability after the plan was effectuated resulted in a \$58 million profit increase within a few years after the plan was implemented...

The Jury could also have concluded that the corporation intentionally pursued a course of conduct intended to result in the adoption of a plan which would severely reduce its reserves for potential enormous payouts on long term disability policies.

Plaintiff introduced evidence from which the jurors could well have concluded that a corporate plan existed to identify vulnerable, disabled insureds who could be targeted for elimination of benefits by the company.”

Diamond v. General American, CA No. 96-02277 at *4-6 (Arizona Superior Ct., June 3, 1999) (Sheldon, J.) (Order reducing “grossly excessive” punitive damages of \$58 million to \$3 million). Judge Sheldon later granted the Plaintiff’s Motion for Reconsideration and request for remittur on the grounds that the \$3 million award was “simply too small to achieve the type of punishment which the jurors clearly intended to impose by their verdict.” Diamond v. General American, CA No. 96-02277 at *16-8 (Arizona Superior Ct., October 5, 1999) (Sheldon, J.). (The parties later settled for an undisclosed sum)

In McKendry v. Paul Revere Life Ins. Co., the federal District Court for the District of Arizona granted the defendant’s Motion for New Trial and/or Remittur, but stated that:

“[T]he jury could have concluded reasonably that this was . . . a case of reprehensible conduct that included both a premeditated attempt over a period of years to terminate the plaintiff’s benefits for any plausible reason regardless of the harm to the plaintiff in order to increase profits, and an attempt to conceal that conduct.” CA No. 96-754 PHX PGR at *4 (D.Ariz. March 31, 2000) (Rosenblatt, J.).

Even if the carrier eventually pays the claim, it may not escape the charge that it committed bad faith. The Arizona Supreme Court in Zilisch analyzed whether a carrier was off the hook for bad faith once it came up with an offer that “a jury could find reasonable.” 196 Ariz. At 237, 995 P.2d at 279. After reviewing Arizona law, the court made the following observations:

“An insurance contract is not an ordinary commercial bargain; ‘implicit in the contract and the relationship is the insurer’s obligation to play fairly with its insured.’ The insurer has ‘some duties of a fiduciary nature,’ including ‘equal consideration, fairness and honesty.’ Thus, ‘an insurer may be held liable in a first-party case when it seeks to gain unfair financial advantage of its insured through conduct that invades the insured’s right to honest and fair treatment’ and because of that, ‘the insurer’s eventual performance of the express covenant—by paying the claim—does not release it from liability for bad faith’ . . . ”Id at 156, 726 P.2d at 572.

“[W]hile fair debatability is a necessary condition to avoid a claim of bad faith, it is not always a sufficient condition. The appropriate inquiry is whether there is sufficient evidence from which reasonable jurors could conclude that in the investigation, evaluation, and processing of the claim, the insurer acted unreasonably and either knew or was conscious of the fact that its conduct was unreasonable.” Id. at 237-8, 995 P.2d at 279-80 (internal citations omitted).

While not favored by the law, punitive damages may be imposed to further states' legitimate interests in punishing unlawful conduct and deterring its repetition. See BMW of North America, Inc. v. Gore, 517 U.S. 559, 568 (1996). Punitive damages are recoverable in insurance bad faith tort actions when an insurer intends either to injure the insured or "consciously pursued a course of conduct knowing that it created a substantial risk of significant harm to the insured." Hawkins v. Allstate Ins. Co., 152 Ariz. 490, 733 P.2d 1073, cert. denied, 484 U.S. 374 (1987).

States have various statutes defining entitlement to punitive damages. See, for example:

A plaintiff must prove by clear and convincing evidence that the wrongdoer's conduct was "outrageous, such as acts done with malice or bad motives or reckless indifference to the interests of another person." Ace at 1246 (citing Alaska Stat. Section 09.17.020).

California Civil Code Section 3294(a)

In an action for the breach of an obligation not arising from contract, where it is proven by clear and convincing evidence that the defendant has been guilty of oppression, fraud, or malice, the plaintiff, in addition to the actual damages, may recover damages for the sake of example and by way of punishing the defendant.

In closing, disability carriers have ample experience in handling claims in good faith and dealing fairly with their insureds. Claims based merely on a disagreement over the denial or termination should be approached with the attitude of any other breach of contract case. However, when the carrier evidences its intent to terminate legitimate claims in its rush to reduce reserves, in depth investigation will often turn up bad faith practices that warrant litigation focused both on the contract damages and on damages for the violation of the duty and obligation to protect and deal fairly with its insured.