Negotiating the insurance bad-faith case

Preparing and posturing the insurance case for resolution

By Guy O. Kornblum and Charles D. Cochran

Insurance is unique in that the insured does not know whether the policy will cover a risk until a loss occurs. There is no assurance that a risk will be acknowledged by the carrier until it becomes a reality. Since insurance is not like a product which you can test beforehand, there is always a level of uncertainty even after there is a loss. When a risk occurs, it usually poses a potentially-harsh financial loss to the one protected, which can cause significant worry and stress until the claim is resolved. This translates to more than just contract damages if the claim is not timely and objectively handled in accordance with the insurer's contractual promises.

Insurance claims and lawsuits are unique

- They normally involve either an underlying prior lawsuit or claim that is documented by a "file," which is maintained by the insurer, tracks the claim's handling, and provides an early picture of what the company did and why;
- Special rules for good-faith claims handling apply and must be followed by the insurer in administering, managing, and resolving claims; as noted in this article, these principles result from statutes, regulations, and industry and internal insurance company standards;
- A "David" vs. "Goliath" scenario is present in cases when individuals or small businesses are the claimant or insured fighting the large insurance corporate giant; thus, there can be a greater emotional picture caused by financial loss and hardship.

Types of bad-faith claims

Bad-faith claims usually arise out of three general types of insurance claims:

The *failure-to-settle cases*, which involve an unreasonable refusal of the carrier to settle a claim against its insured within the limits of coverage, resulting in a judgment in excess of the policy's limits, and thus exposing the insured to a personal liability.[1]

The *failure-to-defend cases* in which the carrier refuses to accept a tender of defense which is unreasonable, and the insured suffers both the costs of defense and the costs of settlement or judgment.[2]

The *unreasonable refusal or delay* in adjusting and resolving a first party claim, such as a claim for an underinsured or uninsured motorist benefits, or any other type of first party claim requiring the insurer to directly pay the insured or, in the case of life insurance, a beneficiary of the coverage.[3]

Sometimes the insurance adjuster anticipates a bad-faith claim, such as if the jury awarded more than the policy limits in the underlying case and exposed their insured's personal assets. An insurance adjuster might also expect a bad-faith claim if an arbitrator awarded more than the policy limits in an Uninsured or Underinsured Motorist Arbitration, an appraisal on a property claim has resulted in an award well in excess of what the insurer offered, a long-term disability claimant has been denied benefits, or a claim in a payment mode is terminated with time left on the claim for monthly benefits for total or partial disability.[4]

Who is handling the claim?

Insurance coverage and bad-faith claims are not normally handled by adjusters who manage the more routine claims. This is because these claims normally involve coverage positions that set precedents for interpretation of policy provisions, as well as challenges to the insurer's claims practices.

In the more ordinary claim, e.g., auto, trip and fall, dog bite, the first adjuster who is responsible for the claim has very little authority or experience to evaluate it. However, that is not the case when the carrier is sued. When an insurer is sued, its financial assets are exposed because of an extra-contract claim, risking the insurer's assets beyond the underwriting and claims reserves. Instead of an ordinary adjuster, you are now dealing with a claims representative who is defending the insurer's claims practices and decision making, and who is also guarding the company coffers.

In addition, this claims representative will be reporting to the home office and is likely a more senior claims officer. This means that in the initial presentation of a claim against the insurer directly for bad-faith, the insured's attorney needs a thorough written presentation so that the high-level adjuster can inform the superiors of the seriousness of the claim.

Obtaining the insurance company file[5]

Before any evaluation of the case takes place, the plaintiff's counsel must obtain the complete claims file by a proper discovery request. No bad-faith case can be evaluated without a thorough review of the claims file by counsel, and perhaps also by an insurance claims expert who can spot the substandard claims practices.[6] If the insurance company is asserting an "advice of counsel" affirmative

defense, the defense counsel's file should also be obtained in discovery.[7]

The insurance file will include what are now electronic file notes entered by the adjusters which chronologically track the claims handling. The file notes document the information requested and received, the claims decision making, and the comments of those involved. They also track the notes regarding the evaluation and settlement efforts. A review of the claim file and these entries is the first step in the process of assessing whether the insurer met its good-faith duties regarding the investigation,[8] evaluation,[9] and payment obligations for the coverage at issue.[10] Next, the entries need to be put in chronological order so an outline of the claims actions by the insurer can be prepared. This will tell "what" the company did, but may not reveal "why" these actions were taken. To determine the "why," plaintiff's counsel may need to take depositions of key claims personnel before the contract and extra-contract exposure can be evaluated.

Computerized evaluation software

In the property and casualty area, computerized evaluation programs are often used to assess claim value. This program might be called Xactimate if it is evaluating the damage to a home,[11] or perhaps Colossus if it is used to value a liability claim.[12] Normally, claims handlers are restricted to the computerized programs' value determination for both payment and settlement options.

The Colossus system works by having adjusters in-put information regarding the claimed bodily injury. Insurance adjusters are told to take information about liability, injuries, and economic damage claims, such as wage loss, and put these "value drivers" into the parameters of the Colossus software. The adjuster then enters injury codes that define the injuries sustained. The software provides a range on what the claim is worth. Next, a supervisor reviews the file to affirm or reject the settlement range and give the authority to settle the case. However, there can be misuse of these programs.[13]

Misuse arises when the adjuster does not use the correct information, i.e., codes that accurately reflect the diagnosis and medical assessment of the injuries for assessing the claim. For example, if the adjuster puts in whiplash protocols instead of the objective injury (e.g., disk protrusion – an objective injury), the system will improperly evaluate the claim. Thus, in cases in which this "tool" is used by the insurer, it will be essential to conduct discovery on how this program was used, what information was considered, why information that was relevant to the evaluation was not considered, and to what extent the adjuster relied on the results in evaluating and making decisions about settlement efforts.

Posturing for evaluation and negotiation

Insurance bad-faith cases offer an early opportunity for resolution for several reasons.

First, these cases present a unique opportunity for an early evaluation. If there are coverage issues, they can be evaluated by reviewing the policy provisions and the applicable law. Because there is already a "paper trail" with the claims file, there is an excellent source for preparing a chronology of claims handling and an analysis of what was done and why. Thus, there is an early opportunity to learn about the claims handling, and the reasoning, or lack of such, behind it.

Other files are also available, such as an underwriting file, and claims manuals or written policies for the handling of the type of claim involved. These can provide guidelines on what procedures the insurer views as part of the good-faith claims process. The client and his insurance broker can also add information to the "claims story."

Second, bad-faith cases are costly to prepare and try. Capturing the case early, evaluating the damages, and looking at the down-the-line costs should motivate both sides to review the case to see if settlement at an early stage is prudent.

Thus, counsel can be aggressive in attempting resolution by inviting the defense to discuss the case or set a mediation date.

Evaluating the issues

Evaluating a case entails compartmentalizing it into the issues relating to the contract vs. the extra-contract (i.e., tort) claims. Since the measure of damages is different between contract and the extra-contract damages, there needs to be a breakdown of the potential liability and damages, both contract and tort.[14]

The purpose of the statutory and regulatory principles that outline the good-faith claims handling principles is to create a *proactive set of guidelines*, not a passive process. They establish that insurance companies, in responding to a claim of an insured, *have specific tasks that they must perform in order to reach a timely and efficient point for evaluation, payment and settlement efforts*, and cannot sit back and resist their payment obligations or insist that the file is not in a state for evaluation and payment because of the lack of information. The latter is totally contrary to the good-faith claims handling principles in most states.

In our view, there are ten basic areas of assessment:

- Was the claim promptly acknowledged?[15]
- Did the insurer "adopt and implement reasonable standards for the prompt investigation and processing of claims"?[16]
- Did an investigation of a claim begin within a reasonable period of time from notice of the claim?[17]
- Did the insurer "attempt to effectuate a prompt, fair and equitable settlement of a claim after liability [became] reasonably clear?"[18]
- Were the insured's financial interests treated equally with those of the insurer, or did the insurer subordinate the insured's interests to its own?[19]
- Did the insurer conduct a thorough, fair and objective investigation of a claim; that is did the insurer investigate all of

the facts supporting payment of a claim as well as those that might support limiting or denying a claim?[20]

• Was the insurer objective in evaluating a claim?[21]

• Did the insurer timely respond to all communications?[22]

• Did the insurer provide a substantive response to communications that reasonably anticipate such?[23]

The claims handling can be measured against these basic principles, perhaps with the help of your insurance claims consultant/expert.[24]

The timing of negotiations

Getting the carrier to the table involves assessing the point at which the case is ripe for evaluation and negotiation. At this point, plaintiff's counsel should have a good idea of what was done and why. This then allows an evaluation of whether the good-faith claims principles have been satisfied. When the time is right, the invitation to negotiate or mediate should be communicated to defense counsel. This usually comes at the "plateau," where the parties have sufficient information to determine the potential liability of the insurer as to both the contract and extra-contract claims, and to assess the risks and costs of going forward.

Presenting the case to encourage settlement discussions

If mediation is scheduled, a written demand or a mediation statement is a must. Here, the burden is on the plaintiff. If a demand letter is chosen, the case must be carefully and fully outlined with exhibits to support the claims. If mediation is scheduled, the mediation statement must be provided to the opposing counsel and the carrier. This should be done even if the carrier does not provide plaintiff with its statement. There can be no holding back if the case is to be settled.

Beware, however, if the carrier is not willing to exchange a comprehensive mediation statement because then it is likely not coming to the mediation in good-faith, and will simply attend what it hopes is a "fire sale." Our suggestion is that you decline to mediate in that instance.

The presentation for the plaintiff should be organized in the same fashion as we have outlined, with the first attention to the contract claim if it has not been resolved.

In reviewing the claims handling, the focus should be on the basic principles outlined above and the facts that lead to the conclusion that the carrier did not comply with the recognized good-faith principles.

The demand letter or mediation statement might be supplemented by a confidential video with interviews of the client, family members, medical providers, other witnesses, and even experts[25] which are "mini" direct examinations. The video should be treated as confidential, using the settlement or mediation privileges.[26]

We also frequently supplement our submissions with a confidential letter to the mediator with additional information, which can be disclosed if it will help bring closure to the case later in the negotiations.

Preparing the client for mediation

A client deserves to understand and be prepared to make decisions about settlement. Insurance cases require some special handling. First, the client must understand how insurance policies and coverage work. Clients typically do not understand the limitations of coverage, both as to scope and financial limits. Often we find they are surprised to learn of these limits. "The agent never told us," they say. That may be true, but was the agent obligated to go over these limits under the circumstances, and how does this impact the liability of the insurer (or the agent/broker if also a defendant)?[27]

As to claims handling, this is usually an emotional situation for the client. Many are angry and frustrated at the insurer's behavior, so some intervention might be required to calm the emotions and bring rationality to the decision-making process.

The mediation materials, mediation statement, and any video should be sent to the defense well in advance of the mediation. One technique is to post them in the "cloud" and track who accesses the site that you provide for reviewing these materials before the mediation.

Mediation day: Authority matters

The key to the mediation day is communication, however that is best handled. Opening sessions are fine if they do not raise the temperature and are more matter-of-fact and focused on information gathering, rather than tension-building presentations.

It is also very important to have someone from the carrier, with the authority to resolve the claim, present at the mediation. You should get that assurance from defense counsel or the mediator before attending the mediation. Any last-minute effort to avoid this appearance should result in the mediation being continued.

If the preparation has been thorough and the briefs have been exchanged, then the stage should be set for productive discussions. In many "bad-faith" cases the mediator may need to become more evaluative than facilitative. A mediator may need to evaluate the claims in order to contribute to the discussion of the issues and how they might be viewed by a judge or jury. This will help get the parties to be realistic about the value of the matter and the carrier's exposure both as to the contract and extra-contract claims.

We have already addressed some of the impediments to settlement, which include:

• The plaintiff has not obtained all the information necessary to present the case for settlement or mediation (e.g., not obtaining the claim file, not getting a review by a knowledgeable expert who can evaluate the claims handling);

• The carrier representative with the full authority to resolve the matter is not present at the mediation;

• The carrier's approach is to continue a "low ball" approach and not participate in settlement discussions in good-faith.[28]

A final comment

Insurance bad-faith cases offer the opportunity to direct negotiations or mediation at a reasonably early stage in the litigation process, but it is up to plaintiff's counsel to make the process work. The claims files and documents must be reviewed and an expert must be consulted on the "wrongs" that were committed using the "good-faith" claims handling guidelines as reflected in the case law, statutes, applicable regulations, customs in the industry, and company guidelines (or absence of them). Once that is done a careful outline of the case, including the economic and non-economic losses of the client, must be communicated. Ultimately, a thoughtful presentation and analysis in a credible case should get the carrier to the table for discussions about settlement.

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Endnotes

[1] Judicial Council of California Civil Jury Instruction (2017) No. 2334.

[2] Judicial Council of California Civil Jury Instruction (2017) No. 2336.

[3] Judicial Council of California Civil Jury Instruction (2017) No. 2331.

[4] Claims subject to the Employee Retirement Income Security Act of 1974 (§ Pub.L. 93–406, 88 Stat. 829, enacted Sept. 2, 1974, codified in part at 29 U.S.C. 18) include long term disability coverage under a "group plan" and are litigated under rules subject to the federal statute, unless exempt. *See Health Plans and Benefits: ERISA*, United States Department of Labor, https://www.dol.gov/general/topic/health-plans/erisa (last visited Apr. 4, 2017).

[5] Early in the case plaintiff's counsel should request in writing that the carrier preserve all documents, electronic files, and related materials regarding the case. Electronic discovery ("eDiscovery") is discovery of electronic information in litigation. In 2009, the California legislature passed the Electronic Discovery Act, an urgency statute, to address specific issues that frequently arise in eDiscovery. The Electronic Discovery Act is modeled in part on federal rules governing eDiscovery, which took effect December 1, 2006. *See* Fed. R. Civ. P. 16 (b)(3)(B)(iii), (iv), 26(b)(2)(B), (b)(5), (f)(3)(c), 34(b)(1)(C), (b)(2)(D), (b)(2)(E), 37(e). The electronic information sought by eDiscovery is called "ESI." ESI is an acronym for "electronically stored information," defined as "information that is stored in an electronic medium." West's Ann.Cal.C.C.P. § 2016.020(e). "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities. West's Ann.Cal.C.C.P. § 2016.020(d). The Federal Rules do not precisely define "electronically stored information." FRCP Rule 34(a) covers information "stored in any medium." Examples of electronic media include: computers, email and other servers, memory sticks/flash drives, CDs, DVDs, backup tapes, cell phones.

[6] Guy Kornblum and Daniel Bailey, *Using Insurance Experts in Bad Faith Cases: Should I or Shouldn't I*, Trial, Feb. 2000, at 30-37.

[7] While some attorney files may be protected from discovery and admissibility, there are instances where they may not be protected from disclosure or use at trial, or any protections have been waived. *See* Mendes & Mount LLP, *Discovery in coverage and bad-faith litigation: are courts permitting more invasive discovery?*, Lexology, http://www.lexology.com/library/detail.aspx?g=977a656f-ba49-4a2a-a42c-7c21af31c96e (last visited Apr. 4, 2017).

[8] David Polin, *Insurer's Failure to Investigate Claim in Good Faith*, 46 Am. Jur. Proof of Facts 3d 289 (2017). *See also* West's Ann.Cal.Ins.Code § 790.03(h)(3) (failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies). *See also* 10 Cal. Admin. Code § 2695.7(d) (requiring the insurer to "conduct and diligently pursue a thorough, fair and objective investigation . . . .") An "investigation" is defined as "all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond." 10 Cal. Admin. Code § 2695.2(k).

[9] *See, e.g.* West's Ann.Cal.Ins.Code § 790.03(h)(5) (not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear). See 10 Cal. Admin. Code § 2695.7 for the California "good faith" standards for a "prompt, fair and equitable settlements."

[10] *See* Guy Kornblum, *Insurance "Bad Faith" Basics, Parts I and II*, 24 Cal. Bus. L. Prac. 3, 96, 123 (2009). *See also*, J. Feinman, *The Law of Insurance Claims Practice: Beyond Bad Faith*, 47 Tort Trial & Ins. Prac. L. J. 2, 693 (2012).

[11] For example, Xactimate is a program used in the property claims area. It is described as follows: "Xactimate, the industry's easiest-to-use and most comprehensive software solution for property claims, revolutionizes property claims estimating and guarantees that you will never be tied to your office or a single computer again to estimate a claim." *Xactimate*, Xactware, http://www.xactware.com/en-us/solutions/claimsestimating/xactimate/28/professional/?gclid=CJ3P9K_fkL4CFQqPfgod3HQA1w (last visited Apr. 4, 2017).

[12] "Colossus® is the insurance industry's leading expert system for assisting adjusters in the evaluation of bodily injury claims. Colossus provides adjusters access to your company's claims data within a defined business process management framework for evaluating injuries, treatment, resolution, impairment and general damage settlements. Colossus helps your adjusters reduce variance in payouts on similar bodily injury claims." The program was designed by Computer Science Corporation. *Colossus*, DXC.TECHNOLOGY, http://www.csc.com/p_and_c_general_insurance/offerings/26121/57637-colossus (last visited Apr. 4, 2017).

[13] The use of this type of evaluation software has been subject to substantial criticism. *See* Leslie Scism and Erik Holm, *Auto Insurers Criticized for Using Injury-Evaluation Database*, THE WALL STREET J., www.wsj.com/news/articles/SB10001424052702303918204577446663047523538?KEYWORDS=colossus&mg=reno64-wsj. See also, https://insurancenewsnet.com/oarticle/Former-Allstate-claims-manager-offers-insight-into-computerized-auto-injury-payo-a-369874 (last visited Apr. 4, 2017).

[14] *See* Polin, *supra* endnote xii.

[15] 10 Cal. Admin. Code § 2695.5(b) provides: "Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant." Forms must be promptly provided under 10 Cal. Admin. Code § 2695.5(e).

[16] *See* West's Ann.Cal.Ins.Code § 790.03(h)(3).

[17] In California, this is 15 days from notice. 10 Cal. Admin. Code §2695.5(e).

[18] *See* Mendes & Mount LLP, *supra* endnote xi.

[19] *See* Polin, *supra* endnote xii. *See also* West's Ann.Cal.Ins.Code § 790.03(h)(3); 10 Cal. Admin. Code § 2695.7(d); 10 Cal. Admin. Code § 2695.2(k).

[20] See 10 Cal. Admin Code § 2695(d). *See also* Cal. Admin. Code § 2695.2(k) (giving a broad definition of "investigation").

[21] *See* Polin, *supra* endnote xii. *See also* West's Ann.Cal.Ins.Code § 790.03(h)(3); 10 Cal. Admin. Code § 2695.7(d); 10 Cal. Admin. Code § 2695.2(k).

[22] *See* 10 Cal. Admin. Code § 2695.5(b). This type of response is not required if there is litigation pending.

[23] While these are taken from the California Unfair Clams Practices Statute (West's Ann.Cal.Ins.Code § 790.03(h)(3)) and the California Administrative Cod (10 Cal. Admin. Code § 2695.1 *et seq*.), they reside in the body of case law that has developed over the past decades during which the courts have spoken on claims handling issues. *See* Polin, *supra* endnote xii. *See also* West's Ann.Cal.Ins.Code § 790.03(h)(3); 10 Cal. Admin. Code § 2695.7(d); 10 Cal. Admin. Code § 2695.2(k).

[24] The revisions to Rule 26(b)(4) of the Federal Rules of Civil Procedure invite this approach since you can now have confidential communications with an expert who is later designated as a trial witness.

[25] *See* Kornblum and Bailey, *supra* endnote x.

[26] Guy Kornblum, *Confidentiality in Settlement Negotiations and Mediations, in* Negotiating and Settling Tort Cases: Reaching the Settlement 705-731 (Thomason West/American Association for Justice 1 ed. 2013 (Rev. 2015-16).

[27] Steven Plitt, *A Review of Insurance Broker Duties Under California Law*, INS. J., http://www.insurancejournal.com/magazines/features/2014/10/06/342115.htm (last visited Apr. 4, 2017).

[28] *See* 10 Cal. Admin Code § 2695.7(g) (regulating against "low balling").