



THE DELETERIOUS EFFECTS EXPANSIVE BAD-FAITH LITIGATION HAS ON INSURANCE MARKETS

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EXECUTIVE SUMMARY

NAMIC's purpose in disseminating this paper on unfair claims practices complaints lodged against insurance companies is to reiterate that the, at times, antiquated concept still thrives in many U.S. jurisdictions and its employment continues to grow in others. General acceptance and complacency concerning these allegations should not stifle a continuing debate as to the efficacy of such causes of action, which are in many cases redundant to state insurance regulation.

It is not the intention of NAMIC to call into question legitimate claimants who are routinely and efficiently paid by insurers on a timely basis. The paper merely seeks to point out that as "bad-faith" claims have developed over the last century, some of the rationale for their existence is no longer operative. Put simply, bad faith is a disruptor to insurance marketplaces where there already exist adequate guardrails from regulators, reputational risk, competitive risk, and other market forces. It is our contention that the paradigm of court regulation of insurers should be revisited and abated, or at least reexamined for the redundancies and excessive issues that exist.

This paper contains an elementary overview of many of the issues facing insurers in the current climate, which will suggest there is a shrinking rational justification for widespread utilization of the bad-faith concept. The discussion that follows will cover the following topics:

- The evolution of statutory claims from common law notions;
- First- and third-party differentials;
- The pitfalls associated with such schemes;
- The duplication of state-based regulation and court regulation;
- Market destabilization effects in state legislative activity;
- Sample judicial verdicts for context;
- Causes and effects to the marketplace; and
- The road forward

Further, the intent of this paper is not to suggest a one-size-fits-all mentality – there are no simple solutions to these problems. For public policymakers who consider reintroduction or expansion of the bad-faith environment, there should be a cost/benefit analysis conducted to determine whether intended goals will be achieved and at what cost to insurance markets and policyholders. We must proceed carefully in considering the relative utility of bad-faith claims so that we do not crash upon the rocks of the law of unintended consequences. It is likely many of the stakeholders in this debate believe they are correcting perceived misdeeds and therefore righting a wrong. Unfortunately, in many instances, there is an exacerbation of a non-existent problem that only adversely affects the insurance consuming public by allowing a costly second lawsuit or proverbial "bite at the apple." Inordinate and unwarranted costs and expenses to insurance operations inevitably must be considered. This ultimately concerns all who participate in insurance marketplaces and, in particular, insurance consumers.

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INTRODUCTION

The evolution of extracontractual liability or by the more pejorative descriptor “bad-faith” for insurers – liability placed directly upon an insurance company in excess of contracted-for policy limits and premium recouped for such policy limit exposures – has now meandered its way through the U.S. court system for nearly a century. Despite a pervasive and growing menace to insurance markets and the potential to increase costs for companies and consumers alike, there appears to be a resurgence in certain jurisdictions of the notion that this type of cause of action remains laudable despite the overwhelming evidence to the contrary.

Put simply, extracontractual liability is a draconian attempt to rein in presumed, though often not actual, misconduct by insurers and to supposedly level the field of claim resolution between the parties. In practice, however, it often appears a few anecdotal pieces of evidence, sometimes grossly misrepresented, create a fear of a supposed canyon in bargaining power between claimants and insurers that must be corrected through drastic measures.¹

The pendulum has swung too far in favor of plaintiff attorneys seeking large recoveries, and in many instances, the facts and law do not factor into this equation. Any time a claim decision doesn’t fulfill the high expectations and grossly exaggerated beliefs of a plaintiff’s counsel, extracontractual liability, or bad faith, is drawn into the conflict and used to inflict maximum damage without discretion to everything in its path. Bad-faith claims have now been twisted into an untenable choice for insurance companies that in many instances are harmed regardless of the path they take to resolve them. As a result, there is reputational risk at stake for insurance companies, not to mention paying premature or excessive claims that are unwarranted. Many times, preventive settlement actions must be taken to forgo the added costs of bad-faith litigation and potentially enormous verdicts for nominal harm supposedly caused to the litigant.” Further, alleged bad faith may not cause any additional harm than already existed in the underlying and alleged claim loss, which may also have meritorious concerns.

As a general proposition, the assertion that insurance companies do not want to pay claims in a timely and efficient manner is illogical and contrary to the long-term interests of insurers. Business models are built on the efficient payment and resolution of claims. Delaying responses or failing to pay reasonable damages are not sustainable endeavors that can only result in reputational harm, competitive risk, consumer backlash, regulator response, and the added tort system costs that must all be responded to in kind. To be clear, this does not mean that issues do not occur.

However, solely because any human endeavor can be prone to error on occasion, this should not create the types of responses inflicted upon insurers for highly technical and non-material instances of non-compliance. The ramifications from what is, in many instances, an overreaction eventually find their way to the consuming public that must ultimately pay, directly or indirectly, for a litigation dynamic gone awry.

However well-meaning the concept of bad faith extracontractual liability may have been, its continual existence or expansion is not only harmful to the basic principles of insurance and providing assurance for risk, it creates an insidious lottery mentality.² This type of regime costs each and every insurance consumer, and bad-faith reform or removal measures should be entertained if protection of consumers is truly the goal.

The arguments made in a recent opinion by the 1st Circuit Court of Appeals clearly and concisely lay out some of the fallacies of bad-faith allegations against insurance companies, but, sadly, are often disregarded in reaching bad-faith decisions in other jurisdictions. The court opined that entities that are “in the business of insurance are required to handle claims in good faith and to respond reasonably to the exigencies of the settlement process ... [a]n insurance carrier is not to be held to a duty of prescience ... a firm that is in the business of insurance commits an unfair claims settlement practice by failing to effectuate

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prompt, fair and equitable settlements of claims in which liability is reasonably clear or by refusing to pay claims without conducting a reasonable investigation ... liability is not reasonably clear if an element in the underlying claim is subject to good-faith disagreement ... an insurer who has investigated a claim and has a good-faith basis for concluding that liability is not reasonably clear does not violate [the law] either by delaying a settlement offer or for withholding one altogether ... perfection is not the standard that [the law] imposes upon the handling of a claim....”ⁱⁱⁱ

If jurisdictions would follow these tenets of law on a regular basis the vast majority of outcomes would be much different and stability in the system possibly regained. However, partiality, passion, anecdotal concern, innuendo, and conjecture are in many instances allowed to permeate courts and legislatures. As a result, bad-faith claims sometimes seem to be a pre-determined outcome in search of a means to an end.

COMMON LAW VS. STATUTORY UNFAIR SETTLEMENT CLAIMS PRACTICES

The origins of unfair claims practice allegations began in implied common law covenants of good faith and fair dealing in the area of contract law. Parties to contractual deals were expected to act with utmost good faith and reasonable dealing with each other to achieve the spirit and intent of the agreement they had entered. It should be noted that this initial common law^{iv} duty was expected of both parties. Unfortunately, and as will be discussed further, this concomitant duty is now largely and almost exclusively placed upon insurers while some claimants’ attorneys and other respective parties’ conduct are not factored into any outcome.

Eventually jurisdictions allowed or created an evolution of the unfair claims practice allegation to enter the tort realm and the good faith and fair dealing standard to be transposed into a duty to settle claims and pursue actions directly against the insurer. Claimants began suing insurers for failing to settle claims they believed should have been entertained. Tort suits differed from breach of contract suits because the scope and type of damages allowed were greater.

Suddenly, there were two recoveries or two lawsuits, one for the underlying tort loss, e.g. medical bills, pain and suffering, or mental anguish, and a second suit with excess limits and punitive damages possibly added for failing to settle a claim within the insured’s policy limits. This not only created a double recovery for one loss, but also opened the door for the cause of action against the insurer to influence decisions concerning claims payments and liability determinations. It should be noted that the original premise of such bad-faith claims was that there was the knowing, intentional conduct of insurers rather than an ordinary slip-up or negligent mistake.

At some point in this evolution, the National Association of Insurance Commissioners^v entered into the realm of expected claim practice conduct by promulgating a Model Unfair Trade Practice Act. The model act included a number of specific parameters that an insurer could potentially cross the line between permissible and non-permissible activity in conducting business. The UTPA discusses many practices such as misrepresentations, false advertising, defamation, rebating, boycott, coercion, and intimidation as well as unfair discriminatory practices. The model law attempted to be a one-size-fits-all prescriptive model that additionally encompassed claim handling. The claims standards were subsequently broken out as a standalone model law, the Model Unfair Claims Settlement Practice Act, that listed multiple and extremely broad offending claim practices that provided the foundation for what would become additional material for lawsuit causes of action in bad faith.^{vi}

Despite this laundry list of potential violations by an insurer, the NAIC model did specify that to be found violative of the conduct the alleged activity had to be committed with such frequency as to indicate a general business practice. This was an extremely important qualification. The early iteration of bad faith was essentially an intentional act that was being punished.

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This qualification has been eroded in a number of jurisdictions, and the slippery slope of severely punishing negligent or unintended harm has become a larger factor in current claim practice discourse. The UCSPA has been adopted in some form in all U.S. jurisdictions along with accompanying regulations that detail specific time responses to inquiries and other specified conduct used to discern insurer violations of law.^{vi}

Further, the model language and drafting notes remark that no language expressly provides a claimant with a private right of action against violators of the act's provisions. Consequently, it is left to judicial decision-making in many instances to create the cause of action. In other instances, legislators have specifically referenced the NAIC model and incorporated the same into their code.

Unfortunately, the NAIC model law has now become ammunition for salvos fired constantly at insurers for bad-faith conduct. If an insurer responds one or two days beyond a 15-day requirement for responses to communications from claimants, they have technically violated an unfair claim practice standard despite the fact that the one- or two-day delay did not harm a consumer or policyholder in any material fashion. Reasonable standards for investigations have become the subject of mounds of litigation as plaintiff attorneys have tried to hold each insurer to an impossible burden to track down every minute fact regardless of how it might affect the outcome of a claim or the associated cost.

While courts attempt to weed out non-meritorious claims, the plaintiffs' bar has become adept at eliciting facts that require courts to allow these cases to go to juries. Judicial decisions as to what is a reasonable settlement offer are disseminated near-daily, requiring potentially constant realignment of compliance depending upon the jurisdiction. Ascertainment of when liability is "reasonably clear" becomes a common issue. In many instances, courts wrangle with coming to correct decisions in these complicated precepts. The inundation of these claims and the gray area they operate in only increase payouts, reinforcing the casino mentality and a paradigm shift from what essentially began as a laudable effort. If legislatures broadly or vaguely permit a practice, courts are left to discern and interpret its meaning that, unfortunately, can and has led to widespread inconsistencies.

FIRST-PARTY CONCERNS

The growth and body of law created by unfair claim settlement allegations can be somewhat concisely divided into first- and third-party concerns. First-party concerns deal with those in contractual relations with an insurance company. For a stated premium, a contract is entered into between a policyholder and insurer and for the premium paid, the insurer agrees to indemnify the policyholder or other third parties for unexpected loss to, or caused by, the policyholder in the future based on specified contingencies and exceptions. Breach of contract actions that have been in the common or case law for many centuries allow a party to sue for specified damages in the eventuality of a breach of contract terms or failing to honor the same when triggered.

It is from this concept the original good faith and fair dealing concept evolved. Each party owed a contractual duty to not only honor the terms of the agreement, but to also support the union in a fair and reasonable manner to bring about completion of the transaction. Damages were usually limited to compensating the harmed individual for out-of-pocket losses. However, jurisdictions moved beyond contract breach causes of action by allowing tort lawsuits for failing to honor contractual insurance terms. For instance, courts were charged with deciding appropriateness of paying settlements and in many instances within and up to the policy limits of coverage. Verdicts that exceeded policy limits and were not paid or tendered by insurers prior thereto, exposed the insurers to the entire excess verdict. Consequently, the insurer, for defending the claim with legitimate

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reasons and not paying the entire policy limit, found themselves inexplicably paying excess verdicts in addition to their limits as a form of “punishment.” Evidentiary sufficiency for court decisions can vary widely from jurisdiction to jurisdiction.

One of the leading influential cases in first-party recoveries was in California’s 1973 case *Gruenberg v. Aetna Insurance Company*.³⁴ As early as 20 years prior, the Supreme Court of California had recognized that an insured could sue for damages in contract and tort when an insurance company fails to settle a third party-claim against its insured and that refusal resulted in an award in excess of policy limits. However, in *Gruenberg* the court expanded its earlier decisions to hold that an insured could also sue for damages in contract and tort when the insurer breached the contract by failing to pay insurance proceeds due the insured.

In *Gruenberg*, arson was suspected and investigated, and the insured created more concern by failing to cooperate with the investigation. After a magistrate dismissed charges for lack of probable cause, the insured sued Aetna, which refused to pay due to the information obtained in its investigation. Nevertheless, the Supreme Court of California allowed a cause of action to be sustained. The court found that “[t]here is an implied covenant of good faith and fair dealing in every contract, including insurance policies, that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. Therefore, an insurer who refuses to accept a reasonable settlement within the policy limits in violation of its duty to consider in good faith the interest of the insured in the settlement is liable for the entire judgment against the insured even if it exceeds the policy limits... Accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort.” In a separate discussion, the court disregarded the lack of cooperation of the insured and essentially stated that nonperformance of contractual provisions fails to excuse a bad-faith breach.

As these permitted causes of actions expanded across the country, the NAIC model law on claims practices evolved and first-party claimants who had a loss could now become averse to their own insurer. They could now litigate their respective ideas of what was a fair and reasonable response by the insurer, timeliness, thoroughness of investigation, and amount entitled for a loss.³⁵ Interestingly, some of these losses being first-party in nature were actually caused by the policyholder who now filed a lawsuit against their own insurer for a claim created by their own activity. Additionally, policy coverage decisions or whether the loss is expected to be indemnified under the contract language can also give rise to suits against their own insurer when denials occur based upon existing policy language and the circumstances of each loss.

THIRD-PARTY CONCERNS

Third-party concerns involve contractual insurance policies for liability coverage that promise to pay for losses incurred or caused by first-party insureds that harm other parties. However, with the duty to settle within policy limits and the NAIC model law on unfair claim practices, third parties not only have a lawsuit against the person who allegedly caused them harm but also against their insurer. If third parties believe they didn’t receive an appropriate amount of damages for that alleged harm, if they weren’t responded to within time periods set by statute or if investigations were not conducted to their specifications an additional cause of action was born. Thus, a second lawsuit and potential recovery evolved in this realm as well.

This second bite at the apple for a single automobile wreck or other loss scenario could cause an insurer to now pay for two losses while having only recouped premium for the underlying insurance coverage policy limits. The concept of extracontractual liability was created, and insurers now could be paying double along with inclusion of punitive damages in sometimes enormous amounts. Any understanding of the concept of insurance pooling for losses of pool members would reveal that this double or exponential recovery is not sustainable unless more premium is obtained from other members of the pool as costs increase.

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Third-party liability for bad faith is problematic because a lawsuit is directly against another entity's insurance company with which there is no privity of contract, the original reason the duty of good faith and fair dealing began in the common law. Third parties are by nature antagonistic to opposing entities' insurance companies.

Despite the overwhelming number of third-party claims that are paid each year without the need for litigation, this cause of action developed. California was instrumental in the growth of third-party extracontractual remedies as well as the aforementioned first-party concerns by holding the insurers liable for excess verdicts when they had rejected offers within the policy limits.^x

It should be clearly understood that if insurers do not have the right to defend their policyholders against fabricated, inflated, or otherwise improper claims, they will be forced to pay exorbitant amounts and subject their own operations to solvency concerns. The U.S. legal system has survived for hundreds of years based on the need to resolve disputes through litigation as well as the concept of due process and fairness of proceedings. The U.S. Constitution and state constitutions clearly lay out the concept of due process. It is an adversarial system. If parties are penalized for defending their legal rights when challenged, it essentially chills the very rights that were pronounced and included in these important governing documents.

Disruption of the system and failure to allow a proper defense exponentially raises claim payouts, and in the short term raises premiums. In the long term it potentially subjects insurance entities to viability concerns. Threats of bad-faith exposure are just that type of disruption. Excessive loss ratios, or a disparity in the amount companies pay out for claims in relation to recoupment of premiums, cannot be sustained for any excessive period for any ongoing entity. Insurance marketplaces need to be able to actuarially account for potential losses within reason, but court and legislative decisions can vastly and dramatically alter a system in balance. Such disruptions must be borne by the insurance-paying public either directly or indirectly depending on the cost driver. It is axiomatic that those who support bad-faith litigation regimes cost the very policyholders who are supposed to be protected while providing a potentially undeserved double recovery.

EXTRACONTRACTUAL LIABILITY PITFALLS

When reviewing the current approach to extracontractual liability and unfair claim practices, there are many pitfalls that should be considered.

PREMIUM, PREMIUM, PREMIUM

As previously mentioned, insurance companies must actuarially account for expected losses by charging an appropriate premium to customers based upon the risk of loss. Certainty and stability are hallmarks of a robust and competitive insurance environment with more steady rates due to losses being more readily ascertained and reasonably predicted in the marketplace.

Bad faith and extracontractual damages destabilize this concept by injecting absolute uncertainty, lack of rationality, extreme subjectivity, and potentially, in some instances, unlimited liability. When an insurer can actuarially account for a policy limit loss, they can create reasonable likelihoods of potential losses to a very high degree that allow for future planning and reserving. In the unfair claim practice world, jurisdiction-by-jurisdiction decisions can wreak havoc on projecting losses and ultimately on the entire system due to undefined and unspecified expectations of conduct that evolve with each statutory pronouncement or jury verdict in excess of contracted policy limits.

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Further, while aspects of alleged bad faith may or may not be directly passed on to policyholders, many dynamics tie up additional capital and accompanying capacity of insurers to write additional business. To name a few:

- The effects of premature settlements;
- Intimidation by plaintiff attorneys that cause weak or non-meritorious cases to be settled;
- The disincentive for insurers to investigate fraud for concern about bad-faith suits; and
- The costs associated with defending such suits.

When insurance companies have their capacity to underwrite additional business curtailed by such schemes, the availability of insurance products is reduced, and market competition is lessened.

VALUE IS NOT OBJECTIVE

A large portion of allegations of bad faith center on value of damages. Many times, insurers may in good faith admit that their insured is at fault for a particular loss or that their coverage is triggered. That doesn't mean they must now pay whatever the claimant demands. A person's subjective belief as to their damages will almost always be more than what a more objective analysis concludes. At the end of the day, no two losses are the same or have the same value. There are a host of statistical facts and studies about the inflated claim requests that can be made in loss scenarios.^{xi}

Claimants who feel their losses are catastrophic must have them compared to others, and similar verdict recoveries, to put the losses into perspective. It is almost routine now for plaintiff attorneys to make a demand in excess of policy limits for every claim they handle, regardless of loss amount. However, every claim is relative. Bad faith is not, and should never be, about a good-faith dispute over the value of claimed damages. This is precisely what the underlying tort claim is about and should be handled in that arena.

Unfortunately, claims of lowball offers that fail to look at all the facts of the case continue to permeate the courts. These claims are meant to influence outcomes and get something in addition to what the claimant was entitled. Cases are replete with stories that may be extremely sympathetic or where there were not adequate policy limits, and findings of bad faith are used as a way to overcome the lack of underlying coverage limits for a large loss. Plaintiff attorneys are well versed in this regard and even attend continuing legal education classes on maximizing damage recoveries.

NUANCES TO LIABILITY DETERMINATIONS

Liability, or causation for an accident, is not always binary. There is not always a party that is totally at fault and a party that is absolutely clear of contribution to the loss. Consequently, principles of contributory and comparative fault have entered onto the legal landscape over many years. Contributory negligence exhibited by a party may entirely bar any recovery against another party. In comparative fault states, a person's own percentage of liability reduces any recovery they may have against another party. In some states, when a person's own liability exceeds a certain percentage, such as 50 percent, they are barred from recovery against another. It is a valid public policy principle that one who contributes to a loss should not benefit from the same as well.

However, in some instances, claimants are not prepared for a non-binary outcome, which causes hostility toward the insurer for merely providing an objective factual event determination for the purposes of dispute resolution and actual legal liability. The inability to accept that contribution to an accident may have occurred lays the groundwork for many

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bad-faith suits. Good-faith disputes over liability where the cause of the accident or loss alleged could have happened under different scenarios should not rise to the level of bad faith. Again, the underlying dispute allows litigants to redress this concern over who caused the accident or loss.

INVESTIGATIONS

Fault investigations can take a great deal of time and expense. Insurers are required to perform an investigation, and many times factual situations as described don't add up. In many instances there are no witnesses present or none willing to participate, and it is one person's word against the other. In some first-party instances the policyholder, who, again, may have caused their own loss, may not have an incentive to be forthcoming about facts surrounding a loss they deem detrimental despite first-party requirements in the policy that policyholders do so. In large loss or complex accident scenarios insurers will often hire experts to review information. However, simply because it is unnecessary to hire experts in all losses doesn't make the investigation less thorough. Claim adjusters utilize technology and other avenues to provide efficient claim investigations. Plaintiff attorneys may influence court decisions, however, to cling to outdated modes of claim review investigation that only increase costs and will not alter the investigative outcome.

Claim payments that are not the responsibility of the pending claim insurer should not simply be reimbursed without question. Further, determining damages is a time-consuming process that is not always susceptible to immediate responses without further inquiry. For instance, a person's medical history may be relevant in determining the actual or legal cause of the accident and subsequent injury. These avenues must be explored to thoroughly ascertain responsibility in claims. Current diagnoses and prognoses of injured parties may not be clearly shown by the medical records and exploring these issues may take additional time. When insurers are forced to pay claims from which their responsibility is not legally required or if they pay inflated demands, costs are needlessly injected into the claim.

The general standard in investigations is whether it was a "reasonable" investigation. This leaves the interpretation open to debate as to what should have been accomplished. Bad-faith cases have been decided that are replete with technical requirements for investigations, which in the end wouldn't have made a material difference in the outcome.

BAD-FAITH SET-UPS

Bad-faith set-ups can also occur and take many forms. Essentially, they are overt actions taken by a plaintiff attorney to "bait" the insurer into committing an act of supposed bad faith. These actions can take the form of extremely large settlement demands that are in excess of policy limits in an attempt to get insurers to simply not respond and to show gross disparity in bargaining positions in an attempt to redefine "reasonable" to a jury or judge.

In a highly contested Florida case,³¹ an insurer was ultimately held liable for bad faith in failing to meet an arbitrary deadline set by the claimant's attorney, which couldn't have been met due to the need to get legal guardianships set up for payment to protect an injured minor. The Florida Supreme Court ultimately reversed the intermediate appellate court and reinstated a bad-faith verdict of nearly \$2 million against the insurer.

Two members of the Florida Supreme Court issued a stinging dissent in the case, stating unequivocally that this amounted to a manufactured bad-faith claim and a "strategy which consists of setting artificial deadlines for claims and the withdrawal of settlement offers when the artificial deadline is not met" with clear intention of reaping open-ended coverage from a policy limits claim. The scheme was successful, in the words of the dissenting justices, as the insured had paid for basically \$20,000 in coverage and received payment in excess of \$2 million.

DISCOVERY ABUSES

Bad-faith litigation ultimately leads to discovery or legal procedural rules which allow each party to ascertain the other side's evidence concerning the merits of their claim or defense. However, abuses of the discovery process can amount to gaining access into an insurer's operations, trade secrets, and ultimately its internal discussions on claims handling. The ultimate prize in these types of cases is to get an unredacted version of an insurer's claim file or proprietary claim manual. The plaintiff attorney hopes to find through this "fishing expedition" any number of innocuous comments or other irrelevant information from which the attorney can turn the dialogue away from the underlying facts/law into a narrative story about the company and its affairs. Additionally, plaintiff attorneys seek to obtain information via sworn depositions and other interrogatories of insurers and their representatives to utilize in other cases to seek similar results or institute class action suits, creating cottage industries that continue to perpetuate the same misguided narratives in additional litigation with other claimants.

Interestingly in some jurisdictions, while the underlying tort claim is still in the process of litigation but due to a statute of limitations or other reason, a second lawsuit is filed against the insurer for bad faith to preserve the lawsuit. So, in this instance, you have the perverse result of an insurer that is trying to adjust an underlying claim in litigation and defend itself from a bad-faith claim at the same time. While some jurisdictions will stay the bad-faith action pending resolution of the underlying claim, some jurisdictions only stay where there is demonstrated prejudice to the carrier, which is, of course, open to interpretation. Consequently, unfair and untenable results can occur where there is attorney-client privileged information that should be ascertained and protected even as the court allows the two suits to continue. This usually requires that multiple counsel be hired to avoid conflicts, increasing loss adjustment costs. Another concern is that if an adverse party obtains confidential claim files that might have reserving information or other privileged information, the result could alter the fairness of the proceedings and how the underlying claim is ultimately resolved.

NEGLIGENCE VS. INTENTIONAL ACT STANDARDS

The original intent of bad-faith litigation was to punish and deter intentional conduct. But intentional conduct has a higher burden of proof, and courts and legislatures have reduced that burden to a negligence standard of "more likely than not" in many instances. This burden can make it easier to find problematic conduct or infer the same through innuendo, conjecture, and speculation. When an insurer is facing potentially 10 times compensatory damages as a multiplier for punitive damage awards, a higher burden needs to be instituted in the interest of due process or fairness.

An Indiana court noted that "[its] case law is replete with reminders of the kind of conduct by the insurer that does and does not constitute bad faith. Poor judgement and negligence do not amount to bad faith, the additional element of conscious wrongdoing must also be present."^{xiii}

LITIGATION ELONGATES A SUPPOSED PROBLEM

When the problems with a permissive bad-faith environment are exposed, the concept doesn't stand up to its supposed ideal. Litigation takes time. Cases can be on dockets for years before ever seeing a jury or other resolution. In the meantime, there are countless costly endeavors in discovery as well as other legal motion practices and accompanying civil procedures. Appeals, when filed, can add additional years. Consequently, there are those who favor other forms of redress such as existing regulatory review or other alternative dispute resolution methods that might more timely resolve alleged concerns.

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REASONABLE STANDARDS APPLIED TO INSURANCE EXPERTISE

Another pitfall to consider is applying the “what would a reasonable person do in like or similar circumstances” standard to these outcome determinations. Insurance is a complex and highly regulated business that has dynamic and expert parameters to its operation. Courts do not expect layperson jurors to determine what they would have done in medical negligence cases, but rather after hearing extensive medical expert testimony decide if a deviation from the standard of care has occurred. However, jurors are routinely asked to place themselves in the place of a sophisticated insurance operation. Many courts do not even allow expert testimony in insurance unfair trade practice suits, further clouding the process for jurors and defendant insurers.

ASSIGNMENT

Even in jurisdictions that do not permit third-party actions directly, plaintiff attorneys have learned to craft legal work-arounds. The concept of assignment is not new, and it allows the contractual assignment of rights from one party to another. In a number of states, first-party insureds can assign their rights in claim disputes with their insurers to third parties. The third party now stands in the insured’s place as if third party is the first party and can explore all rights and accompanying recoveries. This can incentivize potential abuses of the claim dynamic. The claimants that are directly involved in the claim are now removed and the substituted party doesn’t possess the same attributes as the original party that can lead to extreme claim activity with little to no downside such as in Florida’s assignment of benefit crisis recently addressed by their legislature.

ATTORNEY-CLIENT PRIVILEGE IMPEDIMENTS

During the course and scope of a claim from inception through litigation, many issues concerning coverage, liability, and damages can arise and must be factored into the decision for the insurer. Insurers must often rely in such cases on the advice of counsel. All of these discussions are generally privileged under the law, meaning they cannot be disclosed to other parties under any circumstances.

However, courts have the authority to compel disclosure and order discussions disclosed to litigants. This creates uncertainty for insurers as to what can be discussed with counsel for concern it may later be disclosed, hindering their ability to respond to litigation effectively.

Such forced disclosures also raise issues of attorney-client privilege, as companies are forced to spend countless hours attempting to determine whether a privilege is waived. This completely disrupts the ability of an insurer to protect its interests and those of its policyholders. It also tilts the playing field considerably against the defendant.

ATTORNEY INVOLVEMENT

Permeating the entire culture of bad-faith allegations is the increasing inevitability of attorney involvement in even the most rudimentary claims. This activity can hamper, delay, and lengthen the claim process and increase costs.

A study conducted in 2018 by the Insurance Research Council found that reimbursement rates by insurers were essentially the same with or without attorney involvement and, incredibly, less for average payments per dollar of economic loss when attorney fees were factored into the equation.^{iv}

NAMIC ISSUE ANALYSIS

In “Countrywide Patterns in Auto Injury Insurance Claims,” the IRC collected data on more than 85,000 closed claims with payment under private passenger automobile coverages. The data found attorney involvement has been increasing over the last decade and that cost inflators can be correlated between the involvement of attorneys, even in low severity claims, and in the ultimate payments.

The study revealed that while attorney involvement may ultimately obtain a higher settlement or verdict for a claimant, any gains for the claimant are quickly subsumed or nullified by the attorney fees and costs to obtain the higher amount, resulting in a status quo average reimbursement or lower net reimbursement. As the report clarifies, 67 percent of bodily injury automobile claims studied were settled for \$10,000 or less in 2017 and 89 percent for \$25,000 or less.

While only 11 percent of all claims studied were in excess of \$25,000, attorneys were being retained at an average of 1 in 2 claims with scant, if any, benefit shown for the consumer/claimant by way of added recovery. This demonstrates the industry’s consistency on paying claim losses. It further reveals an added cost of doing business in the bad-faith world.

ATTORNEY FEES

Attorney fee awards should be distinguished from attorney fees, which generally refer to hourly fees paid to an attorney to perform legal services for a party. Another payment arrangement, called the contingency fee, allows a plaintiff attorney to only collect a fee if the attorney recovers a settlement or verdict on behalf of a client, usually as a percentage of recovery sometimes exceeding 40 percent plus additional cost and expenses. Added to the mix is the American Rule, which states that parties pay for their own attorney fees regardless of who wins. This has been in jurisprudence for at least a century and is different than the English common law that requires the loser to pay regardless of which side. However, some federal and state causes of actions or other codifications allow for the losing party to pay the winning parties’ attorney fees in addition to damages. These statutes almost always require defendants to pay the fees to the plaintiff and not vice versa.

Attorney fee awards are additional fuel to bad-faith schemes. When statutory mandates provide for attorney fees to be paid to winning parties it incentivizes attorneys to get involved, increases exposure to loss, potentially inflates claims, and maximizes recoveries. In most personal injury representations, higher losses correlate into higher compensation recouped for the plaintiff attorney. Insurers are more than willing to pay meritorious claims with reasonable settlement values. Potential attorney fee awards, however, cause many reasonable settlement offers to be rejected by the claimant with the hope of obtaining larger awards in litigation under this departure from the American Rule.

PUNITIVE DAMAGES

Punitive damages in bad-faith claims, in many instances, bear absolutely no proportion to the conduct exhibited. The United States Supreme Court noted as much in opining that verdicts for punitive damages can be unconstitutional when “unlimited jury or judicial discretion in the fixing of punitive damages may invite extreme results that are unacceptable under the Due Process Clause. Although a mathematical bright line cannot be drawn between constitutionally acceptable and constitutionally unacceptable that would fit every case, general concerns of reasonableness and adequate guidance from the court when the case is tried to a jury properly enter into the constitutional calculus.”^{xv}

The arguments for punitive damages tend to reveal a major disconnect between the purported purpose of punitive damages and their simultaneous push for bad-faith claims based on negligence. Punitive damages are damages to punish and deter conduct, based generally upon intentional conduct principles. However, there is a high burden of proof to determine if someone acted in a deliberate and willful manner to harm another. Likewise, intentional conduct has never

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been condoned in society and has always been penalized. Nevertheless, the same proponents of bad faith continually want to lower the bar to a simple negligence standard that often is a 51 percent standard. The case for punitive damages is weak in today's litigation negligence standard environment. The lower burden no longer meets the higher aspirational standard for the alleged policy. Few verdicts reveal an intentional harmful conduct on behalf of the insurance company that was either a widespread or communicated practice or policy that was exhibited in a number of claims to demonstrate it was an implemented business practice.

CLASS ACTIONS

Bad-faith class actions are another tactic used by the trial bar to leverage the punitive aspect of bad faith to extract maximum recoveries from insurers. However, class actions take the extracontractual experience far from its initial roots of merely leveling the playing field and ensuring good faith negotiating to an exponential recovery for alleged conduct extrapolated for many claimants however de minimis or inconsequential. The plaintiff attorneys usually are the only party making a substantial windfall in these types of cases, taking up to 40 percent or more of an aggregated nuisance recovery^{xvi} with each consumer/policyholder receiving only a minute portion.

DUPLICATION OF INSURANCE REGULATION BY THE COURTS

It is worth reiterating that the insurance industry in the U.S. marketplace is one of the most highly regulated industries existing today.

Every state code has at least one entire chapter – sometimes more – devoted to the regulation of the insurance industry. In addition, there exists regulations, bulletins, directives, and other written pronouncements that populate libraries and electronic databases. Further, there are entire volumes of court decisions dealing with the business of insurance. In the current digital age, terabytes of data are engorged daily with insurance content.

Under the longstanding congressional passage of the McCarran-Ferguson Act, regulation of insurance is handled at the state level. The National Association of Insurance Commissioners as a coordinating body of thought and principles in insurance regulation promulgates a multitude of model laws, regulations, best practices, operational manuals, training, and more for state-based regulators to use.^{xvii}

The NAIC also is involved in training state-based regulators on examinations of the financial and market conduct of insurers. State market conduct claim examiners pull an array of claim files randomly that insurers retain and review for consistency with state laws and best practices. There exists the ability within the state regulatory structure to issue cease and desist orders against insurers for alleged conduct, issue corrective action to be taken that can be monitored for years, fine the company, and ultimately order the company to alter its conduct or remove its license to do business. These types of exams are transparent and generally made public. Regulators also have subpoena power and the ability to obtain records and other operational information of insurers.

According to NAIC's State Resources Report, in calendar year 2018 there were nearly 11,000 insurance department staff employees in the U.S. regulating insurance companies and staffing levels have averaged at or above that level for the last decade.^{xviii} That same report shows that state budgets for regulation have grown from \$1.2 billion to more than \$1.4 billion over the same period. Likewise, in 2018 there were more than 1,783 examinations of insurance companies conducted by U.S. regulators either dealing with financial, market conduct, or combined aspects. All states' insurance departments have

NAMIC ISSUE ANALYSIS

resources and divisions to investigate and/or prosecute insurance fraud as well. There is absolutely no question there is a robust and adequate state-based network of regulators handling insurer conduct including review of claim practices.

In light of the nature and scope of the regulation of the industry with a substantial system of checks on alleged improper conduct of insurance entities, the bad-faith tort legal system appears to be piling on excessively. The duplication of insurance regulation is a concept that needs to be addressed when reviewing alleged unfair claim practice abuses and market concerns. As discussed herein, there is the court system that attempts to essentially and concurrently “regulate” the business of insurance by its operations and resultant verdicts. This inevitably puts rate pressure on insurers to recoup appropriate premium from policyholders to meet the burdens and demands of operating in a state jurisdiction that essentially allows double recoveries for a single loss.

EVIDENCE OF MARKET DESTABILIZATION IN STATE LEGISLATIVE ACTIVITY

A review of activity in various jurisdictions reveals the insidious cost to consumers that an expansive bad-faith litigation environment can extract. More revealing, however, is that states still consider moving toward more expansive bad-faith regimes despite overwhelming studies that show the deleterious effects of such a litigious environment.

A look at legislative activity also reveals the confusion and ambiguity when trying to define conduct that states believe to be actionable. A mention of how a few states handle, or are considering handling, bad faith demonstrates the inconsistencies and legal entanglements states set up for insurers that tend to hamper the business of insuring the public. It further shows that several states are moving to expand bad faith claims in a number of disconcerting ways.

CALIFORNIA

A 2001 research brief from the RAND Corporation, “How Do Third-Party, Bad Faith Liability Bodily Injury Claims Affect Automobile Insurance Costs and Compensation?”^{xx} details the California experience regarding third-party bad faith. The history as described includes a California Supreme Court decision that created a cause of action for third-party bad faith only to then have a subsequent court reverse the decision. Not to be outdone, the California Legislature passed a law reinstating the allowance of such lawsuits, only to have the legislation overturned by a statewide referendum before going into effect.

The report found that after the creation by the court, frequency and severity of bodily injury claims went up. Before the referenced case, California was essentially in line with 31 other tort states. The reversal of the case led bodily injury payments to fall when compared to 29 of the other 31 states and frequency declined when compared to all referenced states. However, payments were found to be “much higher than the amounts paid on similar claims in other tort states.”

FLORIDA

In a recent study, “Third-Party Bad Faith in Florida’s Automobile Insurance System, 2018 Update,” the IRC found that, “[b]ad faith lawsuits targeting automobile insurers in Florida have imposed a heavy burden on the state’s auto insurance system and consumers. The possibility of winning large bad-faith settlements and court judgments creates powerful incentives for potential claimants and their attorneys to file auto liability insurance claims that otherwise would not be filed. The IRC estimates that deterioration in the auto liability claims environment attributable to Florida’s third-party bad-faith law resulted in approximately \$1.25 billion in excess bodily injury (BI) liability claim costs in 2017.”^{xx}

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Additional key findings of the IRC study included the following.

- The average cost per insured vehicle of BI liability claims in Florida has increased rapidly in recent years – 103 percent from 1995 through 2017. In contrast, the same cost per insured vehicle in three other major no-fault states – New Jersey, New York, and Pennsylvania – that do not authorize bad-faith lawsuits against insurers was essentially unchanged or increased very little over the same period.
- Many more BI liability claims are being filed in Florida than would likely be the case if the state did not authorize third-party bad-faith lawsuits. The BI liability claim frequency rate (the number of claims paid per 100 insured vehicles) rose 36 percent in Florida from 1995 through 2017. Over the same period, BI claim frequency in New Jersey, New York, and Pennsylvania fell 43 percent. For the nation as a whole, BI claim frequency decreased 26 percent from 1995 through 2017.
- The IRC estimates that Florida's third-party bad-faith legal environment was responsible for an average of \$106 in additional claim costs for every insured vehicle in the state in 2017. For a household with two vehicles, the additional cost averaged more than \$200. The additional costs for all insured vehicles across the state totaled approximately \$1.2 billion in 2017. For the 12-year period from 2006–2017, Florida's third-party bad-faith environment was responsible for \$7.6 billion in additional systemwide costs.

KENTUCKY

Kentucky law identifies unfair claims settlement practices that are prohibited and expressly mentions that a private cause of action exists in favor of both an insured and a third-party claimant. It has further been interpreted by their courts that it is not necessary to prove that an insurer's conduct constituted a general business practice in order to recover.

LOUISIANA

Louisiana allows an insured or claimant to pursue an insurer for damages if the insurer does not affirmatively undertake to adjust claims promptly and fails to reasonably settle claims. It has been interpreted by their courts that proof of actual damages is not a prerequisite for recovery under this statutory scheme.

NEW YORK

Legislation considered in New York in 2018 concerning potential first-party bad-faith recoveries for policyholders led the actuarial firm Milliman to conclude that a massive premium increase would be thrust upon the New York consumer if passed. It was estimated that if the pending legislation were implemented, an increase in annual premium to property/casualty policyholders was estimated at \$4 billion. Additional consequences of such bills would include no-fault or personal injury protection coverage fraud, an unintended expansion of coverage, and additional litigation for an already overburdened judiciary. While not passed, the ideas continue to be introduced and discussed.

NEW JERSEY

New Jersey is facing similar potential exposure to consumers as in New York. Milliman's estimates of increased costs due to proposed bad-faith bills in 2018-19 show expected increased annual loss and loss adjustment expenses of \$2.2 billion if passed. This would correspond to an estimated increase in annual premium to policyholders in New Jersey of \$2.5 billion.

NAMIC ISSUE ANALYSIS

The state has been considering legislation that would broaden the ability of policyholders to bring suits against insurers and, in addition to attorney fees, its provisions would allow for treble damages. The bill has a reduced standard to prevail in suits that will make recoveries more likely regardless of the facts of the case. Additional concerns involve its specific language that “[i]n any action filed pursuant to this act, the claimant **shall not** [emphasis added] be required to prove that the insurer’s actions were of such frequency as to indicate a general business practice.” The statute is extremely vague, so the insurer could be liable for actual damages, attorney fees, and treble damages for any innocuous or negligent occurrence or error.

An insurance defense attorney commented that such bills do not “fairly protect the interest of consumers and insurers.” He goes on to state that if it became law, the bill “would seek to solve a problem that doesn’t exist...It also would serve as sort of bonanza to trial lawyers and incentivize them to convert any insurance claim issue into a bad faith suit under this Act.”^{xvi}

RHODE ISLAND

Adverse first- and third-party bad-faith bills in 2011 that were considered in the state were estimated to increase personal auto premiums by \$100 million or roughly \$215 per insured, making it the highest priced premium for drivers in the United States.

OREGON

The state has a history of considering measures for passage expanding bad faith. A bill introduced in 2012 would have authorized class actions against insurers that violate insurance regulations and expansive punitive damage recovery provisions. It also included attorney fee provisions. The bill would also have allowed the state’s attorney general, not its insurance regulator, to investigate insurer conduct through its investigative powers.^{xvii} These types of expansive concepts continue to be explored in the state.

WASHINGTON

Washington passed insurer conduct legislation in 2007 that established a statutory private cause of action for insurance policyholders to sue their insurance companies if claims were denied in bad faith. The statutory change and ensuing market disruption were studied by the IRC in the report “The Impact of First-Party Bad-Faith Legislation on Key Insurance Claim Trends in Washington State.”^{xviii} The findings revealed, in part, that the statutory mandate caused a “significant increase in the severity of homeowners insurance claims in the state and contributed to an estimated overall increase in loss costs totaling as much as \$190 million during the first two years following enactment.” The report also explained that the statutory changes included allowing treble punitive damages along with associated costs and attorneys’ fees.

WEST VIRGINIA

Reforms in the state in 2005 included removal of a third-party cause of action, and the resultant effects were dramatic. In the study “The Impact of Third-Party Bad-Faith Reforms on Automobile Liability Insurance Claim Costs in West Virginia,”^{xix} the IRC found that even a small state like West Virginia showed substantial savings to its loss cost environment for insurers and ultimately consumers, totaling approximately \$200 million during the first five years after enactment.

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JUDICIAL VERDICT LANDSCAPE

In briefly looking at the judicial verdict landscape concerning bad-faith recoveries, it is not difficult to find examples of excessive recoveries against insurers in nearly every jurisdiction. The cases referenced below are a small infinitesimal fraction of overall case results, but they provide some context for what insurers can encounter in various jurisdictions. In many instances, irrespective of the underlying facts and arguments of the parties, juries are awarding more than 100 to 150 times the policy limits as damages. Considering simply the concept of grossly excessive damages for alleged conduct, it is hard to imagine these types of results being sustained if inflicted on other entities in other contexts and, as discussed herein, may be unconstitutional.

Unfortunately, due to the disparity in bargaining power that bad faith presents to the industry, many of these claims get confidentially settled pre-suit or prior to an actual trial, leaving many of the resolutions unreported. Nevertheless, a brief sampling of case results demonstrates what insurers can be subjected to in various jurisdictions.

MADRIGAL V. ALLSTATE INDEMNITY CO., CALIFORNIA

Allstate Indemnity Company appealed a verdict for bad faith refusal to settle under California law that awarded three claimants \$14 million. Allstate had twice tendered its policy limits of \$100,000 in the claim, but the court stated that it was too late to cure the alleged violation. Allstate argued that some of the information needed in its investigation was incomplete and not provided by claimants and making an offer was therefore “outside its control.”

DAVIS V. FIDELITY NATIONAL TITLE INSURANCE, FLORIDA

Landowners had construction delayed due to an underlying property dispute. While there was a demand of \$40,000 to settle the claim, it ultimately settled for \$10,000 more at \$50,000. Subsequently, the party sued for lost profits and punitive damages because it wanted to build a housing development. A jury ultimately awarded \$2 million despite the insurer arguing in good faith that any damages flowing from the disagreement were speculative at best.

GRUBER V. MARSHALL, KANSAS

In Gruber v. Marshall, No. 2014-cv-00302 (Kan. Dist Ct. 2018), from the United States District Court for the District of Kansas, the policyholder was awarded approximately \$11.6 million on a \$100,000 policy. The case involved an airplane crash resulting in the death of a passenger, and despite the policyholder’s desire to settle the case early, the insurance company did not offer its policy limit of \$100,000 for over a year. The court found that had the insurance company offered its policy limit earlier, it would have protected the policyholder’s estate from exposure to any further claims or suits brought by the victim’s estate. As a result, the court found the insurance company liable for the entire verdict of \$11.6 million.

MOSLEY V. PROGRESSIVE AM. INS. CO., FLORIDA

Award of nearly \$22.7 million for bad faith against the insurer despite it tendering its \$10,000 policy limits for failing to advise the insured of the need to provide an affidavit and consequences of settlement failure in the case.

BOICOURT V. AMEX ASSURANCE CO., CALIFORNIA

An award of more than \$2 million pursuant to a coverage available of only \$100,000 because the insurance carrier initially refused due to privacy reasons to disclose the policy limits.

NAMIC ISSUE ANALYSIS

MATSON TERMINALS V. HOME INSURANCE CO., CALIFORNIA

Denial of coverage based upon a policy exclusion resulted in a compensatory damage award for \$23.5 million and additional punitive damages of \$11 million for an alleged \$10 million earthquake claim.

VANN V. THE TRAVELERS INSURANCE COMPANY, CALIFORNIA

Denial of coverage for environmental damage led to a bad-faith verdict in excess of \$26 million.

METROPOLITAN PROPERTY AND CASUALTY INSURANCE COMPANY V. HEDLUND, CALIFORNIA

The insurer was found liable for \$5 million for bad faith for failing to respond to a demand within 15 days. The policy limit was \$250,000.

JURINKO V. THE MEDICAL PROTECTIVE CO., PENNSYLVANIA

A federal jury awarded more than \$7.9 million including \$6.25 million in punitive damages in a doctor's claim that his insurer's failure to offer the limits of his policy led to a malpractice verdict against him.

O'NEILL V. GALLANT INSURANCE CO., ILLINOIS

The court found bad faith in failing to tender \$20,000 in policy limits thereby awarding more than \$3 million in bad-faith extracontractual damages.

THE IMPACT OF EXPANDING BAD-FAITH REGIMES

There are concomitant causes and effects as a result of bad-faith litigation that should be discussed and factored into any discussion about the way forward. The discussion herein should also be a strong cautionary tale for those states that are contemplating expansion of bad-faith statutes to include first- or third-party causes of actions.

PREMATURE SETTLEMENTS

There is no doubt that a system that values bad-faith recoveries over more rational schemes would cause premature settlements in cases that should otherwise be litigated for insurer vindication. While settlements are generally good public policy when entered into willingly by both parties, many times insurers are forced into settlements due to the litigation analysis rather than whether their actions were right or improper. When insurers are less likely to attempt to vindicate actions that they believe were correct due to other consequences, settlements get paid and that inordinately costs consumers. The insurer is clearly doing what it believes to be the correct strategic litigation decision in light of the jurisdictional and risk dynamic, and the cost to the system is significant.

EXCESSIVE CLAIM PAYMENTS

Additionally, excessive claim payments result from overly punitive jurisdictions that do not respect difficult and legally defensible positions that insurers must make. Consequently, insurance companies must employ principles based upon legal risk reduction and litigation mitigation in dealing with difficult jurisdictions. The resultant payments, which again can be excessive, are the cost of doing business in such areas.

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FRAUD INCENTIVES

Jurisdictions that embrace a lawsuit lottery mentality additionally incentivize fraud by encouraging inflated claims with the hope of getting nuisance settlements or other recoveries from bad faith, winner-take-all scenarios. Unfortunately, many of these cases are settled without further litigation due to the risks of punitive damages, extracontractual damages, and other recoveries inherent in the system. This scheme allows fraud and fraudulent activities to hide in the gray areas of these claims and as such go undiscovered or are never addressed.

INCREASED LOSS ADJUSTMENT EXPENDITURES

Cases that have to be defended when allegations of bad faith appear can be costly. As discovery is pursued by the claimants, an insurer can have several of its executives and middle managers as well as claims staff deposed. Counsel must be hired to defend decisions, including attorney-client privileged information that claimant's counsel will ultimately try to obtain. This again is in addition to the underlying tortfeasor claim that ultimately costs insurers by paying for essentially two litigation cases as opposed to one. Separate counsel and firms may have to be hired to represent insurers and the underlying policyholder.

LITIGATION INCREASES TO AN ALREADY OVERBURDENED JUDICIARY

Litigation as a result of bad-faith allegations can hinder an already overburdened judiciary docket. Courts may stay bad-faith litigation while the underlying suit is still pending, but ultimately two cases of litigation running on separate rails of the judiciary must be handled in turn.

RATE PRESSURE

All these considerations ultimately lead to unnecessary and overburdensome costs that do nothing to resolve the original concerns. The cost of doing business in a jurisdiction gets factored into rates, loss ratios, investment income, and operational bottom line, and consumers must pay increased premiums needed to substantiate the costs anticipated in jurisdictions or even worse suffer from lack of competition as insurers believe they can no longer gainfully do business under the current state of affairs.

EXPANSION TO OTHER LINES

As bad-faith issues develop in a given jurisdiction, cottage industries may grow and expand into other areas, such as workers' compensation insurance. Concerns with such expansion include divergence from the basic foundations of the workers' compensation grand bargain that provides a statutory remedy for injured workers and precludes litigation. In essentially a no-fault system concerning worker contribution to any loss, the worker is protected from protracted lawsuit in which they may not ultimately prevail.

Unfortunately, court decisions have chipped away at the exclusivity premise by allowing bad-faith actions to proceed. Despite there not being a bad-faith cause of action in statute for workers' compensation in some jurisdictions including Oklahoma, the Oklahoma Supreme Court found that the state law recognized a common law duty of good faith and fair dealing in paying benefits and that insurance carriers would be subject to bad-faith suits.^{xx}

NAMIC ISSUE ANALYSIS

In a workers' compensation scheme, the employer that has purchased the insurance for its protection of claims by injured workers is the actual first party and in privity of contract with the insurer. Any first-party common law duties of implied good faith and fair dealing are owed to the employer, but not the employee.^{xvii} Failure to grasp such nuances can lead to misguided results.

Further, these disputes between employees and employers can be handled administratively and within the grand bargain and exclusive remedy concepts of the state workers' compensation system. States have insurance regulators and labor departments with statutory jurisdictions in these areas. Adding a tort cause of action completely shifts the situation and causes extreme disruption to the general and founding principles on which workers' compensation is and has been based for more than 100 years.

AFFORDABILITY/AVAILABILITY

As costs are added to the consumer by the bad-faith system, legislators and court decisions may be causing consumers to be priced out of the market. There are mandatory financial responsibility laws in states that require the purchase of at least minimum policy limit coverage for automobile usage for instance. As prices must increase to meet the demands of the bad-faith system, consumers must absorb the increases to some extent. Additionally, state laws require that rates be adequate, which means enough premium must be charged to meet expected losses.

However, there is a population that will make the unfortunate and illegal decision to not purchase insurance due to the required costs. The uninsured rates for states inevitably rise, and this places more burdens or rate pressure on those consumers who must purchase uninsured motorist coverage to protect themselves against loss.

Further, insurers may choose to not underwrite or insure policies in certain states due to the lack of stability in the public policies and/or judicial decisions found there. Depending upon the respective market, availability of insurance and healthy competition can be affected by making insurance operations futile or not worthwhile in certain jurisdictions.

THE PATH FORWARD

Due to the concerns with bad-faith litigation schemes, solutions should be explored by policymakers where possible. While not an exhaustive list or discussion, the path forward should include analysis of the following concepts.

REPEAL AND/OR REVISIT

While in some jurisdictions, elimination, repeal, and/or abolishment of bad-faith regimes might not seem palatable, a careful consideration of the issues outlined above should lead to a conversation about reopening, curtailing, or outright banning such schemes.^{xviii} When the costs to particular states and their citizens are explored and objectively reviewed, the harm contained in these proposals and the picking of a few winners over many losers should lead ineluctably to the conclusion that the practice is outdated and no longer necessary.

There are those who assert that there is a great disparity between insurers and policyholders when it comes to control of information, which insurers use to their own advantage, and therefore lawsuits are needed to check that conduct. However, these are misguided and often unsupported assumptions and allegations. Business models and robust insurance marketplace competition require that insurers treat policyholders and claimants with the utmost care, precision, timeliness,

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and an overall positive experience concerning service. An insurer that consistently harms policyholders or fails to pay claims when due risks enormous reputational harm. Some of the theories propounded against insurers do not make rational sense. Market forces clearly and unequivocally help regulate conduct of insurers on a daily basis and should not be disregarded as a significant influence on insurer conduct in the absence of bad-faith litigation.^{xviii} Consumers demand timely and efficient claim handling, underwriting response, and superior service. Additionally, consumers do not hesitate to shop for alternatives where disenchanting.

Further, statutory causes of action are not homogeneous across the United States. Even a cursory review of jurisdictional laws shows that some states allow both causes of actions for first- and third-party claims; others allow one or the other but not both; and finally, states ban or do not provide for either cause of action. Consequently, this discussion concerning the efficacy of such bad-faith schemes is more than reasonable given the patchwork and inconsistent landscape on this topic.

IMMUNITY/EXHAUSTION OF ADMINISTRATIVE REMEDIES/DOCTRINE OF PRIMARY JURISDICTION

Insurance regulators are the primary regulator of insurers in state jurisdictions and some deference to their findings is in order. If a company has been examined by the regulator and given a pass rating on claims activity, there should be some type of immunity for individual or class action claim liability for bad faith until further examination or other substantial triggers are met. Such regulatory activity should at a minimum be taken into consideration in any action taken by a court of law.

Further, the concept of exhaustion of administrative remedies should be reviewed that requires administrative actions be taken before litigation may ensue. Also, insurance regulators have been determined in a number of judicial case decisions and statutory pronouncements to be the primary jurisdiction for insurance regulation without concurrent jurisdiction of courts such as in the rate-filed doctrine which essentially states that the regulator has exclusive jurisdiction to determine the setting of rates by insurers and that courts should not be allowed to second-guess such decisions.

ADMINISTRATIVE PROCEEDINGS VS. LITIGATION/ALTERNATIVE DISPUTE RESOLUTION

Administrative proceedings before insurance commissioners do not necessarily entail the same level of costs and other expenditures required in modern courtrooms. If deference to the regulator is palatable, expedited proceedings with limited discovery could be entertained for these allegations. Additionally, mandatory alternative dispute resolution should be considered given the sensitive nature of these claims and expertise needed to understand them. An educated neutral party versed in insurance principles could more likely streamline the issues than force judges and jurors to grapple with the same.

OPPORTUNITIES TO RECTIFY ALLEGED CONDUCT BEFORE LITIGATION PERMITTED

Insurers must be given the notice and opportunity to rectify alleged issues before resultant litigation is filed. Claimants should be required as a prerequisite to filing claims to provide the insured with advance notice and allow for resolution. Insurers should then be given the opportunity to “fix” the alleged violation over a specified period of time. Further, offers that are deemed sufficient and fair but rejected may result in pleadings being dismissed as a reasonable resolution attempt was made.

NAMIC ISSUE ANALYSIS

ARTIFICIAL DEADLINES AND DE MINIMIS HARM

Deadlines that are missed must result in real material harm to claimants and shown to be intentional in nature, and a proportionate response to the actual harm resulting therefrom should be paramount in any analysis. Emotional concerns should not in and of themselves give rise to the awarding of damages. De minimis or nominal harm or technical violations should not be grounds for an extended class action lawsuit or cause of action. Similarly, thresholds of material harm should have to be met before sustaining causes of action.

CAPS ON ALLEGED DAMAGES

If the goal is to ensure consumers are protected, the focus should be getting the insurer that has allegedly failed to handle claims in an appropriate manner moving forward in the correct fashion. Damages themselves should be limited to only rare or outrageous conduct that is intentional in scope exhibited in a number of different claims over a period of time. Compensatory damages, if any, must be completely independent of damages incurred in underlying claims and certainly not duplicative. Damages should be capped to a reasonable amount to provide some stability to the marketplace.

NO PUNITIVE DAMAGES ALLOWED

Punitive damages should be banned entirely. If allowed, there should be a high burden to establish the need for punishment and demonstrated material harm, and the damages should be capped so there is a reasonable relation to the conduct exhibited and not multiples of 10- or 20-times or higher compensatory damages. The concept is outdated and unfairly excessive. Punitive damages may be appropriate to penalize intentional conduct. However, the lower burdens discussed herein that amount to negligence standards should not permit a punitive aspect to a recovery for essentially unintended human error.

REVERSE BAD FAITH

Affirmative defenses, summary judgements, and immediate findings for the insurer should be granted or found where insurers have documented evidentiary proof of their requests to seek information, cooperation, and responses from first- or third-party plaintiff attorneys and have been ignored. Demands once made should not be allowed to be revoked unless exceptional circumstances demonstrate material prejudice or a definable change in circumstances.

CONTRIBUTION TO THE BAD-FAITH SCENARIO SHOULD BAR RECOVERY

Where an insured or third-party plaintiff attorney actively contributes in:

- Failing to accept a reasonable offer;
- Failing to help resolve investigations due to a lack of cooperation;
- Making exorbitant claim settlement demands knowing they do not have such damages; and/or
- Abusing, delaying, or hindering the insurers' ability to investigate liability or damages and pay the claim in due course

any recovery by the insured or third-party claimant should be barred in its entirety or any such award reduced to the extent of non-cooperation or contribution to the event.

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ATTORNEY FEES

The American Rule should be upheld that parties pay their own attorney fees whether they prevail or not. The one-sided issue of attorney fees only destabilizes markets and leads to excessive harm to individuals and costs to the system that are unnecessary and unwarranted, as in Florida's assignment of benefit crisis.^{xxx} When attorneys can recover their fees from a defendant insurance company directly as opposed to from their own client, there can be incentives to pursue otherwise non-meritorious claims as well as inflate loss costs. When insurers deny the claim, the bad-faith assertion enters the scenario and the insurer either pays or risks a double suit as well as paying the other side's attorney fees. There is really no downside to "rolling the dice" in these cases for the plaintiff attorney. Further, as mentioned above, in Florida when the claim is assigned to a vendor or non-party, the original policyholder is no longer in the picture and the assignee or the person who receives the transferred right to the claim has nothing to lose as well.

CLASS ACTION/TORT REFORM

Substantive class action reform is still needed at the state and federal levels. The 108th Congress addressed class actions in the Class Action Fairness Act of 2005. However, work remains to implement stronger reforms in this area by clarifying jurisdictional requirements and thresholds for removal to federal courts of class actions, disallowance of multiple attempts at seeking class certification when initially denied, and evidentiary standards of proof, to name only a few of the abuses that continue to exist.

Legislation would be helpful to

- Ensure that each proposed class member suffers the same type and scope of injury as class representatives;
- Establish a reliable and administratively feasible mechanism for the court to determine whether putative class members fall within the class definition for recovery;
- Consider repeat participation by class representatives in other litigation;
- Limitation of attorney fees to a reasonable percentage of recovery;
- Require attorneys to complete distribution to class members before being paid;
- Create a disbursement accounting of funds;
- Issue a stay of discovery while preliminary motions are pending; and
- Appellate review as a matter of right

are further reforms that should be explored both in states and by Congress.

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CONCLUSION

Insurance companies are valuable, responsible, and critically important corporate citizens. They contribute to the economy in each of the states, not to mention globally, and employ nationally in excess of 3.3 million individuals^{xxx} with nearly \$271 billion in insurance payroll in 2018.^{xxx} Added to this equation are the premium taxes collected and paid by insurers into state coffers annually in an amount approaching \$22.5 billion.^{xxx} This insurance revenue is used by states for reasons that are considered vital to state government operations.

In 2017, more than \$406 billion of losses were incurred by the property/casualty industry.^{xxxii} By far, most were paid without claimants having to incur more than a phone call and provide possibly some rudimentary documentation. Those same claims were paid on time and without any concern or issues by the claimant. Though not widely reported, this represents the typical experience for the insurance buying public.

Those instances that end up in the media, and ultimately the courts, are usually a result of good faith disputes of liability or damages. Unfortunately, when the insurance industry avails itself of the legal right to defend a claim, a disproportionate and excessive response has been created that is crippling the ability of insurers to operate effectively in insurance markets.

These concerns should be taken seriously by anyone considering expanding the scope of this type of bad-faith litigation. When cost/benefit analyses have been conducted, they clearly and conspicuously reveal that only one segment of the population is benefiting from the growth of bad faith – the plaintiffs' attorney bar. The mad dash to turn a basic policy limit that was procured for an actuarially sound price into a jackpot lottery result that was never paid for is antithetical to basic insurance principles, not to mention common fairness, and harms everyone who ends up paying for the inordinate benefits granted to the few. A revisit of current and existing bad-faith regimes is clearly in order as well. More needs to be done to reduce or eradicate the disproportionality of these schemes.

Despite being considered by many as faceless entities with deep pockets, insurers, and more importantly, their policyholders, are pervasively harmed by bad-faith abuse. Foundational public policy in this arena should acknowledge that the insurance industry provides the vital lifeblood of protection of policyholders' assets, economic growth and vitalization, and the ability of citizens to harness and incorporate their dreams. While everyone should be required to play by rational and reasonable rules, excessive, unfair, and inconsistent activity in this regard is a detriment that needs to be eradicated from the system.

THE DELETERIOUS EFFECTS EXPANSIVE BAD-FAITH LITIGATION HAS ON INSURANCE MARKETS

ENDNOTES

ⁱNAMIC's intent in disseminating this white paper is not to criticize or in any way impugn the overwhelming majority of legitimately injured claimants or those who have otherwise suffered a loss that NAMIC member insurers or other insurers almost automatically, timely, efficiently, fairly, and consistently indemnify for incurred claims on a daily basis. It is the gross misapplication and overuse of the bad-faith system that has been created by overzealous plaintiff attorneys who have caused the claim experience to be overrun with imprudent legislation, in many instances unsubstantiated or unwarranted verdicts, and abuses of the system that harm all consumers that is the target of this discussion. See among other thoughts on the subject, Motivation for Attorney Involvement in Auto Injury Claims, Insurance Research Council (2016). The IRC report, as well as prior work by the group, discusses issues concerning excessive and unnecessary costs incurred in claims with excessive attorney involvement including "excessive utilization of medical services, claim abuse, litigation, and, ultimately upward pressure on the cost of insurance for consumers." Additional discussion is centered on the consumer claimant who ultimately pays a large portion of the damage or loss recovery to the attorney and why attorney retention is not necessarily due to a poor claim experience with the insurer.

ⁱⁱThe information, case cites, statutory references, or other discussions contained herein this paper are not meant to be legal advice or legal research. Any party reviewing the same should conduct their own due diligence and research before relying upon the content contained herein. A number of cases and statutes as well as other specified content have been utilized to provide context, examples, and/or background only of concepts. There is no representation that the material has not been updated, altered, overturned, and/or repealed.

ⁱⁱⁱCalandro v. Sedgwick Claims Management Services, Inc. (Slip No. 18-1637) (MA)(2019) Hon. David Souter, associate justice (Ret.) of the Supreme Court of the United States, sitting by designation.

^{iv}"Common law" is basically defined as judge-made law or precedent that was accepted as being in existence although not codified.

^v"The National Association of Insurance Commissioners is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S." See www.naic.org

^{vi}Offending claim practices according to the NAIC model include knowingly misrepresenting to claimants/insureds relevant facts or policy provisions to coverages at issue; failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies; failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies; not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear; compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; refusing to pay claims without conducting a reasonable investigation; failing to affirm or deny coverage of claims within reasonable time after having completed its investigation related to such claim; attempting to settle claims for less than the amount that a reasonable person would believe that insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of the application; attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insurer; making claim payments to an insured or beneficiary without indicating the coverage under which each payment is being made; unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form; failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions; failing to provide forms necessary to present claims within 15 calendar days of a request with reasonable explanations regarding their use; and failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

^{vii}See NAIC Unfair Claims Settlement Practice Act - NAIC Model Laws - MDL-900 - www.naic.org.

^{viii}See Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973).

^{ix}NAMIC has previously explored first-party bad-faith concerns in 2008. See First-Party Insurance Bad Faith Liability: Law, Theory, and Economic Consequences, Tennyson and Warfel (2008), <https://www.namic.org/pdf/publicpolicy/080926BadFaith.pdf>

^xComunale v. Traders & General Insurance Co., 328 P.2d 198 (Cal. 1958)

^{xi}See e.g., among others, the Insurance Information Institute Background on: Insurance Fraud <https://www.iii.org/article/background-on-insurance-fraud>; Coalition Against Insurance Fraud <http://www.insurancefraud.org/index.htm>; and the "Insurance Research Council Finds that Fraud and Buildup Add Up to \$7.7 Billion in Excess Payments for Auto Injury Claims," Press Release February 3, 2015 and <https://www.claimsjournal.com/news/national/2015/03/12/262176.htm#>

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- ^{xii} *Berges v. Infinity Ins. Co.*, 896 So.2d 665 (Fla. 2005)
- ^{xiii} *Autumn Glen Homeowners Ass'n v. Travelers Ins. Co.*, 2015 U.S. Dist. LEXIS 33317 (U.S. District Ct. S.D. IN, March 18, 2015).
- ^{xiv} *Countrywide Patterns in Auto Injury Insurance Claims*, Insurance Research Council (2018)
- ^{xv} *Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1 (1991)
- ^{xvi} A nuisance recovery can involve an insurer that chooses, based upon the exigencies and factors of litigation and risks associated therewith, to offer an amount that is enough to “buy its peace” and be released from vexatious litigation without ever admitting to any type of liability or fault in the matter. Many times, it is a cost/benefit analysis. When used in class action scenarios, the amounts can be exponentially larger based upon multipliers of risk and projected loss adjustment expenditures.
- ^{xvii} See <https://www.naic.org>
- ^{xviii} 2018 Insurance Department Resources Report, Volume One (2018), NAIC, https://www.naic.org/prod_serv/STA-BB-19-01.pdf
- ^{xix} *The Effects of Third-Party Bad Faith Doctrine on Automobile Insurance Costs and Compensation* by Angela Hawken, Stephen J. Carroll, and Allan F. Abrahamse, RAND MR-1199-ICJ, 2001, https://www.rand.org/pubs/research_briefs/RB9036/index1.html.
- ^{xx} *Third-Party Bad Faith in Florida's Automobile Insurance System*, 2018 Update, Insurance Research Council (IRC), 2018.
- ^{xxi} *Insurers Could Face More Bad Faith Suits if N.J. Legislation Passes*, Denise Johnson, Claims Journal, August 9, 2018, <https://www.claimsjournal.com/news/east/2018/08/09/286155.htm#>.
- ^{xxii} See HB4126 (2012) Oregon Legislature.
- ^{xxiii} *The Impact of First-Party Bad-Faith Legislation on Key Insurance Claim Trends in Washington State*, Insurance Research Council (IRC), (2011).
- ^{xxiv} *The Impact of Third-Party Bad-Faith Reforms on Automobile Liability Insurance Claim Costs in West Virginia*, Insurance Research Council (IRC), 2011.
- ^{xxv} See e.g., *Sizemore v. Continental Casualty Company, et al.*, 2006 OK 36, 142 P.3d 47 (OK 2006); *Pierce v. International Ins. Co.* 671 A.2d 1361 (DE 1996); *Aslakson v. Gallagher Bassett Servs.*, 2007 WI 39, (WI 2007); *Buhmeyer v. Case New Holland, Inc.* 446 F.Supp.2d 1035 (S.D. Iowa 2006); *Moran v. Travelers Prop. & Cas.*, 1998 Conn. Super. Lexis 3244, (Conn. 1998).
- ^{xxvi} *Savage v. Educators Ins. Co.*, 908 P.2d 862 (Utah 1995).
- ^{xxvii} See e.g. *Bad Faith Reforms and Auto Insurance Affordability; The Rough Notes Company, Inc. – To The Point*, Mary Ann Cook, June 25, 2019, <http://roughnotes.com/bad-faith-reforms-and-auto-insurance-affordability/>.
- ^{xxviii} See e.g. *How market forces are disrupting the insurance industry*, Fuad Butt, IBM Insurance Industry Blog, March 7, 2017, <https://www.ibm.com/blogs/insights-on-business/insurance/market-forces-disrupting-insurance-industry/>.
- ^{xxix} *Florida Governor Signs AOB Reform Bill; Law to Take Effect July 1*, The Insurance Journal, May 24, 2019, <https://www.insurancejournal.com/news/southeast/2019/05/24/527402.htm#>.
- ^{xxx} See *Insurance Carriers and Related Activities Employment by State, 2017*, Insurance Information Institute, <https://www.iii.org/publications/a-firm-foundation-how-insurance-supports-the-economy/a-50-state-commitment/employment>.
- ^{xxxi} See *Insurance Payrolls, 2013-2017*, Insurance Information Institute, <https://www.iii.org/publications/a-firm-foundation-how-insurance-supports-the-economy/driving-economic-progress/insurance-payrolls>
- ^{xxxii} See *Premium Taxes by State, Property/Casualty and Life/Health Insurance, 2018*, Insurance Information Institute (III), <https://www.iii.org/publications/a-firm-foundation-how-insurance-supports-the-economy/a-50-state-commitment/state-taxes>
- ^{xxxiii} See *Incurred Losses by State, Property/Casualty Insurance, 2017*, Insurance Information Institute, <https://www.iii.org/publications/a-firm-foundation-how-insurance-supports-the-economy/a-50-state-commitment/incurred-losses-by-state>.

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