

THE FOLLOWING IS ADAPTED FROM A TALK BY ROBERT K. SCOTT, ESQ.

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PRACTICAL TIPS AND TECHNIQUES FOR EFFECTIVELY TRYING

A BAD FAITH CASE

Summary: Insurance Commissioners have picked up the slack and stepped in to regulate disability claims handling. They have done this across the country. Their actions have set a new minimum standard for proper claims handling. In addition, a recent regulation in California has paved the way towards limiting language that provided what insurance companies have claimed was the absolute right to interpret their policies, which they habitually did to favor themselves at the expense of the insureds

Introduction

In the last few years there few cases concerning disability claims handling have reached any of the 50 states' Courts of Appeal or their Supreme Courts. The same is true of bad faith cases in general. One of the reasons for the lack of state disability handling and bad faith case decisions has been a very effective technique used by the insurance defense bar—they have tried to move most of these cases from state courts to a federal court. The insurance companies then seek, by summary judgment motion, to persuade the judge to limit or reduce the plaintiff's bad faith cause of action or damages.

Once the insurance defense lawyers have done this, with the uncertainty of the remaining causes of action to be resolved and, of course, the uncertainty of the trial, they try to settle. This creates a tough choice for the plaintiff and his/her attorney. It typically takes two years to appeal a decision through any federal circuit court. That delay acts as a deterrent to holding onto the case and taking the appeal on the loss of the bad faith cause of action. As a result, there have also been fewer appellant decisions in the federal Circuit Courts of Appeal as well. That has left some of the over-aggressive, if not downright improper, claims handling by the insurance companies, almost unchecked.

All of us who have practiced in insurance bad faith for many years have seen the pendulum swing to the side of carriers. Surprisingly, the group that has stepped in to level that field and bring the pendulum back closer to neutral has been the National Association of Insurance Commissioners (hereinafter "NAIC") and the individual Insurance Commissioners and their staffs from each of the impacted states.

This paper will deal with two of those practices. The theme is that the results of the Insurance Commissioners work sets a new minimum standard for claims handling. This new minimum standard has come about as a result of the insurance regulators' exercise of administrative discretion in either sanctioning an insurance company for its claims practices and/or changing the way policy definitions or policy terms can be utilized.

This paper suggests that the new standard can then be applied, through expert testimony, to demonstrate that when other carriers fail to comply with that NAIC or insurance commissioner standard they should be found in bad faith as being below the industry standards for claims handling.

The UNUM Settlement and What it Means to All Insurers

Press Release dated November 18, 2004:

“Multi-state, federal settlement address concerns regarding UnumProvident claims handling

200,000 to be offered re-assessment of claims”

The chief insurance regulators of Maine, Massachusetts, and Tennessee released an examination of the claim handling practices of the three disability insurers owned by UnumProvident Corporation. Also, there was a settlement that required these companies to go back and change their practices and to reassess certain claims going all the way back to 1997. Overall, 47 other states and the District of Columbia joined in with these three Insurance Commissioners in doing a Multi-state Examination of Unum Life Insurance Company of America, the Paul Revere Life Insurance Company, and Provident Life and Accident Insurance Company. The result of this Multi-state Market Conduct Evaluation identified several claims handling practices that were of concern to the regulators as follows:

1. Excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits;

- Unfair evaluation or interpretation of attending physicians or independent medical examiners reports;
- Failure to evaluate the totality of the claimant's medical condition and,
- An inappropriate burden placed on the claimants to justify the eligibility for benefits.

These specific points are flushed out in the specifics of the agreements that can be found by looking at the Maine, Massachusetts and Tennessee Insurance Commissioner reports that give “spicy” detail to the particular conduct that they found was wrong and inappropriate.

The press release goes on to note that:

“The companies will pay a \$15 million dollar fine and they will stand ready to forfeit an additional \$145 million dollar fine if they don’t meet the terms PLAN FOR CORRECTIVE ACTION as set forth in those agreements.”

The websites for the three insurance commissioners are listed in the attached press release.

This investigation, although not receiving much publicity, impacted beyond the plaintiffs’ bar. It significantly changed the way that this insurance company (UNUM) does business. It should be noted that UnumProvident still has approximately 50% market share of the group disability insurance business in the U.S. and less than 25% of the individual disability insurance products. This should cause a number of insurance companies, in the same field doing the same type of business, to review and investigate their own practices to make sure that they comply with these new minimum standards of claims handling. However, it has not been the case. The only insurance company that has changed as been Unum. Other carriers continue to deny claims using the old model criticized in the points of correction detailed above. It is now incumbent on the claimants and the plaintiffs bar in this area to impose the same standards to the other insurance companies. It would not be fair to Unum to have to bear the burden alone. Other insurance companies and claims professionals should be held to the same standard.

Training

Recent depositions testimony from the Unum claims handlers have confirmed training regarding the above referenced criteria. They have been given specific classroom instruction and written documents that give them direction as to when to seek out an IME to resolve issues and upon what basis they can terminate claims. There is oversight that there had not been in the past. However, when depositions are taken of other disability carriers, no such parallel training has been implemented. Many carriers have been doing essentially the same types of unfounded denials without medical support and continue to do so. When asked if they received any training in the last six months, updating their criteria or sharpening their skills on claims evaluation and processing, the universal answer is “No.”

Education

Claims personnel from other insurance companies are not given any additional education opportunities. They are not encouraged to attend or become members of any claims associations as they have been in the past. They are never educated in the “world of insurance” or the “Unum Settlement.” They are only trained to do their own claims handling at their desk and never told that the outside world, including the NAIC, may have something to say about how that is done.

Experience

Unless the claims handler is in a senior position and has come from the outside world of claims handling, they would never be exposed to the potential of changing the handling based on the NAIC multi-state task force and its final work product. It should be noted that in today's world almost every claims handler has a screen with access to the internet and almost any claims handler has the availability to seek input from management, through his or her supervisor, about claims handling. Almost universally true, when depositions are taken in the ongoing cases we find that there is an obvious lack of training or experience other than in literally processing that companies claims.

Regulation Ending Insurers' Claims to be Be Able to Exercise Absolute Discretion

In the last few weeks the California Insurance Commissioner approved a proposed rule change in the "Discretionary Clause" language in *Erisa* and non-*Erisa* insurance policies issued in California. This change was based upon a 2002 Joint Executive Committee planning of the NAIC. The change was titled "Prohibition on the Use of Discretionary Clauses Model Act" and reads:

- No policy, contract, certificate or agreement offered or issued in this State providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interrupt the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

After extensive briefing, an order adopting this decision was signed by one of the deputy commissioners to Insurance Commissioner John Garamendi on March 22, 2005. Judicial review is sure to follow. The Rule is applicable to all policies that are in place in California where disability is a trigger of some benefit.

The final decision goes on to say that the Commissioner's action is not pre-empted by *Erisa* and that the clause should be read into *Erisa* plans. This should draw some litigation on this issue and, ultimately, it will be up to a court to decide. However, the further use of this clause, should set an additional industry standard to discredit the use of discretionary clauses. They have been specifically disfavored now by the NAIC through its model legislation and specifically found to be in violation of California law and practice in California by the California Insurance Commissioner. Therefore, the prospect of insurance carriers continuing to use this discretionary language without further training of their staff to disregard this language and without an internal review of this, very well should constitute an additional basis for bad faith. In *Erisa* settings, it should at least cause the discretionary clause to be set aside and re-weighing or *de novo* hearing rules should apply.

Again, this standard and the rule making authority from the California Insurance Commissioner should be available for an expert witness to review, consider and, if appropriate, testify that the insurance company knowing, or deemed to know of this decision, failed to properly analyze and instruct its claims staff. In fact, even when the

case is in litigation, the carrier can be criticized when it failed to voluntarily change its position when the matter was brought to its attention by opposing counsel. This could constitute conscious disregard by the insurance company, thereby, exposing it to punitive damages by failing to properly use the right standard. That approach was recognized and approved of in the *Moore* case.

Conclusion

The absence of the evolving bad faith decisions has been answered by the NAIC. State Insurance Commissioners are responding and promulgating specific regulations and model acts useful in establishing the minimum standards for policies and claims handling. Expert witness and counsel can weave these together to create, yet again, the tapestry of the bad faith case trial.