Chapter 5

Direct Your Learning

Good-Faith Claim Handling

After learning the content of this chapter and completing the corresponding course guide assignment, you should be able to:

- Explain how the law of bad faith relates to an insurer's duty of good faith and fair dealing and how the legal environment affects the law of bad faith.
- Describe the parties to a bad-faith claim.
- Describe the bases of bad-faith claims.
- Describe the damages that can be awarded for bad faith or extracontractual liability.
- Summarize the defenses available to an insurer in a bad-faith claim.
- Describe the elements of good-faith claim handling.
- Define or describe each of the Key Words and Phrases for this chapter.

OUTLINE

Develop Your Perspective

What are the main topics covered in the chapter?

To properly handle claims, claim representatives must understand the duty of good faith and fair dealing imposed on insurers through case law and statutes. The claim representative uses this knowledge to avoid bad-faith claim handling practices and to defend those bad-faith claims that arise.

Identify the good-faith claim handling practices in your state.

- Are these practices based on statutes or case law?
- Are these practices based on the NAIC Model Unfair Claims Settlement Practices Act?

Why is it important to learn about these topics?

Claim representatives who act in bad faith expose their employers to fines, penalties, and the possibility of significant monetary damage awards. Acting in bad faith also diminishes the reputation of the insurer, the claim representative, and the insurance industry.

Review the unfair claims settlement practices act of your state or the NAIC Model Act.

- Do you consistently handle your claims in compliance with the applicable act?
- What, if anything, do you need to improve on?

How can you use what you will learn?

Analyze a claim you are handling.

- What, if any, investigation activities have the potential to lead to an allegation of bad faith?
- How have you documented your file to avoid or mitigate this exposure?

Chapter 5
Good-Faith Claim Handling

A primary function of insurers is to pay valid insurance claims. Claim representatives should strive to handle claims with utmost good faith and in an ethical and professional manner. Good **faith** is broadly defined as giving consideration to the insured's interests that is at least equal to that given to the insurer's interests in handling a claim. Insurers have developed best practices or guidelines to help claim representatives act in good faith. Consequently, in the majority of insurance claims, no allegations of bad faith arise. Yet allegations of bad faith in insurance claims remain one of the most troublesome and controversial issues for insurers and claim representatives. This chapter contains examples of bad-faith allegations to make claim representatives aware of the complexity of such claims. These examples highlight the kinds of actions and activities that may lead to allegations of bad faith against an insurer.

Good faith
In insurance, consideration given to the insured's interests that is at least equal to that given to the insurer's interests in handling a claim.

Because interactions with claim representatives are often the only personal contacts that the general public has with an insurer, the claim representative's actions may be closely scrutinized and are often criticized. These criticisms, whether or not legitimate, can result in bad-faith allegations against an insurer. The claim representative's conduct is imputed to the insurer, which is legally liable for its employees' acts that are within the course and scope of employment. Consequently, bad-faith lawsuits usually name the insurer as the defendant, not the claim representative, even though it is the claim representative's actions that come into question. Therefore, claim representatives must understand what constitutes good-faith claim handling and what does not. In this chapter, the discussion of bad faith focuses on a claim representative's actions, which are, in reality, the insurer's actions.

No single widely-accepted definition of bad faith exists. However, Black's Law Dictionary (Eighth Edition 2004) defines "bad faith" in insurance as:

> An insurance company's unreasonable and unfounded (though not necessarily fraudulent) refusal to provide coverage in violation of the duties of good faith and fair dealing owed to an insured. Bad faith often involves an insurer's failure to pay the insured's claim or a claim brought by a third party.

Although some state laws define bad faith differently or more specifically, the Black's definition is useful for discussion of the issue because it is broad enough to encompass actions that courts nationwide have determined to constitute bad faith. Different courts also have reached seemingly contradictory decisions about actions that constitute bad faith. Therefore, claim representatives must be familiar with the bad-faith laws in all jurisdictions in which they handle claims.

State laws may also vary on who can sue an insurer for bad faith. In a claim context, bad-faith allegations can be brought by both first-party and third-party claimants. First-party bad-faith claims involve an insured's allegations of wrongdoing against an insurer in relation to the insured's own personal losses, such as property damage or uninsured/underinsurer motorist injuries. Third-party bad-faith claims arise in liability insurance and generally involve claims against the insured that the insured believes the insurer did not handle in good faith. The most typical third-party bad-faith claim alleges a failure to settle a third party's bodily injury claim within policy limits followed by a verdict that exceeds the policy limits. Only a few states allow third-party claimants to sue an insurer for bad faith.

To avoid bad-faith allegations, claim representatives must understand the law of bad-faith claims, who can make such claims, the bases of bad-faith claims, and the types of damages that courts can award. In addition, claim representatives should understand the defenses that insurers can use against bad-faith claims and how good-faith claim handling practices can make these defenses available to the insurer.

APPLY YOUR LEARNING

A Word of Caution

The definition of bad faith and the actions that constitute bad faith vary by state. Claim representatives should be familiar with the bad-faith laws and any related regulations in all states in which they handle claims, so that they can follow good faith claim handling practices as defined in each state and avoid actions that could lead to a bad-faith allegation.

LAW OF BAD FAITH

The law of bad faith developed in response to the perception that insurers were placing their own interests ahead of their insureds' interests. In some cases, insureds became personally liable for losses or damages they believed were covered by their insurance, and they sued their insurers for breach of contract. **Breach of contract** is the failure, without legal excuse, to fulfill a contractual promise. The insureds alleged that, by wrongfully denying or mishandling their claims, the insurers had failed to fulfill their contractual promise.

Breach of contract
The failure, without legal excuse, to fulfill a contractual promise.

However, in some of these cases, breach of contract remedies were perceived to be inadequate. The legal remedy for breach of contract is damages in an amount up to the contract's terms, or the policy limits. Consequently, if an insurer wrongfully denied or mishandled a claim, the policyholder would have to go through the expense, stress, and delay of a lawsuit to get the insurer to pay what it should have rightfully paid under the policy. Furthermore, if the insurer's actions caused the insured to be liable to a third party for damages above the policy limits, the insured would be responsible for those damages as well.

Because contract remedies were considered inadequate in such cases, insureds brought lawsuits against insurers for alleged torts, such as fraud and intentional infliction of emotional distress. However, such cases often failed because of the difficulty of proving in court that the insurer's behavior was either fraudulent or outrageous enough to award damages for emotional distress.

Eventually, some courts decided that insurers have an implied duty of good faith and fair dealing when settling claims, requiring insurers to value their insureds' interests at least as much as their own. This duty applies by extension to claim representatives. Insurers' failure to comply with this duty can result in a bad-faith claim. Therefore, bad-faith law evolved from the special relationship between insurers and insureds based on the implied duty of good faith and fair dealing.

Insureds and claimants continue to seek new bases for bad faith claims, such as invasion of privacy, defamation, libel, or slander based on letters or documents in the claims files. In addition, the standard of conduct for proving bad faith continues to evolve. This section describes the duty of good faith and fair dealing, the legal environment of bad faith, and the standard of conduct required to sustain a bad-faith claim.

Duty of Good Faith and Fair Dealing

Most bad-faith claims for breach of the implied duty of good faith and fair dealing arise under insurance-related contracts rather than other types of contracts. Why have bad-faith claims developed to such an extent in insurance? Insurance contracts involve the public interest and require a higher standard of conduct because of the unequal bargaining power between the parties. The insured has less "bargaining power" than the insurer because the insurer not only dictates the terms of the contract (the policy), but also usually controls the claim investigation, evaluation, negotiation, and settlement.

Public Interest

As previously mentioned, states regulate insurers to protect consumers against illegal business practices and against insurer insolvency because it is in the public interest that insurers have the financial resources to pay claims. Courts also want to protect the public interest by ensuring that insurers pay claims they owe. In cases in which insurers have acted in bad faith and have harmed the public interest, courts require them to pay damages beyond their contractual obligations.

Higher Standard of Conduct

In comparison to other contracts, insurance contracts require a higher standard of conduct—utmost good faith. Because of the nature of insurance contracts, both the insured or applicant and the insurer must disclose all pertinent facts.

The insurer must disclose all the terms of the insurance policy, and the applicant must disclose all the information needed to accurately underwrite the policy.

As previously mentioned, the parties to insurance contracts have unequal bargaining power. Insurers are often perceived as powerful corporations with vast resources. Even if the insured is a large, financially strong corporation, insurers are considered to have greater bargaining power because they develop the insurance contract and settle the claims. When individual consumers purchase an insurance policy, they generally must accept the policy terms written by the insurer.

In addition, many insurance policies specifically state that the insurer controls the investigation and settlement of a claim. For example, Section II—Liability Coverages of ISO's homeowners policy states the following: "We may investigate and settle any claim or lawsuit that we decide is appropriate."[1] Because insurers control how claims are resolved, courts reason that insurers should be responsible for the outcome of their claim handling if they have acted in bad faith. Thus, courts hold insurers to a higher standard of conduct to discourage insurers from abusing their position of power. Consequently, filing and defending bad-faith lawsuits has become a specialty in the legal community.

To conclude that an insurer has acted in bad faith, courts must determine the standard of conduct to which the insurer should be held. Can an insurer be guilty of bad faith for unintentional mistakes or errors in judgment? Or, must an insurer's behavior be intentional, wanton, or reckless to constitute bad faith? Courts differ about whether bad faith should be based on negligence or on gross or intentional misconduct. In many cases, the results are the same regardless of the standard because insurers' actions can be considered both negligent and reckless or intentional.

Some courts use a negligence (sometimes called due care) standard in determining whether a claim representative's (and, by extension, the insurer's) actions constitute bad faith. Some courts may use negligence as a basis to award compensatory damages but award punitive damages only when the insurer has exhibited gross misconduct.

Many courts have rejected a negligence standard for bad faith. They hold insurers liable only if their behavior is found to be intentional or to constitute gross misconduct. To prove intentional misconduct, a complainant must show that the claim representative intended both the misconduct and the consequences, for example, denying coverage with the knowledge that coverage applies under the policy.

When applying a gross misconduct standard, courts have historically looked for signs of "dishonest purpose, moral obliquity, conscious wrongdoing... some ulterior motive or ill will partaking of the nature of fraud."[2] Bad faith may fall somewhere between simple error and outright fraud. Other courts have used terms such as "arbitrary, reckless, indifferent, or intentional disregard"[3]

of a party's interests to describe bad-faith behaviors. Because these behaviors are judged on a subjective basis, courts attempt to determine the claim representative's state of mind at the time that bad-faith acts are alleged to have occurred.

Claim representatives should understand the subjective interpretation of negligence and gross misconduct. The difference between negligence and gross misconduct is determined by the court's or jury's interpretation of the facts. For example, a claim representative issues a coverage denial after performing an incomplete investigation. One court might consider the incomplete investigation to be the result of an oversight or of mere negligence. Another court might conclude that deciding coverage without being fully informed is clearly reckless and arbitrary and, therefore, constitutes gross misconduct on the part of the claim representative. Although the standard of care required varies by jurisdiction, some areas of bad faith, such as the parties to a bad-faith claim, remain stable.

Legal Environment of Bad Faith

Bad faith litigation is becoming more common, and the bases on which bad-faith claims can be brought are expanding. In this constantly changing climate, claim representatives must make an effort to stay informed about the bases of bad-faith claims so that they can provide good-faith claim handling in every instance. Although charges of bad faith are often unfounded, they drain insurer resources. Allegations of bad faith, legitimate or not, continue to proliferate.

APPLY YOUR LEARNING

A Word of Caution

Even if a lawyer's initial letter to an insurer regarding a claim makes an allegation of bad faith, that does not mean that the insurer is guilty of bad faith. However, responses to such letters should be timely and carefully crafted. The claim representative may wish to consult with a supervisor or manager and possibly an attorney when drafting this response.

Although most bad-faith law is case law, state legislatures can pass laws that affect bad-faith claims. For example, in October 1999, the governor of California signed the California Fair Insurance Responsibility Act to take effect January 1, 2000. This Act would have allowed claimants to sue insurers for unfairly or fraudulently delaying or denying claim payments. The legislation was put to a popular vote as Propositions 30 and 31 in March 2000 and was defeated. Similar legislation was defeated by a Wyoming legislative committee in December 1999. These examples illustrate why claim representatives must be aware of the status of bad-faith laws in the states in which they handle claims and of additional circumstances that can put them and their employer at increased risk of bad-faith claims.

PARTIES TO A BAD-FAITH CLAIM

Defendant
The party (person or entity) against whom relief or recovery is sought in a lawsuit.

In bad-faith lawsuits, the insurer is usually the **defendant**, that is, the party against whom relief or recovery is sought in a lawsuit. Most states do not allow bad-faith claims against claim representatives because they are not parties to the contract. However, claim representatives can be held personally liable for fraud, conspiracy, or other torts in some states.

Plaintiff
The person or entity who files a lawsuit and is named as a party.

Several kinds of parties can be plaintiffs in bad-faith claims. The **plaintiff** is the person or entity who files the lawsuit and is named as a party. In addition to policyholders and claimants, excess insurers can pursue claims for bad faith against primary insurers. Excess insurers are insurers that offer policy limits to insureds above the limits provided by underlying policies. This section describes how these parties make bad-faith claims against insurers.

Policyholders

Policyholders are those persons or entities who own an insurance policy, whether or not they are the insured. In property-casualty insurance, the policyholder is usually the insured, but that is not always the case. Generally, insurers face two types of bad-faith lawsuits from policyholders: first-party lawsuits and third-party lawsuits. In a first-party bad-faith lawsuit, the policyholder sues its own insurer for bad faith in handling a first-party claim, that is, a claim for payment to the insured under the policy.

Example of First-Party Bad-Faith Lawsuit

The insured, a long-haul trucker, was involved in an accident that damaged his tractor-trailer. His insurance policy provided $30,000 coverage for collision damage, payable within sixty days after the insurer received a proof of loss or a damage appraisal. The trucker submitted the proof of loss but did not receive payment until almost nine months after the accident. The delay occurred because of a series of mistakes and inattention on the insurer's part and through no fault of the insured. The insured trucker was unable to work during those nine months and lost seniority status with his employer. He sued his insurer for negligent claim handling, breach of contract, and unfair and deceptive practices. He was awarded $70,000 in damages. The court stated that insurers have a duty to act "in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear."[4]

In a third-party bad-faith lawsuit, the policyholder sues its own insurer for bad faith in handling a third-party claim. For example, the insurer may have provided an inadequate defense of the insured in a lawsuit by a third party (the claimant), or the insurer may have conducted an inadequate investigation. If, because of these actions, the insured is found liable for a judgment in excess of the insured's policy, a bad-faith lawsuit brought by the insured may result

the insurer's liability for the excess judgment. Or, rather than filing the lawsuit, the insured may assign the right to pursue a bad-faith claim directly to the claimant. Some states allow claimants who are not policyholders to sue the insurer directly.

Example of Third-Party Bad-Faith Lawsuit

Smith is involved in a car accident with Jones. Smith is insured by JKL Insurance Company. The facts of the accident clearly show Smith is at fault. Jones has suffered serious injuries as a result of the accident. Smith, who has a $300,000 auto policy limit, demands that JKL settle Jones' claim within the policy limit. Jones also makes a demand to JKL for the policy limit to settle the claim. JKL fails to respond to both Smith's and Jones' demands. Jones sues Smith for negligently causing the accident and wins a $1 million judgment. Smith, in turn, sues JKL for a bad-faith failure to settle Jones' claim within policy limits. At trial, the court holds that JKL's failure to respond to both Smith's and Jones' demands was bad faith because JKL had not given the insured's interests as much consideration as its own.

Claimants

When a claim representative's conduct results in a liability judgment against the insured that exceeds policy limits (referred to as an excess judgment), the insured is required to pay for the amount of judgment that exceeds policy limits, an obvious harm to the insured. However, the claimant (the party originally harmed by the insured) may also be harmed by having to collect the excess from the insured. Furthermore, if the insured has no financial resources to pay the excess, the claimant cannot collect the judgment's full amount.

Can a claimant sue an insurer for bad faith? Because the contract between the insured and the insurer is the basis for the implied duty of good faith and fair dealing, a claimant who is not a party to the insurance contract generally cannot sue an insurer for bad faith. There are exceptions, however.

For example, an insured can assign rights against the insurer to the claimant. The insured may do this to avoid paying the claimant. In exchange for this assignment, the claimant generally signs a covenant with the insured not to pursue recovery of the excess judgment from the insured. Thus, the claimant assumes the insured's rights to sue the insurer for bad faith for the excess judgment, and in return the insured protects its personal assets from the claimant.

Statutes or developing case law can also permit claimants to sue insurers for bad faith. For example, the California Insurance Code provides that a claimant who has obtained a judgment against an insured has a right of direct action against any insurer that issued a policy covering the loss.[5] In addition, a few states have unfair claims settlement practices acts that allow claimants to sue insurers. These acts are described later in this chapter.

Example of Bad-Faith Claim by a Claimant

Ann Johnson is severely injured in a car accident. The party responsible for the accident has a $100,000 auto policy limit. Ann demands the policy limit as settlement, but the insurer offers only $65,000. Ann sues the responsible party and obtains a $750,000 judgment. The responsible party assigns his rights against the insurer to Ann. Ann sues the insurer for bad faith and wins. The court rules that the insurer has acted in bad faith by failing to pay the policy limit demand, which exposed the insured to the $750,000 judgment. The court enforces the $750,000 judgment against the insurer.

Excess Insurers

Excess insurers write policies that provide coverage over the limits of the insured's primary policy. Excess insurance does not pay a loss until the loss amount exceeds the underlying policy limits (or a certain sum, if the underlying policy does not provide coverage). For example, a homeowners policy (in this context, the underlying policy) may have a liability limit of $300,000. An excess policy may provide coverage up to a $1,000,000 limit above the $300,000 limit of the underlying homeowners policy so that the insured has $1,300,000 in total coverage.

If a claimant wins a judgment in excess of the underlying policy limits, the excess insurer must pay the excess up to its policy limits. Thus, excess insurers have an interest in how insurers (called primary insurers) handle claims presented against the underlying policy. Bad-faith claims in this context arise when the excess insurer is different from the primary insurer.

An excess insurer can pursue a bad-faith claim against a primary insurer through equitable subrogation or through a direct action.

With equitable subrogation, an excess insurer has the same rights as an insured to bring a claim against an insurer because it is harmed in the same way an insured is harmed by a judgment in excess of the primary policy limits. Because the rights are the same, the primary insurer can use the same defenses against an excess insurer's claim as it can use against an insured's claim. Bad-faith claim defenses are described later in this chapter.

Some courts have ruled that excess insurers may bring direct actions against insurers for bad faith. These courts reason that an insurer should not be allowed to take chances with the excess insurer's money by risking an excess verdict. If courts impose on primary insurers a duty of care toward the excess insurer, then that duty encourages settlements, keeps the premiums for excess insurance low, and creates no extra burden for the primary insurer who is already under an obligation to settle the claim in the insured's interests.

Example of Bad-Faith Claim by an Excess Insurer

A federal court applied Illinois law to impose on the primary insurer a direct duty of care toward an excess insurer because "it is reasonably foreseeable that a primary carrier's [insurer's] unreasonable refusal to settle a claim against the insured may injure excess carriers of whose existence the primary carrier is aware during the settlement negotiations."[6] Claim representatives who learn that insureds have excess insurance should document that information in the claim file and discuss with their claim managers how to proceed regarding whether to provide a complete copy of the claim file to the excess insurer.

Just as there are limitations on who may bring suit for bad faith, there are limited bases on which a bad-faith lawsuit can be brought.

BASES OF BAD-FAITH CLAIMS

Generally, bad-faith claims arise from claim or coverage denials, verdicts in excess of policy limits, state statutes that create a bad-faith cause of action, or unfair claims settlement practices acts.

Bases of Bad-Faith Claims

- Claim denial
- Excess liability claim
- Statutory bad faith
- Violations of unfair claims settlement practices acts

In each of these situations, an insurer's claim practices can be used as grounds for the bad-faith claim. Insurers' use of good-faith claim handling practices can help reduce the frequency and severity of an insurer's exposure to bad-faith claims.

Claim Denial

When insureds file claims, they expect their policies to provide coverage for the loss. A claim representative must thoroughly investigate a claim and determine whether the claim is covered. Sometimes after such an investigation, the claim representative finds that no coverage applies and denies the claim entirely. In other claims, a claim representative may find that part of a claim is covered and denies only the portion of the claim that is not covered.

When a claim is either fully or partially denied, the insured or the claimant may retain a lawyer to pursue coverage for the claim. Lawyers' involvement increases the possibility of a bad-faith claim because the lawyer has a better understanding of the actions (such as inappropriate claim denials) that can be the basis for a bad-faith claim. However, claim representatives who follow good-faith claim handling practices should not be overly concerned by the involvement of a lawyer.

In some jurisdictions, if an insurer denies coverage and a court finds that coverage does in fact apply, the insurer is liable for the full judgment regardless of having complied with good-faith claim handling practices. Therefore, an insurer can be liable for a judgment even if the claim representative believes in good faith that no coverage exists. Claim representatives should fully document the reason for their decision when fully or partially denying a claim because either action can present the possibility of a bad-faith lawsuit.

Excess Liability Claims

As previously discussed, bad-faith claims can also be based on excess liability. For an excess liability claim to be filed, a final judgment or settlement must have been entered against the insured and the amount of the judgment must be in excess of the insured's policy limit. The insured is not required to have paid the judgment before bringing suit; the judgment alone is enough for a bad-faith claim to be pursued.

In lieu of a final judgment, some courts allow a settlement in excess of the policy limit to be the basis of the claim. For example, if an insurer refuses to settle a claim, the insured can settle with the claimant, and the settlement may be in excess of the policy limits. The insured can then sue its insurer for the settlement amount including the amount above the policy limits. If the insured can produce evidence that the claimant would have settled the claim within the policy limits if the insurer had properly handled the claim, a court can find the insurer liable for the entire amount including the amount in excess of the policy limits even though the settlement was not fixed by a judgment.

Generally, excess liability claims arise from either of the following two situations:

1. The insurer refuses the opportunity to settle within policy limits.
2. The insurer refuses to settle.

Failure to Settle Within Policy Limits

An excess liability claim can arise when the insurer has an opportunity to settle the claim within the policy limits but fails to do so. This opportunity occurs when a claimant demands the policy limits or an amount within the policy limits to settle the claim. Some courts require that the claimant actually make this demand before the insurer can be faulted for failure to settle within the policy limits. However, other courts (and some state statutes) hold that an insurer has an affirmative duty to explore settlement whether or not a demand has been presented. Some courts weigh the chances that the insurer

could have settled the claim within policy limits even though the claimant made no demand; they may impose excess liability if the insurer should have known that the chances of an excess verdict were high if the claim were not settled out of court. This duty to settle is not imposed upon the claim representative until he or she has had a reasonable opportunity to investigate the claim to determine liability.

Refusal to Settle

An excess liability claim can also be pursued when the insurer wrongfully refuses to settle the claim. The insurer may deny the claim (as discussed previously), or the failure to settle may result from the insurer's own negligence. For example, a court found an insurer liable for an excess judgment because the insurer did not use a standard of care at least equivalent to the care that a reasonable person would use in the management of his or her own affairs. A court may also find an insurer liable for an excess judgment if it finds no reasonable justification for the insurer's refusal to settle.

An important factor in evaluating an insurer's potential bad faith for failure to settle is the likelihood or foreseeability of an excess verdict. The greater the foreseeability that the verdict will exceed the insured's liability limits, the greater the likelihood of a finding of bad faith for refusal to settle. On the other hand, an insurer is not likely to be found at fault for failing to foresee an unexpectedly large verdict.

Strict Liability

Some insureds have attempted to pursue bad-faith claims based on strict liability, under which the insurer is liable for any excess settlement or judgment even though the insurer is not at fault. Almost all courts have stopped short of imposing strict liability, but some have placed burdens on the insurer or have used language which seems to support strict liability. If strict liability is imposed by courts for excess liability, an insurer is liable for the policy limit plus any excess liability if it has an opportunity to settle within policy limits and fails to do so, and if an excess judgment results. For example, a court may hold that an insurer has the burden of proving that its refusal to settle was based on reasonable and substantial grounds. To date, only one state has imposed strict liability on insurers for rejecting a reasonable written offer within policy limits. Claim representatives should determine whether the laws in states in which they handle claims impose strict liability on insurers under these circumstances.

Statutory Bad Faith

Some states have statutes that specifically define what constitutes insurers' bad faith and that allow a bad-faith cause of action. Under those statutes, plaintiffs have the right to pursue claims against insurers if they fall within the statutory definition of bad faith. For example, Pennsylvania enacted a statute in 1990 providing for recovery of punitive damages, interest, attorneys' fees

and costs if an insured could prove bad faith.[7] Before that date, Pennsylvania did not recognize first-party bad faith as a cause of action against an insurer. In jurisdictions with bad-faith statutes, claim representatives should pay particular attention to the criteria outlined in the statute and the case law interpreting the statute.

Unfair Claims Settlement Practices Acts

Many states have unfair claims settlement practices acts, which specify what a claim representative can and cannot do when handling a claim. Such statutes may also require claim representatives to be licensed if they handle claims in that state. Claim representatives should be familiar with the provisions of the acts in any states in which they handle claims.

While the acts vary by state, many states base their unfair claims settlement practices laws on the Model Unfair Claims Settlement Practices Act developed by the National Association of Insurance Commissioners (NAIC). This act outlines the activities that are considered unfair claim settlement practices. A review of the Model Act provides a general understanding of the conduct that constitutes an unfair claim settlement practice.

Provisions of the NAIC Model Act

The NAIC Model Act specifies wrongful claim settlement practices. Some provisions apply to first-party claims only, and others apply to third-party claims. Violations of the Model Act are those "committed flagrantly and in conscious disregard of the Act" or "committed with such frequency to indicate a general business practice." Therefore, a single instance of carelessness or indifference typically does not violate the Act. To comply with the Model Act, claim representatives should treat both insureds and claimants with respect and professionalism. The provisions of this act are found in the appendix to this chapter.

Enforcement

The NAIC Model Act specifies that its provisions are to be enforced by state insurance departments. The stated purpose of the act is not to punish insurers and claim representatives but to elevate the standard of conduct for claim handling by all insurers for the benefit of all involved and to avoid bad-faith claims. However, state insurance commissioners can issue statements of charges or violations against insurers, require hearings on those charges, and impose appropriate penalties against the insurer if the charges are proven.

The NAIC Model Act allows regulators to impose one or more of the following penalties and sanctions on insurers found guilty of violating the act:

- Fines
- Interest on an overdue claim payment

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- Fines
- Interest on an overdue claim payment

- Payment of other fees and costs
- Injunctions or cease-and-desist orders
- Suspension of a claim representative's or insurer's license
- Revocation of a claim representative's or insurer's license

The act sets fines of up to $1,000 per violation and up to $100,000 in the aggregate. For example, if a claim representative violates several different provisions of the act in the same claim, each violation may be subject to a fine (assessed against the insurer, not the claim representative), and the total fines may not exceed the aggregate limit. If a violation is considered flagrant or in conscious disregard of the act, fines may reach $25,000 per violation and $250,000 in the aggregate. Insurers pay fines to the state department of insurance, not to the insured. Suspension and revocation of licenses are extreme penalties and are usually imposed only after other penalties have proved ineffective. An insurer can appeal an insurance commissioner's decision either through an administrative board or through the court system. Generally, insurers who have been penalized or sanctioned take corrective action to prevent further violations.

State Provisions

Most states have incorporated some or all of the Model Act's fourteen provisions into their state insurance codes. Some states have fewer provisions, but they are phrased in general terms to fit most situations. Other states have additional provisions that address the following:

- Misleading a claimant about the statute of limitations
- Requiring a polygraph test
- Causing a disproportionate number of complaints
- Requiring the use of a drive-in estimating service owned by the insurer
- Requiring more than two competitive estimates for property damage
- Failing to carry and exhibit an adjuster's license card
- Discriminating against claimants who are represented by a public adjuster

Whether a state unfair claims settlement practices act has a few provisions or many, the goals of those provisions usually fall into one (or more) of the following five categories:

1. Promptness
2. Honesty
3. Responsiveness
4. Fair-mindedness
5. Even-handedness

Keeping these categories in mind while handling claims may help claim representatives avoid exposing themselves or their employer to bad-faith claims.

Bad-Faith Lawsuits Under the Model Act

In addition to the case law and statutory bases for filing a bad-faith lawsuit, some states allow insureds and claimants to bring lawsuits against insurers for violation of the state version of the Model Act. Other states allow only insureds and not claimants to bring such a lawsuit. Courts in a few states allow a bad-faith lawsuit if the Model Act violation is part of a general business practice.

Many state laws either specifically prohibit bad-faith lawsuits based on violations of unfair claims settlement practices acts or are silent on the issue. If the law is silent, lawyers pursue bad-faith claims and ask courts to decide. Court decisions vary by jurisdiction, so claim representatives must know the laws on bad faith in every state and jurisdiction in which they handle claims.

APPLY YOUR LEARNING

A Word of Caution

Violations of the Unfair Claims Practices Act are damaging even in states that do not allow them to be used as the basis for a bad-faith lawsuit. Evidence of behavior that violates an act is likely also evidence of the "malice," "reckless disregard," or "bad faith" necessary for bad-faith lawsuits.

Other Bases for Bad Faith

Insureds may use violations of other statutes or regulations as evidence of alleged bad faith and/or alleged extracontractual liability against an insurer. Bad-faith claims are sometimes based on fraud, deceit, conspiracy, defamation, libel, and slander. For example, an insured may bring a bad-faith lawsuit against an insurer because the claim representative told the insured's creditors that the insured had committed fraud, without having sufficient information to support this allegation. In addition, bad-faith allegations are sometimes made for violations of privacy rights.

Bad-faith claims are not the only risk insurers face from improper claim handling. They may also face extracontractual liability claims, that is, claims for damages outside the insurance policy, such as punitive damages, or in excess of the insurance policy. Such claims can be made as part of a bad-faith claim or they can arise under other state and federal statutes and regulations.

DAMAGES RESULTING FROM BAD FAITH OR EXTRACONTRACTUAL LIABILITY

Insurers found liable for bad faith or responsible for extracontractual liability are required to pay damages to the harmed party. Damages in bad-faith or extracontractual lawsuits may be based on common-law or statutory provisions, and they vary by jurisdiction. If a plaintiff wins a bad-faith or extracontractual lawsuit, the insurer may be required to pay the plaintiff compensatory damages, punitive damages, lawyers' fees and court costs, and prejudgment interest.

Compensatory Damages

Compensatory damages are a monetary compensation to a victim for harm actually suffered. Compensatory damages can include contractual damages, consequential damages, and/or emotional distress damages, which are damages for mental suffering without physical injury.

Contractual damages are the amounts payable under the contract according to the contract's terms. For example, in a coverage lawsuit, contractual damages are the full amount of coverage up to the policy limits.

Contractual damages
The amounts payable under the contract according to the terms of the contract.

Consequential damages are damages awarded by a court to indemnify an injured party for losses that result indirectly from a wrong such as a breach of contract or a tort. They can be out-of-pocket expenses that can be quantified and itemized, such as the following:

Consequential damages
A payment awarded by a court to indemnify an injured party for losses that result indirectly from a wrong such as a breach of contract or a tort.

- Amount of an excess verdict over policy limits
- Verifiable business losses
- Expenses associated with filing the lawsuit and participating in the litigation process
- Interest or other statutorily prescribed damages for delay
- Lawyers' fees

In some jurisdictions, these expenses may not be considered consequential damages but instead may be prescribed by statute or common law.

In states that regard bad faith as a tort, courts may award emotional distress damages as part of compensatory damages. But courts have used different standards to determine when emotional distress is sufficient to incur damages. For example, some courts award damages if the insured suffers a property loss or an economic loss that causes emotional distress, even if the emotional distress is not severe. Some courts award damages when the insured suffers emotional distress, even when the insurer does not intend to cause the distress. Other courts award emotional distress damages only if a physical injury results or if the insurer's misconduct was intentional, malicious, or willful.

Punitive Damages

Punitive damages, which are damages imposed in order to punish the wrongdoer, can result in very large monetary awards. Many bad-faith claims include a demand for punitive damages because the potential awards can be lucrative for both the claimant and the claimant's attorney. However, punitive damages are not always awarded in bad-faith claims. The standard for awarding punitive damages varies by jurisdiction but generally requires proof of insurer behavior that is worse than ordinary wrongdoing, such as malicious, fraudulent, or oppressive behavior. Some states require proof that the insurer's conduct was intentional, reckless, gross, wanton, or recklessly indifferent for punitive damages to be awarded.

When evaluating a claim for punitive damages, courts ask questions such as the following:

- Did the insurer intend to harm the insured?
- Did the insurer substantially harm the insured?
- Was the insurer's conduct so blatant that a reasonable person would foresee the harm to the insured?
- Does the insurer have substantial net worth?
- Do state laws influence when and what amount of punitive damages are allowed?

The amount of a punitive damage award can be influenced by a variety of factors. One factor may be the insurer's compensation or bonus plan. For example, if claim representatives receive incentive-based compensation to close claims quickly or to reduce claim payments, the insurer may run a greater risk of a punitive damage award, because this conduct may be contrary to public interest. Another factor that can influence a punitive damage award is an insurer's reaction to a bad-faith claim. A court may not look favorably on an insurer that shows no remorse for serious claim handling deficiencies. Candor in admitting mistakes and an open and honest approach to dealing with complaints can help insurers reduce their exposure to punitive damages.

Insurers generally support the following limits on punitive damages:

- Punitive damages should not exceed the amount of compensatory damages awarded except in unusual cases.
- Higher punitive awards are appropriate only in cases in which the plaintiff has not received a substantial award of compensatory damages and the defendant's conduct is outrageously reprehensible.
- Evidence supporting punitive damages must be specific to the harm suffered by the plaintiff and should not be based on misconduct occurring in other jurisdictions or at other times.

Lawyers' Fees and Court Costs

Among the types of consequential damages commonly imposed in bad-faith or extracontractual liability cases are lawyers' fees and court costs. Insureds or claimants incur lawyers' fees in bringing bad-faith lawsuits. In addition, if the insurer has refused to defend the underlying claim, insureds and claimants may incur lawyers' fees to defend the underlying lawsuit. In some states, statute or common law allows recovery of such lawyers' fees as part of damages in bad-faith cases. Even in states without such laws, individual courts may allow recovery of lawyers' fees as part of consequential damages resulting from the insurer's conduct. Those courts reason that when the insured must hire a lawyer to obtain the benefits the insurer wrongfully refused to provide, the lawyer's fees are an economic loss and are recoverable as consequential

damages. Similarly, courts may allow the insured or claimant to recover court costs. However, some courts have refused to award attorneys' fees and costs if the claimant would have incurred the fees and costs regardless of the outcome of the suit.

Interest

If an insured pays an excess judgment and then wins a bad-faith lawsuit against the insurer to recover the payment of the excess judgment, the insurer may have to pay the insured the statutory interest rate on that excess judgment amount. Some courts award interest on the claimed damages because the insured was deprived of the money while the insurer had the money to earn interest. Some states' laws allow interest and penalties to be assessed against an insurer solely because of its failure to promptly pay a claim. In addition, some courts have allowed an excess insurer to claim prejudgment interest if the primary insurer was found to have negligently refused to settle.

The amount of damages resulting from a bad-faith or extracontractual liability claim can be sizeable because of all the different types of damages allowed. Claim representatives should be aware of these and other potential consequences of bad faith as they handle claims. Despite their best efforts to handle claims with good faith, bad-faith allegations will still be made, so the claim representative and the insurer must be prepared to defend against these claims.

DEFENSES TO BAD-FAITH CLAIMS

Insurers faced with bad-faith lawsuits have many defenses, some of which may be a total defense to the claim, others of which may be a partial defense to the claim. While any one of the defenses may be sufficient for the court to dismiss a lawsuit, an insurer that can assert more than one defense is more likely to succeed in defeating a bad-faith claim or reducing the amount of damages awarded. Each defense must be analyzed in relation to a specific lawsuit to determine whether it can be used.

Defenses to Bad-Faith Claims

Defenses That Result in Dismissal of Lawsuit

- Statutes of limitations
- Lack of right to sue
- Reliance on lawyers' advice
- Insured's collusion with the claimant
- Debatable reasonable basis
- Statutory defenses
- Fair dealing and good documentation
- Comparative bad faith

Defenses That Reduce Damages

- Comparative bad faith
- Contributory negligence
- Availability of higher limits

Statutes of Limitations

Statute of limitations
A statute that imposes time limits on when a cause of action can be brought, starting from the time the cause of action accrues.

One defense to a bad-faith lawsuit is the expiration of the statute of limitations. **Statutes of limitations** impose time limits on when a cause of action can be brought, starting from the time the cause of action accrues. These statutes apply to bad-faith claims. If the time limit specified in the statute of limitations has expired, the court will dismiss the bad-faith lawsuit.

The time allowed to file a lawsuit allowed by statutes of limitations varies depending on whether the lawsuit alleges a breach of contract or bad faith as a tort. The period also varies by state. Generally, the period ranges from two years to six years from the date the bad faith occurs. The claim representative and the insurer's defense lawyer should check state law to determine the statute of limitations that applies to a particular bad-faith lawsuit.

A common issue in cases involving a statute of limitations is the starting date of the statutory period. Some courts have held that the starting date for a bad-faith lawsuit begins when the insurer denies the claim or otherwise wrongfully withholds benefits. Other courts have held that the time does not begin to run (or toll) until the damages are ascertainable. For example, in excess liability cases, the statute begins to run when a final judgment in excess of the policy limit is awarded. If a bad-faith claim is based on an insurer's refusal to defend an insured, the statute begins to run when the insurer refuses to defend. Because these conditions vary by state, an insurer's lawyer should determine whether the statute of limitations is a valid defense in a given case.

Lack of Right to Sue

Policyholders, claimants, and excess insurers may have the right to sue (also called standing) for bad faith, depending on state law. If claimants and excess insurers do not have the right to sue for bad faith under the state's law, then the insurer can defend against the claim by challenging their standing to sue.

Several states, called direct action states, do allow a claimant to directly sue a tortfeasor's insurer. Claim representatives should check with their defense lawyers to determine whether the states in which they handle claims are direct action states.

One way for a claimant or an excess insurer to gain the right to sue is to obtain the policyholder's right to sue through an assignment. If a policyholder has assigned policy rights to the claimant, defense lawyers should ascertain whether the assignment is legal; an illegal or improper assignment can be a valid defense.

Reliance on Lawyers' Advice

Another possible defense against a bad-faith claim is reliance on lawyers' advice (often called the advice of counsel defense). If an insurer relies on the opinions and advice of competent, independent lawyers in reaching the

decision that leads to a bad-faith lawsuit, the insurer can use that fact to build a defense. Evidence that an insurer obtained a lawyer's advice may be used to indicate that the insurer acted reasonably and with proper consideration in handling the insured's claim. Using lawyers' advice as part of a defense may require proof of the following:[8]

- The insurer acted on the lawyer's advice.
- The insurer disclosed all the facts to the lawyer.
- The insurer relied on the lawyer's advice in good faith.

Proof that the insurer followed a lawyer's advice may be effective in reducing or eliminating punitive damage awards. A court may reason that an insurer's good-faith reliance on a lawyer's advice eliminates the elements of oppression, fraud, or malice required for a punitive damage award. However, one drawback of relying on this defense is that doing so may waive any attorney-client privilege and thus allow the insured to review the file of the insurer's attorney.

Insured's Collusion With the Claimant

Another defense that can lead to dismissal of a bad-faith claim is collusion between the insured and the claimant. For example, an insured and a claimant may conspire to help the claimant recover an excess judgment in a lawsuit resulting from a claim and agree to split the proceeds if the lawsuit is successful. Such collusion is more likely to occur in the following situations:

- The insured and the claimant have an ongoing business relationship.
- The insured and the claimant are related or close friends.
- The insured will benefit indirectly from the claimant's recovery, such as in the case of a minor child suing a parent/insured.

Collusion can also occur when an insured enters into an agreement with the claimant, after a court awards damages above the policy limits, that the claimant will not collect the judgment from the insured's personal assets. Courts carefully scrutinize any such agreements before honoring them.

Another potential opportunity for collusion arises when there is a coverage issue in a claim. The insured may share the insurer's reservation of rights letter with the claimant for the purpose of coaching the claimant on how to assert an allegation so that it is covered and therefore payable by the insurer and not the insured.

The following are two indicators of possible collusion:

- The insured's attitude suddenly becomes more favorable toward the claimant during the claim process.
- The insured is uncooperative and does not appear to be concerned about possible personal excess exposure.

Courts are usually unsympathetic and intolerant of collusion and are likely to rule against the insured and claimant if collusive behavior is discovered.

Debatable Reasonable Basis

Another possible bad-faith defense stems from the existence of a debatable question. If an insurer has a reasonable basis on which to debate whether a claim is covered, the insurer should not be liable for a bad-faith refusal to pay a claim. For example, a claim representative makes a good-faith investigation and determines that a claim is not covered. The insured disagrees and sues for coverage, alleging bad faith in the original coverage determination. A court can find that the claim is covered and still find that no bad faith was involved if the court believes there was a reasonable basis for the original coverage denial. Some courts have held that a claim is "fairly debatable" if a reasonable insurer would deny or delay payment of a claim with the same facts and circumstances. If the questions are fairly debatable, the insurer is not acting in bad faith by seeking to resolve the questions before making payment. To use the debatable question defense, insurers must show that there is a reasonable justification in law or fact for denying or delaying payment of the claim.

Another measure of whether a claim involves a debatable question is whether the insured is entitled to a summary judgment on coverage. A court grants a **summary judgment** when it determines that no factual issue exists in a case. The insurer would file for a summary judgment on the grounds that the policy does not cover the claim and that, therefore, there are no factual issues to be decided by the court. The court's refusal to grant a summary judgment would indicate that the factual issue of coverage is in dispute, that is, that it is a debatable question. In having attempted to resolve this question before making payment, the insurer would not, then, have been acting in bad faith.

Summary judgment
A judgment granted by the court when it determines that no factual issue exists.

Statutory Defenses

Federal and state statutes designate other defenses insurers can use to seek a dismissal of a bad-faith lawsuit. Any applicable statutes must be examined for any defenses that may apply to a particular bad-faith claim. For example, some states require insurers to report suspected insurance fraud to the state attorney general's office. To insulate insurers from angry insureds who are suspected of fraud and have been reported, these states offer the insurer immunity from related lawsuits. Obviously, there should be no bad-faith claim against the insurer for reporting suspected fraud in good faith if the suspicion is reasonable.

Fair Dealing and Good Documentation

Insurers can use fair dealing and good documentation as a defense to a bad-faith claim. Good-faith claim handling practices and supporting evidence can help defend bad-faith lawsuits by establishing that insurers have dealt fairly with insureds and claimants. Documentation in each claim file demonstrates how insurers conduct the claim investigation, evaluate claims, and negotiate claims. Activity logs; correspondence; and documentary evidence such as police reports, damage estimates, and medical bills can indicate that claim

ntatives, supervisors, and managers are doing their jobs properly. Such ce is part of a successful defense strategy for a bad-faith claim.

aling and good documentation are especially important in defending ith claims resulting from claim denial and those resulting from claim sentation errors. Claim representatives should have a thoroughly docu- claim file before denying a claim. Investigative attempts should be nented irrespective of whether the results are good or bad for the insurer. aling practices and good documentation can also help claim repre- tives explain and correct errors. When an error is discovered, a sincere gy and quick action to correct it can help in avoiding and defending faith claims.

m representatives should follow their company's procedures or best tices in documenting their files. They must operate as if every note, form, letter in their claim files will be read to a jury. In addition, claim represen- ves should adopt the following practices from the first day of the claim dling process through the time the claim is closed:

- Request and obtain all necessary information or documentation before deciding to accept or deny a claim
- Include in their files detailed analyses of the coverage(s), the liability issues, defenses, percentages of liability for all parties, and damages issues
- Support their analyses with facts and documents in their files, not rumors or innuendos
- Avoid making derogatory or malicious comments about the insured, counsel, or witnesses
- Avoid exploiting or making comments about exploiting the claimant's or insured's financial hardship
- Avoid delays in handling a claim
- Avoid substantial variances between reserves and payments or offers made
- Avoid attempts to persuade public authorities to bring criminal charges against any person, but supply requested information about possible criminal activity as permitted by the applicable state
- Avoid attempting to coerce experts to change their testimony

The best defense to a bad-faith claim is sufficient evidence that the claim has been handled following good-faith practices. Good-faith claim handling must be thoroughly documented so that it can be made apparent to a jury or judge if a bad-faith claim is filed.

Comparative Bad Faith

The duty to act in good faith applies to both the insurer and the insured. Therefore, in some jurisdictions, evidence that an insured has acted in bad faith may allow the insurer to use the defense of comparative bad faith in

a bad-faith lawsuit. The comparative bad-faith defense permits dismissal or reduction of a bad-faith claim if an insured failed to deal fairly with the insurer by breaching one or more implied duties. For example, an insured delays reporting an accident in which he or she is at fault and also fails to cooperate in the accident investigation. If the insured later sues the insurer for bad faith in handling that claim, evidence demonstrating that these actions prevented the insurer from properly handling or settling the claim against the insured may establish comparative bad faith as a defense. Comparative bad faith as a defense is recognized in only a few jurisdictions.

Example: Comparative Bad-Faith Defense

An insured's home was damaged by fire. The insurer paid the insured for the damage, although the insured claimed he was not fully compensated. Five months after the first fire, a second fire destroyed what remained of the home. The insurer denied the claim because the second fire was caused by arson. The insured sued the insurer for breach of contract, bad faith, and violations of the unfair insurance practices act. The court found in the insurer's favor because the insured had set the second fire, had made misrepresentations to the insurer, and had failed to protect the property after the first fire.[9]

Contributory Negligence

Another defense that may be used in a bad-faith lawsuit is contributory negligence. In some states, proof of any contributory negligence by the insured prevents recovery. However, most states use a comparative negligence approach, reducing the amount of damages that may be awarded. If the insured contributed to the damages, the insurer's bad-faith damages are reduced by the percentage that the insured contributed. Generally, a contributory negligence defense is available only in states that permit negligence as a basis for a bad-faith claim.

Availability of Higher Limits

Insurers can sometimes use the defense that higher limits of insurance were available to the insured to reduce the size of a bad-faith claim award. Because insurance coverage is readily available and insureds can purchase adequate policy limits through primary or excess insurers, an insured who has a policy with minimal limits may have difficulty putting all the blame for an excess judgment on the insurer. Evidence that the insurance producer encouraged the insured to purchase higher limits can help the insurer establish this defense. Although it is not a complete defense to a bad-faith claim, the fact that higher limits were available but were rejected by the insured may reduce the size of the award against the insurer.

ELEMENTS OF GOOD-FAITH CLAIM HANDLING

As previously mentioned, good faith is broadly defined as consideration given to the insured's interests that is at least equal to that given to the insurer's interests in handling the claim. This broad definition allows courts great leeway in deciding what constitutes good faith in a given situation. As a result, common sense and good judgment must underlie all claim handling.

Good-faith claim handling involves thorough and timely investigation, documentation, evaluation, negotiation, and communication. In addition, claim representatives should seek legal advice when appropriate. Finally, the insurer's management of all claims is important to good-faith claim handling.

Thorough, Timely, and Unbiased Investigation

Investigations that are thorough, timely, and unbiased are the foundation of good-faith claim handling. If claim representatives investigate claims adequately, they will have sufficient evidence of their good-faith efforts to conclude claims. That evidence is helpful in defending bad-faith lawsuits.

Claim representatives should thoroughly investigate claims and collect all relevant and necessary evidence. Investigation should continue as long as new facts develop or become available. Claim representatives should develop the information and documentation necessary to determine liability and damages and should make decisions once they believe they have sufficient information to do so. They should not delay decisions while trying to uncover or investigate what could be construed by a jury as unnecessary information.

A claim file must be organized so that the information is readable and easy to follow. For example, medical bills, doctors' reports, and other information on each claimant should be in a logical order. Photographs, police reports, and other documentary evidence should be sorted for easy reference.

In a thorough investigation, the claim representative is alert for new information that may change the course of the claim. For example, a homeowner files a claim for an injury to a visitor who fell on his front step. This may appear to be a simple claim. However, a claim representative may discover from the homeowner's statement that the visitor was actually a resident of the household or was on the premises as a business customer. Either situation may exclude coverage under the homeowner's policy. Without the additional investigation, the claim representative may have paid a claim that was not covered by the policy.

Claim representatives often determine when an investigation is sufficiently thorough, using their own judgment. For example, the insurer's claim handling guidelines offer guidance about which claims require statements and from which parties. However, a claim representative may decide a statement is necessary for a specific claim, even if the guidelines do not

require it. In any case, an investigation should be thorough enough to satisfy a judge and jury that the claim representative followed good-faith claim handling procedures. Evidence of compliance with company procedures or best practices used in investigation helps convince the court or jury.

Investigation must also be timely. An insured who makes a claim expects prompt contact from the claim representative. Most insurers have guidelines requiring the claim representative to contact the insured and the claimant within a specific period, such as twenty-four hours after the claim has been submitted. Timely contact with the parties to the claim benefits the insurer in several ways. First, parties are more likely to remember the details of the loss accurately. Memory fades quickly over time; therefore claim representatives are most likely to get complete, accurate information from insureds and claimants if they contact them promptly. Second, the parties are more likely to share information if contacted promptly; prompt contact reassures insureds and claimants that their claims are important and makes them less likely to accept the advice of others who may encourage them to retain a lawyer or pursue unnecessary litigation. Documentation of timely contact in the claim file can help prove an insurer's use of good-faith claim handling procedures and/or the insurer's compliance with the provisions of the Model Act.

Finally, the investigation should not be biased. Bias in claim handling is a predisposition to a particular outcome. When investigating claims, claim representatives should pursue all relevant evidence, especially evidence that establishes the claim's legitimacy, without bias. They should avoid asking misleading questions that slant the answers toward a particular outcome, such as "The light was red when you saw it, wasn't it?" In addition, claim representatives should work with service providers that are unbiased and have no conflict of interest. As mentioned previously, courts and juries may not look sympathetically on medical providers or repair facilities that always favor insurers. Investigations should seek to discover the facts and consider all aspects of the claims so that decisions are impartial and fair.

When conducting a good-faith claim investigation, claim representatives must comply not only with state unfair claim practices acts, but also with federal statutes. These statutes, designed to ensure the privacy of confidential information, include the Health Insurance Portability and Accountability Act of 1996, the Gramm-Leach-Bliley Act, the Sarbanes-Oxley Act, and the Fair Credit Reporting Act.

Health Insurance Portability and Accountability Act of 1996

Claim representatives must be careful in handling confidential information learned about an insured or a claimant during the course of a claim investigation. Several statutes and regulations govern the handling of information. Congress established the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[10] to address the use and disclosure of individual health information. HIPAA applies to health plans, healthcare clearing houses (that process health information), and healthcare providers, termed "covered entities" in the act. Its major goal is to protect individuals' health

information while allowing the flow of information to provide and promote high quality healthcare. A major aspect of the primary rule in this act concerns the disclosure of medical information in connection with claims or potential claims.

HIPAA describes permitted uses and disclosures of protected information. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, as follows:

- When the information is disclosed to the individual
- When the information is used in treatment, payment, and healthcare operations, such as sending a patient's medical records to another doctor
- When the individual is given the opportunity to agree or object to certain disclosures
- When the information is incident to an otherwise permitted use and disclosure
- In the interests of public health
- As limited data for the purpose of research, public health, or healthcare operations

A covered entity may rely on professional ethics and best judgment in deciding which of these uses are permitted. Claim representatives must be aware of HIPAA restrictions and obtain the necessary authorizations to obtain HIPAA-protected information.

Gramm-Leach-Bliley Act

Congress enacted the Gramm-Leach-Bliley Act of 1999 (GLB)[11] to protect the security and confidentiality of customers of financial institutions. GLB sets forth requirements for protecting and using customer information. GLB applies to financial institutions such as banks, securities firms, insurers, and others who provide financial services and products to consumers and protects both current and prior customers of these institutions. The act includes requirements for handling confidential information and a disclosure provision, which requires companies to advise consumers of the company's information-sharing practices.

The protected information ranges from general biographical background information to information revealed in connection with a transaction. The act also provides several exceptions, including information required to be shared in administering a financial transaction authorized by a customer or made in connection with fraud prevention. Claim representatives must be aware of GLB because it may restrict their access to financial information obtained by their company for a purpose other than a claim, but which would be useful to the claim investigation.

Sarbanes-Oxley Act

Congress enacted the Sarbanes-Oxley Act[12] in 2002 in response to the financial and accounting scandals of the 1990s. This act requires publicly traded

companies to meet and certify certain financial disclosure requirements. It requires commercial insureds and many insurers to conduct more intense investigations of their claims from an accounting standpoint to make sure they comply with the law. This requires more extensive reporting of claim information, greater accuracy in setting claim reserves, and more extensive audits of claims and claim files.

Fair Credit Reporting Act

Congress enacted the Fair Credit Reporting Act[13] in 1970 to promote the accuracy and privacy of personal information assembled by credit reporting agencies. The personal information includes credit reports, consumer investigation reports, and employment background checks.

The act requires reporting agencies to follow "reasonable procedures" to protect the confidentiality and privacy of personal information. To this end, procedures are established to handle personal information that includes the right to access and correct credit information.

Claim representatives should be aware of the restrictions imposed by the Fair Credit Reporting Act should they find it necessary to obtain or disclose an insured's or a claimant's financial information during a claim investigation. Claim representatives should check with their supervisors or managers to determine what "reasonable procedures" are in place to protect the confidentiality of this information.

While a violation of these statutes may not lead to a bad-faith claim, it may lead to a claim for extracontractual liability because the violations fall outside the scope of the policy but have occurred during the course of claim handling.

Complete and Accurate Documentation

A common saying among claim representatives is that if an activity, action, or event is not written in the claim file, it did not happen. A claim file must provide to anyone who reads the claim file a complete and accurate account of all the activities and actions taken by the claim representative. Claim representatives must remember that a claim file may be read by many different people, each with a different purpose. The claim representative's supervisor or manager may read the file to provide assistance to the claim representative. A home-office examiner or an auditor may review the file for compliance with claim handling guidelines. Claim department peers may review the file as part of a roundtable discussion of reserving. The underwriter, the agent, or the broker may review the file to determine whether the coverage determination or valuation is appropriate. A state insurance department may review the file in response to a complaint or during a market conduct study. Defense counsel, and maybe even the claimant's counsel, will review the claim file during the course of litigation. Mediators and arbitrators may review the file as part of a dispute resolution process. Regardless of who reads the file, no reader should

be left wondering why something did or did not happen or how a conclusion was reached.

Fair Evaluation

Another aspect of good-faith claim handling is the fair evaluation of the claim. This is particularly important in liability claims. A fair approach to evaluating liability claims is to evaluate them as if no coverage limit existed. This approach helps claim representatives avoid the mistake of unfairly attempting to settle a claim for less than the policy limit when it may be worth more.

A crucial element of fair claim evaluation is a prompt evaluation. The evaluation of a claim usually takes place at the conclusion of the investigation, when the claim representative has received all supporting documentation. Unfair claims settlement practices acts often specify time limits within which evaluations of coverage and damages must be completed. Claim representatives' compliance with these requirements helps reduce the insurer's exposure to bad-faith claims.

Promptness is also important in responding to the claimant, the insured, or their respective lawyers' demands. If a letter specifies a time limit for reply, the claim representative should make every effort to respond within that limit or should respond by telephone and explain why more time is needed. The call should be confirmed promptly in a follow-up letter or e-mail. Any time extension agreed on should be documented by a letter and a copy should be placed in the claim file.

Courts have dismissed bad-faith claims based on unreasonable time limits. In some cases, the opposing side may set intentionally unreasonable limits to raise the inference of bad faith or to pressure a claim representative into settling before thoroughly investigating the claim. Prompt handling and constant attention help avoid these situations.

If a letter or another communication contains a demand that is at or near the policy limits, a prompt reply is particularly important. The lawyer may contend that the case is worth much more than the policy limits but that the client will accept the policy limits if the claim is settled quickly. If the claim representative has properly evaluated and documented the claim file, this time demand should pose no problem.

Claim representatives can perform a fair evaluation if they have conducted a thorough, timely, unbiased investigation and understand the jurisdiction of the claim. In addition, to assist in making a knowledgeable evaluation, they can consult with sources inside and outside the insurance company, including the following:

- Co-workers
- Supervisors and managers

- Defense lawyers who are already involved in the case
- Other defense lawyers who are not involved in the case
- People who represent a typical jury
- Computer-generated damage or injury evaluations
- Jury verdict research companies

Information about settlements or trial results from similar cases gained from any of these sources can help claim representatives knowledgeably evaluate the claim. However, each claim is unique and should be evaluated on its own merits.

Fair evaluations are based on facts, not opinions. A claim representative's statement in the file that "I think the case is worth $50,000" is of little value unless the investigation and file documentation substantiate that amount. Claim representatives determine a range of claim amounts based on the facts of the claim, the credibility of the evidence, and applicable laws. This is not an exact science. File documentation showing that the claim representative used best practices to evaluate a claim is evidence of good-faith claim handling. Of course, the amount of the eventual verdict or damages will be used to argue for or against a bad-faith claim.

Good-Faith Negotiation

Good-faith negotiations flow naturally from thorough, timely, unbiased investigations and prompt, fair evaluations. Courts in some jurisdictions have held that an insurer cannot be liable for bad faith for not settling a claim unless the claimant has made a settlement demand. However, claim representatives should take the initiative in making realistic offers when doing so is likely to promote a settlement. Such offers may include an offer to settle before a demand is ever made.

Although claim representatives must make realistic offers and carefully consider all demands, lawyers are not held to the same standard. They can make exaggerated demands in a vigorous representation of their clients, and their clients often expect them to do so, in the hope of obtaining the best settlement possible. Claim representatives should evaluate each claim fairly and respond to such demands by offering a settlement that is consistent with the evidence and documentation in the claim file. They should not trade unrealistic offers and demands with lawyers, as such behavior may result in an unrealistic settlement. All responses to demands should be reasonable and made in a courteous and professional manner.

Claim representatives should not allow their emotions or egos to affect negotiations. Unchecked emotions or egos can stop negotiations and prompt arguments. Judgment becomes clouded and the spirit of fair dealing can be replaced with bad feelings. When this happens, everyone loses, and it

is more difficult for an insurer to prove that it has followed good-faith claim handling procedures.

Claim representatives should use policy provisions, such as arbitration clauses, when applicable, to resolve disputes over the settlement amount. Adherence to the policy provisions and payment of the amount determined through arbitration places the insurer in a better position to defend a bad-faith lawsuit.[14] Claim representatives should consider all possible forms of voluntary alternative dispute resolution, including mediation or a series of face-to-face negotiations to resolve claims.

Regular and Prompt Communication

Communicating with all parties to a claim (for example, the insured, the defense attorney, and the excess insurer) is a crucial aspect of good-faith claim handling and resolving claims. Keeping insureds informed is especially important because they expect it, they are most likely to make a bad-faith claim, and they may have the most important information about an accident. Regular and prompt communication with the insured achieves several important results, including the following:

- The insured feels like a part of the defense and can offer assistance.
- The insured can participate in discussions about the possibility of settlement and the handling of the claim.
- The correspondence with the insured documents the insurer's good-faith claim handling and the basis for its judgment about settlement.
- The correspondence establishes that the insured gave the insurer informed consent to take on the defense of the case and to decide how to defend it.

The defense attorney should also regularly and promptly inform the insured of all major events in the defense. Any request by an insured not to be informed of these events should be confirmed in writing. Claim representatives and lawyers should document telephone and personal communication in writing and confirm what they learn in such communications if it is crucial to the claim.

If defense lawyers fail to communicate promptly and regularly, claim representatives should contact them to solicit information and correct any misunderstandings. Claim representatives cannot abandon claims to defense lawyers and still meet good-faith claim handling standards.

Written communication from the defense lawyer to the insured may include the following:

- A letter advising that the insurer has received a demand for policy limits with an explanation of the insurer's planned course of action
- A letter indicating that negotiations have stalled, that the claimant has retained a lawyer, and what the insured should do if he or she receives a summons

- If suit is filed, a letter stating the defense lawyer's name, address, and phone number; identifying coverage questions or reservations of rights that result from the lawsuit; advising the insured of a possible excess verdict or punitive damages; and advising the insured of the right to hire a lawyer at the insured's own expense
- A letter stating that the claim has been settled without trial
- A letter stating that the court's decision is being appealed

If the insured has excess insurance, the claim representative should notify the excess insurer of the claim and provide the insured with copies of all communications. The excess insurer may request a copy of the claim file and may or may not want to be actively involved in the claim thereafter to protect its interests. Additionally, if the insured hires a lawyer, that lawyer will want to be kept advised of significant claim activity.

Competent Legal Advice

As previously mentioned, following the advice of competent lawyers can be considered evidence that an insurer acted in good faith. Lawyers who defend the insured should be selected based on their experience, knowledge of the law, and success in the courtroom. Lawyers have an ethical obligation to be loyal to the insured first and the insurer second, because the insured is the lawyer's client, regardless of who is paying the lawyer's fees. Defense lawyers who are overly optimistic about their chances of successfully defending a case may not be good choices, because their optimism may be unproven and can expose the insured and insurer to an excess verdict. Claim representatives should provide lawyers with all information and documentation necessary to reach a complete and accurate opinion and should avoid any attempts to influence the lawyer's independent judgment.

When resolving a coverage question, insurers should avoid conflicts of interest by using lawyers other than the defense lawyers hired to defend an insured. Asking a lawyer who defends an insured a coverage question creates an ethical dilemma for that lawyer because the answer may not be in the insured's best interest. Insurers that use in-house or staff lawyers (lawyers who are the insurer's employees) to defend insureds should be especially sensitive to the possibility of a conflict of interest and, if any appearance of such a conflict exists, should use outside lawyers.

Effective Claim Management

An insurer's claim management directly affects a claim representative's ability to handle claims in good faith. Claim management in this context refers to how claim departments are managed by claim managers and claim supervisors.

Claim management involves many duties. Although every duty is important, the following three are crucial to good-faith claim handling:

1. Consistent supervision
2. Thorough training
3. Manageable caseloads

Consistent Supervision

Supervisors and managers should work with claim representatives frequently and consistently to ensure that claims are investigated, evaluated, and resolved promptly and accurately. Supervisors and managers are responsible for quality control and for ensuring that claim representatives follow proper claim handling practices. They should make notes in files to document their reviews and to provide instruction and guidance. If a supervisor recognizes delays or improper claim handling practices, he or she must act to correct the problems and document those actions.

Managers also have a responsibility to maintain proper claim handling standards and practices. They develop guidelines for claim handling and are ultimately responsible for ensuring that the guidelines are followed.

Supervisors and managers have more settlement authority (the authority to settle a claim up to a specified dollar amount) than claim representatives. Therefore, they should become involved in the settlement evaluation and strategy when the claim representative's settlement authority is exceeded.

Thorough Training

Insurers should provide continuous and consistent training for claim representatives relating to all necessary claim handling procedures and best practices as well as to good-faith claim handling. Training is essential when a claim representative handles a new type of claim or a more complex, serious claim for the first time. Claim representatives should make an effort to continually improve their competence in handling claims, and training is one way to improve.

Manageable Caseloads

Supervisors and managers must monitor the number of claims assigned to a claim representative (referred to as caseload or pending) to ensure that the work is manageable. Situations arise when caseloads increase, such as when one or more claim representatives leave the company or are out of the office for an extended period. At some point, a claim representative's caseload may become unmanageable and increase the possibility of a bad-faith claim. Supervisors and managers must monitor caseloads to identify potential problems and reassign claims or provide support to ensure good-faith claim handling.

Claim representatives who practice good-faith claim handling know their job is to properly and expeditiously resolve claims according to the facts, law, and policy language. They do not delay or minimize claim payments. Some insurers summarize good-faith claim handling as "doing what is right." Claim representatives who adopt this attitude are likely to avoid or reduce the occurrence of bad-faith claims.

SUMMARY

Insurers and the claim representatives who work for them have a duty of good faith and fair dealing in claim handling. This requirement is imposed on insurers and claim representatives because of (1) the public interest in ensuring that insurers have the financial resources to pay claims and that they pay claims fairly and promptly, (2) the unequal bargaining power of the parties to the insurance contract, and (3) the insurer's control over the investigation and resolution of the claim. If insurers or their claim representatives do not live up to the standard of good faith and fair dealing, they are said to be acting in bad faith.

The definition of bad faith varies by state but can be generalized as any unfounded refusal to pay a claim. Courts have interpreted this definition in many ways, so claim representatives must be aware of the bad-faith law in every state in which they handle claims. Generally, a bad-faith lawsuit can be based on the claim representative's negligence or gross or intentional misconduct.

Bad-faith claims or lawsuits are usually brought by the insured against the insurer for the handling of the insured's first-party claim or the handling of a third-party claim against the insured. If the insured assigns the right to sue his or her insurer for bad faith to a claimant, the claimant can sue the insurer for bad faith. Bad-faith claims can also be brought against an insurer by an excess insurer that has had to pay a claim because of the insurer's bad faith.

Bad-faith claims usually result from a claim or coverage denial, a verdict in excess of the policy limit, or a violation of a state statute or of an unfair claims settlement practices act. In an effort to bring uniformity to the standard of conduct to which insurers and claim representatives are held, the NAIC created the Model Unfair Claims Settlement Practices Act, which act lists practices that are generally accepted as unfair claims settlement practices. Most states have adopted some or all of the Model Act's provisions.

Damages resulting from bad faith or extracontractual liability can vary by jurisdiction. Generally, they can include compensatory damages, emotional distress damages, and punitive damages. Among compensatory damages are lawyers' fees, court costs, and interest.

Insurers and claim representatives have several defenses available to combat a bad-faith claim or reduce the amount of damages awarded. The defenses include statutes of limitations, lack of right to sue, reliance on lawyers' advice, insured's collusion with the claimant, debatable reasonable basis, statutory

defenses, fair dealing and good documentation, comparative bad faith, contributory negligence, and availability of higher policy limits.

To use these defenses, the insurer and the claim representative must be able to show they acted in good faith. The claim file must contain documentation of a thorough investigation; a fair, prompt, and knowledgeable evaluation of the claim; and a documentation of good-faith negotiation. The file should reflect prompt and adequate communication among the parties to the claim, the insurer's consideration of legal advice, and adherence to the insurer's claim management practices. The file should also show compliance with federal statutes such as the Health Insurance Portability and Accountability Act of 1996, the Gramm-Leach-Bliley Act, the Sarbanes-Oxley Act, and the Fair Credit Reporting Act.

Handling claims in good faith also means handling claims ethically. Ethics in claim handling is the topic of the next chapter.

CHAPTER NOTES

1. Form ISO HO 00 03 05 01, Copyright ISO Properties, Inc., 1999.
2. *Slater v. Motorists Mut. Ins. Co.*, 174 Ohio St. 148, 187 N.E.2d 45 (1962).
3. *Commercial Union Ins. Co. v. Liberty Mutual Ins. Co.*, 393 N.W.2d 161, 164 (Mich. 1986).
4. *Pickett v. Lloyd's*, 621 A.2d 445, 451 (N.J. 1993).
5. California Insurance Code Section 11580(b)(2).
6. *American Centennial Ins. v. American Home Assur. Co.*, 729 F. Supp. 1228, 1232 (N.D. Ill. 1990).
7. 42 Pa. C.S.A. §8371.
8. "Bad Faith in the 90's: Successful Tactics & Strategies for Defending the Insurer," sponsored by The CPCU Society's Golden Gate Chapter, presented by Ropers, Majeski, Kohn & Bently, a Professional Corporation, San Francisco, p. 33.
9. *Chapman v. Norfolk & Dedham Mut. Fire Ins. Co.*, 39 Conn. App. 306, 665 A.2d 112, cert. denied, 235 Conn. 925, 666 A.2d 1185 (1995).
10. Quoted and/or adapted from Department of Health and Human Services, *OCR Privacy Brief*, available at the department's Web site: www.hhs.gov/ocr/hipaa/ (accessed October 17, 2005).
11. 15 U.S.C. § 6801 et seq. (2005).
12. 15 U.S.C. § 7201 et seq. (2005).
13. 15 U.S.C. § 1681 et seq. (2005).
14. "Bad Faith in the 90's: Successful Tactics & Strategies for Defending the Insurer," p. 45.

Appendix

Provisions of 1990 NAIC Model Unfair Claims Settlement Practices Act

This appendix presents Sections 3 and 4 of the act, with illustrative examples.

Section 3—Unfair Claims Settlement Practices Prohibited

It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this Act if:

A. It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder; or

B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4—Unfair Claims Practices Defined

Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

Example

A claim representative tries to reduce claim payments by withholding information or misleading an insured on lesser-known coverages, such as additional living expenses, rental-car coverage, or business interruption.

B. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

Example

A claim representative is too busy to answer telephone messages or to respond to letters from insureds and claimants. A short delay with proper explanations may be tolerated, but some statecodes require telephone contact within forty-eight hours and responses to letters within ten days.

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

Example

Most insurers require claim representatives to contact the parties within twenty-four hours. An insurer without such a rule may violate this provision by failing to adopt reasonable contact standards. Or insurers may have such standards and fail to implement them. For example, even though an insurer has a twenty-four-hour contact rule, claim representatives may know that supervisors never hold them to that standard. In addition, investigations that are unnecessarily prolonged may violate this standard of timely contact or investigation.

D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

Example

An accident occurs for which coverage is available under two policies from two insurers. If the two insurers pass the claim back and forth to avoid making payment even though each is clearly liable for at least a portion of the loss, they have violated this provision.

E. 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;

Example

A claim representative approaches an insured with a settlement offer that is only a fraction of what the claim is worth. This behavior is a blatant violation of the letter and the spirit of the Model Act and can therefore be a basis for a bad-faith claim.

F. Refusing to pay claims without conducting a reasonable investigation;

Example

A claim representative obtains incomplete facts about a loss, decides the damage is not covered, and denies the claim all in one phone conversation with the insured. If a reasonably complete investigation would show that the denial is incorrect, such a denial violates the Model Act.

G. Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

Example

A claim representative sends a coverage question report to claim management, who sends it to a lawyer, then to the home office. If each step takes a week, the process results in a substantial delay, which may be considered unreasonable under the Model Act.

H. Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

Example

An insured sees the terms "guaranteed replacement cost" on an advertising brochure. However, the policy has conditions that restrict the instances in which insureds can receive that benefit. If the difference between what is advertised and what the policy provisions are is too great or misleading, this provision of the Model Act may require the insurer to handle the claim according to what was stated in the advertising instead of the policy provisions. To do otherwise would be considered unreasonable under the Model Act.

I. 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 insured;

Example

After a policy is bound (coverage promised to the insured), the agent realizes that an expensive piece of jewelry requires a limitation on coverage. If the limitation was not explained to the insured prior to the policy being bound, that change in the policy must be promptly communicated to the insured. If not, the insured would be correct in assuming that any loss would be handled without the limitation.

J. Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

Example

A claim representative settles a claim by mailing a check to the insured without an explanation. The claim representative may have mistakenly failed to include an explanation or may have done so deliberately under the assumption that, given an explanation, the insured might have challenged the amount.

K. 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;

Example

An insured files a claim and completes several forms itemizing the damaged property. Several weeks later, the insurer requires the insured to comply with the conditions of the policy by filing a sworn statement and proof of loss that requests the same information already obtained. Redundant requests for information that cause unreasonable delay must be avoided even though a policy may allow for them.

L. 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;

Example

An insured makes a claim for $2,500 for a damaged roof based on an estimate from a contractor. If the claim representative mails a denial letter to the insured but the letter does not provide an explanation of the reasons for the denial of coverage, he or she has probably violated the Model Act. There may be valid reasons for denial, but those reasons must be explained to the insured.

M. Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use;

Example

An insured needs personal property inventory forms to list damaged contents. When the insured requests blank forms from the insurer, the claim representative has fifteen days in which to provide them. This is the only provision in the Model Act in which a specific number of days is stated. Failure to comply with this provision is a violation of the Model Act.

N. 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;

Example

An insurer uses specific glass-replacement shops that provide discounts for the work done for insureds. If these shops do careless work, the insurer must act to improve their quality or discontinue doing business with them.

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