9 – Good-Faith Claims Handling

**1 – Law of Bad Faith**

**Objective**: Determine how the law of bad faith relates to an insurer’s duty of good faith and fair dealing

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. Because interactions with claims representatives are often the only personal contacts that the general public has with an insurer, the claims representative’s action may be closely scrutinized and are often criticized. These criticisms, whether legitimate, can result in bad faith allegations against an insurer.

To avoid bad-faith allegations, claims representatives must understand the law of bad-faith claims. Bad faith law evolved from the special relationship between insurers and insureds based on the implied duty of good faith and fair dealing.

**No** single widely accepted definition of bad faith exists. Black’s Law Dictionary 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 malicious 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.

**Development of the 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 insured’s 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. The insureds alleged that, by wrongfully denying or mishandling their claims, the insurers had failed to fulfill their contractual promise.

In some of these cases, breach of contract remedies were perceived to be inadequate. **The legal remedy for breach of contract is damages in amounts 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 an insurer’s behavior was either fraudulent or outrageous enough to award damages.

Eventually, some courts decided that insurers have an implied duty of good faith and fair dealing when settling claims. Insurer’s failure to comply with this duty can result in a bad-faith claim.

Insureds and claimants continue to seek new bases for bad-faith claims, such as invasion f 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.

Bad-faith claim – a claim that implies or involves actual or constructive fraud, a design to mislead or deceive another, or a neglect or refusal to fulfill some good-faith duty or some contractual good-faith obligation.

**Duty of Good Faith and Fair Dealing**

Most bad-faith claims for breach of implied duty of good faith and fair dealing are 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**

States regulate insurers to protect consumers against illegal business practices and against insurer insolvency because it is in the best interest of the public for insurers to have the financial resources to pay claims. Courts also want to protect the public interest by ensuring that insurers pay claims they owe. Incases 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.

The parties to insurance contracts have unequal bargaining power. Insurer 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 Insurance Services Office’s (ISO) homeowners policy states the following: “We may investigate and settle any claim or lawsuit that we decide is appropriate” **Because insurers control how claims are resolved, courts reason that insurers should be responsible for the outcome of their claims handling if they acted in bad faith. Thus, courts hold insurers to a higher standard of conduct to discourage insurers from abusing their position of power**.

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 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 claims representative’s (and, by extension, the insurer’s) actions constitute bad faith for unintentional mistakes or errors in judgment**. 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 complaint must show that the claims 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 look for signs of “dishonest purpose, moral obliquity, conscious wrongdoing…. Some ulterior motive of ill will partaking of the nature of fraud.” Bad fail may fall somewhere between simple error and outright fraud. Other courts have used terms such as “**arbitrary, reckless, indifferent, or intentional disregard” of a party’s interest to describe bad-faith behaviors.** Because these behaviors are judged on a subjective basis, courts attempt to determine the claims representative’s state of mind at the time that bad-faith acts are alleged to have occurred.

**Claims representatives should understand the subjective interpretation of negligence and gross misconduct. The differences between negligence and gross misconduct is determined by the court’s or jury’s interpretation of the facts**. For example, a claims representatives 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 claims representative. Although the standard of care required varies by jurisdiction, some areas of bad faith, such as the parties to a gad faith claim, are typically the same.

**2 – Parties to a Bad-Faith Claim**

**Objective**: Evaluate the legal rights of these plaintiff types in a bad-faith claim: Insureds; Claimants; Excess insurers

Various types of plaintiffs can bring bad-faith claims – allegations that an insurer has neglected to fulfill its duty – and lawsuits against an insurer. Each type of plaintiff has unique legal rights that dictate how the bad-faith claims process will proceed. Understanding the rights of the parties involved in bad faith claims helps claim representatives and insurers protect themselves.

The insurer is usually the defendant in a bad-faith lawsuit. Most states do not allow bad-faith claims against claim representatives because they are not parties to the contract. However, some states allow claims representatives to be held personally liable for fraud, conspiracy, or other torts. Insureds, claimants, and excess insurers are the plaintiffs in bad-faith claims. State laws may vary on who can sue an insurer for bad faith.

**Insureds**

In a claims context, insureds can allege bad-faith through first-party lawsuits or third-party lawsuits.

**First-Party Lawsuits**

**In a first-party bad-faith lawsuit, the insured sues his or her own insurer for bad faith in handling a claim involving the insured’s personal loss, such as property damage.**

Example: An insured, a long-haul trucker, was involved in an accident that damaged his tractor-trailer. His insurance policy covered the $30,000 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 for almost nine months. The delay occurred because of a series of mistakes and inattention on the insurer’s part, not through any fault of the insured. Because the trucker could not have his truck repaired during that time, he was unable to work and lost seniority status with his employer. He sued his insurer for negligent claims handling, breach of contract, and unfair and deceptive practices. He was awarded $70,000 in damages. The court stated that the 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.”

**Third-Party Lawsuits**

**In a third-party bad-faith lawsuit, the insured sues his or her own insurer for bad faith in handling a third-party claim**. For example, the insurer may have inadequately defended the insured in a lawsuit brought by a third party (the claimant), or the insurer may have conducted an inadequate investigation. If the insured is found liable for a judgement in excess of the policy limits because of these actions, the insured can bring a bad-faith lawsuit against the insurer to try to hold it liable for the excess judgement. Sometimes, the insured might give the third-party claimant the right to file this lawsuit against the insurer. Only certain states allow claimants who are not insureds to sue the insurer directly.

For example, Pedro is involved in a car accident with Mia. Pedro is insured by Insurance Company. The facts of the accident clearly show that Pedro is at-fault. Mia has suffered serious injuries as a result of the accident. Pedro has a $300,000 auto policy limit, and Mia’s attorney offers to settle the case for $300,000. However, insurance Company only offers a $50,000 settlement. Mia sues Pedro for negligently causing the accident and wins $1M judgment. As Pedro only has a $300,000 policy limit, his is now responsible for the remaining $700,000; therefore, Pedro sues Insurance Company for a bad-faith failure to settle Mia’s claim within the policy limits after the original offer. At trial, the court holds that Insurance Company’s failure to respond to settle for the policy limit was bad faith because Insurance Company did not give the insured’s interests as much consideration as its own.

**Claimants**

Can a claimant sue an insurer for bad faith when the claim representative acted n 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.

For example, **an insured can assign rights against the insurer to the claimant. The insured may due this to avoid paying the claimant. In exchange, for the assignment, the claimant generally signs a covenant (an agreement) not to pursue recovery of the excess judgement from the insured**. Essentially, the claimant assumes the insured’s right to sue the insurer for bad faith for the excess judgment, and in return the insured protects assets from the claimant.

In addition, a few states have unfair claims settlement practices acts that allow claimants to sue insurers. Case law has evolved to permit claimants to sue insurer for bad faith in some states.

**Excess Insurers**

Excess insurers write policies, such as umbrella policies, that provide coverage over the limits of the insured’s primary policy. Excess insurance does not pay until the loss amount exceeds the underlying policy limits or the drop-down coverage for certain losses. **If a claimant wins a judgement in excess of the underlying policy limits, the excess insurer must pay the excess up to its policy limits – meaning that excess insurers have an interest in how primary insurers handle claims.** 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 after being harmed by a judgement in excess of the primary policy limits**. For example, a homeowners policy has a liability limit of $300,000, and the excess policy provides another $1M of coverage above the $300,000 limit, meaning the insured has $1.3M in total coverage. There is a covered bodily injury claim against the homeowner, and the primary insurer refuses an offer to settle within policy limits for $300,000. The claimant sues the homeowner and wins an $800,000 judgment. While the excess policy covers this amount, the excess insurer could sue the primary insurer because it did not originally settle for $300,000

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 judgment. By imposing on primary insurers a duty of care toward the excess insurers, courts encourage settlements, keep the premiums for excess insurance low, and create no extra burden for the primary insurer, who is already under an obligation to settle the claim in the insured’s interests.

**Claims representatives who discover that excess insurance could apply to a loss should document that information in the claims file and follow notice and reporting procedures associate with the excess policy**.

**3 – Bases of Bad-Faith Claims**

**Objective**: Examine these bases of bad-faith claims: Claim or coverage denial; Excess liability; Statutory bad faith; Unfair claim settlement practices

While the majority of insurance claims do not result in bad faith, those that do are troublesome and controversial for insurers and claims representatives (reps). Understanding the limited bases on which a bad-faith lawsuit can be brought can help reps avoid these allegations.

An insurer’s claims practices can be used as grounds for a bad-faith claim, and the use of good-faith claims handling practices can help reduce the frequency and severity of an insurer’s exposure. Generally, bad-faith claims arise from several bases:

* Claim or coverage denials
* Excess liability claims
* Statutory bad faith
* Unfair claim settlement practices acts

**Claim or Coverage Denial**

When insureds file claims, they expect their policies to provide coverage for losses. A rep must thoroughly investigate a claim and determine whether the claim is covered. **Sometimes after such an investigation, the rep finds that no coverage applies and denies the claim entirely. In other claims, the rep may find that part of a claim is covered and deny only a portion of it.**

If a claim is either fully or partially denied, **the insured or claimant may retain an attorney to pursue coverage. this increase the possibility of a bad-faith claims because lawyers have a better understanding of actions (such as inappropriate claim denials) that can be the basis for a bad-faith claim**. However, **reps who follow good-faith claims handling practices should not be overly concerned by an attorney’s involvement.**

In some jurisdictions, in an insurer denies coverage and a court finds that coverage does in fact apply, the insurer is liable for the full judgement, regardless of having complied with good-faith claims handling practices. Reps should carefully document their reasons for fully or partially denying a claim because either action can trigger a bad-faith lawsuit.

**Excess Liability Claims**

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

Rather than waiting for a final judgment, some courts allow a settlement in excess of the policy limit to be the basis for the claim. For example, if an insurer refuses to settle a claim 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 withing the policy limits if the insurer had properly handled th 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.

**Sources of Excess Liability Claims**

**Excess Liability claims can arise from several situations, including these:**

* **The insurer refuses the opportunity to settle within policy limits – Before an insurer can be faulted for this, some states require that the claimant offer to settle withing the policy limits. However, other states hold the insurer responsible for exploring whether settling within the policy limits is likely or reasonable.**
* **The insurer refuses to pursue settlement – an insurer can wrongfully refuse to pursue settlement of a claim by denying liability or being negligent. When handling a claim, insurers should use a standard of care that a reasonable person would use in managing his or her own affairs.**
* **The insurer is subject to strict liability – under strict liability, the insurer is liable for any excess settlement or judgement even though the insurer is not at fault. But in reality, only one state has imposed strict liability on insurers for rejecting a reasonable written offer within policy limits; other courts place burdens that have some aspects of strict liability on insurers**. Claim resp should be familiar with the laws and decisions made in states where they work.

**Statutory Bad Faith**

Some states have statutes that specifically define what constitutes insurer’s 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 has a statute providing for recovery of punitive damages, interest, attorney’s fees, and costs when an insured can prove bad faith. Colorado’s bad-faith statutes allow an insured to recover two times the delayed or denied settlement plus attorneys’ fees and costs.

In many states, the criteria for bad-faith liability require more than mere negligence on the part of the insurer. In jurisdictions with bad-faith statutes, claim reps should pay particular attention to the criteria outlined in the statute and the case law interpreting the statute.

**Unfair Claim Settlement Practices**

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

While the acts vary by state, many states base their unfair claim settlement practices on the Unfair Claims Settlement Practices Act, a model act developed by the National Association of Insurance Commissioners (NAIC). This act outlines the activities that are considered unfair claim settlement practices.

**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, reps should treat both insureds and claimants with respect and professionalism.

Some of the actions defined as unfair claims practices relate to failure to act with promptness. For example, in acknowledging claims-related communications, providing forms necessary to present claims (required within fifteen days r a request), investigating and settling claims, and affirming or denying coverage after completion of an investigation. Other relate to failure to adopt and implement standards.

Additional unfair claims practices defined in the act include misrepresenting relevant claims – related facts or policy provisions, failing to settle claims fairly and in good faith, failing to investigate a claim before denying it, offering unreasonably low settlements, delaying investigation or payment by requiring extra paperwork, and failing to provide a reasonable and accurate explanation for claims denial or offers to compromise.

**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 insurance and claims representatives, but to elevate the standard of conduct for claims handling by insurers for the benefit of all involved and to avoid bad-faith claims. However, state insurance commissions can issue statements of charges or violations against insurers, require hearings on those charges, and impose appropriate penalties if the charges are proven.

**The NAIC model act allows regulators to impose one or more of these penalties and sanctions on insurers found guilty of violating the act:**

* **Fines**
* **Interest on an overdue claim payment**
* **Payment of other fees and costs**
* **Injunctions or cease-and-desist orders**
* **Suspension of claims reps or insurer’s license**
* **Revocation of a claim reps 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 rep 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 rep) up to 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 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 through either an administrative boar or 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, sand other have added additional provisions. Regardless, the goals of their provisions support promptness, honesty, responsiveness, fair-mindedness, and even-handedness.

Claim representatives should keep these goals in mind to avoid exposing themselves or their employers to bad-faith claims.

**Bad-Faith Lawsuits Under the Model Act**

Some states allow insureds and claimants to bring lawsuits against insurers for violating the state version of the model act, while other states allow only insureds to bring such suits.

Many state laws either specifically prohibit bad-faith lawsuits based on violations of unfair claim settlement practices act or are silent on the issue. If the law is silent, lawyers pursue bad-faith claims and ask courts to decide.

Violations of the model 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 rep 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 claims 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 arise under other state and federal statutes and regulations.

**4 – Damages For Bad Faith Or Extracontractual Liability**

**Objective:** Describe the damages that can be awarded for bad faith or extracontractual liability

In addition to bad-faith claims arising from improper claim handling, insurers may also face extracontractual liability claims, that is, claims for damages outside the insurance policy.

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 make these payments to the plaintiff:

* Compensatory damages
* Punitive damages
* Lawyers’ fees and court costs
* Prejudgment interest

**Compensatory Damages**

Compensatory damages are a monetary compensation to a victim for har 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.**

**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:**

* **Amount of an excess verdict over policy limits**
* **Verifiable business losses**
* **Expenses associated with filing the lawsuit and participation 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, wonton, or recklessly indifferent for punitive damages to be awarded.**

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

* 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 favorable to 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 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 lawyer’s fees and court costs**. Insureds or claimants incur lawyer’s fees in bringing bad-faith lawsuits. In addition, if the insurer has refused to defend the underlying claim, insureds and claimants may incur lawyer’s fees to defend the underlying lawsuit. In some states, statute or common law allows recovery of such lawyer’s fess as part of damages in bad-faith cases. Even in states without such laws, individual courts may allow recovery of lawyer’s 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 attorney’s 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 judgement 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 the excess judgement 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 reps 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 rep and the insurer must be prepared to defend against these claims.

**5 – Defenses To A Bad-Faith Claim**

**Objective**: Examine the defenses available to an insurer in a bad-faith claim

Insurers faced with bad-faith lawsuits have many defenses. Understanding these defenses can increase claim reps awareness of how to avoid actions that could result in bad-faith claims.

An insurer faced with a bad-faith lawsuit has a choice of several defenses – some that provide a total defense of the claim and some that provide only a partial defense. An insurer that can assert more than one defense is more likely to defeat a bad-faith claim or reduce the amount of damages awarded. Each defense must be analyzed in relation to a specific lawsuit to determine whether it can be used:

|  |  |
| --- | --- |
| Defenses That **Result in Dismissal** of Lawsuit | Defenses That **Reduce Damages** |
| Statute of limitations | Comparative bad faith |
| Lack of right to sue (lack of standing) | Contributory negligence |
| Reliance of lawyers’ advice |  |
| Insured’s collusion with claimant |  |
| Debatable reasonable basis |  |
| Statutory defenses |  |
| Fair dealing and good documentation |  |
| Comparative bad faith |  |

**Statutes of Limitations**

Statutes of limitations apply to bad-faith claims. A court will dismiss a bad faith lawsuit if the time limit specified in the statute of limitations has expired.

Statutory periods vary depending on whether the alleged bad faith is considered a breach of contract or a tort. Statutory periods also vary by state, generally ranging from 2-6 years from the date the bad faith occurs. The claim rep and the insurer’s defense lawyer should check the state law to determine the statute of limitations that apply to a particular bad-faith lawsuit.

Another common issue is starting date of the statutory period. Courts have differed on whether the statutory period for a bad-faith lawsuit begins on the date the insurer denies the claim or otherwise wrongfully withholds benefits or whether it begins on the damage the damages are ascertainable. For example, in excess liability cases, the statute begins when a final judgement in excess of the policy limit is awarded. For a bad faith claim based on an insurer’s refusal to defend an insured, the statute begins when the insurer refuses to defend.

**Lack of Right to Sue (Lack of Standing)**

State laws vary on which parties have the right to sue (also called standing to sue) an insurer for bad faith. Insureds, claimants, and excess insurers all may have standing, depending on state law. The lack of right to sue can be a defense for an insurer if, for example, a claim has been brought by an excess insurer in a state that does not give excess insurers the right to sue.

Several states allow a claimant to bring a bad-faith action directly against the insurer of a tortfeasor. In these states a claimant who has been injured in an auto accident caused by another driver, for example, could sue the insurer of the at-fault driver for bad faith in handling the claim. Claim reps should check with defense lawyers to determine whether the stat in which the handle claims allow direct actions for bad-faith claims.

A claimant or an excess insurer that has no standing to sue under state law may still bring suit if the policyholder assigns the right to sue. In such cases, defense lawyers should ascertain whether the assignment is legal; an illegal or improper assignment can be a valid defense.

**Reliance on Lawyer’s Advice**

An insurer can base its defense against a bad-faith lawsuit on its reliance on the opinions and advice of competent, independent lawyers. This is called the **advice of counsel defense, and it can be used to indicate that the insurer acted reasonable and with proper consideration in handling the insured’s claim. For the defense to be successful, some courts require proof of these assertions:**

* **The insurer disclosed all the facts to the lawyer**
* **The insurer acted or 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 punitive damages. However, this defense may waive attorney-client privilege, meaning the insured can review the file of the insurer’s attorney.

**An 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 claimant may conspire to help the claimant recover an excess judgment and agree to split to proceeds. This type of collusion is more likely when the insured and the claimant have a business or personal relationship.

Collusion can also occur after a court has awarded damages above the policy limits, if the claimant agrees not to collect the judgment from the insured’s personal assets. Courts carefully scrutinize any such agreements before honoring them.

Another potential opportunity for collusion arises from coverage issues. The insured may share the insurer’s reservations of rights letter with the claimant and coach the claimant on how to describe a claim so that it is paid by the insurer and not the insured. Claims representative should look for indicators of possible collusion. For example, the insured’s attitude toward the claimant may suddenly become more favorable. Or the insured may become uncooperative and exhibit lack of concern about possible personal excess exposure. A claim rep who suspects collusion should immediately alert claims management because of potential conflicts of interest between the insurer and insured, as well as coverage issues requiring special handling.

**Debatable Reasonable Basis**

**In a lawsuit for bad-faith refusal to pay a claim, the insurer’s defense may be that it had a reasonable basis for questioning whether the claim was covered**.

For example, a claim rep 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 because 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. To use the debatable question defense, insurers must show that they had reasonable justification in law or fact for denying or delaying payment of the claim**.

In a bad faith claim based on denial of coverage, an insured may file for summary judgment (meaning the case would be decided without a trial taking place) on the grounds that the policy covers the claim and that no factual issues need to be decided by the court. The court’s refusal to grant a summary judgment indicates that factual issue of coverage remain in dispute – in other words, that debatable questions exist. By attempting to resolve this question before making payment, the insurer would not, then have acted in bad faith.

**Statutory Defenses**

Federal and state statutes designate other defenses insurer can use to seek dismissal of bad-faith lawsuit. For example, **some states require insurers to report suspected insurance fraud to the state attorney general’s office.**

**Obviously, there should be no bad-faith claim against the insurer for reporting suspect fraud in good faith if the suspicion is reasonable, so most states offer the insurer immunity from related lawsuits**.

**Fair Dealing and Good Documentation**

**Good-faith claims handling practices and supporting evidence can help defend bad-faith lawsuits by establishing that the insurers have dealt fairly with the insureds and claimants**. **Documentation in each claim file demonstrates how insurers conduct the claims investigation, evaluation, and negotiate claims**.

**Activity logs, correspondence, and documentary evidence, such as police reports, damage estimates, and medical bills, can indicate that claim reps, supervisors, and managers are doing their jobs properly, which is part of a successful defense strategy for a bad-faith claim**.

Before denying a claim, claim reps should have thorough documentation. Investigative attempts should be documented regardless of the results for the insurer. Fair dealing practices and good documentation can also help claim reps explain and correct errors. When an error is discovered, a sincere apology and quick action to correct it can help in avoiding and defending bad-faith claims.

Claim reps should follow their company’s best practices in documenting files, which they should assume will be read to a jury. In addition to requiring thorough documents, these best practices often include avoiding derogatory comments and showing only analyses that are supported by facts.

**Comparative Bad Faith**

**The duty to act in good faith applies to both the insurer and the insured**. So, in a few jurisdictions, evidence that the 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 fails to deal fairly with the insurer by breaching on or more implied duties.

For example, and 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 the insured’s actions prevented the insurer from properly handling or settling the claim may establish comparative bad faith as a defense.

**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.

**6 – Elements of Good-Faith Claims Handling**

**Objective**: Examine the elements of good-faith claims handling

Good faith in claims handling requires an insurer to demonstrate, at minimum, an equal amount of consideration for the insured’s interest as its own. Because this broad concept provide courts with a low of leeway in deciding what constitutes good faith in a given situation, the claims representative must use common sense and good judgment to minimize the potential for bad-faith claims.

**These are some of the primary elements of good-faith claims handling:**

* **Thorough, timely, and unbiased investigation**
* **Complete and accurate documentation**
* **Fair evaluation**
* **Good-faith negotiation**
* **Regular and prompt communication**
* **Competent legal advice**
* **Effective claims management**

Thorough, Timely, and Unbiased Investigation

Investigations that are thorough, timely, and unbiased are the foundation of good-faith claims handling. If claims 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.

**Thorough Investigation**

**Claims reps should collect all relevant and necessary evidence. Investigation should continue as long as new facts develop or become available. Claim reps 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.** In a thorough investigation, the claim rep is alert for new information that may change the course of the claim file.

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, the claim rep discovers from the homeowner’s statement that the visitor was on the premises as a business customer, and coverage may therefore be excluded under the homeowner’s policy. Without the additional investigation, the claim rep might have paid a claim that was not covered by the policy.

Claim reps use their own judgement to determine when an investigation is sufficiently thorough. Example; even if an insurer’s claims handlings guidelines offer guidance about which claims require statements and from which parties, a claim rep may decide that an additional statement is necessary for a specific claim.

Many insurers hire experts to assist in the investigation of the cause of loss and the amount of damages. How an insurer selects such an expert and uses the information they provide can have bad-faith implications. Insurers must make a good-faith effort to find experts who are reputable within their profession and who will provide unbiased evaluations. Insurers may face bad-faith claims for failing to consider an expert’s opinion in denying a claim or for failing to ascertain the unreliability of an expert’s opinion.

**Timely Investigation**

**An insured who makes a claim expects prompt contact from the claim rep. Most insurers have guidelines requiring the claim rep 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 reps 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 inf contacted promptly; prompt contact reassures insureds and claimants that their claims are important and makes them less likely to accept the advise 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 the insurer’s use of good-faith claims handling procedures.

**Unbiased Investigation**

**Investigations should seek to discover the facts and consider all aspects of the claim in order to reach an impartial decision. Claims reps 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 reps should work with service providers that are unbiased and have no conflict of interest.** Courts and juries may not look sympathetically on medical providers or repair facilities that always favor insurers.

While striving for impartiality, claim reps must still be alert to indicators of possible fraud and investigate them thoroughly. Even if the evidence is not sufficient to bring criminal charges, in some states a preponderance of evidence that fraud was committed may be sufficient to defeat a claim. Some states allow claim reps to seek waivers or extensions of statutory deadlines for accepting or rejecting claims so that they can investigate suspected fraud; in such cases, the suspicions must be based on evidence and clearly documented in the file.

**Compliance With Federal Statutes**

When conducting a good-faith claim investigation, claim reps must comply not only with state unfair claim practices act, but also with federal statutes. These statutes, designed to ensure the privacy of confidential information, include the Health Insurance Portability and Accountability Act, which deals with the disclosure of private health information; the Gramm-Leach-Bliley Act, which seeks to protect the security and confidentiality of customers of financial institutions, the Sarbanes-Oxley Act, which imposes financial disclosure requirements on publicly traded companies; and the Fair Credit Reporting Act, which promotes the accuracy and privacy of personal information assembled by credit reporting agencies.

**Complete and Accurate Documentation**

A common saying among claim reps is that if an activity, action, or event is not recorded in the claim file, it did not happen. A claim file must provide a complete and accurate account of all the activities of and actions taken by the claim rep.

**Claims reps should be aware that many people, each with a different purpose, may read a claim file. A supervisor or manager** may read the file to monitor performance or provide guidance. **A home-office examiner or an auditor** may review the file for compliance with claim handling guidelines. **Claims 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 rep 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 file as part of a dispute resolution process. **Claim files should provide complete information for all these purposes**.

**Fair Evaluation**

Fair evaluations are based on facts, not opinions. Claim reps determine a range of claim amounts based on the facts of the claim, the credibility of the evidence, and applicable laws. File documentation showing that the claim rep sued best practices to evaluate a claim is evidence of good-faith claim handling.

Fair evaluation is particularly important in claims, which may result in damages that exceed policy limits. By evaluating liability claims as if no coverage limit existed, claim reps can 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 promptness. Evaluation usually takes place at the conclusion of the investigation, when the claim reps has received all supporting documentation. Compliance with statutory time limits for completion of evaluations of coverage and damages can help reduce the insurer’s exposure to bad-faith claims

Promptness is also important in responding to the claimant, the insured, or their respective lawyer’s demands. If a letter specifies a time limit for reply, the claim rep should make every effort to respond within that limit. If more time is needed, the claim rep should arrange for an extension by telephone, confirm it promptly in a follow up letter or email, and document it in the claim file.

A prompt reply is particularly important to a communication that contains a demand for settlement that is at or near the policy limits. 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 reps has properly evaluated and documented the claim file, this time demand should pose no problem.

Fair evaluations result from thorough, timely, and unbiased investigation and from an understanding of the laws of the jurisdiction in which the claim is brought. For assistance in making evaluations, claim reps can consult with sources inside and outside the insurance company, including co-workers, supervisors and managers, defense lawyers, people who represent a typical jury, and jury verdict research companies.

Many insurance companies use claim evaluation software to determine a claim’s worth. The extent to which an insurer uses claim evaluation software should be balance against the insurer’s duty of good faith and fair dealing which requires each claim be analyzed on its own merits.

**Good-Faith Negotiation**

Good-faith negotiations flow naturally from thorough, timely, unbiased investigations and prompt, fair evaluations.

**Although claim reps 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 reps should 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. Every demand should be documented in the file, along with reasons for accepting or rejecting it.

To resolve disputes over settlement amounts, claim reps should use policy provisions such as arbitration clauses, when applicable. An insurer that adheres to policy provisions and pays the amount determined through arbitration is in a better position to defend a bad-faith lawsuit. Claim reps 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 claims 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 have the most important information about an accident. Regular and prompt communication allows the insured to participate in the defense and in discussions about the possibility of settlement. Correspondence with the insured provides important documentation for the file that can serve as evidence of the insurer’s good-faith claims handling**.

The claim rep has a duty to inform the insured of policy provisions that apply to the claim, rights under the policy, and steps to be taken to get maximum benefits. Additional questions form the insured should be answered promptly. The duty to inform stems from the insurer’s duty of utmost good faith under the insurance contract and is also required under many state’s unfair claims practices.

Communications by and with attorneys in the case is also important. The defense attorney should 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 reps and lawyers should document telephone and personal communication in writing and confirm information from such communications that is crucial to the claim.

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

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 protects its interest. Additionally, if the insured hire a lawyer, that lawyer will want to be kept advised of significant claim activity.

An insurer’s internal organization can influence the efficiency and effectiveness of communications between claim reps and parties to a claim, attorneys, and others. If an insurer centralizes call-handling by using customer service reps to field telephone calls, it should allow call center staff to access claim files so that they can respond to specific questions. Claims reps should be informed of calls relating to claims they handle and should be allowed to contact insureds and claimants directly. Insurers that use mail centers must ensure that correspondence form insured, claimants, or attorneys is delivered to the appropriate claim rep.

**Competent Legal Advice**

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 unproved and can expose the insured and insurer to an excess verdict. Claim reps 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 questions, insurers should avoid conflicts of interest by using lawyers other than defense lawyers hired to defend an insured. Asking a lawyer who defends and insured a coverage question creates an ethical dilemma for the lawyer because the answer may not be the insured’s best interest. Insurers that use in house or staff lawyers 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. Insurers often request independent opinions on claim-related issues from attorneys not involved in the claim. Such opinions can provide impartial analysis of an issue and research about approaches other courts have taken.

**Effective Claims Management**

An insurer’s claims management directly affects a claims rep ability to handle a claim in good faith. Claims management in this context refers to how claims departments are managed by claims supervisors and managers. Claim management involves many duties. Especially crucial to good faith claims handling are consistent supervision, thorough training, and manageable caseloads.

Supervision and managers are responsible for ensuring that claims are investigated, evaluated, and resolved promptly and accurately and that claims reps follow proper claims handling practices. Mangers develop guidelines for claims handling and are ultimately responsible for ensuring that the guidelines are followed. Insurers should provide continuous and consistent training for claim reps relating to all necessary claim handling procedures and best practices as well as to good-faith claims handling. Training is essential when a claim rep handles a new type of claim or more complex, serious claim for the first time. Supervisors and mangers must monitor the number of claims assigned to each claim rep to ensure that the work is manageable. To ensure good-faith claim handling, they should identify potential caseload problems and reassign claims or provide additional support when necessary.

Many insurers hire management or strategic consultants to improve the efficiency of claims handlings. In selecting such consultants, the insurer must make certain that the consultant is aware of the special requirements of the insurance industry.