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"Institutional Bad Faith": The Risks and How to Avoid Them

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Insurers with policyholders in the United States train their claims personnel to avoid the bad faith pitfalls that can transform a minor claim into a major headache. Adjusters are taught to follow the claims procedures; to document their activities; to be prompt and thorough in their investigations; to communicate with the insured frequently and respectfully; to keep management apprised of their decision-making; and to be on the lookout for signs that a policyholder may be setting a bad faith trap. These measures are effective in reducing the risk that a claim handler's misstep might lead to bad faith exposure for the insurer.

However, even impeccable adjuster conduct may not fully insulate the insurer from one type of bad faith exposure: the risk that a court or jury will find that company-wide practices coerced or encouraged its adjusters to deny policyholders the full benefits of their insurance coverage. In cases involving allegations of "institutional bad faith", as such claims have been labeled, the conduct of the individual adjuster, and even the merits of the coverage claim, diminish in importance. The plaintiff in such a case focuses on the insurer as an institution, alleging that its policies, systems, or incentives compel individual adjusters to deny claims or otherwise shortchange policyholders on benefits under an insurance contract.

As dangerous as "traditional" bad faith claims can be, the risks presented by institutional bad faith allegations can be even greater. Because the primary target is the company's policies, such allegations can implicate an insurer's entire way of doing business – expanding the scope of discovery that may be allowed and the evidence that may be admitted at trial. Such evidence may be used to inflame the trier of fact and to play on existing prejudices against the insurance industry. Moreover, because the notion of institutional bad faith purports to implicate an insurer's general approach to claims, an enterprising lawyer can transform a factual case developed for one plaintiff into a blueprint for inexpensive litigation of numerous bad faith claims by others who may be dissatisfied with the resolution of their insurance claims.

This chapter examines claims of institutional bad faith and how they differ from traditional bad faith litigation. It considers the types of company policies and systems that have been argued – and, in some instances, found by courts – to constitute evidence of institutional bad faith. The chapter also discusses the various risks presented to insurers by institutional bad faith claims and, finally, steps insurers can take to limit their exposure. To understand the unique and troubling characteristics of institutional bad faith claims, however, it is helpful first to compare them with their precursor, the traditional bad faith claim.

1. Traditional Bad Faith

In most circumstances and in most states, insurers are not fiduciaries, and are not required to put their insureds' interests above their own. E.g., *St Paul Fire & Marine Ins. Co. v. Onvia, Inc.*, 165 Wn. 2d 122, 130 (2008). Nonetheless, insurers are expected to act with their insured's interests in mind when adjusting claims or defending and settling third party claims. The duty imposed upon insurers is often expressed in terms of a requirement that insurers must place their insureds' interests at the same level as their own interests. A leading third-party bad faith case in New York expresses the standard for the tort of bad faith as "a deliberate or reckless failure to place on equal footing the interests of its insured with its own interests when considering a settlement offer." *Pavia v. State Farm Mut. Auto. Ins. Co.*, 82 N.Y.2d 445 (1993). California utilises the same concept: "[t]o fulfill its implied obligation, an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests." *Frommoethelydo v. Fire Insurance Exchange*, 42 Cal.3d 208, 214-215 (1986).

This standard allows an insurer to take into account its legitimate need to contain costs, and to keep defence and indemnity payments as low as reasonably possible, in order to compete effectively and to make a profit. Further, it allows an insurer to make an honest error without the risk of bad faith liability, so long as it has a legitimate basis for its view that benefits are not owing as a matter of contract. E.g., *Tomaselli v. Transamerica Ins. Co.*, 25 Cal.App.4th 1269, 1280-81 (1994). ("The mistaken withholding of policy benefits, if reasonable or if based on a legitimate dispute as to the insurer's liability under California law, does not expose the insurer to bad faith liability.")

However, if an insurer disregards the insured's legitimate interest in coverage merely in order to save costs, it could be held liable not merely for the coverage that is found owing as a matter of contract, but for consequential damages and, if the insurer's conduct is genuinely egregious, for punitive damages and/or attorneys' fees and costs as well. Common examples of insurer bad faith are:

- ***Liability insurer's failure to settle within policy limits where liability is reasonably clear***. This is the classic example of a bad faith claim, and is premised upon the differing incentives that arise from the insurer's limited exposure to the limits of coverage only, and the insured's exposure to the full amount of the claimant's injury. The bad faith claim, if successful, allows the insured to recover extra-limits liability and thus more closely aligns the interest of the insurer with that of the insured.
- ***Denial of a claim without adequate investigation***. An incorrect coverage decision rendered after a failure to

perform a thorough investigation may support a finding that the denial was sufficiently unreasonable as to expose the insurer to bad faith liability.

- ***Liability insurer's failure to defend***. In most jurisdictions, an insurer's duty to defend arises whenever the underlying complaint gives rise to the possibility of a covered claim. Unreasonable refusal to defend, or inadequate performance of the duty (for example, by refusing to authorise necessary expenses such as for expert witnesses) may give rise to bad faith.
- ***An unfounded failure to pay a covered first-party claim, or imposing improper conditions on payment***. An insurer may fail to pay a covered claim for a number of improper reasons. For instance, *Skaling v. Aetna Ins. Co.*, 799 A.2d 997, 1012 (R.I.2002), the court described first-party bad faith (under Rhode Island law) as the "absence of a reasonable basis in law or fact for denying the claim or an intentional or reckless failure to properly investigate the claim and subject the result to cognitive evaluation". A claims handler may have ignored evidence of coverage, or attempted to cut off the risk of further liability by demanding a release in exchange for paying a clearly covered claim. A claims handler may, on the other hand, have delayed payment in order to improve the appearance of his cash flow figures.

In each of these typical scenarios, the insurer's bad faith exposure would result from a finding of improper conduct with respect to the specific claim: an unreasonable or improperly motivated failure to investigate, defend, settle, or pay. The merits of the individual claim, and its handling by the adjuster and perhaps the immediate claim supervisor, are typically the primary focus of the trier of fact.

2. Institutional Bad Faith

In contrast to the traditional bad faith claim, allegations of institutional bad faith focus less on the actions of the claims adjuster or other personnel who were directly responsible for denial of a contested claim. Rather, they target company or departmental policies and mechanisms that allegedly coerce or incentivise claims staff to deny policyholders the benefits due under their insurance policies. The ostensible rationale for such claims is that an adjuster must make a claims decision strictly on the merits of the claim's facts and circumstances after a proper investigation, but management has allegedly introduced other influences into the decision-making process to cause the adjuster to deny claims for other, improper reasons.

The concept of institutional bad faith grew out of efforts by some insurers to control costs and increase profits in the 1990s, when the consulting firm McKinsey & Company was tasked by certain companies to develop new claims management strategies. McKinsey embraced the idea of the claims department as a profit center. In presenting this concept to Allstate Insurance Company, McKinsey created a now-notorious slide presentation which exhorted Allstate to abandon the claims handling practices suggested by its famous "good hands" claims slogan in favour of an adversarial "boxing gloves" approach. Under McKinsey's strategy, a computerised claims management system would be calibrated to produce claims valuations well below the average of prior valuations, and those amounts would be offered to policyholders on a non-negotiable "take it or leave it" basis. McKinsey estimated that nearly 90 per cent of policyholders, when faced with the prospect of a substantial delay in receiving any benefits, would accept the offer. Under the McKinsey strategy, the "boxing gloves" would be brought out for the other claimants. McKinsey predicted that most would eventually conclude that litigating the coverage claim would be too time-consuming and expensive, and would accept the low offer.

Through discovery in disputed cases, McKinsey's consultations became a matter of public knowledge despite the strenuous efforts of Allstate, which ultimately expended considerable money and effort to defend bad faith claims and mend the reputational harm caused by the McKinsey approach. Partly due to these disclosures, institutional bad faith allegations have proliferated. These claims attack company-wide practices, like the valuation method advocated by McKinsey, that plaintiffs allege are unrelated to accurate claims adjustment and imposed simply to cut payments.

One type of institutional bad faith claim focuses on adjuster compensation, promotion, or perceptions of job security as improper influences on claims decisions. A plaintiff might allege, for instance, that insurance management have dangled before adjusters the prospect of bonuses, raises, or advancement (or, alternatively, adverse job action) as motivation to meet certain targets for reduced benefit payments. Another type involves allegations that an insurer has taken claims decisions out of the hands of individual adjusters by relying on computer models to establish values for given categories of claims instead of individual claim assessments by adjusters. Alternatively, an institutional bad faith claimant may contend that an insurer has adopted a policy of arbitrary reductions in claim payments in order to meet company-wide profit targets. The claimant might allege a corporate goal of transforming the claims department into a profit center, or a department-wide policy of arbitrarily cutting claims payments.

Here are some of the practices that plaintiffs have characterised (and, in some instances, courts have acknowledged) as evidence of institutional bad faith:

- ***"Post-claim underwriting" and use of a "point system".*** In *White v. Continental General Insurance Company*, 831 F. Supp.1545 (D. Wyo. 1993), three insureds claimed that Continental had a policy of reviewing medical histories on insurance applications – and extensively investigating undisclosed pre-existing medical conditions – only after a claim had been made. The insureds presented evidence that Continental operated a point system in which claims personnel were required to earn 100 points daily, and were awarded 2.5 points for each claim paid or denied but 5 points for finding a pre-existing condition that led to denial of a claim. The Wyoming federal court found that this evidence presented a genuine issue of fact as whether Continental was liable for bad faith.
- ***Compensation or promotions tied to reduced claim payments***. A common allegation is that an insurer motivates its staff to deny or undervalue claims by linking employment benefits – a promotion, raise, or bonus – to an adjuster's success in reducing claim payouts. State Farm was sued for bad faith based on evidence that it had set targets for its adjusters aimed at meeting a company goal of having the most profitable claims service in the industry, and that raises and promotions were based on meeting the targets. Although State Farm sought to dismiss the bad faith allegations on the basis that the individual claim it had denied was "fairly debatable", the court found that the evidence was sufficient such that a jury could find that State Farm acted unreasonably. *Zilisch v. State Farm Mutual Automobile Insurance Company*, 995 P.2d 276 (Ari. 2000) (en banc). Other courts have allowed discovery of employee compensation and bonus practices as possible evidence of bad faith. *Niver v. Travelers Ind. Co. of Illinois*, 433 F.Supp.2d 968 (N.D. Iowa 2006); *Grange Mut. Ins. Co. v. Trude and Wilder*, 151 S.W.3d 803 (Ky. 2004).
- ***Quotas to meet profit targets without regard to claim merit***. In *Merrick v. Paul Revere Life Insurance Co.*, 594 F.Supp.2d 1168 (D.Nev.2008), the plaintiff presented evidence that the insurer set targets for claim terminations without regard to the circumstances of individual claims, and punished claim

units that did not meet their quotas. Management also pressured adjusters to meet quotas by posting the company's stock price in the units and updating it throughout each day to remind the claims staff of the effect of their activities on the company's financial performance. A court found these and other practices to be part of a corporate scheme to reduce payments without regard for the merits of individual claims, and the insurer was assessed punitive damages of $26 million.

- ***Rigid adherence to computer-driven claim valuations***. Insureds allege that insurers have committed bad faith by adopting computerised claims management systems to set unduly low mandatory claim values and by coercing adjusters to offer settlements at even lower values. There is nothing inherently improper about using a computerised system to assist adjusters in valuing claims, as long as the adjuster retains the discretion to make changes based on individual circumstances. Courts have refused to find that use of a computer management system would support a finding of bad faith where the adjusters were not bound by computer-generated values. *Milhone v. Allstate*, 289 F. Supp.2d 1089 (D. Ariz. 2003) (settlement offered was higher than the computer-generated value); *Kosierowski v. Allstate Ins. Co.*, 51 F.Supp.2d 583 (E.D. Pa. 1999) (same).
- ***Other alleged institutional claims mandates***. Policyholders have alleged that other corporate practices have been applied in order to arbitrarily drive down claims values, such as setting reserves that deviate from regulatory requirements to achieve unfairly low claim values. Policyholders have also alleged that insurers engaged in bad faith by targeting certain types of claims – such as nervous disorders or soft tissue claims – for aggressive, cost-cutting treatment, or establishing a company-wide policy to offer settlements that are a specific percentage below claims values the insurer internally has assigned. E.g., *Merrick v. Paul Revere Life Insurance Co.*, 594 F.Supp.2d 1168 (D.Nev.2008). It is not bad faith to instruct claims handlers to review categories of claims that lend themselves to fraud or over-valuation. But a court might find bad faith if an insurer imposes standards that require claims handlers to reduce or deny such claims by pre-established percentages.

Traditional and institutional bad faith may be indistinguishable where a claims adjuster's unreasonable conduct on an individual claim is specifically dictated by an unreasonable company policy, such as, for instance, if senior management has directed its claims personnel to deny all claims in a category without investigation. An adjuster might also carry out subtler corporate policies aimed at denying or diminishing rightful benefits of coverage – such a scenario might reveal elements of both traditional and institutional bad faith. However, institutional bad faith allegations are most clearly distinct from traditional bad faith when they attack business practices aimed at legitimately managing costs. Because any insurance organisation will have cost-management policies that touch upon the claims function, any insurer is potentially vulnerable to institutional bad faith litigation.

3. Risks and Costs of Institutional Bad Faith Claims

The risks and costs of such litigation can be substantial, even for an insurer that ultimately prevails in a case or otherwise avoids bad faith liability.

For instance, because institutional bad faith allegations focus on company policies rather than the handling of an individual claim, a court may view the scope of permissible discovery to be much broader than for traditional bad faith claims. Discovery may be ordered into corporate policies that may have only a tenuous link to the claims function, or the handling of other claims which ostensibly have been influenced by such a policy. This increases the costs of defending the claim as well as the risk of disclosing information that can be used (fairly or otherwise) against the insurer.

More important, company-wide discovery could yield information that, though immaterial to the adjuster's handling of the claim at issue, but may nonetheless be deemed admissible at trial as evidence of an ostensibly relevant company-wide policy. A plaintiff's lawyer could portray responsible cost-management practices as part of a scheme by the insurance company to deny benefits due under insurance contracts. Such evidence could distract the trier of fact from assessing the bad faith allegations based on the reasonableness of the adjuster's conduct on the individual claim.

Institutional bad faith litigation can also give rise to a multiplicity of claims. Because a company-wide practice may allegedly affect many policyholders, it is more likely that a single institutional bad faith complaint could be brought by multiple plaintiffs, thus increasing the insurer's potential exposure. Plaintiff's lawyers have publicly discussed the possibility of bringing such claims as class actions on the theory that common issues (i.e., an alleged corporate policy encouraging the denial of claims) would predominate, and have argued that presumptive multiplier limits on punitive damages awards should not be applied in institutional bad faith cases.

An insurer's exposure can also be heightened through a multiplicity of lawsuits. The evidence and arguments assembled for one institutional bad faith case may readily be applied to other claims that allegedly were denied due to the same company-wide practice. With such transferable work product, a plaintiff's lawyer's cost to bring additional cases is reduced, and the lawyer can more easily recruit new plaintiffs. This, of course, translates into a greater risk that the insurer will have to deal with repetitive litigation concerning the same practices.

4. Minimising the Risks of Institutional Bad Faith Claims

Efforts to minimise institutional bad faith risk may be segregated into two categories: (i) strategies to avoid bad faith claims; and (ii) measures to take if an insurer finds itself in institutional bad faith litigation.

a. Prevention

Like any business, an insurer is entitled to implement systems to manage costs. Insurers may properly impose controls on claims handlers that will insure uniform, accurate, and timely claims handling and to ensure, to the extent possible, that only valid claims are paid. Further, they are entitled to utilise bonus and promotion programmes that reward efficiency and accuracy. Allegations of institutional bad faith may arise, however, when controls or incentive programmes have the appearance of rewarding claims handlers for denying, delaying, or reducing claims payments indiscriminately. Insurers can undertake the following steps to minimise the risk that their legitimate business practice could be misconstrued as bad faith.

- Review claims procedures and incentive programmes carefully, and flag any practices that would appear to an outsider to undercut the authority of individual adjusters to handle the claim fairly. Better yet, have a third party review the procedures and programmes.
- For any practice that is flagged, articulate a good-faith

reason, based in the practical realities of claims handling, that the practice is appropriate and does not unfairly affect policyholders. Again, it is a good idea to run the reasoning by a third party as a "reality check".

- If a persuasive good-faith reason for a practice cannot be articulated, change it so it can be justified persuasively. For instance, it would be difficult to provide a credible good-faith rationale for a mandate that claims payments must be reduced purely to meet arbitrary corporate targets. It is not bad faith, however, for an insurer to make projections. Claims projections and targets legitimately based on prior claims experience would be more readily explained than mandatory targets based solely on arbitrary financial goals.
- Prepare written explanations for all claims handling practices and incentives that show their grounding in efficient, good-faith claims handling. Consider including these in training and procedures manuals so that it is clear to adjusters that the practices are to promote sound claims handling and not to meet arbitrary financial targets. Review the manuals and revise them as needed to ensure that no practices are described in a way that could be misinterpreted.
- Ensure that adjuster training and continuing education programmes include content on the duty of good faith and fair dealing, the requirements of claims settlement statutes, and the risks of violating these obligations.
- Make sure that, under claims procedures, adjusters have the authority to deviate from set rules, in consultation with management if appropriate, in order to deal fairly with the policyholder. The use of a computerised claim valuation programme is not bad faith as long as adjusters are free to depart from its output. It may be beneficial to include in training or procedures manual statements to confirm that computerised systems are there to aid each adjuster's exercise of judgment, not to substitute for it.

b. In litigation

If an insurer is sued for institutional bad faith, the following strategies may be employed to manage the scope of the proceeding and the risk of follow-on litigation:

- Make an early motion to dismiss or narrow the claim based on a lack of nexus between the alleged institutional practice and the handling of the specific claim at issue. Several insurers have successfully contended that an alleged company-wide practice, even if in effect, did not prevent the claims handler from providing the individualised claims handling that the insured was entitled to. See *Milhone v. Allstate*, 289 F. Supp.2d 1089 (D. Ariz. 2003); *Montoya Lopez v. Allstate Insurance Company*, 282 F.Supp.2d 1095 (D. Ariz. 2003); *Knoell v. Metropolitan Life Insurance Company*, 163 F.Supp.2d 1072 (D.Ariz. 2001); and *Kosierowski v. Allstate Insurance Co.*, 51 F.Supp.2d 583 (E.D. Pa. 1999).
- Consider asking the court to bifurcate the litigation so that bad faith issues are only addressed after there has been a resolution of insurance coverage issues. The coverage/breach of contract issue itself may be relatively narrow in scope – perhaps the facts of the claim are largely undisputed and need only be applied to the four corners of the insurance policy. The court might be persuaded of the efficiency of bifurcation, particularly if the plaintiff is pressing for costly, far-reaching discovery to develop institutional bad faith allegations. Apart from efficiency, deferring bad faith issues would allow the insurer to negotiate settlement in the coverage phase without a bad-faith Sword of Damocles hanging over it.
- Resist the plaintiff's efforts to take discovery regarding company policies having a doubtful connection to claims handling. A recurring theme in resisting discovery and otherwise defending the claim should be that the plaintiff is pursuing "institutional" theories because there is no evidence the individual claim was handled improperly. Also point out the cost of company-wide discovery having dubious relevance. Consider proposing that the court review materials *in camera* to dispel any skepticism about their irrelevance.
- Negotiate or move for a protective order to protect discovery materials from being used or disclosed outside of the litigation. The goal would be to prevent plaintiff's counsel or other lawyers from having a ready-made discovery bundle to use in other bad faith cases against the insurer.
- Make sure claims management and senior management are on board to assist in defending the claim. They must commit to devoting the time necessary to help defense counsel formulate strategy, to assist with factual development, and to prepare to testify at deposition and/or trial. Management witnesses will have to explain and justify the corporate practice. If they do not do it well when they testify in the first case, they may have to revisit their mistakes if the insurer is sued again for the same practice.

5. Conclusion

The prospect of institutional bad faith litigation can serve as a useful deterrent for an insurer that might otherwise be tempted to implement systems designed to reduce claims payouts indiscriminately. However, its focus on company policies rather than the adjuster's individual conduct makes such litigation susceptible to misuse: a plaintiff can unfairly attack an insurer's legitimate systems and controls – designed to ensure accurate, consistent cost-effective claims handling – as an alleged engine of bad faith. As the foregoing discussion shows, however, an insurer can act to minimise this risk. It can vet its systems to ensure that no claims-related policies could reasonably be construed to encourage unfair treatment of policyholders. It can clearly document why that is the case. Moreover, if the insurer nonetheless is sued for bad faith, it can adopt the litigation strategies outlined above to limit costly and unfairly prejudicial disclosures, and to maintain the court's focus on what should be the ultimate question: whether the adjuster acted reasonably and fairly in handling the individual claim.

Acknowledgment

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Lewis Baach is recognised in *Chambers USA* (2008-2011) as one of the top law firms for insurance matters.

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