I. Regulatory Requirements

A. Timing for Responses and Determinations

Rule 43 of the Rules and Regulations of the Arkansas Insurance Department, effective January 1, 2001, defines “certain minimum standards which, if violated with such frequency as to indicate a general business practice, will be deemed to constitute unfair claim settlement practices.” The Rule is promulgated pursuant to the authority granted by sections 23-66-201 et seq., 23-76-103, 23-76-119, and 23-94-204 of the Arkansas Code Annotated. Rule 43 generally requires acknowledgement of a claim within 15 days and a complete investigation within 45 days. Any prolonged negotiation over settlement must be accompanied by notice that the statute of limitations may be running. Releases should not extend beyond the claim that gives rise to the settlement payment. There are numerous other requirements that should be consulted and incorporated into claims handling procedures.

B. Standards for Determinations and Settlements

Claims handling standards are set forth in the above Rule 43 of the Rules and Regulations of the Arkansas Insurance Department. Standards for prompt investigation of claims are set forth in Section 8 of Rule 43. Standards for prompt, fair and equitable settlements applicable to insurers are set forth in Section 9 of Rule 43. Standards for prompt, fair and equitable settlements applicable to private passenger automobile insurance are set forth in section 10 of Rule 43. Sections 8 to 10 do not apply to persons that are defined as Health Carriers under Section 5(m) of Rule 43. In addition, Section 9 does not apply to surety and fidelity insurance, or mortgage guaranty, or other forms of insurance offering protection against investment risks. Rule 85 addresses recoupment of overpayments. As of May 1, 2006, health insurers can only recoup the overpayments made to providers for eighteen months after the payment.
C. Privacy Protections (In addition to Federal Gramm-Leach-Bliley Act)

Rule and Regulation 77 (Standards for Safeguarding Customer Information) of the Arkansas Insurance Department establishes standards for developing and protecting insurance customer information. The Rule is promulgated pursuant to the authority granted by sections 23-61-108, 23-61-113, 23-66-207, 25-15-203-204 of the Arkansas Code Annotated, and other applicable laws of rules. This rule was enacted in compliance with the federally-mandated Gramm-Leach-Bliley Act passed by the United States Congress.

II. Principles of Contract Interpretation

"The terms of an insurance contract are not to be rewritten under the rule of strict construction against the company issuing it so as to bind the insurer to a risk which is plainly excluded and for which it was not paid. Although we construe ambiguous provisions in favor of the insured, the issue whether a contract is ambiguous is a question of law for the court to resolve, and an ambiguity will be found ‘only when a provision is susceptible to more than one reasonable interpretation.’ As Justice George Rose Smith once put it, ‘an insurance contract is to be construed strictly against the insurer; but where the language is unambiguous, and only one reasonable interpretation is possible, it is the duty of the courts to give effect to the plain wording of the policy." Unigard Sec. Ins. Co. v. Murphy Oil, USA, 331 Ark. 211, 221-22, 962 S.W.2d 735 (1998) (internal citations omitted) (emphasis in original).

III. Choice of Law

When the insurance policy does not contain an effective choice-of-law provision, the Arkansas Supreme Court applies a most-significant-relationship analysis. The Court looks to five factors to determine which state has the most significant relationship to a particular case: "(1) the place of contracting; (2) the place of negotiation of the contract; (3) the place of performance; (4) the location of the subject matter of the contract; (5) the domicile, residence, nationality, place of incorporation and place of business of the parties." Scottsdale Ins. Co. v. Morrow Land Valley Co, LLC, 2012 Ark. 247, 411 S.W.3d 184, 189 (Ark. 2012).

IV. Extra-contractual Claims Against Insurers: Elements and Remedies

A. Bad Faith

1. First Party

Arkansas law recognizes a tort cause of action for bad faith.

To establish first party bad faith (‘FPBF”), the insured must establish first, that he
has sustained damages; second, that the defendant insurance company was guilty of bad faith in an attempt to avoid liability under its policy; and, third, that such conduct proximately caused damage to the plaintiff. Bad faith is not the mere failure or refusal to pay a claim. It requires affirmative misconduct, without a good faith defense. Furthermore, the affirmative misconduct must be dishonest, oppressive, or malicious. Malicious is defined as an action carried out with a state of mind characterized by hatred, ill will, or a spirit of revenge. *Aetna Cas. & Sur. Co. v. Broadway Arms Corp.*, 281 Ark. 128, 664 S.W.2d 463 (1983); *see also* AMI 406.

The Arkansas appellate courts have attempted to define the parameters of FPBF and have provided some general guidelines. “[M]ere refusal to pay a claim does not constitute the first party tort of bad faith when a valid controversy exists with respect to liability on the policy.” *Cab v. Ark Mun. League Mun. Health Benefit Fund*, 285 Ark. 419, 422, 688 S.W.2d 720 (1985), “Real and honest” disagreements over coverage cannot support a claim of FPBF. *Stevenson v. Union Standard Ins. Co.*, 294 Ark. 651, 654-55, 746 S.W.2d 39 (1988). A showing of pressure to settle does not automatically create a jury question in FPBF cases. *Id.* at 655. A failure to investigate or a delay in investigating is not the kind of affirmative conduct required for a successful claim of FPBF. *Reynolds v. Shelter Mut Ins. Co.*, 313 Ark. 145, 148-49, 852 S.W.2d 799 (1993). Negligence or gross ignorance cannot support a claim of FPBF. *First Marine Ins. Co. v. Booth*, 317 Ark. 91, 95, 876 S.W.2d 255 (1994). Acts done after a suit alleging FPBF has been filed cannot support the claim, though “dogged insistence on misapplying [pertinent case law] could provide tangible evidence of bad faith [were it to occur] before [the] action was filed.” *Parker v. S. Farm Bureau Ins. Co.*, 326 Ark. 1073, 1084-85, 935 S.W.2d 556 (1996).

The greatest danger of bad faith liability in Arkansas arises from some interaction between the insurer or its agent and the insured. Recovery is rare when there merely has been a denial based on some interpretation of policy language or events giving rise to eligibility. *See, e.g.*, *Cincinnati Life Ins. Co. v. Mickles*, 85 Ark. App. 188, 201, 148 S.W.3d 768, 777 (2004) (bad faith may arise from attempt to avoid just obligation to insured, as well as attempt to avoid liability under a policy). In *Mickles*, there was evidence that the insurance company altered the insured’s application, lied to the insured about the identity of the enrolling agent, referred (in correspondence to the State Insurance Department) to the insured’s misrepresentations despite having knowledge that there had been no such misrepresentations, and failed to investigate the circumstances of the case after learning of the lies to the insured. *Id.* The appellate court affirmed a punitive damage verdict of $1 million against the insurer. Later the appellate court sustained a punitive damages award against the agent, subject to a remittitur of the verdict to $750,000 instead of the $2 million awarded. *Aon Risk Servs. v. Mickles*, 96 Ark. App. 369, 242 S.W.3d 286 (2006).

verdict was upheld based on evidence that the insurance company altered records to make it appear that the policy had lapsed when it had not and that the insurance company deceived the insured into signing a statement acknowledging that his premium payment was not timely. *Id.* at 32-33.

The Arkansas Supreme Court next upheld a verdict in favor of an insured in *Viking Ins. Co. v. Jester*, 310 Ark. 317, 836 S.W.2d 371 (1992). In *Viking*, the insurance company appeared to take advantage of an uneducated insured in appraising the value of her damaged automobile. The insurance company called the insured at work. When the insured returned the call after work, she explained that the mill where she worked only allowed emergency phone calls, that when she received calls at work it scared her because she assumed there was an emergency, and asked the insurance company to not call her there. The insurance company representative replied that “Oh, well, that just sounds like a personal problem to me.” *Id.* at 321-22.

The insurance company then phoned the insured at work again a week later. This call angered the insured’s boss. After work, the insured returned the call and the insurance company representative told the insured that the car dealership’s appraisal was high because he was “expecting you to [bargain] [him] down.” The insured was also told that she “did not know how big business is handled” and that she was “just a dumb broad from a hick town in Arkansas.”

The trial court refused to direct a verdict for the insurance company, and the jury returned a verdict in the insured’s favor. The Arkansas Supreme Court affirmed, finding that “there was evidence indicating that the claims representative dealt dishonestly with the plaintiff in the appraisal value of her car, and at the same time, was oppressive in calling her at the mill, abusive in her language, and coercive in dealing with her insured. In addition, there was evidence implying that the [insurance company] converted the wrecked car in order to place the [insured] under pressure to settle.” *Id.* at 328.

The Arkansas Supreme Court again upheld a jury verdict in favor of an insured in *Southern Farm Bureau Cas. Ins. Co. v. Allen*, 326 Ark. 1023, 934 S.W.2d 527 (1996). The evidence before the jury included two conversations between the insurance company’s agent and the insured in which the jury could have inferred that the insurance company lied about the coverage available under the policy and actively concealed the coverage from him. *Id.* at 1027-28.

The Arkansas Supreme Court next upheld a jury verdict in favor of an insured in *Columbia Nat’l Ins. Co. v. Freeman*, 347 Ark. 423, 64 S.W.3d 720 (2002). The court found that there was sufficient evidence of each of the following acts for a jury to decide that they had been committed by the insurance company and that each of the following acts would be evidence of bad faith: (1) failing to pay covered ongoing business expenses; (2) failing to provide a temporary business location for the insureds after agreeing to provide one; (3) failing to comply with an agreement as to the cost of
building repairs; (4) altering of the insured’s claim file; (5) falsely accusing the insureds of being uncooperative and threatening to reduce the settlement offer; and (6) indicating to the insureds that their hiring of an attorney had “complicated” matters. Id. at 430-31. The court upheld the verdict based on this evidence finding that it could “constitute[] oppressive conduct carried out with a state of mind characterized by ill will.” Id. at 431.

2. Third Party.

In Southern Farm Bureau Cas. Ins. Co. v. Parker, 232 Ark. 841, 341 S.W.2d 36 (1960), the Arkansas Supreme Court approved a set of jury instructions that set out the elements of a claim of third party bad faith (“TPBF”): (1) that the underlying claim could have been settled within the policy limits; (2) that the insured demanded that the insurance company settle the case and the insurance company refused; (3) that a verdict in the underlying case resulted in the insured being forced to pay the portion of the verdict which exceeded the policy limits; and (4) that the refusal to settle was negligence. Id. at 845. The court also held that there may be liability when an insured proves either negligence or bad faith. Id. at 847. Moreover, the court held that, under a standard duty to defend clause, the insurance company becomes “a fiduciary to act, not only for its own interest, but also for the best interest of [the insured].” Id. at 849.

The question of liability in TPBF cases largely turns on who is examining the conduct of the insurance company and its attorney. If a court is ruling on a summary judgment or sitting as fact finder, it will be more hesitant to second guess the insurance company or its attorney, while a jury will have little compunction in finding the insurance company liable. Compare McChristian v. State Farm Mut. Auto. Ins. Co., 304 F. Supp. 748, (W.D. Ark. 1969) (granting bench trial verdict in favor of insurance company); Greer v. Mid-West Nat’l Fire & Cas. Ins. Co., 305 F. Supp. 352, (E.D. Ark. 1969) (granting bench trial verdict in favor of insurance company); Great Am. Ins. Co. v. Ratliff, 242 F. Supp. 983, (E.D. Ark. 1965) (granting summary judgment in favor of insurance company); Dreyfus v. St. Paul Fire & Marine Ins. Co., 238 Ark. 724, 384 S.W.2d 245 (1964) (affirming summary judgment in favor of insurance company) with Southern Farm Bureau Cas. Ins. Co. v. Jackson, 346 F.2d 484, (8th Cir. 1965) (affirming jury verdict in favor of insured); Southern Farm Bureau Cas. Ins. Co. v. Mitchell, 312 F.2d 485, (8th Cir. 1963) (affirming jury verdict in favor of insured); Southern Farm Bureau Cas. Ins. Co. v. Parker, 232 Ark. 841, 341 S.W.2d 36 (1960) (affirming jury verdict in favor of insured). It should also be noted that, based on this limited survey, an insurance company’s chances for success in defending a claim of TPBF appear to rise considerably if the case is in federal court rather than state court.

In sum, these cases are very fact intensive and their outcomes vary widely.

3. Damages

Plaintiff would be entitled to recover under tort law all damages proximately
caused by the insurer’s conduct, including punitive damages.

B. Fraud

Elements of Fraud:

1. The defendant has made a false representation of material fact;

2. The defendant knows that the representation is false or does not have a sufficient basis of information to make it;

3. The defendant intends to induce the plaintiff to act or refrain from acting in reliance upon the representation;

4. The plaintiff justifiably relies upon the representation; and

5. The plaintiff suffers damages as a result of the reliance.


C. Elements of Intentional Infliction of Emotional Distress and Outrage

In order to sustain a claim for outrage, or intentional infliction of emotional distress, the defendant’s conduct must be so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and be regarded as atrocious and utterly intolerable in a civilized society. *Fuqua v. Flowers*, 341 Ark. 901, 20 S.W.3d 388 (2000); *M.B.M Co. v. Counce*, 268 Ark. 269, 596 S.W.2d 681 (1980). Initially, the trial court must determine whether conduct may reasonably be regarded as so outrageous as to permit recovery. *Givens v. Hixon*, 275 Ark. 370, 631 S.W.2d 263 (1982); *Davis v. Tn-State Mack Distributors, Inc.*, 981 F.2d 340 (8th Cir. 1992). Once this determination has been made, the plaintiff must demonstrate the following elements: “(1) the defendant intended to inflict emotional distress or knew or should have known that emotional distress was the likely result of his conduct; (2) the conduct was ‘so extreme and outrageous,’ was ‘beyond all possible bounds of decency,’ and was ‘utterly intolerable in a civilized community’; (3) the actions of the defendant were the cause of the plaintiff’s distress; and (4) the emotional distress sustained by the plaintiff was so severe that no reasonable person could be expected to endure it.” *Crockett v. Essex*, 341 Ark. 558, 563-564, 19 S.W.3d 585 (Ark. 2000) (citing *Angle v. Alexander*, 328 Ark. 714, 945 S.W.2d 933 (1997). “The type of conduct that meets the standard for outrage must be determined on a case-by-case basis”, and the Arkansas Supreme Court has stated that proof to establish this tort must be “clear cut.” *Hollomon v. Keadle*, 326 Ark. 168, 931 S.W.2d
D. **State Consumer Protection Laws, Rules, and Regulations**

The Arkansas Deceptive Trade Practices Act, Ark. Code Ann. § 23-66-201 to -214, regulates trade practices in the business of insurances, and forbids misrepresentation as to benefits, terms, dividends, or shares of surplus, unfair ethnic or gender discrimination, and unfair claims settlement practices. Unfair settlement practices include misrepresenting facts and failure to acknowledge and respond promptly to communication. Arkansas Insurance Department Rule 43, effective January 1, 2001, provides specific guidance, in the form of standards for prompt, fair and equitable settlement. It is an unfair trade practice to refer an individual to the state comprehensive health insurance pool for the purpose of separating that person from group coverage. Ark. Code Ann. § 23-79-513.

E. **State Class Actions**

Class actions may be brought in Arkansas pursuant to Rule 23 of the Arkansas Rules of Civil Procedure. Rule 23 provides in relevant part that, “[o]ne or more members of a class may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.”

A “class” under Rule 23 exists when the factors above are satisfied and “the court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy.” *BNL Equity Corp. v. Pearson*, 340 Ark. 351, 10 S.W.3d 838 (2000).

V. **Defenses in Actions Against Insurers**

A. **Misrepresentations/Omissions: During Underwriting or During Claim**

Courts may consider rescission of contracts when there is the presence of mistake, fraud and other instances where enforcing the instruments would be inequitable or unjust. *American Ins. v. Mountain Home Sch. D.* 9, 300 Ark. 547, 780 S.W.2d 557 (1989).

An insurance policy will be void if a material misrepresentation, which was relied upon by the insurance company, is made on an application for coverage. An insurance carrier has no duty to investigate the accuracy of the facts as set forth in an application. The good faith or lack of knowledge by the insured of the misrepresentations is

Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent recovery under the policy of contract unless either:

(1) Fraudulent; or

(2) Material either to the acceptance of the risk or the hazard assumed by the insurer.


B. Preexisting Illness or Disease Clauses

Pending implementation of the Patient Protection and Affordable Care Act of 2010, a policy of insurance under Arkansas is nothing more than a contract and is to be governed by the ordinary rules for contract interpretation when it comes to preexisting conditions. A common sense approach should be used, and courts are required to strictly interpret exclusions to insurance coverage and to resolve all reasonable doubts in favor of the insured. Entertainment Innovators. Inc. v. Scottsdale Ins. Co., 839 F.Supp.654 (W.D. Ark. 1993).

As set forth in State Nat'l Life Ins. Co. v. Stamper, 228 Ark. 1128, 312 S.W.2d 441 (1958), the weight of authority is that:

The sickness should be deemed to have had its inception at the time it first manifested itself or became active, or when sufficient symptoms existed to allow a reasonably accurate diagnosis of the cause, so that recovery can be had, even though the disease, germs or infections was [sic] present in the body prior to the excluded time, if the condition was latent, inactive, and perhaps not discovered.

Before an illness or condition can be said to be excluded for the reason that it pre-existed the policy, there must at least have been sufficient manifestation of it to make the insured seek a diagnosis, and it must be of such a nature that a reasonably accurate diagnosis could have been made with reasonable medical certainty. Old Equity Life Insurance Co. v. Crumby, 241 Ark. 982, 411 S.W.2d 292 (1967).

However, it has been held that a condition was excluded under a pre-existing condition exclusion, even though the symptoms were allegedly insufficient to allow a reasonably accurate diagnosis prior to the policy’s effective date. Kirk v. Provident Life & Acc. Ins. Co., 942 F.2d 504 (8th Cir. 1991).
C. Statutes of Limitation


VI. Beneficiary Issues

A divorce does not effect a de facto or constructive change of beneficiary, and when insurance policies are not addressed in a divorce decree, the rights of designated beneficiaries of the contracts of insurance are determined in accordance with contractual law without regard to the effect of a divorce between the insured and the beneficiary. Kent v. USAble Life, 84 Ark. App. 359, 361, 141 S.W.3d 895 (2004).