Recent Developments in Insurance Court Decisions and Regulatory Issues

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I. “Bad Faith” state-by-state update

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<td>AK</td>
<td>The tort of bad faith requires that the insurance company’s refusal to honor a claim be made without a reasonable basis.</td>
<td>Ennen v. Integon Indem. Corp., 268 P.3d 277 (2012); see also Gov’t Emples. Ins. Co. v. Gonzalez, 403 P.3d 1153 (2017).</td>
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<td>AL</td>
<td>The plaintiff in a &quot;bad faith refusal&quot; case has the burden of proving: (a) an insurance contract between the parties and a breach thereof by the defendant; (b) an intentional refusal to pay the insured's claim; (c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason); (d) the insurer's actual knowledge of the absence of any legitimate or arguable reason; (e) if intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim. In short, the plaintiff must go beyond a mere showing of nonpayment and prove a bad faith nonpayment, a nonpayment without any reasonable ground for dispute. Or, stated differently, the plaintiff must show that the insurance company had no legal or factual defense to the insurance claim.</td>
<td>Nat'l Ins. Ass'n v. Sockwell, 829 So. 2d 111 (2002); see also Madison Cty. v. Evantson Ins. Co., 2018 U.S. Dist. LEXIS 187673 (N.D. Ala. 2018).</td>
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<td>AR</td>
<td>The standard for establishing a claim of bad faith is rigorous and difficult to satisfy. In order to state a claim for bad faith, one must allege that the defendant insurance company engaged in affirmative misconduct that was dishonest, malicious, or oppressive.</td>
<td>Unum Life Ins. Co. of Am. v. Edwards, 362 Ark. 624 (2005).</td>
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<td>AZ</td>
<td>The tort of bad faith arises when the insurance company intentionally denies, fails to process, or pay a claim without a reasonable basis for such action.</td>
<td>Noble v. National American Life Insurance Co., 128 Ariz. 188 (1981).</td>
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<td>CO</td>
<td>Evidence of intent, such as intentional misconduct, actual dishonesty, fraud, or concealment is not a prerequisite to recovery on a claim of bad faith breach of an insurance contract. It is the affirmative act of the insurer in unreasonably refusing to pay a claim and failing to act in good faith, and not the condition of nonpayment, that forms the basis for liability.</td>
<td>Farmers Group, Inc. v. Trimble, 691 P.2d 1138 (1984); see also TBL Collectibles, Inc. v. Owners Ins. Co., 285 F. Supp. 3d 1170 (D. Colo. 2018).</td>
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<td>CT</td>
<td>To constitute a breach of the implied covenant of good faith and fair dealing, the acts by which a defendant allegedly impedes the plaintiff’s right to receive benefits that he or she reasonably expected to receive under the contract must have been taken in bad faith. Bad faith in general implies both actual or constructive fraud, or a design to mislead or deceive another, or a neglect or refusal to fulfill some duty or some contractual obligation, not prompted by an honest mistake as to one’s rights or duties, but by some interested or sinister motive. Bad faith means more than mere negligence; it involves a dishonest purpose. Accordingly, because the covenant of good faith and fair dealing only requires that neither party to a contract do anything that will injure the right of the other to receive the benefits of the agreement, it is not implicated by conduct that does not impair contractual rights.</td>
<td>Capstone Bldg. Corp. v. Am. Motorists Ins. Co., 308 Conn. 760 (2013).</td>
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<td>FL</td>
<td>Fla. Stat. Ann. § 624.155 provides remedies for both first- and third-party causes of actions. Section 624.155 provides that an insurer has acted in bad faith if it has not attempted in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for the insured’s interest.</td>
<td>State Farm Mut. Auto. Ins. Co. v. Laforet, 658 So. 2d 55 (1995).</td>
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<td>GA</td>
<td>Penalties for bad faith are authorized where the insurance company does not have reasonable grounds to contest the claim and there is no dispute question of fact.</td>
<td>Lee v. Mercury Ins. Co., 343 Ga. App. 729 (Ct. App. 2017).</td>
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<td>HI</td>
<td>The applicable standard for a first-party bad faith claim has been articulated as follows: The insured need not show a conscious awareness of wrongdoing or unjustifiable conduct, nor an evil motive or intent to harm the insured. An unreasonable delay in payment of benefits will warrant recovery for compensatory damages. However, conduct based on an interpretation of the insurance contract that is reasonable does not constitute bad faith. Further, where an insurer denies the payment of no-fault benefits based on an open question of law, there is obviously no bad faith on the part of the insurer in litigating that issue.</td>
<td>Willis v. Swain, 219 Haw. 478 (2013)</td>
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<td>IA</td>
<td>To establish an insurer’s bad faith, the plaintiff is required to prove: (1) the insurer had no reasonable basis for denying the plaintiff’s claim or for refusing to consent to settlement; and (2) the insurer knew or had reason to know that its denial or refusal was without reasonable basis.</td>
<td>Bellville v. Farm Bureau Mut. Ins. Co., 702 N.W. 2d 468 (2005).</td>
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<td>ID</td>
<td>To recover on a bad faith claim under Idaho law, the insured must show: &quot;1) the insurer intentionally and unreasonably denied or withheld payment; 2) the claim was not fairly debatable; 3) the denial or failure to pay was not the result of a good faith mistake; and 4) the resulting harm is not fully compensable by contract damages.</td>
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<td>IL</td>
<td>While the insurance company, in determining whether to accept or reject an offer of compromise, may properly give consideration to its own interests, it must, in good faith, give at least equal consideration to the interests of the insured and if it fails so to do it acts in bad faith.</td>
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<td>IN</td>
<td>An insurer that denies liability knowing there is no rational, principled basis for doing so has breached its duty. To prove bad faith, the plaintiff must establish by clear and convincing evidence that the insurer had knowledge that there was no legitimate basis for denying liability.</td>
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<td>KS</td>
<td>In deciding whether the insurer’s refusal to settle constituted a breach of its duty to exercise good faith the following factors should be considered: (1) the strength of the injured claimant’s case on the issues of liability and damages; (2) attempts by the insurer to induce the insured to contribute to a settlement; (3) failure of the insurer to properly investigate the circumstances so as to ascertain the evidence against the insured; (4) the insurer’s rejection of advice of its own attorney or agent; (5) failure of the insurer to inform the insured of a compromise offer; (6) the amount of financial risk to which each party is exposed in the event of a refusal to settle; (7) the fault of the insured in inducing the insurer's rejection of the compromise offer by misleading it as to the facts; and (8) any other factors tending to establish or negate bad faith on the part of the insurer.</td>
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<td>KY</td>
<td>A plaintiff must establish the following: (1) the insurer must be obligated to pay the claim under the terms of the policy; (2) the insurer must lack a reasonable basis in law or fact for denying the claim; and (3) it must be shown that the insurer either knew there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed.</td>
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<td>LA</td>
<td>To prevail under 22:1892(B)(1), the claimant must establish that the insurer received satisfactory proof of loss, failed to pay the claim within the applicable statutory period, and that the failure to timely tender a reasonable amount was arbitrary and capricious.</td>
<td><em>Henderson v. State Farm Mut. Auto Ins. Co.</em>, 244 So. 3d 576 (Ct. App. 2017).</td>
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<td>MS</td>
<td>In Mississippi, a judge must find (1) that the insurance company did not have a &quot;legitimate or arguable reason to deny payment of the claim&quot; and (2) that the plaintiff made a &quot;showing of malice, gross negligence, or wanton disregard of the rights of the insured.&quot;</td>
<td><em>Vaughn v. Monticello Ins. Co.</em>, 838 So. 2d 983 (2001).</td>
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<td>MT</td>
<td>Where liability resulting from an automobile accident is reasonably clear, and a third-party claimant's damages undisputedly exceed mandatory minimum policy limits pursuant to § 61-6-103, MCA, the prompt, fair, and equitable settlement of such claims cannot be forestalled by an insurer based on an illusory bad faith or breach of contract claim that its insured may bring. To refuse payment based on such unfounded potential liability is, in and of itself, a deceptive practice within the meaning of § 33-18-201(6), MCA.</td>
<td><em>Watters v Guaranty Nat'l Ins. Co.</em>, 2000 MT 150 (2000).</td>
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<td>NV</td>
<td>Bad faith is established where the insurer acts unreasonably and with knowledge that there is no reasonable basis for its conduct.</td>
<td><em>Colony Ins. Co. v. Colo. Cas. Ins. Co.</em>, 2018 U.S. Dist. LEXIS 111818 (D. Nev. 2018)</td>
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<td>OK</td>
<td>Under Oklahoma law, the essential elements of a bad faith claim are as follows: &quot;(1) claimant was entitled to coverage under the insurance policy at issue; (2) the</td>
<td><em>Inks v. USAA Gen. Indem. Co.</em>, 2018 U.S. Dist. LEXIS 131337 (N.D. Okla. 2018).</td>
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<td>PA</td>
<td>The PA Superior Court defines bad faith on the part of an insurer as “any frivolous or unfounded refusal to pay proceeds of a policy.” Accordingly, to succeed on a bad faith claim, “a plaintiff must allege that the insurer (1) did not have a reasonable basis for denying benefits under the policy; and (2) knew or recklessly disregarded its lack of reasonable basis in denying the claim.”</td>
<td>Kiessling v. State Farm Mut. Auto. Ins. Co., 2019 U.S. Dist. LEXIS 24085 (E.D. Pa. 2019) (citing Terletsky v. Prudential Prop. &amp; Cas. Ins. Co., 437 Pa. Super. 108 (1994).)</td>
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<td>RI</td>
<td>For a claim of an insurer's bad faith, a plaintiff must establish the absence of a reasonable basis for the insurer's denial of benefits, and the insurer's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.</td>
<td>Skaling v. Aetna Ins. Co., 799 A.2d 997 (2002).</td>
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<td>SD</td>
<td>There is bad faith when (1) there is an absence of a reasonable basis for denial of policy benefits and (2) the knowledge or reckless disregard of a reasonable basis for denial.</td>
<td>Haney v. Am. Family Mut. Ins. Co., 223 F. Supp. 3d 921 (D.S.D. 2017).</td>
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<td>TN</td>
<td>The Tennessee Supreme Court has defined bad faith as the failure of an insurance company to act in good faith and in a diligent manner in its investigation, negotiation, defense, and settlement of claims brought.</td>
<td>United States Roller Works, Inc. v. State Auto Prop. &amp; Cas. Ins. Co., 2018 U.S. Dist. LEXIS 41045 (M.D. Tenn. 2018).</td>
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<td>TX</td>
<td>An insurer breaches its duty of good faith and fair dealing when the insurer has no reasonable basis for denying or delaying payment of a claim, and the insurer knew or should have known that fact.</td>
<td>Universe Life Ins. Co. v. Giles, 950 S.W. 2d 48 (1997); see also Carroll v. State Farm Mut. Auto Ins. Co., 2018 U.S. Dist. LEXIS 146032 (N.D. Tex. 2018).</td>
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<td>UT</td>
<td>The implied covenant of good faith performance contemplates, at the very least, that the insurer will diligently investigate the facts to enable it to determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim. If an insurer acts reasonably in denying a claim, then the insurer did not contravene the covenant.</td>
<td>Prince v. Bear River Mut. Ins. Co., 2002 UT 68 (2002).</td>
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<td>VA</td>
<td>There are two elements in a bad faith claim: (1) the insurer's contractual liability to pay under the policy; and (2) the lack of a reasonable basis to deny or compromise the claim.</td>
<td>Manu v. GEICO Cas. Co., 293 Va. 371 (2017).</td>
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To succeed on a bad faith claim, the policyholder must show the insurer's breach of the insurance contract was unreasonable, frivolous, or unfounded. An insurer's denial of coverage based on a reasonable interpretation of the insurance policy does not lead to bad faith liability.

To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.

New York Insurance Regulations

These changes to the New York Insurance Law have created significant compliance issues for insurers:

A. Insurance Circular Letter No. 1 (2017) (access to medical records)

Statutory background and current practices:

Under Insurance Law § 3203 and § 3105(b), an insurer may take advantage of mandatory two-year incontestability language in its policy. The contestability period is the time during which an insurer may investigate a claim or, if supported, rescind the coverage.

The Department has concluded that insurers, relying upon the incontestability provision, have sought to rescind life policies on the grounds that they cannot obtain copies of the decedent's relevant medical records. Accordingly, the Superintendent has concluded, this practice has placed the burden of production on the life insurance beneficiary. (January 26, 2017 New York State Department of Financial Services, Circular Letter No. 1)

The Insurance Superintendent believes that such a practice violates the Insurance Law in that a beneficiary may not be able to obtain such records or may decide simply not to provide them to the insurer.

Accordingly:
(1) “any business practice by an insurer that, absent any evidence of a material misrepresentation, requires a beneficiary to furnish claim information, including medical records, so that an insurer may investigate whether an applicant made a misrepresentation when applying for life insurance, is not attempting to effectuate prompt, fair and equitable settlements of claims in good faith” under Insurance Law § 2601(a)(4).

(2) The Superintendent will deem to be an unfair practice “any policy form provision that imposes a duty or obligation upon a beneficiary to waive the deceased insured’s physician-patient privileged and furnish, or assist in furnishing, the insurer with the deceased insured’s medical records or other claim information about the insured, other than proof of death in order to receive the death benefits” under Insurance Law §3201 (c ) (2).

Practical implications:

Fundamentally, this new rule creates significant disadvantages for life insurers who have the right under the particular policy to investigate whether the insured made a material misrepresentation on the application for coverage. Assuming that the insured did make such a misrepresentation in her medical history, the insurer cannot compel the production of those medical records unless it has evidence that a misrepresentation has been made.

Questions raised by this rule include:

** are there other means by which an insurer can obtain information without having to request a medical authorization?
** Does an insurer need to change its underwriting practices at the time of application?
** May an insurer still utilize conventional forms of investigation to demonstrate “evidence of a material misrepresentation” that do not involve directly obtaining medical records?


Statutory background and current practices:

New York law prevents a life insurer from unfairly discriminating between individuals of the same class and expectation of life, in the amount or payment of premiums, or rates charged for policies of life insurance or annuity contracts. It also prohibits insurers of life, disability income and long-term care insurance from refusing to insure or continue to insure, limiting the amount, extent or kind of coverage, or charging a different rate for the
same coverage solely because of a physical or mental disability, impairment or disease, or prior history of the disability disease except where permitted by law or regulation and based upon sound actuarial principles or reasonably anticipated experience. (June 22, 2018 New York Department of Financial Services, Insurance Circular Letter No. 8)

Antiretroviral pre-exposure prophylaxis ("PrEP") treatment may reduce the likelihood that a person may eventually contract HIV ("human immunodeficiency virus infection"). According to the Centers for Disease Control and Prevention, daily use reduces the risk of infection by more than 90%. (Id.)

Following an investigation of industry practices, the Superintendent has advised insurers and fraternal benefit societies that underwrite life, disability and long-term care insurance that “underwriting decisions based solely on applicant’s use of PrEP are inconsistent with Insurance Law § 4224. The basis for the rule is the finding that an underwriting assessment that treats a person who has used PrEP differently (by declining coverage or otherwise provides more costly or reduced coverage) than a person who is potentially exposed but not taking PrEP.

**Practical implications:**

As with each of the rules discussed, the fact that the New York Department has adopted them creates the distinct possibility that other states will put them in place as well.

May an insurer comply with this rule simply by modifying its existing underwriting procedures to exclude this treatment?

Let’s assume that the applicant’s medical records suggest or infer that he or she may be receiving this treatment (or would qualify for it). Then, it follows, the insurer has to take the initiative to follow up to find out if the individual has in fact received the treatment.


**Statutory background and current practices:**

Based upon consumer reports, the Superintendent believes that life insurer’s use of "unconventional sources or types of external data" such as algorithms and predictive models – not directly related to the applicant’s medical condition – violates Insurance Law. (January 18, 2019 Department of Financial Services Insurance Circular Letter No. 1)
Recognizing that the use of technology provides valuable information in the underwriting process, life insurers may only rely upon it if they “can establish that the data does not use and is not based in any way on race, color, creed, national origin, status as a victim of domestic violate, past lawful travel, or sexual orientation in any manner, or any other protected class” and that the “external data source is not unfairly discriminatory and complies with all other requirements in the Insurance Law and Insurance Regulations.” In short, life insurers are now charged with the burden of proving that the use of any of these underwriting tools do not discriminate in any respect. Similar to the Circular Letter cited above, the Superintendent relies upon Insurance Law § 4224(a)(2) and (b)(2) (anti-discrimination).

In addition, life insurers are obligated under Insurance Law § 4224(a)(2) to notify an insured or potential insured of the “specific reason for a declination, limitation, rate differential or other adverse underwriting decision,” including the “specific source of the information upon which the insurer based its adverse underwriting decision.”

**Practical implications:**

A plain reading of this rule is that life insurers cannot rely on existing algorithms or predictive models at all.

**D. Amendment to Regulation 187 (2019) (Increased suitability obligations upon producers and insurers)**

**Statutory background and current practices:**

Effective August 1, 2019, amendments to the New York Insurance Regulation 187 will take effect, and the Regulation will be renamed as the “Suitability and Best Interests in Life Insurance and Annuity Transactions.”

The broad-scale revisions apply to life insurance and annuity producers and insurers, including imposition of the following duties:

- Requiring that the “best interests:” of the consumer be considered in all transactions, both during the initial presentation of the produce and when the policy or contract is in-force;
- Providing “suitability information” relating to the risks, the consumer’s financial situation, and the complexity of the transaction;
- Disclosure of the basis on which the producer is compensated;
- Producers may not describe themselves as financial planners unless they are properly licensed; and
Establishment of policies and procedures to demonstrate supervision over producers and generally to ensure compliance with these rules.

**Practical implications:**

The essence of these widespread changes is to force insurers to develop stronger disclosures in the sale and ongoing insured-insurer relationship and to implement increased supervision over their producers.

It is unclear at first blush if these rules were the result of increased complaints or a general concern that insureds simply do not understand the arrangement by which producers are paid. As with other areas of state insurance regulation, though, insurers are deemed to be in the best position to provide as much information as possible to insureds.

II. **New ERISA Disability Claims Regulations**

The new regulations apply to claims filed after April 1, 2018. This segment is intended to discuss the impact of the most relevant rules to insurers and third-party administrators.

A. **Independence and Impartiality – Avoiding Conflicts of Interest**

*(Applies to initial decisions and appeals)*

When deciding that a claimant is not entitled to benefits administrators must:

*avoid conflicts of interest,*

ensuring that the decision regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claim adjudicator, medical or vocational specialist)

must not be made based upon the likelihood that the individual will support the denial of benefits.

Proactive/responsive practices an administrator/insurer could adopt:

- Including the text of the rule in its claim procedures manual
- Conduct training of claims department
- Work with outside medical and vocational vendors on its own compliance policies
- Review existing bonus/compensation arrangements
- Consider including a “compliance” statement in all decision letters
- Be able to demonstrate independence and impartiality if asked
- Conduct ongoing training
B. Disclosure Requirements for “adverse benefit determinations”  
*(Applies to initial decisions and appeals)*

When an administrator denies a disability claim or upholds a denial on appeal, the administrator’s decision letter must:

- contain a *thorough discussion of the reasons*, specifically the basis for the administrator’s disagreement with:
  1. The views of the claimant’s health care providers and vocational professionals;
  2. The views the administrator obtained of medical or vocational experts – even if the advice provided was not relied upon (note that this requires the administrator to disclose to the claimant any opinions of experts it retained supporting approval of the claim with which the administrator disagreed, and the reason the opinion was not sufficient to support approval of the claim); and
  3. A favorable disability ruling by the Social Security Administration

Provide to the claimant any internal rule, guideline, protocol or similar criterion the plan relied upon or provide a statement that such rule does not exist.

Notify the claimant in the initial denial letter of his/her right to obtain free copies of all documents, records, and other information relevant to the claimant’s claim for benefits.

Proactive/responsive practices an administrator/insurer could adopt:
- Review existing decision letter templates
- Adopt new templates
- Focus on opinions contained in medical reviews and independent medical examinations – particularly if they disagree with the treating physician
- Ensure that the decision-maker(s) carefully review medical reports and vocational assessments
- Exercise best efforts to obtain the claimant’s Social Security file
- Conduct training on the Social Security Disability process
- Consider adding an additional decision letter reviewer

C. Claimant’s right to review and respond to new information  
*(appeal only)*

Prior to rendering an adverse decision on appeal, administrators must provide notice to the claimant (free of charge) of the following:

1. Any new or additional evidence considered, relied upon, or generated by the plan, insurers or other person making the benefit determination in connection with the claim.
This information must be given to the claimant “as soon as possible” and with enough time for the claimant to review and respond before the decision date.

2. give that rationale to the claimant “as soon as possible” and with enough time for the claimant to review and respond before the decision date.

Proactive/responsive practices an administrator/insurer could adopt:

- Take advantage of the 45-day extension available as soon as it knows that matters exist outside the control of the administrator
- Consider “tolling” of the claim decision while waiting for the claimant’s response
- Set a deadline for the claimant to respond
- Advise any outside medical reviewers or other experts of the possibility of having to respond to new information from the claimant
- Review privacy-protection policies – is there a way to permit communications to and from the claimant by electronic means (encrypted email or web portal)

D. “Deemed” exhaustion of claims and appeal processes

If the plan fails to establish or follow claim procedures consistent with the requirements of this section:

then a claimant may proceed to file suit in court under ERISA on the theory that the claimant did exhaust his/her administrative remedies.

The consequence of this action is: the claim or appeal is deemed denied without the exercise of discretion by the fiduciary.

A claim will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is unavailable if the violation is part of a pattern or practice of violations by the plan.

The claimant may request a written explanation of the violation from the plan and the plan must respond within 10 days. If a court rejects the claimant’s request that the claim be deemed exhausted, the claim will be sent back on remand to the administrator for review and decision.

Proactive/responsive practices an administrator/insurer could adopt:

- Incorporate into continuous training program
- Explain the basis for any request for an extension of time