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Humanizing the Insurance Company in Bad Faith Actions

Leah Kippola-Friske
Moderator
NILAN JOHNSON LEWIS PA
Minneapolis, Minnesota
lkippola-friske@nilanjohnson.com

Brett Bacon
FRANZ WARD LLP
Cleveland, Ohio
bbacon@franzward.com

William Hittler
NILAN JOHNSON LEWIS PA
Minneapolis, Minnesota
whittler@nilanjohnson.com

Introduction

Much has been written recently on the topic of "humanizing" the insurance carrier in its interactions with its policyholders. This concept has also been discussed when the company denies a claim for benefits and a lawsuit follows, often alleging that the company is liable for extra-contractual first-party and third-party "bad faith" damages. Given that a successful plaintiff may be able to recover consequential damages, emotional distress damages, and attorney's fees as a part of a bad faith suit, the exposure to the insurer can be extremely high.

Our objective in this paper is not to opine on the merits of adopting such a litigation strategy, but rather to take a more eclectic view of these issues, including:

- The benefits of doing so when the insured is asserting that the carrier has breached its duty of "good faith";
- Reasons that the approach may not work;
- Timing issues on when the strategy can be applied, such as (i) the company's overall claims review philosophy; (ii) the claims process itself; and (iii) in pleadings, discovery; mediation, and trial;
- How the plaintiff, mediator, judge, arbitrators, or a jury will consider the company's effort to portray itself in a more "human" light; and
- The importance of the company's efforts at demonstrating that its employees and claims review processes show "good faith" in deciding the claim for benefits under the policy.

Bad Faith Defined

Bad faith is defined generally as an insurer's breach of its duty of good faith and fair dealing – such that its claim denial lacks any reasonable basis, the insurer's knowledge that the claim should have been paid, and some element of malicious intent. Although exceptions exist on a state-by-state basis, by and large the insured/policyholder must first prove that the insurer breached the terms of the applicable insurance policy in order to maintain a bad faith claim. The tort of bad faith is usually recognized by common law, but can also be codified in state statutes, either independently or in addition to the common law.[i]

Some courts articulate the operative legal standard as the company having no reasonable basis for deciding the claim. The standard bad faith complaint sets forth the evidence of numerous incidents of alleged bad faith, sometimes beyond the decision itself (such as deficient claims processes), or a history of similarly-unsupported decisions where the company's motive appears to be to maximize its profits.

There can be no bad faith as a matter of law where the insurer simply makes an erroneous decision or policy interpretation that could have gone either way. Legally speaking, such a decision is characterized as one that is "reasonably debatable" or where there exists a "bona fide dispute." *See Duncan v. Primerica Life Ins. Co.*, No. 2:21-cv-01106-JAM-DMC, 2023 U.S. Dist. LEXIS 23866, at *1 (E.D. Cal. Feb. 10, 2023). Similarly, a decision based on an unsettled legal issue is usually not enough for the plaintiff to meet his or her burden of proof. *See Collier v. ReliaStar Life Ins. Co.*, 2012 U.S. District LEXIS 33577 (N.D. Cal. Mar. 13, 2012) (rejecting 15 separate "purported deficiencies" in the insurer's handling of her disability claim and dismissing plaintiff's bad faith claim), *aff'd*, 589 Fed. Appx. 821 (9th Cir. 2014).

To the extent that the insurance carrier can prove that its conduct demonstrated a more "humanized" claims review process (even though the claim was ultimately denied), does that constitute a defense to a bad faith claim? Though we have not located any case law holding to that effect, it could be argued that the company's commitment to "humanization" can support proof of its good faith handling of the claim.

Plaintiffs rely upon a vast array of arguments – often in combination --to support bad faith. Some of them include the following:

** The insurer failed to adequately investigate a claim or denied it without adequate supporting evidence;

** The company intentionally failed to pay the claim in a timely manner, when liability was certain (defined as "substantial evidence" supporting approval);

** Interpreting a policy provision in such a way as to favor the insurer, not the insured;

** Forcing an insured to bring a lawsuit because the insurer has not paid the claim or sought to settle it for an unreasonable amount;

** Treating a policyholder as an adversary during the claims review process, rather than as a customer;

** Ignoring evidence in the claim file that directly supports payment of the claim;

** Failing to follow internal company claim guidelines or industry standards;

** Not telling the claimant what evidence it would accept to prove that she or he met the policy's definition of "total disability";

** Relying upon outside medical experts whose opinions were inadequate, not independent, or reflected bias in favor of denying the claim;

** Terminating a (disability) claim after paying benefits for a long period of time;

** Failing to pay a life insurance policy benefit on the grounds that another potential beneficiary may also have a right to the benefits; and

** Denying a life insurance beneficiary's claim where the insured made a material misstatement of fact on an application, or the claim was excluded under the policy's terms.

Representative Sampling of Bad Faith Cases

Life, Health, and Disability

Millis v. Ameritas Life Ins. Corp., 2022 U.S. Dist. LEXIS 91102, *31 (N.D. Ill. May 20, 2022):

The district court granted summary judgment in favor of the insurer on plaintiff's bad faith claim, finding that the insurer invested significant resources over an extended period of time to determine the extent of plaintiff's disability including retention of several medical and financial consultants.

Walker v. Life Ins. Co. of N. Am., 2023 U.S. App. LEXIS 3070, at *22-23 (11th Cir. Feb. 8, 2023) (long-term disability):

Plaintiff asserted a claim for bad faith denial of her long-term disability claim, following the insurer's payment of benefits for 24 months. The district court dismissed the claim on summary judgment on the grounds that the insurer had an "arguable reason" for denying benefits under Alabama law. On appeal, the Eleventh Circuit affirmed, holding that the insurer was "at least arguably justified in determining" that the Appellant did not qualify for benefits, based on the insurer's consideration of a "full range of information. . . including information that was contrary to the reports on which it ultimately based its determinations."

Duncan v. Primerica Life Ins. Co., 2023 U.S. Dist. LEXIS 23866, * 19 (E.D. Cal. Feb. 10, 2023) (life insurance):

In this case, plaintiff argued that the defendant "failed to conduct a complete and through investigation" by not reaching out to plaintiff to investigate the decedent's circumstances, did not examine medical records, did not coordinate between investigative staff working remotely, and only conducted a limited review of the claim in response to the Insurance Department's inquiry. The district court granted judgment in favor of plaintiff on the basic death benefit but dismissed plaintiff's bad faith claim. Specifically, the court held that plaintiff was not entitled to benefits under a terminal illness accelerated benefit and that plaintiff had failed to establish that the defendant's conduct "rises to the level of a conscious and deliberate act" permitting plaintiff to recover additional damages.

Poinsett v. Life Ins. Co. of N. Am., No. CIV-21-1205-F, 2022 U.S. Dist. LEXIS169540 (W.D. Okla. Sep. 20, 2022) (disability):

The insured submitted a claim of benefits under a long-term disability policy, and, after initially approving the claim, the insurer reversed the decision, terminated the benefits, and denied the insured's appeal. The insured then sued alleging bad faith. The insurer argued the bad faith claim failed under Illinois law, which applied under the policy's choice-of-law provision. The insured then argued that Oklahoma law should apply, which permits bad faith to be pled as an independent tort. The district court noted that while Oklahoma courts generally honor choice-of-law provisions, there was caselaw holding that tort claims, like bad faith, are not subject to choice-of-law provisions unless expressly noted within the provision. Therefore, the court held the choice-of-law provision did not apply, and Oklahoma law applied under the "most significant relationship" test.

Mantooth v. Health Care Serv. Corp., 2021 U.S. Dist. LEXIS 12730, *6-8 (N.D. Okla. Jan. 25, 2021):

The plaintiff in this suit was insured under a Blue Cross Blue Shield health insurance policy. The district court dismissed plaintiff's bad faith claim for denied health insurance policy benefits, holding that the claim was premised on re-alleging the allegations of the breach of contract claim. Those assertions, the court found, did not meet the standard under Oklahoma law that the plaintiff show (i) breach of the insurance policy; (ii) an unreasonable refusal to pay the claim without a reasonable basis – or no proper investigation was performed – or the insurer did not evaluate the results of the investigation properly; (iii) the insurer did not deal fairly and in good faith with the insureds; and (iv) the insurer's violation of its duty was the direct cause of the complained-of injury to the insureds.

Property & Casualty/Other Insurance

Lemon v. State Farm Fire & Cas. Co., No. C20-3018-LTS, 2022 U.S. Dist. LEXIS 115142 (N.D. Iowa June 28, 2022) (homeowner insurance):

The insurer was sued for breach of contract and bad faith failure to pay benefits. The court noted that, under Iowa law, the burden falls on the insured to demonstrate that "no single basis for denial existed." Because the court found the insurance claim was "fairly debatable," the insured's bad faith claim was dismissed.

Kinsale Ins. Co. v. Pride of St. Lucie Lodge 1189, Inc., No. 2:21-cv-14053-KMM, 2022 U.S. Dist. LEXIS 127224 (S.D. Fla. July 14, 2022) (general liability):

Under Florida law, an insurer's affirmative duty to initiate settlement negotiations applies only where liability is clear. According to the district court, liability was not "clear" enough to trigger the duty to initiate settlement negotiations, even though a jury found the insured 70% at fault.

Columbia Ins. Co. v. Waymer, 860 Fed. App'x 848 (4th Cir. 2021) (personal injury):

The Fourth Circuit held in this action that the insurer did not violate its state-law duty to act in good faith toward its insured. Specifically, the fact that the insurer rejected the injured plaintiffs' settlement demand was not bad faith because the insurer lacked adequate information or opportunity to evaluate the risk of an excess judgment before the 10-day settlement demand expired. Given that lack of information, it had a reasonable basis for refusing to settle.

What Does "Humanizing" The Insurance Company Mean?

As a threshold matter, it is entirely appropriate to note there are serious criticisms about the idea of trying to present the company's witnesses at trial as being "folksy and conversational"; informing the jury about the positive public and civic acts"; and the economic and human benefits that company has provided.[ii] The basis for such a view is that because the likelihood of a large adverse judgment originates with the juror's fear of the insurance company (rather than merely disliking it), it doesn't matter much how friendly the employees are or how good of a corporate citizen the company is.[iii] Nonetheless, there is considerable value to the insurance carrier using "humanization" in bad faith litigation in an appropriate and effective way. Here are some options to consider:

Think of litigation as an extension of the customer-company relationship, reflecting the fact that most bad faith suits are brought on the belief that the company did not keep its promise(s).[iv]

Adopt a philosophy independent of the litigation venue that prioritizes the company's goal of acting in "good faith" in its overall operations including underwriting, sales and marketing, claim review, communications with insureds, and claim denial protocols.

The insurer recognizes that it has a long-term, relationship with its policyholder, sometimes described as "special" depending on whether the insurer is a fraternal benefit society.

Consider routine interactions with the policyholder as an opportunity to apply a "humanization" approach.

Treating plaintiffs in litigation as customers, not as adversaries.

Remember that credibility is always important.

Practical Scenarios and Strategies

- Day-to-day communications and interactions with policyholders – while simply acting with empathy may not dissuade a dissatisfied policyholder from suing, it may go a long way to developing a storyline that the carrier's approach was to look for proof that the claim should be paid, not the opposite.
- Interactions between the legal department and the claims department should consider the likelihood that the claimant/policyholder may be trying to obtain evidence that the company has acted in a malicious or vindictive manner. Internal communications within the claims department can also provide an opportunity to foster a positive, more personal approach to deciding claims and dealing with customers/policyholders/insureds.
- Creating positive relationships with the court and opposing counsel – be reasonable, trustworthy, and forthright.[v]
- Making an earnest and positive connection to the plaintiff (whether he/she is an individual or a company representative).

- Deposition witness preparation – knowing that the other attorney will be focused on specific instances of intentional mistakes. Note that in bad faith discovery every aspect of the claims review process will be carefully analyzed.
- Court hearings and appearances, particularly where a motion to dismiss a bad faith claim has been filed – can the company show that its decision was rational, based on solid information, and carefully made?
- Presentation and conduct at mediation – many of the same protocols used in court apply to mediation regardless of whether the case ends up being settled. If the mediator and the plaintiff (who may not have met anyone from the company before this moment) finds that the company employed a rational, well-supported process that led to the claim being denied, then the chances of resolving the matter may improve.
- Presenting company employees at trial – although a courtroom is more formal and structured, consider having the company's witnesses approach their testimony the same way they would meet with a policyholder or insured at their respective place of business or home.

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[i] The vast majority of states have recognized first-party bad faith causes of action, as well as 35 states allowing third party bad faith. *See* https://www.iadclaw.org/assets/1/7/50_State_Insurance_Bad_Faith_Reference_Guide.pdf, (accessed May 6, 2023). Cf. https://www.alfainternational.com/wp-content/uploads/ALFAI-2022-IPG-Quick-Reference-Guide.pdf (accessed May 6, 2023) (setting forth listing of states that permit punitive damages in insurance cases).

[ii] *See* "'Humanizing' the Insurance Company and its Employees," ALFA Insurance Practice Roundtable 2017, at 1.

[iii] *Id.*, at 2-3.

[iv] *Id.*, at 3.

[v] *Id.*, at 4.