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Feature Article

ADJUSTMENT OF DISABILITY CLAIMS AND THE PROBLEM OF BAD FAITH

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The initial adjustment and subsequent administration of a long-term disability claim is *mostly* a matter of sound common sense, a knowledge of ethical and customary adjustment practice, and the ability to understand medical, vocational, and rehabilitation records and reports. [FN1][FN1] As with all other adjusters your handling coverage matters, the adjuster-or examiner-working on a disability claim must keep in mind that a fundamental ethical principle of adjustment is *Look for coverage!* Of course, this maxim does not imply that insurers should pay for claims they do not owe or should pay more than they owe. With the spirit of adjustment is to keep track of and to keep looking for ways in which the insured might actually be covered. This is true even if the insured's claim is not as clear as it might be. Of course the maxim *Look for coverage!* applies to all insurance and all insureds, although it does not apply to tort claimants, when the insurance is liability insurance. [FN2][FN2]

The common sense component of it is generated by the contract itself. The principle questions are:

- Is the policyholder disabled?
- Totally so?
- Partly so?
- Is the alleged type of disability covered?
- Might there be another type which is covered?
- When did the policyholder become totally disabled?
- Was the policy then in effect?
- Are there any pre-existing conditions? (If so, does it matter?)
- What caused the disability?
- How long will the disability clearly and certainly last?
- How long might the disability last?
- What kind of work can the insured perform, if any? (Does it matter if he can do something? If so, what?)
- Can the insured be rehabilitated?
- Can the insurer require that the insured pursue rehab?

Sometimes, insurers wish to investigate whether there was fraud, or merely negligent misrepresentation, in the application process. Sometimes this can be inquired into, sometimes not. Often it depends on how much time has elapsed since the start of the policy. Obviously, many of these questions turn on the opinions of physicians, psychologists, the policyholder himself, a rehab specialist, vocational specialist, and the like. In addition, the

relevance of this or that question will be determined by the content of the insurance policy.

The knowledge adjusters have of customary, sound, and ethical adjustment practice results from experience, training, and education. Many companies have codes of adjustment practice. Many adjuster organizations have the same thing. Some schools which provide adjuster and insurance education by courses on these matters. [FN3][FN3]

The tools disability claims adjusters have to work with are fairly standard:

- Applications from the insured (both applications for insurance and applications for benefits);
- Narratives from the insured;
- Questionnaires as submitted to the insured, such as occupational duties questionnaires (extremely important, as already noted);
- Authoritative descriptions of the insured's occupation-both general and specific (governmental, scholarly, popular);
- Medical records from treating physicians (and the like);
- Treatment notes from treating physicians (and the like);
- Medical reports (including an appropriate number of correctly timed IME reports);
- Records from treating psychologists (and the like);
- Treatment notes from treating psychologists (and the like);
- Psychological reports (historically exact and newly commissioned);
- Functional capacity examination (a test);
- Transferrable Skills Analysis (a test);
- Other psychological tests;
- Surveillance photos, films, and videos (a/k/a spy videos);
- Interviews with those who know the policyholder (field or telephonic);
- Interviews with the insured (field or telephonic);
- Interviews with business associates and subordinates (field or telephonic).

Notice that these tools fall into roughly three categories: historical facts, medical inquiry, [FN4][FN4] formal testing (including physical, psychological, social, and vocational). Naturally, insurers should avoid making unreasonable demands for information. [FN5][FN5]

What is interesting about disability adjusting is that each case is multidimensional-even complex-and each case permits some creativity. Also, treatment and diagnostic methods change, so insurers need to keep abreast of innovation and use it. What is needed in the way of information varies from case to case. It turns not only on the hard facts of the case but upon the personalities involved.

Of course, adjusting disability claims is not entirely unique. Indeed, it resembles the adjustment of worker's compensation claims. After all, isn't worker's compensation often a form of disability insurance? Certainly, they are both forms of health insurance. [FN6][FN6] Nevertheless, the complexities of disability claims adjustment provide all sorts of opportunities for both plaintiff and defense counsel. Defense counsel has the opportunity for demonstrating that the insurance company made a lot of appropriate inquiries, did a lot of thinking, viewed a lot of materials, thought more, *reasoned carefully*, discussed (or debated) matters *objectively*, processed *rationaly*, and so forth, in the service of processing the claim. [FN7][FN7] The plaintiff's lawyer has the opportunity for showing all of the things that the insurance company did not do and all of the ways in which it failed to appreciate the material that it had. [FN8][FN8]

Bad Faith

There is a paradox surrounding the relationship between bad faith and disability insurance. On the one hand, as we shall see, disability cases are extremely difficult to win. On the other hand, at least arguably, there are reasons why they should be winnable. Arthur L. Fries, a well-known California insurance agent-broker has made the following observation:

It's never been harder to get a disability claims payment. Carriers and administrators seem to be scrutinizing claims with a higher degree of protection than the Secret Service provides to the president! Today, many carriers have trouble differentiating a "legitimate" claim from a "gray area" claim. A hierarchy of individuals-including nurse practitioners, in-house medical personnel and accountants-is now involved in evaluating claims. Just one wrong answer or wrong word in a claim in a claim form or Attending Physician Statement could result in denial or termination." [FN9][FN9]

In effect, Fries is arguing that insurance agents can help claimants under disability policies avoid what could be charitably described as insurer skepticism. Fries's outlook is as valuable for lawyers as it is for agents. [FN10][FN10] Fries also raises an interesting question. Might an agent be guilty of bad faith if he fails to help an insured or fails to give appropriate advice?

We will handle this section in two subsections. First, we shall discuss some general principles, using Texas law as a paradigm. Second, we shall discuss a couple of recent cases from different jurisdictions.

General Substantive Principles of Insurance Bad Faith Litigation

There are two forms of insurance bad faith: common law and statutory. [FN11][FN11] Texas law is somewhat typical, so we will use it as an example for general principles. Common law bad faith applies to first party insurance, if Texas (or similar) law applies. [FN12][FN12] Disability insurance is first party insurance, so if Texas law applies to the adjustment process consequent upon a disability claim, the Texas common law of insurer bad faith applies. [FN13][FN13] Under this sort of law, an insurer can be liable for bad faith if it handles the adjustment unreasonably, irrationally, or something of the sort. So far, if ERISA applies, the state law of bad faith does not. [FN14][FN14] ERISA may not apply to agents and brokers, [FN15][FN15] although the law of bad faith may. [FN16][FN16]

The Texas law of first party insurer bad faith involves a relatively flexible standard. An insurer is guilty of bad faith if it denies a claim without a reasonable basis or unreasonably delays the payment of a claim which is owed. Whether a basis for denial is reasonable or whether a delay is unreasonable may very well involve fact issues and go to a jury. There is no clear definition in Texas case law as to how to draw the line between there being a reasonable basis and there being no reasonable basis. This remark is not intended to be a criticism of Texas law. It is difficult to see how one could draw such a line. That's what juries are for.

Statutory bad faith is controlled by the Texas Deceptive Trade Practices Act, article 21.21 of the Insurance Code, and article 21.55 of the Insurance Code. Article 21.55 prescribes a fairly rapid time schedule for processing claims. That time schedule would be extremely difficult to meet in the context of disability claims. As a consequence, the adjuster must keep the factual inquiry rolling and must stay in contact with the insured. Article 21.21 prohibits misrepresentations of various sorts and requires that insurers make prompt, fair, and equitable payment once liability becomes reasonably clear. The trinity of concepts-prompt, fair, and equitable-is used by a large number of states in their statutory bad faith rules. (Notice that the concepts of promptness, fairness, and

equitability are not the same trinity as appear in some writings about adjustment. [FN17][FN17] They emphasize promptness, fairness, and *efficiency*. Perhaps those writers and thinkers should use quadrilateral instead of a triangular trinity. Perhaps they should use promptness, fairness, equitability, and efficiency.)

Other states have somewhat different common law bad faith standards and somewhat different statutes, even though the previously mentioned triangular trinity appears in the law of many states. While there are significant and subtle differences, the theme of insurer bad faith law in virtually every state is to require that insurers

- Tell the truth to their insureds;
- Always make appropriate disclosures of anything relevant to their insureds;
- Not irrationally delay processing claims;
- Not use their superior financial power to suppress insureds;
- Fairly investigate claims, where “fair” means objectively and thoroughly;
- *Look for coverage*; and
- Engage in at least minimally rational reasoning about claims.

In some states, *no reasonable basis standard* is not used. Instead, the standard is one of whether the claim is *fairly debatable*. In yet other states the standard is *arbitrariness*. In some states negligence is sufficient for bad faith. In some states it is not. (Of course, some states don't even have a common law bad faith for poor claim denial at all.) [FN18][FN18]

Underlying the law of bad faith is the idea that insurers are at least quasi-fiduciaries of their insureds. This means that insurers may not place their own interests ahead of the insureds. [FN19][FN19] In general, insurers have not been held to be fiduciaries of their policyholders, although one wonders whether this rule should apply to disability insurers. (Of course, any fiduciary has the right to determine whether a person in the role of *B* is defrauding him or making misrepresentations to him. They must treat the insured's interest as at least equal to their own. [FN20][FN20] Obviously, if an insurer is providing incentive bonuses to a claims administrator, when the bonus goes up the more claims are denied, it is unlikely that this standard will be met.

It has proven to be extremely difficult to recover for bad faith against disability insurers. [FN21][FN21] No doubt this is at least in part because of the complexity of the adjustment process, and the voluminous number of records involved. It is not impossible, however. [FN22][FN22] Perhaps the most promising avenue for bad faith against a disability insurance is the use of “whores” when it comes to performing IME examinations, vocation-related examinations, and the like.

Some Recent Cases

In this subsection, we shall discuss three (3) cases, all decided in the last couple of years. Not all of them are actually bad faith cases, but perhaps they should have been. We begin with one of the most interesting cases around. It involves huge blunders. These cases will illustrate that bad faith is a difficult area, at least in the disability insurance context. Usually, policyholders do not prevail in these actions. Our conjecture is that policyholders prevail less often in disability cases than they do in property insurance cases.

The *Michael* Case: An Outrage?

One of the most fascinating bad faith cases involving disability insurance is *Michael v. Trustmark Insurance*

Company, the opinion of a Massachusetts trial court after the trial of an action before it and not a jury. [FN23][FN23] The opinion is entitled FINDINGS OF FACT, RULINGS OF LAW AND A JUDGMENT OF THE COURT.

David Michael first purchased disability insurance in early 1986. The policy was issued by CNA. Trustmark purchased the policy from CNA in 1996 and had already been administering it for approximately a year. In 1986, Michael was General Manager in a car dealership. Toward the end of 1989, it was necessary for Michael to lay a number of employees off at the business where he was manager. These layoffs distressed him so much that he "felt that he had failed both the owner and the employees." At the end of 1989, one of the owners told employees that there would be no layoffs. Michael knew that this was false, and sure enough more people were laid off. Michael began suffering the symptoms of depression. These included insomnia, the inability to concentrate, the lack of energy, frequent tears, withdrawal, and a loss of his appetite. Michael began seeing a clinical psychologist and stopped working. CNA paid him benefits beginning in 1990; Trustmark took over; benefits continued until early 1999, "when Trustmark ceased payments in a dispute with Michael over access to [some of] his treatment records." Michael received somewhere in the neighborhood of a half of million dollars in claims payments.

By the time of the trial, Michael was somewhat self-employed. He worked as a dog trainer. The court observed that this was "an occupation which was not reasonably consistent with his education, training and experience as a general manager of an automobile dealership." The court further found that Michael's "disability is causally related to the psychiatric illness which Michael suffered in March 1990 while employed" as a general manager of another dealership. The policy in question defined the concept of *total disability* as follows:

Total disability means that because of Injury or Sickness: (1) you are Disabled from performing the substantial material duties of Your regular occupation; and (2) you are under the regular care of a licensed physician other than Yourself; and (3) you are not gainfully employed in an occupation reasonably consistent with Your education, training and experience.

Over the years, Michael saw physicians, psychiatrists, psychologists, and so forth. He took a number of tests at various times. The principal psychotherapist he saw terminated his relationship with Michael in 1999 because the psychologist left his practice to teach full time.

The claim process itself lasted for a considerable period of time. Michael repeatedly authorized those who were treating him to release medical records. Eventually, his principal psychologist towards the end of the period refused to produce records for reasons that are not entirely clear.

At one point, the reinsurer of the policy suggested that Trustmark seek an interview with Michael. This occurred in late 1997. Said the court: "The purpose of this interview was to learn more about Michael's motivation, activities, and treatment goals." Trustmark sought such an interview. Michael retained counsel. Counsel advised Michael to refuse any such interview. The grounds of counsel's refusal was that it was not called for in the express language of the policy. Trustmark suggested as an alternative that it submit a number of written questions to Michael. They were to address the same issues as the interview. Michael's counsel again refused, reiterating that no specific language in the policy required a policyholder to answer such questions. Trustmark's attempt to obtain medical records continued.

In August 1998, Trustmark indicated that unless it obtained information it would cut off benefits. "Michael's counsel protested Trustmark's decision to terminate payments on the grounds that the Policy did not require Mi-

chael to grant access to treatment notes." Trustmark backed off but reserved its right to seek and obtain records. In November 1998, Michael's treating psychologist responded to a series of questions put to him. He did not answer several questions, however, based on instructions from Michael's lawyer. One of the questions concerned Michael's work status. The judge found that the psychologist's refusal to answer this question was irrelevant, since Trustmark knew his work status. Another question pertaining to whether the treatment was geared towards returning Michael to work. According to the judge, "Trustmark had no way of knowing what [the psychologist] was doing in treatment, especially since he had not submitted his treatment notes. Trustmark was equally in the dark on the proposed solutions for returning Michael to work." Even without this information, however, "Trustmark concluded that Michael had proffered sufficient information to permit a decision on total disability as defined by the Policy." [FN24][FN24] In answering these questions, the psychologist, apparently for the first time, indicated that Michael suffered from "Post-Traumatic Stress Syndrome."

A new adjuster took over Michael's case in December 1998. He indicated that the payment of benefits would terminate at the end of the year. Apparently they did not since the "skirmishes over records continued into 1999." Trustmark made payments in January 1999, but ceased thereafter.

In April 1999, counsel for Michael sent a demand letter to Trustmark. The letter accused Trustmark of violating a Maryland statute pertaining to unfair and deceptive trade practices. Trustmark replied approximately a month later summarizing its complaints pertaining to interviews and medical records.

The court begins by analyzing Michael's breach of contract claim. The judge bases her analysis on the policy. The relevant section of the policy states as follows: "[B]enefits will be paid subject to a continuing proof of loss." As the court correctly observes,

the policy provides that Trustmark pay benefits to Michael and that Michael prove his loss on a continuing basis. Trustmark's right to conduct a reasonable investigation of the "proof of loss" and Michael's duty to cooperate in such investigations are implied in these mutual obligations. [FN25][FN25]

Hence, according to the court, the central issue of the case was whether Trustmark's demand for the psychologist treatment notes was reasonable so that Michael was required to see that they were produced. "If Trustmark's demand for access to [the psychologist] treatment notes was reasonable, Trustmark may assert Michael's refusal to grant access as a defense to the breach of contract action. To be sure, observed the court, "no action in [Michael's] Policy obligates Michael to provide treatment notes[,] though he may be required to do so if otherwise reasonable." [FN26][FN26]

The court found that Michael's contention that the insurer could not have access to privileged records without express or explicit language in the policy was unfounded. At the same time, the court concluded that "Trustmark had access to sufficient information, without the contested treatment notes, to verify Michael's claim when it terminated benefits in January 1999." On this basis, the court found that the insurer's termination of benefits was unreasonable. Indeed, although the insurer may have distrusted the psychologist's opinions, they were reasonably supported in correspondence from him. To be sure, said the judge, the insurer could investigate the psychologist's opinion. However, if his treatment notes would not in fact undermine his opinions, the insurer is not entitled to them.

[I]t was not clear that [the psychologist's] treatment notes would answer the questions Trustmark seemed intent on answering. According to the expert testimony which I credit, the treatment notes are necessarily brief and do not reflect the substance of the psychotherapy sessions. It is not clear what Trust-

mark expected to learn from the treatment notes. Furthermore, Trustmark was aware, through its claims representative ..., that Michael had offered to undergo an IME. The availability of an IME was a reasonable alternative to the release of the ... treatment notes. [FN27][FN27]

The insurer had argued that an IME would be useless without the previous psychologist's treatment notes. The insurer did not offer sufficient evidence to sustain this claim. And the judge did not find it reasonable. In addition, "Trustmark offered no evidence regarding precisely what it expected to learn from the treatment notes, only that it wished to have them." [FN28][FN28] In addition, it offered no evidence that the treatment notes needed to meet some objective widely accepted standard. The judge observed that the case might be quite different if the insurer had asked for an IME, and the IME was inconclusive with respect to whether Michael suffered a disability. Consequently, the court concluded that "Trustmark breached its contract by terminating benefits before exhausting all its options for verifying Michael's claim of total disability." [FN29][FN29]

Michael accused Trustmark of statutory bad faith on three separate grounds. First, the insurer had refused to pay benefits even though it did not conduct "a reasonable investigation based on all available information[.]" Second, the insurer failed to "effectuate a prompt, fair and equitable settlement of a claim in which liability had become reasonably clear[.]" Third, the insurer compelled Michael to institute litigation to obtain benefits to which he had a right, and it did this "by offering substantially less than the amount ultimately recovered." [FN30][FN30] Remember! The court found the insurer's investigation of benefits *unreasonable*.

The court rejected these arguments. First, it found that the insurer's investigation of the case was "extensive and appropriate." It also found that its decision to terminate payments was reasonable, even though mistaken. The court was probably impressed by the fact that the insurer had not terminated payments quickly but had let a number of months pass by. [FN31][FN31] Second, the language of the statute requiring promptness, fairness, and equitability of insurers pertains to settlements. The statute authorizes recovery from an insurer which fails to "effectuate a prompt, fair and equitable *settlement* of a claim on which liability ha[s] become reasonably clear." [FN32][FN32] The court observes that there was no settlement in this case. No settlement was ever at issue. What was at issue was the making of payments under the policy. As a consequence, for various reasons, Trustmark could not be liable under that statute. Third, the "low balling" statute in Massachusetts law which authorizes finding of bad faith when settlement offers from an insurer are too low requires that some offer of settlement be made. In this case, the insurer simply refused to make any more payments, and so no offer of settlement was made. On these three bases, although Trustmark had breached the insurance contract, it had not committed statutory bad faith.

Several interesting inferences *can*-and perhaps *may*-be safely derived from the *Michael* case. First, disability insurers have some skepticism about disabilities said to be caused by such mental problems as depression. Second, insureds maximize the probability of recovery if they cooperate with the insurer. (Of course, this is not absolutely always true, but it is quite often true.) Third, non-cooperation by an insured reduces the probability of the insureds making any recovery for insurer bad faith. Fourth, Trustmark was probably irrational in the way it treated Michael. It could easily have gotten all the information it wanted by other means. These other means are fairly obvious. One is therefore tempted to infer a desire on the part of the insurer to get rid of Michael.

The *Hallum* Case: Where Is Bad Faith?

In *Hallum v. Provident Life and Accident Insurance Company*, [FN33][FN33] a panel of the Eleventh Circuit certified a question to the Georgia Supreme Court. The federal District Court for the Northern District of Geor-

gia had granted summary judgment to a physician who had specialized in obstetrics and gynecology for 30 years. Both the policyholder and the insurer agreed that the policyholder suffered from carpal tunnel syndrome and therefore could not continue practicing medicine. The issue was why his disability was caused. Given the age at which he sought disability coverage, if his disability was caused by an *injury* he was entitled to lifetime coverage. If his disability was caused by some *sickness*, his benefits lasted for four years but no longer.

The policy defined *injury* as “accidental body injuries occurring while your policy is in force.” It defined *sickness* as a “sickness or disease which is first manifested while your policy is in force.”

The Eleventh Circuit therefore asked the Supreme Court of Georgia whether Hallum suffered from an *injury* or whether he suffered from a *sickness*. The supreme court began by indicating that the evidence before it indicated that Hallum at no time had had any of the usual diseases generally associated with carpal tunnel syndrome. Instead, the evidence in the record indicated that Hallum's carpal tunnel syndrome was “caused by 30 years of performing the hand motions required by his obstetric/gynecology practice[.]” The supreme court indicated that the Eleventh Circuit had realized this and focused on “carpal tunnel syndrome caused by repetitive hand motions.” [FN34][FN34] The supreme court further indicated that established Georgia law distinguishes between insurance coverage for *accidental injuries* and insurance coverage for *injuries caused by accidental means*. “An accidental injury is an injury that is unexpected but may arise from a conscious voluntary act. In contrast, an injury from accidental means is one that is the unexpected results of an unforeseen or unforeseeable act that was involuntary or unintentionally done.” [FN35][FN35] The supreme court indicates that

The insurance policy [covering Hallum] uses the words “accidental bodily injury,” which, in the context of this policy means a bodily injury that was unexpected, but could have arisen from a conscious or voluntary act. By using “accidental” to modify “bodily injuries,” as opposed to modifying the cause or means of any injury, the Provident Life policy places the focus on the coverage of the injuries, not the means that cause the injuries. Accordingly, an unexpected physical injury that disables the insured is covered as an “injury” under this policy. The court observed that the policy was quite clear that “[a] person could suffer a series of small traumas over an extended period that ultimately resulted in a bodily injury that was disabling. [FN36][FN36]

On this basis, the court concluded that the policy covered “bodily injuries that resulted from a series of actions over an extended period, as well as those that were caused by a single cataclysmic event.” [FN37][FN37]

On the basis of the opinion from the Supreme Court of Georgia, the Eleventh Circuit affirmed the summary judgment granted by the district court. [FN38][FN38] Hallum was entitled to lifetime benefits. The conclusions in this case, while somewhat theoretical, are so obvious that it is difficult to see why there was no action for bad faith brought. The insurer's reasoning was unquestionably irrational and perhaps motivated by greed and not justice. These types of issues have been more common in the past as the result of awkward and mixed vocabulary. [FN39][FN39]

The *Knott* Case Again: Some Knots

In *Provident Life & Accident Insurance Company v. Knott*, [FN40][FN40] the issue was what constituted total disability for a physician who began practicing obstetrics and gynecology in 1968, who had purchased disability insurance in the early 1970s—one in 1970 and a second in 1974—and who sustained a serious injury in an airplane crash and underwent surgery—both in 1985. [FN41][FN41] The doctor brought his lawsuit against the insurer years after the 1985 accident. During the intervening time, the doctor had continued paying for the disabil-

ity policy. In 1995 he turned 65. A few months later he again submitted a claim disability insurance benefits. No new event or accident precipitated the claim; it was again linked to the airplane accident. The carrier made total disability payments for 24 months. Thereafter, it ceased payments since it believed had paid maximum benefits. (According to the applicable policy schedules, the maximum benefit period for disabilities commencing on or after an insured 65th birthday was 24 months. On the other hand, if the total disability commences before the 65th birthday, the insured is entitled to lifetime benefits.)

Knott was thus suing the insurer for failing to pay since 1986. As earlier indicated, Knott sued for coverage, common law bad faith, statutory bad faith, and so on. The doctor's extra contractual claims were controlled by a 2-year statute of limitations. He took the position that the statute did not begin to run until his benefits were cut off in the late 90s. The insurer took the position that the statute began to run in 1986. The carrier's 1986 letter did not explicitly employ the word "deny" or explicitly state that it was Knott's claim. Instead, it indicated that his 90-day elimination period required by the policy had not been satisfied and hence that the insurer had paid the insured too much and might seek restitution.

Thus, the question was when the 2-year statute of limitations began. The underlying question was whether the 1986 letter was claim denial, even though that word did not explicitly appear and even though the idea of a denial was not itself absolutely clear. (Unquestionably, as a matter of law, under Texas law, relevant statutes of limitations for various types of bad faith begin when a claim is wrongfully denied.) Usually, although not always, this is a question of law. At the same time, the Texas Supreme Court has determined that "when 'there is no outright denial of a claim, the exact date of accrual of a cause of action ... should be a question of fact to be determined on a case-by-case basis.'" [FN42][FN42]

Thus, the key question for the court was whether a letter could be a denial letter when it did not use the word "deny" or its linguistic near-relatives. Such things can be decided as a matter of law, agreed the court.

It said that whether the insurer's letter was a denial letter depends upon a close reading of it. Thus, the court was interpreting the language of the letter. A letter from an insurer to an insured may be a denial letter, even if the word "deny" (or its near relatives) do not appear. There is no "magic words" requirement for something constituting a denial letter:

We do not require an insurer to include "magic words" in its denial of a claim. If the insurer's determination regarding a claim and its reasons for the determination are contained in clear writing to the insured. In this case, [the insurer's] 1986 letter conveys its denial of Knott's claim for total disability and the reasons for its decision to reject the claim. [FN43][FN43]

It is now often said that courts are interested in divorcing themselves from legal theory justifying bad faith and are striving towards methods for weakening bad faith actions. The *Knott* decision on statutes of limitations does not quite exemplify this view, since its decision about the insurer's 1986 letter is pretty much correct. At the same time, at least one of the cases it relies upon is clearly wrong, and the statute it deploys does not contain relevant language, even though it is part of the Insurance Code, sanctions slow claims processing, and applies to first party claims. [FN44][FN44]

Three Interesting Cases

The area of health law is a burgeoning field. Consequently, the area of health insurance law is similar. Disability insurance is a type of health insurance. Consequently, we shall be seeing more of it as time goes along.

We close with several interesting cases. Two of them have appeared in the official reports, one of them has not.

First Case: Guilt and Disability

In one case, a physician sexually abused a series of children. He got caught, got convicted, and got sued. The abused children received an assignment of payments under his disability policy, after they took a judgment. It was then up to them to try to establish that the insured physician was in fact disabled. The insurer moved for summary judgment on the grounds that when the doctor pleaded guilty he indicated that he was not under any mental or physical disability. The court denied the insurer's motion and held that the plea agreement was not dispositive. [FN45][FN45] (Question: Why was not the disability caused by the revocation of the license? [FN46][FN46] Should the right to disability benefits be assignable?)

Second Case: Insurer Breach and Consequential Damages

In another case, an insurer cancelled a disability policy after commencing payments. The cancellation was wrongful, as the district court and the court of appeals subsequently found. The insurer paid nearly a half a million dollars. Unfortunately during multiyear litigation, the insured became so hard-pressed financially, that he could not keep up payments on his life insurance, and it lapsed. The insured's daughter sued the disability carrier again contending that if the disability carrier had timely paid what it owed, her father would have had the financial means to pay the premiums on the life insurance policies," and the life insurance policies never would have lapsed. [FN47][FN47] While the court rejected the evidence in this case, the court did not reject the theory. Thus, it is perfectly clear that if the disability carrier breaches its contract, it may be liable for consequential damages, if they can be proved. (Question: How could this sort of thing be proved?)

Third Case: Expert Witnesses

The use of expert witnesses in insurance bad faith cases is fairly common. Often, one side or the other tries to disqualify such witnesses produced by the other side. Sometimes lawyers do not do this, if they believe that the witness to be presented by the other side will actually help them. The idea that expert witnesses in insurance cases can meet these scientific and technical requirements for expert witnesses proposed in some cases by some courts (e.g., *Daubert*) is silly. [FN48][FN48] Science, engineering, and complex mathematics (as opposed to a little arithmetic) are not obviously involved. Nevertheless, it is important for expert witnesses to do things right.

Currently, we are seeing an expert witness for the policyholder in a fairly routine disability case in which there have been a number of medical examinations and in which there are a number of conflicting reports and there is unclear medical evidence that both creates and applies a variety of attractive-sounding principles in unacceptable ways. The expert witness has failed to apply the *law* of the appropriate state correctly, and she has both worded and applied standards and received *ethical principles* also incorrectly. This particular witness applied the standards of the International Claim Association and got several of them wrong. [FN49][FN49]

We shall fictionalize the situation to some degree and leave most of the facts out. We will name the expert witness M.N.Uoorful, and we shall abbreviate this name "MNU." MNU accused the insurer (which we shall call the Universal Disability Insurance Company "UDI") of serious bad faith. She did this by deploying a number of misconceived ethical principles and legal rules. These kinds of arrogant and simple-minded errors can be wonderful sources of cross examination. Interestingly, such a cross examination may be quite standard, leading

questions to be answered "Yes" or "No," or it can be done with non-leading general question, which will almost certainly be answered absurdly. We leave it to the reader to construct the questions.

Consider the first principle MNU recites:

Disability insurers have a duty to investigate *fully* the relevant and applicable facts of any claim.

It might be called the Principle of Full Investigation. The first problem here is with the word "fully." If the word "fully" is taken literally, a carrier would have the duty to investigate every single fact which might have any application to a claim. This simply isn't true. No one thinks that it's true. The correct principle is closer to this:

Disability insurers have a duty to investigate in a reasonable manner the facts relevant to a claim which are presented to them and to make a reasonable inquiry as to further facts, if the material presented to them reasonably suggests their existence and relevance.

A distinction lies between *full* and *reasonable*, as does some conceptual distance. Of course, it is possible that the concept of *full* converges on the concept of *reasonable*. The problem is, of course, that, if that were true, the concept of *full* becomes paradoxical, terribly obscure, and/or the principle itself becomes weak, uninteresting, uninspiring, and perhaps empty. (It is unclear, by the way, what the word "applicable" means in this context, if it doesn't mean something other than "relevant.") It is also clear that MNU's Principle of Full Investigation is required by virtually any state's law of bad faith.

MNU's second principle might be called the "Principle of Fair Consideration." It states, in relevant part, as follows:

The disability insurer has a duty to consider fairly *all* information obtained.

If this second principle is taken in conjunction with the first, it is too strong. If it is understood independently of the first principle, it is too weak. Its spirit, however, is correct. Indeed, it might be formulated differently as the Principle of Objectivity:

Disability carriers have a duty to consider objectively all claims for benefits submitted, including all relevant information submitted and all relevant information which could be obtained by means of a reasonable inquiry.

Fairness and objectivity in the adjustment process are essential to sound and honorable adjustment.

MNU's third principle requires that insurers consider the interests of the insured is at least equal to their own. This principle might be true, although it is not part of the essence of law of bad faith in at least some states. MNU's formulation of this principle, however, goes wrong. Here is her full formulation:

Disability insurers have the duties to (1) consider the interests of their insured at least equal to their own and (2) resolve all undeterminable issues (i.e., issues left open to some doubt) in their insureds' favor.

This could be called the Quasi-Fiduciary Principle. A fiduciary must always treat the interests of the person for whom he is a fiduciary is more important than his own. If someone has an obligation to treat the interests of a person he is serving as at least equal to his own, then he is a quasi-fiduciary. The first conjunct of this formulation is troubling. We have no idea what is really involved in an insurer's treating the interests of an insured as equal to its own. Furthermore, it might well be conceptually possible for an insurer to subscribe to the view that its principles should come first-ahead of those of a single insured-but that they shouldn't finish very far ahead of such interests and that the reason the insurer's interest should be regarded as somewhat superior is to protect the

pool so that all insureds who sustain losses can get paid. The second conjunct of this formulation is either obscure or false. If it means that every issue that an insurer cannot determine, including factual issues, must be resolved in the insured's favor, the principle is false. If an insurer cannot determine a factual issue, it has a right to seek an adjudication. If the insured has not established the claim, the insurer has a right to deny the claim and await adjudication. On the other hand, if the reason that a dispute cannot be determined is because of an ambiguity in an insurance policy, then the insurer does have a duty to resolve the ambiguity in favor of the insured. At the same time, if the reason the insurer cannot determine a claim is because of some obscurity in the law, outside the contract of insurance, the insurer has a right to an adjudication.

MNU's fourth principle, a Principle of Prompt and Accurate Notice, is too stringent. Here is the principle she enunciates:

Disability carriers have a duty to notify their insureds promptly and accurately of significant information or applicable policy provisions which might adversely affect their claims.

Actually, insurers have a right to believe that insureds know the contents of their policies. Many wonder whether this truth has realistic correspondence to the actual world. Nevertheless, the law is quite clear. In addition, the concept of *significant information* is open-ended and therefore probably too broad. Let us suppose an insurance examiner goes over a claim and all of the material affecting the claim, writes an opinion about the claim which is negative, and forwards it to a supervisor. The fact that this has happened is *significant information*. Insurers do not, however, have a duty promptly and accurately to notify their insureds of this fact. Consequently, MNU's principle is too broad. There are some facts, propositions, and gaps in which insurers do have the duty MNU describes. But the principle MNU enunciated is far too broad. It is certainly not integral to virtually any state's criteria of insurer of bad faith. This is a matter of simple logic.

MNU's fifth principle is false. MNU's fifth principle is a Principle of Prompt Payment, and she formulates the principle this way:

Disability insurers have a duty promptly and timely to pay benefits owed under the policy.

MNU's formulation of this principle is inelegant since the adverbs make it redundant, but that is not an issue which needs to be discussed here. At the same time, however, MNU's principle is not a principle of bad faith in any state. Insurers may make mistakes without being guilty of bad faith. Thus, if an insurer reasonably believes that it does not owe benefits under a policy, and is mistaken, it will fail to pay benefits either promptly or timely. Violating this principle does not generate bad faith, although it may constitute a breach of the contract.

MNU's sixth principle might be called the Principle of Procedural Guarantees. She formulates the principle as follows:

Disability insurers have a duty to establish and maintain procedures for the purpose of guaranteeing compliance with the obligations to be found in MNU's ten principles of adjustment, i.e., the here recited MNU list of Principles.

Several things are wrong with this principle. First, since some of the other "obligations" set forth by MNU are not in fact obligations, this principle cannot possibly be true, at least as formulated. Second, it is not a principle of bad faith law anywhere. Third, it is not possible to establish and maintain principles and procedures in social context which will *guarantee* doing the right thing, nor does the law require it. Next, if this principle were taken to mean that a disability insurer has a duty to have procedure manuals, we do not believe that this is an industry standard. It may be a good idea, but it is not a universally recognized standard. Finally, MNU's version of

the principle is obscure because the concepts of *establish* and *maintain* are themselves obscure.

MNU's seventh principle might be called the Principle of Absolute Contractual Rectitude. She formulates the principle this way:

Disability carriers have a duty to know and understand the language and meaning of their insurance policies and to administer their claims accordingly.

This is not a principle of insurer good faith anywhere. If it were, then every error committed by an insurer which resulted in the fact that they misinterpreted their insurance policy, as subsequently determined by a court, would be an instance of insurer of bad faith. This idea is false everywhere.

As if this point were insufficiently problematic, MNU goes on to suggest that it is an industry standard that insurers must in all cases administer their contracts without error. No authoritative legal source, anywhere, has ever suggested that mistakes of this sort constitute bad faith. As a principle of contract law, MNU's seventh principle is closer to right. Indeed, given *contra proferentem*, it may even be actually right. It is a breach of contract to get a contract wrong. However, as suggested, it is not a principle of the law of insurer good faith and fair dealing.

MNU's eighth principle is similarly not a principle of the law of insurer bad faith. This principle may be formulated as follows:

Disability carriers have a duty to know and understand the applicable laws of the controlling jurisdiction and to administer their insureds' claims accordingly.

Perhaps this rule should be called the Principle of Absolute Legal Knowledge. There are a number of technical problems with this principle. First, it is not always clear what jurisdiction controls. This is particularly true when there are insureds sprinkled across a variety of jurisdictions. Indeed, there may not be one controlling jurisdiction. Second, it is not even true that, as a matter of contract law, insurers have the duty described in the principle. Nobody can know everything relevant in a legal situation. Third, it is false as well that this is part of the law of bad faith. It isn't even close. The law of bad faith requires that insurers expend reasonable efforts attempting to understand what law controls and what the content of that law is. It is also a virtually universal truth that the law is not always clear. When the law is not clear, it is not possible to say that insurers are misbehaving themselves when they don't know what the law says. They may find themselves contractually liable when they "guess" wrong as to what the law is, but that is not necessarily a breach of any obligation, other than the obligation to pay found in the contract.

MNU's ninth principle is similarly false and not a principle of the law of bad faith. Her ninth principle can be stated as follows:

Disability carriers have a duty to be able to read, interpret, and understand *all* of the pertinent medical information with sufficient clarity so as to be able to make a fair, objective, and thorough evaluation of their insureds' claims for disability benefits.

This might be called the Principle of Thorough Medical Knowledge. Something of the spirit of this principle is surely true as a legitimate expectation about the business of insurance. It is certainly a valuable ideal. However, it is not the case that all mistakes in interpreting medical data constitute a form of bad faith. Moreover, it is simply not the case that a disability insurer must be able to read the handwriting of every physician who sends data. As an aspirational principle, it is reasonable to ask insurers to be fair, objective, and thorough. MNU's principle, however, is much more stringent than this and much broader.

MNU's Tenth Principle is formulated as follows:

Disability insurers have a duty to seek out information relevant to a claim and to communicate with the insured and his or her physicians in a manner likely to elicit an informed and pertinent response.

This might be called the Principle of Expansive Communication. Again, as an aspirational principle, this is surely to be commended, although MNU's black-and-white formulation of the principle is too stringent, even as an aspirational principle. A better formulation would be this:

Disability insurers have a duty to (1) exercise reasonable care in seeking relevant information to a claimant, when some information has been submitted but some has not, (2) to communicate with the insured and his or her physicians in a rapid and reasonable manner, and (3) to do so to a reasonable extent, in order that the insurer may elicit truthful and relevant information regarding claims.

This principle, like the others on MNU's list, is not a principle of the law of bad faith. The closest it gets to being a legal principle would be as a principle of negligence, and the occurrence of negligent acts is not a sufficient condition for the occurrence of bad faith.

Thus, although MNU's principles sound good, and while the spirit of them can be inspiring, they are neither fruitful portrayals of the details of industry standards, nor do they capture the spirit of the law of bad faith. In fact, they are profoundly misleading, even if the falsities in the principles appear to be smallish, though numerous. One of the reasons they are misleading results from what they leave out. One social function of insurers is to be the guardians of asset pools which are to be used for the payment of legitimate claims. Insofar as that is a legitimate function of insurers, one of their duties is to be skeptical of claims and to require that insureds and their physicians submit truthful, reasonably complete, and consistent information. This might be called the Duty of Moderate Rational Skepticism. After all, we all live in a free, market society in which fraud is not unheard of and financial exaggeration more even common. It is surely not a part of the insurers' duty of good faith and fair dealing to each individual insured, but it is part of their social duties. The law of insurer good faith and fair dealing is and must be consistent with a rationality motivated and limited duty of moderate skepticism. Of course, moderate skepticism is not the same thing as dogmatic skepticism, intransigent skepticism, obtuse skepticism, or pig-headed refusal.

What is the point of all this? Expert witnesses on insurance adjustment who are testifying to both customary and moral matters should think hard about what the right principles, from both topic areas really are. Obviously, careful empirical thought, rigorous logical thought, and sensible moral thought, as well as knowledge, are all required. There is also another problem here. Whether experts should be permitted to testify as to normative moral matters is open to some question-indeed, controversy. [FN50][FN50]

MNU apparently believes that her principles entail that a disability insurer has a duty to obtain an independent, objective medical opinion before denying a claim in every case where longtime medical problems and chronic pain are involved. There is no such industry standard, and the law of bad faith does not require it. Besides, some exclusions defeat coverage even if such medical conditions are present. Thus, MNU apparently believes that her principles require that an IME be obtained in *every* case whether there is a difference of opinion between the insurer and any of the treating physicians. This is not a principle of the law of bad faith. MNU apparently believes that disability insurers have a duty to obtain *all* medical records pertaining to a claimant before it makes any decisions. This is *not* a universalistic principle of the law of bad faith.

MNU is critical of UDI's adjuster-examiners for a variety of questions they did not ask. Under the applicable

principles of bad faith, if the insurer has sufficient information to raise a bona fide dispute, then-at least from the point of view of bad faith-what it has done is sufficient. If MNU were right about this narrow principle, so an insurer could have done a better job, she is not completely right. If an insurer has done a "good enough" job, or a reasonably good job, it is immune from criticism and liability under the law of bad faith. [FN51][FN51] The law of insurer good faith does not require a "best practice."

Similarly, MNU is critical of UDI because its adjustment file does not contain documents reflective of what she believes would be a sounder adjustment practice. If she were right about the condition of the adjustment file, this would not be particularly probative of whether UDI is guilty of bad faith, so long as the file contains sufficient information to raise a bona fide dispute. Our point would be true even if the adjustment were substantially less than perfectly prepared or maintained. MNU is even critical of the informal language some of the adjusters used in describing their conduct in their depositions. At one point, for example, she criticizes a UDI adjuster-examiner for the way he describes his reaction to information. She is apparently suggesting that he is overly emotional, or something of the sort. This kind of criticism-standing alone is silly, from the point of view of discussing insurer bad faith. The mere presence of some emotion in an adjuster or examiner does not imply the presence of bad faith or even irrational reasoning.

MNU is critical of an adjuster-examiner for the way he relies upon and draws inferences from the policyholder's statements that he could drive, mow his lawn, and shop for groceries. From the point of view of bad faith, the question is whether these facts raise bona fide issues and/or questions.

MNU faults UDI for not having established, written procedures of internal appellate review. We do not believe that the having of such procedures is an industry standard, although it is common. The having of such procedures is, under some circumstances, be quite dangerous. If, a senior claims examiner performs a review *de novo* and does so objectively, then there is nothing to complain about. By the way, MNU's principles themselves do not require the existence of *guidelines* for internal appellate review. Moreover, since MNU's principles require that procedures be established to *guarantee* correct decisions, no guidelines for appellate review could ever, possibly do that.

Conclusion

The goal of this paper has been to summarize the structure and evolution of disability insurance policies. It is focused on recent times, although not exclusively. It largely ignores the ups-and-downs, together with the ins-and-outs of ERISA, except to the extent that it is derivative upon common law insurance principles.

The paper has also gone to some length to describe prevailing adjustment practice. Our over all impression from the cases and the news sources involves three observations. First, courts are not especially sympathetic to bad faith actions against disability insurers. Second, most disability insurance appear to try to do the right thing in the claims process most of the time. Third, adjustment handled by disability insurers is not always well organized or terrifically insightful. Even less than perfect adjustment practices, however, are often focused, cautious, perhaps sympathetic, and at least somewhat energetic, even if there is some stumbling or blundering along.

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[FN1]. See n.2 below, however.

[FN2]. "The claim function should ensure the prompt, fair, and efficient delivery [under the insurance company's promise to pay] [¶] In disbursing funds to pay for losses and loss adjustment expenses, the claims representative must serve various interests. The insured expects to be paid promptly and in full." James M. Markham, Kevin M. Quinley, and Layne S. Thompson, *THE CLAIMS ENVIRONMENT* 8 (1993). "The insured should be able to trust the insurance company's claim representative. The claim representative must follow through with promises and be completely honest with the insured." *Id.* at 18. "A claim representative dealing with an unrepresented claimant should be careful not to mislead the claimant." *Id.* at 20. "In order to deliver its promise to pay claims promptly and fairly, the claim department cannot rely solely on its own knowledge and experience. It must use the services of specialists in other fields.... With all service providers, the claim representative must also provide clear and specific instructions as to the scope and limitations of the provider's assignment." *Id.* at 20-21. "The delivery of the [insurer's] promise to pay is the heart of the claim function and process. The claim process involves prompt, fair, and efficient payment of covered losses." *Id.* at 27. Obviously, this is true even if the insured does not quite understand what is covered and what is not covered and hence does not formulate his claim perfectly. "The claim professional must harness all of his or her knowledge and expertise to accomplish the objectives of the claim function. He or she must also adhere to the highest degree of ethical conduct." *Id.* "Insurance companies provide such a vital and necessary service to society that the selling and servicing of insurance is imputed to public trust." *Id.* at 28. As a consequence, investigations by claims representatives should be "objective, thorough, and timely." *Id.* at 29. "The claim representative's primary duty is to fulfill the insurance company's promises to the insured. These promises are contained in the insurance policy." *Id.* at 59. To some degree, many insureds fear insurance companies. "Fear and distrust of insurance companies can be mitigated considerably by a competent, caring claims department. A friendly, courteous manner, a professional attitude, and a *willingness to listen* can do much to alleviate the claimant's fear that he or she is at the mercy of the insurer." *Id.* at 66-67. [Italics added.] "A claim representative cannot 'control' a claim the way a puppeteer controls a puppet or even the way a driver controls a vehicle. In the context of claims, 'control' means that the claim representative directs the progress of the claim and has motivated the claimant to cooperate with the claims representative and the claim process. Taking control of a claim enables a claim representative to make a fair offer to the claimant with the expectation that the offer will settle the claim." *Id.* at 71. "The claim representative must treat the insurer ... with courtesy, dignity, respect, and fairness." *Id.* at 74. Are the axiomatic basis of the maxim *Look for coverage!* can be found in all sorts of places. See the very short but step-by-step description of adjustment to be found in college textbooks of insurance. See Emmitt J. Vaughn and Theresa M. Vaughn, *FUNDAMENTALS OF RISK AND INSURANCE*, 131 (8th Ed. 1999).

[FN3]. See Michael Sean Quinn, *The Ethical Habitat of Adjusters: Part 2. Principles, Problems, and Practicalities*, 10 ENVTL CLAIMS J. 77 (Spring 1998) and *The Ethical Habitat of Adjusters: Part 1. Principles, Problems, and Practicalities*, 10 ENVTL CLAIMS J. 91 (WINTER 1998).

[FN4]. For a very thorough discussion of this aspect of adjustment, see *Voight v. Metropolitan Life Ins. Co.*, 28 F. Supp.2d 569 (C.D. Cal. 1998) (ERISA case). See also *Grady v. Paul Revere Life Ins. Co.*, 10 F. Supp.2d 100

(D.R.I. 1998) (critical of insurer's in-house doctor-analyst). For lawyers representing disabled policyholders against insurers, doctors utilized by disability insurers is a potential issue to pay careful attention to.

[FN5]. *Mowers v. Paul Revere Life Ins. Co.*, 204 F.3d 372 (2d Cir. 2000). (The court reversed a summary judgment. The court found that the insured had a duty to cooperate, but it found that there was a genuine issue of material fact with respect to whether the insurer's request for a functional capacity examination was reasonable.)

[FN6]. *Vaughn and Vaughn*, supra n.2 at 355-56.

[FN7]. Our discussion of adjustment began by asserting that it was mostly a commonsensical matter. This claim may not be correct all the way to the bottom of acquired depth or all the way across careful observation. Two important questions point in the direction of these issues. First, is careful reasoning a matter of common sense always? Second, is objectivity always a matter of common sense? What is rationality? What is careful reasoning? What is genuine objectivity? Obviously, these are philosophical issues of some considerable importance. Obviously, they raise issues about sound medicine and the nature of scientific research. They are not restricted to areas of science, however.

[FN8]. The process of adjusting disability claims is described in some detail in a number of cases. See *Doyle v. Paul Revere Life Ins. Co.*, 144 F.3d 181 (1st Cir. 1998) (including a dissent by Judge Coffin). See also *Stenger v. Provident Life & Acc. Ins. Co.*, 121 F. Supp.2d 1238 (E.D. Wis. 2000), *Norcia v. Equitable Life Ass. Society of U.S.*, 80 F. Supp.2d 1047 (D. Ariz. 2000), *Phelps v. Provident Life & Acc. Ins. Co.*, 60 F. Supp.2d 1014 (C.D. Cal. 1999), *Washburn v. UNUM Life Ins. Co. of Am.*, 43 F. Supp.2d 848 (S.D. Ohio 1998), *aff'd without opinion*, 210 F.3d 373 (6th Cir. 2000), and *Buchanan v. Reliance Std. Life Ins. Co.*, 5 F. Supp.2d 1172 (D. Kan. 1998). ERISA cases also contain a fair amount of material on the process of disability claims adjusting. See *Conley v. Pitney Bowes*, 176 F.3d 1044 (8th Cir. 1999), *cert. denied*, 528 U.S. 1136 (2000), *Chandler v. Raytheon Employee's Disability Trust*, 53 F. Supp.2d 84 (D. Mass. 1999), *aff'd* 229 F.3d 1133, *cert. denied*, 531 U.S. 1114 (2001), *Barnable v. First Fortis Life Ins. Co.*, 44 F. Supp.2d 196 (E.D.N.Y. 1999), *Robinson v. Phoenix Home Life Mut. Ins. Co.*, 7 F. Supp.2d 623 (D. Md. 1998). Interestingly, the *Vaughn and Vaughn* textbook does not suggest that there is any substantial difference between adjusting health claims and adjusting first party insurance claims in general.

[FN9]. Arthur L. Fries, *How Agents Can Help Their Clients Get Disability Claims Paid*, NATL UNDERWRITER (November 11, 2002).

[FN10]. What should the policyholder do if offered a buyback by the insurer? How should the policyholder prepare supplemental materials, if at all?

[FN11]. Sometimes, people attempt to use other causes of action as a substitute for bad faith. Sometimes, litigants try to use intentional infliction of emotional distress. This is not a likely candidate for success. *LaChapelle v. Berkshire Life Ins. Co.*, 142 F.3d 507 (1st Cir. 1998) (Maine law).

[FN12]. Many people believe that rules on bad faith should apply to the first party components of third party insurance, but this is not the place to discuss that. See *Insurer Bad Faith: Expertise & Appellate Review*, 20 INS. LITIG. RPTR. 774 (Oct. 15, 1998), *Struggle, Confusion, and Diversity: Insurance Bad Faith in Texas-Recent Rapid Evolution*, 20 INS. LITIG. RPTR. 175 (March 15, 1998) (discussion of the *Simmons* case), and *Insurer Bad Faith - Sic et Non - Texas Style*, 19 INS. LITIG. RPTR. 485 (August 15, 1997). (This is a discussion of *Giles, Nicolau, and Williams*.)

[FN13]. Claims controlled by ERISA are not included within this observation. Bad faith is preempted.

[FN14]. There is now some hope. *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).

[FN15]. *Holroyd v. Requa*, 603 S.E.2d 417, 2004 WL 2157395 (S.C. App. Aug. 9, 2004).

[FN16]. See Art. 21.21 § 2(a) of the Texas Insurance Code (2004). This section makes it quite clear that agents and brokers may be found liable for violations of statutes specifying what is, in effect, insurance bad faith.

[FN17]. See n.1 supra.

[FN18]. See *Monga v. Security Mutual Life Ins. Co. of N.Y.*, 2002 WL 31777872 (N.Y. Super 2002) (citing New York appellate authority).

[FN19]. In general, fiduciary duties require that a person or entity who is a fiduciary for another to observe the following rules or principles. In these rules or principles the fiduciary is listed as A while the person whose interests are being tended is called B. (1) A must place the interest of B ahead of his own. (2) A must be loyal to B. (3) It must be obvious to a reasonable person familiar with the facts that A is being loyal to B. (4) A must completely disclose all material facts to B. (5) A must not misrepresent anything to B. (6) A must be trustworthy in the eyes of B. (7) A must not perform any acts which would render him untrustworthy. (In other words, they must actually be trustworthy with respect to B.) (7) And so forth.

[FN20]. Should insurers treat the interests of their insureds as somehow more important than their own or should they treat the interests of their insured as equal to their own? Obviously, these are quite different rules. See Michael Sean Quinn, *The Defending Liability Insurer's Duty to Settle: Meditation on Some First Principles*, 35 TORT & INS. L. J. 929, § III, 955ff (2000). (The explicit topic there was the duty to defend, with many of the same considerations apply here and in other first-party contexts.)

[FN21]. *Franklin v. Minn. Mut. Life Ins. Co.*, 97 F. Supp.2d 1324 (S.D. Fla. 2000), *Phelps v. Provident Life & Acc. Ins. Co.*, 60 F. Supp.2d 1014 (C.D. Cal. 1999), *Dym v. Provident Life & Acc. Ins. Co.*, 19 F. Supp.2d 1147 (S.D. Cal. 1998), and *Arenberg v. Central United Life Ins. Co.*, 18 F. Supp.2d 1167 (D. Colo. 1998).

[FN22]. *Egan v. Mutual of Omaha Ins. Co.*, 620 P.2d 141 (Cal. 1979). See *Stenger v. Provident Life & Acc. Ins. Co.*, 121 F. Supp.2d 1238 (E.D. Wis. 2000) and *Norcia v. Equitable Life Ass. Soc. of the U. S.*, 80 F. Supp.2d 1047 (D. Ariz. 2000).

[FN23]. 16 Mass. L. Rptr. 245, 2003 WL 21030177 (Mass. Super. Jan. 14, 2003).

[FN24]. *Id.* at 7.

[FN25]. *Id.* at 9.

[FN26]. *Id.* at 10.

[FN27]. *Id.* at 11.

[FN28]. *Id.*

[FN29]. *Id.*

[FN30]. *Id.* at 12.

[FN31]. When an insurer's doubts, inquiries, investigation, and thoughts are prolonged, findings of bad faith become less likely. *Helus v. Equitable Life Assurance Society of the United States*, 307 F.Supp.2d 1170, 1184-85 (N.D. Cal. 2004).

[FN32]. *Id.* at 13. (Italics added.)

[FN33]. 289 F.3d 1350 (11th Cir. 2002).

[FN34]. *Provident Life and Accident Insurance Company v. Hallum*, 576 S.W.2d 849, 850 (Ga. 2003).

[FN35]. *Id.* at 851. The Supreme Court of Georgia cites a number of cases pertaining to this matter. *Id.* at nn. 1-4.

[FN36]. *Id.* at 851.

[FN37]. *Id.*

[FN38]. *Hallum v. Provident Life and Accident Insurance Company*, 326 F.3d 1374 (11th Cir. 2003).

[FN39]. *Vaughn & Vaughn*, *supra* n.2 at 360-62.

[FN40]. 128 S.W.3d 211 (Tex. 2004).

[FN41]. **The coverage issues are discussed in *Quinn & Koch*, *****

[FN42]. *Provident Life and Acc. Ins. Co. v. Knott*, 128 S.W.3d 211, 221-22 (Tex. 2004). The *Knott* case is citing *Murray v. San Jacino Agency, Inc.*, 800 S.W.2d 826, 828 n. 2 (Tex. 1990).

[FN43]. *Id.* at 222-23. The supreme court relies upon statutory sections and three cases. The statutory sections are not particularly relevant, although-to be sure-they do not explicitly require that the word "deny" (or its near-relatives) be used. It also relies upon three cases. One of these cases holds that an insurer denied a claim by simply closing the file, after an insurer failed to submit any more information. This closure of the file, said the court, constituted a claim denial. *Kuzniar v. State Farm Lloyds*, 52 S.W.3d 759, 761 (Tex. App.-San Antonio 2001, pet denied). This observation about the nature of insurance practice is clearly mistaken. The *Kuzniar* case was wrongly decided, and it should not be relied upon.

[FN44]. Texas Insurance Code, Article 21.55 (2004). Its title is "Prompt Payment of Claims."

[FN45]. *BLH v. Northwestern Mut. Life Ins. Co.*, 92 F. Supp.2d 910 (D. Minn. 2000).

[FN46]. *Allmerica Financial Life Ins. & Annuity Co. v. Llewellyn*, 139 F.3d 664 (9th Cir. 1997).

[FN47]. *Maharan v. Berkshire Life Ins. Co.*, 110 F. Supp.2d 217 (W.D.N.Y. 2000).

[FN48]. *Legal Malpractice and Evidence from Experts*, 30 LITIGATION 40 (Fall 2003). (Olga Seelig was the co-author.)

[FN49]. www.claim.org. The slogan or motto of this organization is *Leading the Way in Claim Excellence*.

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[FN50]. See Edward J. Imwinkelried, *Normative Testimony*, 27 NATL. L. J. 16 (October 25, 2004). According to Professor Imwinkelried, normative principles are essentially controversial and may not really fall within the rules of evidence governing expert testimony. There is another point of view, however. What the expert witness is testifying to is not his opinion as to ethical and moral principles, but his opinion as to which moral principles are widely accepted in the adjustment community. This appears to me to be the sort of thing that expert testimony is about.

[FN51]. For a profound critique of “best practice” ideology, see Laura Nash and Howard Stevenson, JUST ENOUGH 34-36 (2004) (mostly about business and executive success).

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