

# INSURANCE LITIGATION™

Reporter

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## Quality Questioning—*Quellenforschung*

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This journal is the INSURANCE LITIGATION REPORTER. That is not surprising news to anyone who has read this far. A reader couldn't have made it this far without noticing the title and nature of the journal. Since the focus of this journal is upon the litigation of insurance problems, perhaps some notice should be taken of an interesting book about an even more fascinating insurance litigation case. The litigation itself has already been reported here. The journal (through me) now turns to the book, sort of.

### Preface

The book is entitled INSULT TO INJURY. It is subtitled INSURANCE, FRAUD, AND THE BIG BUSINESS OF BAD FAITH. It was written by Ray Bourhis, a San Francisco plaintiff's attorney, who—to some degree—specializes in insurance coverage and bad faith cases. Mostly he represents individual insureds. The book was published in 2005. The narrative mostly concerns the case of *Hangartner v. Provident Life & Accident Insurance Co.*, one of the cases of Bourhis's law firm, Bourhis & Wilson. The case was tried in federal court to a jury, and the insured won, 236 F.Supp.2d 1069 (N.D. Cal. 2002). It was then appealed to the Ninth Circuit, where—with a minor exception—he won again. 373 F.3d 998 (9th Cir. 2004). This is not the only case discussed in the book. Another one is *McGregory v. Paul Revere Life Ins. Co.*, 369 F.3d 1099 (9th Cir. 2004). That, too, was a Bourhis case.

The book currently costs \$24.95 in hardback. The book is satisfactorily printed. It has picture of some of the heros though none of the wicked villains. It also have a very interesting and educational appendix which consists of discovery-and-trial exhibits. Alas, the book does not provide guidance to some website where the entire transcript of the underlying trial can be had. Obviously, such is not a critique of the book itself. For faults, look to the index which is frequently,

and systematically a couple of pages off: computers, it seems, are not everything yet.

The story of this case, narrowly conceived, concerns Joan Hangartner. She was a chiropractor. She developed some sort of bodily affliction and could not continue to work at her table. She sought total disability under her disability policy. She had bought it from Paul Revere, but by the time of the suit Paul Revere had merged into Provident Life, as had Unum Insurance. Thus, the target defendant was Provident. It had paid coverage for a while and then terminated it. INSULT TO INJURY is the story of that case.

The book has several themes: a little history of the insurance industry *in abstracto*, the ideology of the insurance industry, the character of Joan Hangartner, historic-anti-business Spitzerian developments since the trial, plus an impressive journalistic history of the *Hangartner* case. The author of the book was one of the lawyers who represented the insured. His prose is easy going and engaging. Fortunately, Bourhis does not seem to have the expansive streak of passionate—"I am a great lawyer"—narcissism which many authors, who are also lawyers, seem to have when they write about themselves and their exploits. Indeed, Bourhis is in some ways more complimentary with respect to Alice Wolfson, his partner, and one of the other lawyers who helped him try the case, than he is to himself. There are pictures of them all on their website: [www.bourhis-wilson.com](http://www.bourhis-wilson.com). Many of us, who try lawsuits after preparing for them, take pleasure in the occasional book written about the trial of a case. (Those of us who do not try cases, or who try fewer of them as the years age us, delight in at least some of these books, since they fulfill fantasies, wishes, dreams, etc., and provide pictures of a loved and envied reality.) Sometimes lawyers write these books. Sometimes journalists do it. Almost none of them are actually about litigated insurance disputes. Finally, at

long last, we have one that's a pleasure to read. The book is also a learning tool. This book was written by the lead counsel for the insured, as already indicated, and the fact that an involved lawyer wrote it makes it extra special and helpful.

My essay here will dwell upon only one of the interesting themes in the book, more than it will concern anything else. Thus, this essay is not exactly a book review. It is more a discussion of some valuable legal education which can be found in text. My focus will be upon questions utilized for the plaintiff-insured against the defendant-insurer. In insurance bad faith cases, the questions asked, the preparation of the witnesses, and the answers given to the questions of the insured's lawyers are often extremely important in determining the outcome of the case.

## Introduction

The flavor of the text of *INSULT TO INJURY* is so restrained that one finishes the book thinking that the *Hangarter* case could have been won by any dedicated, knowledgeable, and unwavering lawyer. Thus, this book is not so much a celebration of "Bourhisian Genius" as it is an implied and cautious portrait and critique of the inability, the incompetence, or the idiocy of the defendant insurance company that let this particular case go to trial and/or the poor performance of the insurer's lawyers, who should have had the good sense to recommend, advise, advocate, and even push their client toward settlement. Consequently, the Bourhis account of trial preparation and trial presentation is not a portrait of the profundity and the towering legal genius of an insured's lawyer, but instead an engaging and inspiring quasi-textbook on aspects of trial prep and trial execution.

The book concerns several disability insurers—in particular Paul Revere, Unum, and Provident—which over time merged into one company—UnumProvident. It is also about a new corporate "philosophy"—or better pseudo-philosophy, public-relations-philosophy, or journalistic-ideology—that appears, according to Bourhis, to have surfaced during or after the mergers and which was more dedicated to the immediacy of profit than it was to taking the risk of finding ethically based, long-term profit through serving customers. Of course, this tempting and egregious error is a cardinal sin for an insurance

company handling claims, all of which, by a deeply accepted, profoundly true, widely practiced norm, must treat the interest of its customers, i.e., its insureds, at least as importantly as it treats its own. (Many states articulate precisely this requirement for insurers, and some call it the insurer's *special relationship* with its insured, and some mistake it for having fiduciary duties to each of its insureds, although it must be granted that the two ideas are close in content, though not the same.) Provident (a/k/a Unum and UnumProvident) took the other two companies over, and then tried to save the situation by short-changing insureds in a tough-minded way by appearing to enforce the insurance contract justly. Perhaps some of the insureds needed to be cut-off. Perhaps some of them had recovered and no longer needed disability coverage. Perhaps some of them have grown lazy. The idea of disability phoniness for a large number of those insured against disabilities has probably never been true; it is not true now; and it is not likely ever to be true for all or most disabled insureds, as this case—the *Hangarter* trial and appeal—certainly proves.

Insureds frequently present problems for insurance companies, although at least one of the principal problems can be solved. Insurance companies certainly do not owe benefits to everyone who files a claim. Many claims are properly denied or reduced. In addition, some insurers simply pay the benefits they owe. But, says Bourhis, "if an insurance company—any type of insurance company—wants to dramatically increase revenues by denying or terminating valid claims, it can do so." Not all problems created by insureds or insurers can be solved by the insurer, of course. Some insureds are angry people. Some are very skeptical. Some are suspicious of insurers to an inordinate and incurable degree, and so forth.

The Bourhis portrait of the UnumProvident evolution is of a company profit-obsessed as opposed to coverage-oriented. I will not try to retell the tale here. The jury, the district judge, and the three judges on the circuit court all held Unum "guilty" of (Big Time!) bad faith. Mostly, I will pursue a somewhat different goal. I will explore Bourhis's account of quality questioning in depositions and at trial. It should be pointed out that the general themes in Bourhis's critique have been a problem for UnumProvident for several years.

A number of states have fined UnumProvident for the way in which it has handled disability claims. Last year, the U.S. Department of Labor fined it \$1.5m. Recently, the California Department of Insurance announced an \$8m settlement. California then became one of the last states to reach a pact with Unum. The investigations of the governmental authorities “were based on mounting complaints that Unum, the largest U.S. disability-income insurer, improperly denied claims from policyholders who often were unable to work for extended periods of time. The complaints came from holders of both group and individual long-term disability policies.” (Diya Gullapalli, *UnumProvident is Set to Pay \$8M Penalty in California*, WALL STREET JOURNAL C3 (October 3, 2005)). Since the beginning of 1997, “[t]he multi-state agreement reached last year required Unum to review 215,000 claims that were previously closed or denied, improve claims-handling procedures, and bring in new board directors, among other things.” The multi-state pact covered claims denied or closed since the end of 1999.<sup>1</sup>

Given Unum’s record, given the almost certain involvement of the *Hangartner* case in bringing about Unum’s reform, and therefore given the importance of the skills of plaintiff’s lawyers like Bourhis, some focus on what they did seems natural. We now turn to that. The focus is on asking good questions in bad faith cases.

### Some Questions

In his “history” of the case, Bourhis recounts a number of questions which he or his colleagues put to witnesses in various contexts. Some of them appear to have been posed in depositions. Some of them were posed at trial. (Possibly some of those posed at trial were actually posed in depositions, and then either read at trial or repeated at trial. The book

is not clear on this point.) I have long been interested in what questions are helpful in insurance coverage and bad-faith cases.<sup>2</sup> A number of these questions will be repeated here, variations will be suggested, and occasionally there will be some commentary. Reference will also be made to a short essay written by Ray Bourhis, entitled “*The Deposition and Cross-Examination of Claims Managers*.” It is to be found on the firm’s website. Some additional questions which Bourhis has inspired in me will also be added here, for reader consideration. Finally, I will briefly consider designing questions based upon training books for adjusters. In this context I will draw a little on another recently published book entitled THE AWESOME ADJUSTER written by Carl Van and published as a second edition book in 2004,<sup>3</sup> after it had appeared as a series of essays in the magazine CLAIMS. I shall say a bit more about this book toward the end of this piece.

The insurance policy at issue in *Hangartner* was a relatively standard disability policy. Disability policies are not as uniform as, for example, comprehensive general liability insurance policies, but they—the disability policies—exemplify a great many close similarities among themselves (though not, of course, to any sort of liability policy). For example, the coverage agreement in the disability policy typically covers both *total disabilities* and *partial disabilities*. These phrases are defined in every policy I have ever seen. The definitions are not always the same, but they are usually quite similar. For example, the term “total disability” is often defined as follows: “because of an injury or sickness, you are unable to perform the important duties of your occupation.” That is how it was defined in the *Hangartner* policy. One of the most interesting series of questions Bourhis (et al) put to witnesses concerned how this definition worked. In terms of

1. Bad faith claims handling has not been Unum’s only legal problem. It has also been dragged into the finite risk scandal. In 1996 there was a finite risk transaction between Unum and Centre Life Re Ltd., a Bermuda-based company. “The business include[d] about \$1.6 billion in invested assets and \$185 million of annual premiums.” BUSINESS INSURANCE 19 (August 22, 2005).

2. Michael Sean Quinn, *Depositions of Claims People*, 8 COVERAGE 21 (May/June 1998), *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). Michael Sean Quinn and Evan Koch, *Adjustment of Disability Claims and the Problem of Bad Faith*, 19 INS. LITIG. RPTR. 697 (December 3, 2004), and *Disability Insurance: An Elementary and “Puristical” Introduction to Coverage Issues*, 26 INS. LITIG. RPTR. 69 (November 17, 2004).

3. The author’s full name is Carl Van Lamsweerde. Why a frequent writer and speaker on claims matters who heads the International Insurance Institute Inc. would simplify his elegant name for printing purposes is a mystery.

policy meaning and therefore in terms of adjustment the definition is crucial, as are definitions in many policies. Here are versions of some of the questions Bourhis, or his colleagues, must have utilized, and then some:

Q<sub>1</sub>: Is it important to understand this definition [e.g., that of *total* disability] when making a decision about whether the insuring agreement is met?

Q<sub>2</sub>: When acting as an adjuster, is it important for a person to know what this definition means in order to make a decision as to coverage?

Q<sub>3</sub>: In making coverage decisions about the insuring agreement, is it important to understand the meaning of the phrase “the important duties of” in the definition?

Q<sub>4</sub>: How do you decide whether something is one of “the important duties” of the occupation of an insured?

Q<sub>5</sub>: What are reasonable ways for determining which are the important duties of an occupation?

Q<sub>6</sub>: Are there any unreasonable ways in “determining” what the important duties of an occupation are?

Obviously, these are important questions. It should be remembered that a lawyer asking questions often has to struggle with a witness to get him to answer them. Of course, sometimes this cannot be done. Sometimes, when it isn't done, the failure of a witness to give an answer is just as good—or even more important—than getting an answer. It makes the witness look absolutely awful, at least under some circumstances. Delay in answering is also helpful, as we shall see.

An adjuster-witness is going to have to agree that understanding this particular definition is going to be crucial in reasonably or logically deciding whether there is coverage for someone who claims to be totally disabled. If a working adjuster or claims manager says

he doesn't understand it, four conclusions are possible: (i) the witness is lying; (ii) the witness is ignorant; (iii) the witness is stupid; or (iv) the words don't have a clear meaning and the insurer adapts them (or makes them up) as it goes along. Of course, an insurer-witness will never admit any of these.

On this basis, Bourhis turned to another question. “I asked whether this [i.e., the definition of *total* disability in context] means *all* the important duties, *most* of the important duties, or *any* of the important duties.” [31] More fully expounded, Bourhis's question would have to read something like this:

Q<sub>7</sub>: Does the definition of *total disability* mean that, because of injury or sickness, the insured is unable to perform *all* of the important duties of his occupation, *most* of those important duties, or *any* of those important duties?

Perhaps the question could have been a little shorter than that, but not much.

The witness to whom Bourhis put this question was the “Senior Claims Representative” who wrote and signed—or at least signed—the formal letter denying coverage. Not infrequently, adjusters don't actually write their own complicated denial letters. Sometimes they are based upon forms. Sometimes they are based upon letters lawyers have written. Sometimes they are actually written by lawyers. Sometimes those lawyers are from outside the insurer. Sometimes they are in-house. In any case, the reaction of the witness to the question was then, and is now, stunning. When the question was asked him, the witness “wrinkled his forehead and squinted as he looked at the policy. He stared at it for several minutes in silence, seemingly puzzled. [¶] I waited for an answer. This was an issue of major importance... [¶] Why was he just sitting there? Was this the first time he had ever thought about it? I waited him out. Finally, he looked up and said, “The important duties I suppose if it was meant to mean *all*, it would say *all*.”

Subsequently, during the same deposition the witness changed his answer, but that fact is of no interest to me presently. This witness conceded that this change resulted from a discussion with the lawyer protecting the record. It should have been horrifying to the insurance company, since it probably

undermined the credibility of this witness to a fair extent. All rational juries would be shocked when seeing this video. Perhaps there is a lesson here: when deposing claims witnesses from insurers, always video them, at least when one can afford it. (Don't try to do it yourself. Several years ago, a friend of mine, who was broke, took a deposition with a video camera on a tripod between her legs. The camera sat in front of her. Her moving chin was just above it. She looked ridiculous. The camera didn't work well and joggled around. Hence, what seemed like a good idea in theory was an awful idea in practice. Some firms, of course, are large enough and/or rich enough to have their own folks. Obviously, a law firm must be careful about leasing out its video equipment and personnel to other law firms, as the great David Boies discovered, sort of.)

What would really interest me is whether this deposition was on videotape. The several minutes of prolonged silence would be extremely powerful when shown to the jury, since it refutes the idea that the witness had relevant knowledge, not to mention wisdom. Hence, seeing it would be an extremely valuable instrument to utilize in training lawyers who help witnesses get ready for depositions. I indicated earlier that the lawyers for the insurer may not have done a very good job in some ways. Preparing their Unum witnesses was one of the ways in which the job the defense lawyers did was awesomely awful. Of course, this is not a suggestion that the lawyers were guilty of malpractice. The error and fault may not be theirs. Insurers frequently don't want to spend their adjusters' time conversing with lawyers about how to give depositions. In addition, many experienced adjusters believe they know how to be good witnesses. So, why didn't the lawyer for the insurer get the witness ready? Maybe the client stood in the way. (This presents an extremely interesting problem for lawyers representing insurance companies. How far should a lawyer representing an insurer go in trying to advise his client—the insuring entity—that its decision-making people are making mistakes. Should Lawyer ("L") go above the regional claims manager and get the senior officials to get him to be more realistic? What if Adjustor ("A") is refusing a claim in a not-very-bright way? What if L's going up the ladder were to lead to a proper solution in a given case but would lead to L's elimination from the referral list, at least over time? Is this a conflict between

Lawyer's fiduciary duties to the true client and her self-interest? Now back to the true topic.)

Now let us suppose the question regarding the definition of *total disability* were this:

Q<sub>8</sub>:When an insurance policy says that the insured has a *total disability* only if she/he is unable to perform the important duties of her/his occupation, does it mean that the insured must be unable to perform *all* the important duties, that the insured must be unable to perform *most* of the important duties, or does it mean that the insured must be unable to perform *any* of the important duties of her/his occupation?

Put this way, of course, the question is too complicated. It's a bad way to examine most witnesses. It won't be read well by others, e.g., the judge. It cannot be read well, and understandably, upon one reading to a jury. And so forth. Partly, it is complicated because it involves some 60+ words. Many believe—or at least suggest—that questions should not exceed 10-15 words apiece. Partly, the question is too complicated because some of the alternatives are themselves quite unclear. Of course, this fact may be the fault of the policy itself.

Another way to handle this problem is through a sequence of questions. A sequence can be valuable since the witness may look bad several times, and his confusion probably cannot plausibly be said to be derived from the question put to him. Of course, this methodology might not get the dramatic silence from the witness, and such silences are valuable since even one in the right place is tantamount to the ruination of the insurer's case right from the start of discovery. In any case, here is an alternative approach:

Q<sub>9</sub>:An insured is entitled to benefits only if he is *totally disabled* or *partially disabled*, true?

A<sub>9</sub>:Yes.

Q<sub>10</sub>:Let's focus on *total disability*. There is a definition for this phrase in the policy, isn't there?

A<sub>10</sub>:Yes.

Q<sub>11</sub>:An insured is *totally disabled* only if he has an important inability, right?

A<sub>11</sub>:Yes.

Q<sub>12</sub>:The insured who is just *totally disabled* must be unable to perform the important duties of his occupation, right?

A<sub>12</sub>:Yes.

Q<sub>13</sub>:If an insured cannot perform any of the important duties of his occupation, then he is disabled? True?

A<sub>13</sub>:Yes.

Q<sub>14</sub>:If the insured can't perform some of the important duties, but can still perform most of them, would it follow that he was not *totally disabled*?

A<sub>14</sub>:Yes.

Q<sub>15</sub>:If the insured could perform some of the important duties, but he couldn't perform any of the most important duties—the ones central to his occupation—would he be totally disabled?

A<sub>15</sub>:Yes.

Q<sub>16</sub>:If the insured could perform all of the important duties for 30 second intervals on any given day, but couldn't perform them on any given day for longer than that, would the insured be disabled?

A<sub>16</sub>:Yes.

Q<sub>17</sub>:If the insured could perform a few of the important duties but could not perform most of them, the insured would be disabled, true?

A<sub>17</sub>:I don't know.

The most important difference between what I have

proposed and what Bourhis did was that I divided up “all,” “most,” and “any.” My way of doing it is less confusing than his, sort of. Then again, the definition itself is confusing.

Another important difference is that once you are pursuing insight as to what someone is unable to do, the concepts of *all* and *any* may actually refer to the same thing, though in different ways. An integrated, wholeistic question may dramatically invoke the several minutes of silence, which—if it is on video—would constitute a smashing long-term victory at nearly the beginning of discovery. Moreover, the answer of the Senior Claims Representative was stupid, and almost as injurious to the insurer as the several minutes of silence had been a few moments before. Arguably, Bourhis's approach, which triggered stupidity, is to be preferred to an approach which proceeds step-by-step and will, at its best, first get confusion and then get confessions that the adjuster would have to have specific facts in front of him before he could answer. (I call this a “confession” because the claim by an experienced person to be unable to answer any hypothetical questions is often an indication of deliberate and illegitimate avoidance.)

The easy confusion between *all* and *any* is easily illustrated by the way in which the adjuster-witness tried to correct his error after having visited with the attorney protecting the record. The witness said the following: “He had made a mistake before the break, he proclaimed. ‘The important duties wording’ in the policy *did* mean ‘all of the duties,’ after all. That, said [the witness], was what it meant.” [32]At that point, Bourhis asked the witness this: “I asked him if he wished to change his prior testimony. [¶] He said he did. ‘I was tired and confused at the time,’ he asserted. [¶] ‘We took a break. You spoke to your attorney. You came back and you changed your testimony. Is that correct?’ [¶] ‘That is correct.’ ‘They had had lunch, he added.’ ‘So you are telling us that someone would not be qualified for total disability if they could perform *any* one of their important duties?’ ‘Yes,’ he said.” Of course, the statement of the witness was hugely damaging—indeed, damning, since it was then and is now quite obviously false. It is also obviously inconsistent with the language of the policy. Thus the answer provides more than a scintilla of evidence of bad faith.

It is perfectly obvious that someone might be able

to perform an important duty, and yet not be able to pursue their occupation. Bourhis gives this example through a question he put to a witness at the trial:

Q<sub>18</sub>: “[I]f a concert violinist filled out the form saying that her duties included reading music and playing violin, whether this person would fail to qualify for total disability payments just because she could still read music even if she couldn’t play[,]” would this mean that the insured concert violinist was not actually disabled?

At the trial, the testifying witness said that she could not answer that question because it was a hypothetical. The witness had to look evasive.

Further, that answer was a completely devastating admission on the part of the insurer’s witness. There is no possibility whatever that a capable adjuster could not answer that question. Like the witnesses at depositions, this trial witness was not well prepared. Consider an alternative. The real problem here lies in the ambiguity of the definition. An insured is totally disabled if the insured cannot work. An insured is totally disabled if she cannot do her job. An insured is totally disabled if she cannot pursue her occupation. What becomes important in doing the claim, then, is what constitutes an *important* duty. Surely, given the true focus of disability insurance, the idea of an *important* duty is a duty which is central to the performance of one’s occupation. A duty is central to the performance of an occupation if the occupation cannot be performed without performing that duty. If this view is correct—in other words, if I had given the proper specification of the idea of what it is to be *important* in this context—then the correct answer to Bourhis’s question is this:

A<sub>7</sub>: An insured is disabled if he is unable to perform any one or group of the important duties of his occupation, where it is understood that an important duty is one which, if it is not performed, the occupation itself cannot be performed or pursued.

If anyone wants to argue that the concept of *an important duty* in this context means something other than what I have specified, then the concept is

ambiguous, and has to be resolved in favor of the insured.

Interestingly, the way the insurer in this case seemed to deal with the idea of *an important duty* was to ask the insured in the insurance application to identify the important duties of his occupation, and then use that list to determine whether an insured was totally disabled. If this is actually the way an insurer determined what the important duties of an occupation were, that procedure would be so manifestly irrational—so completely unreasonable—that this mode of decision-making would itself be, at the very least, an act symptomatic of—and hence evidence supporting—a finding of insurer bad faith.

The way the insurer cut Hangartner off from coverage was like this. For some reason or another, the insurer came to the conclusion that bookkeeping, of all things, was an important duty in the chiropractic occupation. Since Hangartner had enough brains left to keep books and since she could sit quietly to do so, she could change occupations and be a bookkeeper, the insurance company said that she was not totally disabled, and denied her coverage. Of course, this denial was a complete and obvious mistake. It may be important that solo practitioner chiropractors be able to keep books. But, that is not an important duty of someone’s occupation as a chiropractor. It is an important function of running that kind of business, but not of performing its professional acts. Thus, Unum’s tactic fails to recognize, and therefore repudiates, the proposition that the concept of *important duties* is conceptually tied to performing a given—indeed, antecedently specified—occupation, not to the performance of some occupation or other, not even one with as high or even higher social or economic standing as the one from which the insured is disabled.

### **Insurer Bad Faith**

There was a large verdict and then judgment of insurer bad faith in this case, and it was—so far as money damages are concerned—affirmed. There are several sources of law of insurer bad faith. One is common law. The other is statutory law. Within the statute of many states there a variety of sources of law which can be used against insurers in tort and tort-like cases. Some of these are to be found in state insurance codes; some are to be found in more

general business codes. In any case, Bourhis characterized the essence of California insurer bad faith law this way: "It is illegal for an insurance company to unreasonably delay, terminate, or reject a valid claim. Investigations of a claim must [therefore] be full, fair, and objective. The company's financial interest must never, ever be put above those of the policyholder. . . . [T]his means that the company has to pay up honestly on *legitimate* claims." There are several problems with this characterization. First, I am not clear what the word "legitimate" means. People can make legitimate claims which are outside coverage. The insured just doesn't realize it. The insured might have two policies and one of them might be excess of the other. And so on. If "legit" means *honest* or *intended honesty*, or something of the sort, then it is not the case that the insurer ought to pay all legitimate claims. In contract, if "legit" means *covered*, then—of course—Bourhis is right. Second, I do not believe that an insurer ought ever to consider its own financial interest when deciding whether to pay a claim. Third, I am not exactly sure what the word "full" means when modifying the word "investigation." If the first thing an insurer sees is a clear and absolute exclusion, then the insurer need go no further and investigate other aspects of a claim, even though the maxim "*Look for coverage!*" is a crucial norm of insurance adjustment.<sup>4</sup> Still, Bourhis's elucidation of the idea is pretty good, and it helps general questions.

Here are two questions I would ask, which he did not ask. The question specifies which state law applies. I will call it "X." If it is unclear what state law applies, the questions should be asked for all applicable states, if it is asked at all. In any case, here is a sample:

Q<sub>19</sub>: What are the standards for insurer bad faith recognized by X?

Q<sub>20</sub>: What are the criteria specified in the X *Insurance Code* for judging the adequacy of insurance adjustment?

If the adjuster, claims manager or corporate representative gives "I don't know"-type answers, the

company's goose is beginning to cook. If the adjuster gives mistaken answers, the cooking process also begins. On the other hand, if any of these people give an answer to either question roughly similar to Bourhis's characterization, the company will be fine at that point. Insurer bad faith may not be identical to negligence, but the two are quite similar, and if an insurer used something like the idea of negligence as a way to train its adjusters, the company will probably be providing adequate training for at least part of the law of bad faith. Of course, a related question should also be asked:

Q<sub>21</sub>: Has your company ever provided you training with respect to the legal standards of bad faith in X state?

Of course, if the answer is *Yes* try to get an account of the matter, and documents if possible. If the answer pertained to general training, trace it out. Above all, try to get documents. Often the adjuster will not have them, but if there were some, the corporate library will have them, or the training office will have them. If the training was provided by an outside law firm, as such training often is, then the law firm will probably have copies of the presentation. If nothing else, they will be in the firm's computer. It is worth remembering that many states require adjusters to have a given number of hours of training in any given year, and documents reflecting claims about that can be obtained from some states.

In *Hangartner*, Bourhis's approach was different, although highly effective under the circumstances. Here are some of the things he asked (or which were asked for him):

Q<sub>22</sub>: Are insurers required to adjust claims in a fair manner?

Q<sub>23</sub>: Are insurance adjusters required to investigate claims in a thorough manner?

Q<sub>24</sub>: Are insurance adjusters and claims departments required to be objective in investigating and processing (or handling)

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4. Michael Sean Quinn, *Look for Coverage!* 27 INS. LITIG. RPTR. 461 (July 6, 2005).

claims?

Obviously, the answers to these questions should be three of the following six answers:

Q<sub>22-24</sub>: Yes.

Q<sub>22-24</sub>: Yes, depending in part of the meaning of the key word.

Another set of three might work just as well:

Q<sub>22-24</sub>: Of course. It's virtually axiomatic.

Bourhis got the strangest answers to these questions. Adjusters, claims managers, and so forth said that they did not know. Similarly the claims witnesses were asked for each of the three questions now being considered whether the company had ever trained them in this regard:

Q<sub>25</sub>: Has your company ever trained you that those dealing with claims must be fair in doing so?

Q<sub>26</sub>: Has your company trained you that those dealing with claims must investigate each claim thoroughly?

Q<sub>27</sub>: Has your company taught you that those handling claims must be objective?

Of course, if the witness is a long experienced adjuster who has worked for a number of insurers or adjustment companies, more questions should be asked about what others have taught him. If s/he holds a CPCU, or one of its cousins, then questions should be asked about what is taught in those courses about the ethics of adjustment. In answer to Bourhis's questions, the witnesses said that they did not know the answers. These answers are as damning to the insurer as were the previously discussed answers.

It would also be damning if the witness simply said that they did not understand the question. At that point, an important choice faces the examining lawyer. Should s/he ask:

Q<sub>28</sub>: Why not?

If s/he does, the answer will almost certainly be:

A<sub>28</sub>: Because I do not understand how you are using the word [e.g.,] "objective."

At this point L has to make a choice. (1) L can say what is intended by the questioner of the word, at that moment. (2) L can try to give a general definition. (In which L should either take a dictionary page or a copy of Aristotle's works.) (3) L can ask another question:

Q<sub>29</sub>: How is the term [e.g., objective] generally used in the insurance adjustment industry?

Or:

Q<sub>30</sub>: What do you mean by the term?

(4) L can ridicule A. Often this can be done with questions:

Q<sub>31</sub>: Have you ever taken an objective test?

Q<sub>32</sub>: Do you know what it is to be biased?

Q<sub>33</sub>: Do you think baseball umpires try to be objective in making their calls.

(Often, it is a good idea to find out what sports A knows something about. Genuine expertise is not important. Childhood remembrance is sufficient.) And so forth. (5) Another strategy is simply to ask more or less the same question in several ways. Once this starts, the questioner will get "I don't know"-type answers several times, and this worsens the problem of the defendant carrier.

Why lawyers protecting deposition records for insurers in bad faith cases let this happen is extremely odd. Perhaps they think that the adjuster-witnesses will not be able to discourse learnedly on such topics as the meaning of *fairness*, *objectivity*, *thoroughness*, *fullness*, and so forth. Of course, they are right, because hardly anyone is. Educated philosophers write at length about such topics and often disagree as to subtleties of meaning, foundations, and some

principles. Juries are unlikely to be offended by such limitations. What they are likely to be shocked and insulted by is someone who basically avoids the question and/or tries to claim to have no knowledge when it's perfectly obvious s/he must have some.

Another line of deposition questioning related to insurer bad faith issues used by Bourhis was this one. He put it to the head of claims:

Q<sub>34</sub>:What are your duties as the head of claims?

The witness gave roughly this answer, after having given others:

A<sub>34</sub>:My duties include the responsibility of establishing the companies' claims-handling philosophy.

The content of the next question should be obvious:

Q<sub>35</sub>:And what is that philosophy?

To which he answered,

A<sub>35</sub>:To employ the highest ethical standards in all aspect of our work.

According to Bourhis, he then went on and tried to get the witness to admit that a number of the internal documents of the company did not meet high ethical standards. Of course, the witness refused to be pinned down.

One wonders if there might not have been more questions to ask the claims VP once he gave A<sub>35</sub>. The phrase "highest ethical standards" is virtually a cliché in business circles. Many companies adopt and claim to follow exactly such standards. One therefore wonders what the witness would have done with the following questions:

Q<sub>36</sub>:What is it to be among the "highest ethical standards?"

Q<sub>37</sub>:Give me an example of five of the "highest ethical standards," please.

Almost certainly the witness will not be able to do so.

Almost certainly the witness will not be able to provide a relevant list. At that point L might try this, if s/he has a mean streak, and doesn't mind being thought of even by a possible jury as a bit nasty:

Q<sub>38</sub>:Well, if you can't do five, can you state three?

Failure will almost certainly happen again, unless the witness says:

A<sub>38</sub>:Be fair. Be thorough. Be objective.

Of course, if L gets that answer, the damn has broken, because the witness cannot now claim not to know what the terms mean.

If the witness refused to answer Q<sub>38</sub>, then L should go yet further along the same track and use a smaller number:

Q<sub>39</sub>:If you can't give me three, there must be only one. What is it? What is *the* highest ethical principle of insurance adjustment (or—if you like—the insurance business)?

The witness will almost certainly fail to answer. S/he may even sneer. S/he may act outraged and offended. S/he may even claim the question is somehow frivolous, which it isn't. The witness may also feel persecuted, even if such is not actually shown. Of course the witness is in fact persecuted, as s/he should be, given how reasonable questions are being asked but not answered.

Yet another alternative is available. Try to get the corporate motto, the corporate insignia, the corporate ethics, and especially the one page preface of corporate ethics. If that is not gotten, L might ask a claims manager this question:

Q<sub>40</sub>:Please describe for me the fundamental principles of the business ethics, or business values of handling first-party insurance claims.

Rest assured, the answer will be dynamite. This would be true even if the question ended with the three words "health insurance claims," so long as ERISA was not involved.<sup>5</sup> My favorite response to this question came from a lawyer defending the insurer. He

objected. He claimed that business ethics was entirely subjective and had nothing to do with the governing principles of the law of insurance bad faith. I asked A if he understood what the defending lawyer had said. A said that he did. I then asked him if he agreed that he therefore understood the meaning of the word "subjective," and he said that he did. I then asked if the words "subjective" and "objective" had opposite meanings. The lawyer then again insisted that the witness not answer on the grounds of relevance. The lawyer was removed shortly thereafter.

Not only was the lawyer's approach wrong, but his view of the relationship between some parts of the law and some parts of ethics, morals, and values was wrong. Bad faith, fairness, reasonable decision-making, reasonable conduct, and even negligence are all tied to ethics and values under at least some circumstances, e.g., business decision-making. Lawyers should remember that obscurity, confusion, and uncertainty (as it were) on down the line in a chain of reasoning and/or explanation is not a problem for the hearer. Nobody understands everything, especially at the foundations of moral reasoning. Indeed, hesitation at or near the foundations may be quite reasonable and thoroughly understandable. It is a witness's refusal to start down the line when the opening question is reasonable that upsets, offends, and badly influences the jury. Such tactics should be condemned, and lawyers protecting records should be careful in thinking about them. Complete and total ethical relativism, irrationalism, and/or emotivism have been dying for two generations, at least, and they are now pretty much dead. Hardly anyone thinks now that in the ethical world that the "Cole Porter Principle" that *Anything goes!* is alive and well, even though many, especially on the secularistic and at least somewhat liberal side, believe that *Many things go!* is a sound method for beginning moral reasoning, especially in sexual matters. Hardly anyone thinks that a similar principle of adverturmsomeness and freewheeling societal liberty applies to business ethics or business law. Not even the senior executive officers

of UnumProvident believe that the insurance industry is unbound from serious moral principles.

### Documents

The book, *INSULT TO INJURY*, has an interesting series of exhibits attached at the end. There are documents used by the plaintiff at the trial. Apparently, Bourhis and his compatriots had to struggle to get some of them, and several are quite damning. His "Exhibit 4," for example, is an internal memo circulated at the top entitled "Revised 1998 Budget—Individual Disability Claims." In the body of the document the topic is said to be a "claim improvement initiative." There is not a word in the memo about fairness, thoroughness, fullness, or objectivity. The memo is a call to reduce payments on claims, even though that will require a slight increase in adjuster staffing. The memo at least implies that a 1% reduction in the payment of claims could increase profits by as much as \$80m.

Another exhibit is another memo, this one entitled "Institutionalizing the Scrub." It discussed a procedure for claims handlers which will require each of them to list the 10 "claimants where intensive effort will lead to successful resolution of the claim. As one name drops off, another name will be added." Of course, any sane insurer will take the view that "successful resolution" means elimination of doubt. Thus, there would be successful resolution if an insurer came to the conclusion that a claim was unquestionably owed. Given the name of the memo—"Scrubs"—this view seems highly doubtful, even if scrub has two meanings: (i) get rid of, and (ii) clean up. (Of course, in the end it will be for the jury to "understand" what is going on in such memos, but there is hardly any doubt what will happen.)

Another document is Exhibit 11. It is entitled "Outline for 'INFORMATION MANAGEMENT,'" and it was presented by the "Law Department." It is generally about how to manage the disposal of documents. At length it recommends, preaches, and requires that documents not needed for processing

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5. Interestingly, Bourhis—like many lawyers for insured—hates at least some ERISA provisions and court interpretations. The feeling (or, better yet, fear) is, of course, well founded. As Bourhis puts it, "With nothing to motivate them to pay ERISA claims fairly, many insurers simply don't. In fact, UnumProvident, in a highly confidential internal company memo that we got our hands on, actually bragged that it could save more than 95 percent of what it would otherwise have to pay if a claim was preempted by ERISA." Of course, ERISA claims financed by insurers are not always decided by insurers.

claims be destroyed. It says this even though section I.D. of the outline reads this way: "In a nutshell, when you're writing for the Company or about the Company, keep it straight, keep it right—and most importantly, keep it ethical—keep it legal!"<sup>6</sup>

Section II requires that adjusters keep private matters private. Oddly enough, part of this section pertains to keeping company information secret. Adjusters are ordered to shred legal audits, for example, plus all documents prepared for lawsuits, and all copies of drafts. What these orders are doing in a major section on so-called "private," i.e., non-biz, is a mystery. This is especially true when section III.B reads this way: "Retain only those documents needed for operations, legal compliance, and official archives." All other documents should be destroyed as they are no longer needed for an operation, and when an operation ends, there should be a special search-and-destroy mission. Section III.E formulates a general maxim: "Do not be a 'pack rat' who saves them 'just in case.'"

Of course, in the days when insurance companies retained millions of pieces of paper and instructed their adjusters never to throw anything out, Exhibit 11 would start a revolution, and might be a bit suspicious. Nowadays, a direction to *throw out unneeded stuff* is not so surprising. Still, the organization of Exhibit 11 has a troubling feature. I myself have never had much luck getting any mileage out of examining witnesses on document retention policies, whether at deposition or trial.

The most damning document in the whole group is a cartoon constituting a corporate insignia and used to express the corporate spirit. Here is a reproduction. It was Exhibit 1 in the book and no doubt printed up big and tall for the jury:

## Hungry Vultures...



There are a number of things to notice about this cartoon. It would be great fun at a trial to explain the meaning of this wretched exhibit. It might be quite effective if not explained, but even more effective if expounded. I do not know precisely what Bourhis and his colleagues did. (Of course, it makes little difference, given the size and nature of their victory.)

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6. Underlining in the text of the exhibit.

In any case, to explicate the cartoon, think first about the picture. The birds are marginally cute, but not very attractive. They have huge beaks, which scratch, kill, devour, and make noise. The beaks of the birds in the picture are much larger than vulture beaks usually are. Keep in mind that this is a picture of vultures. Vultures are not loved birds. Cervantes has Sancho say to the Knight of the Sorrowful Face in Chapter 31 of DON QUIXOTE, more or less, that “a bird in the hand is worth more than a vulture above.” (The dispute here is whether Senor Knight should remain true to Dulcinea or marry the foreign princess as whom Dorotea is fictionally posing.) The pictured vulture figures constitute an image of the hated and the feared. Furthermore, they are even associated with the disgusting. Moreover, they represent killing and death. Significantly, the vultures are pictured relaxing on a branch. One of them is napping. This suggests that the key figure in the cartoon is lazy

Second, think about the title, “Hungry Vultures. . .” It leaves no doubt about the content of the picture. It implies that the entities pictured need something to eat. Hence, a corporate emblem is not about the needs of the insured or the customers of the insurance company, but about the needs of the company—one need in particular: the need to devour. At this point, or later, it should be kept in mind that vultures generally devour carrion—the already dead and rotting.

The caption goes with the rest of the cartoon. It consists of three components. The first one is the statement, “Patient, my foot[.]” The second is a three-period entry, suggesting a pause in speaking. The third element is the statement, “*I’m going to kill something.*” Vultures do not usually kill to eat. They principally eat the already dead detected by smell to be on the ground, already decaying. Apparently, the bird with its eyes closed, and relaxing, has told the bird on the observer’s right to take it easy about being hungry and that something would turn up presently. In other words, the bird on the observer’s left has told the bird on its left (and our right) to be patient. He might even have been advised that patience is a virtue and quite often a good thing which is rewarded in the long run. The talking bird—the one on our left—has refused the advice. It is as if he were saying, “Patience? Nonsense! Patience is for the birds! That is exactly what I am not going to be. I am dynamic and aggressive, even pushy. In our line of work, as it were,

are they not too virtues as well?” The bird on the left is announcing that he is going to go get something to eat and is going to proceed in an unusual, perhaps even radical manner, if need be, and kill something in order to eat it. Kill “something”? What might that mean? Nothing is identified as the kind of thing for which he will look. Nothing is excluded. So far as Speaking-Left-Bird is concerned, *Anything goes.*

To put the matter succinctly, this corporate emblem—even for inside fooling around only—constitutes savagery and is therefore utter madness as a business move or gesture. If it was used at any official adjuster functions, the message was “Feed the company, your source. Feed yourselves! Do so by killing claims! What is involved in the claim matters not! Get rid of them! Don’t go hungry! Don’t nap. Don’t be lazy. Don’t be a mere observer sitting on a branch.” Anyone in the company producing this and using it as part of his job should have been fired or sent to therapy. Anyone who arranged to use it as a joke, should be sent back to high school, and the “joke” should have been suppressed immediately. Hardly ever in the history of litigation has there ever been a better document than this one to hand to a jury.

Bourhis explicitly makes an interesting point about his exhibits. He remarks that he could not get much out of at least one senior witness about the meaning of these documents. He implies that he didn’t have much luck in this area at all. Many of us don’t. The lesson here is not to expect much from company witness with respect to documents which condemn the employer of the witness. Get your interpretation out of experts at trial. Sometimes you can even get it out of the experts for the defendant insurer. (In this case, Bourhis made considerable progress with a physician who had done evaluations for the company in previous years, but had grown disgusted with the company’s claims philosophy and had left. Such witnesses often carry problems with them. Often they can be painted as people who hated new management or were guilty of some unpleasing, suspicion-generating wrong.)

### **Testimonial Reversal at Trial**

New witnesses from insurance companies often say different things at trial than were said in depositions. Even deposed witnesses sometimes say

different things. Here is how it is often handled. A company witness shows up at trial for direct examination, which is by the company's lawyers. They are asked different questions than they were asked in the deposition, so they give different answers. To some extent, this saves them from the embarrassment of contradicting themselves—though not completely. Something like that happened in the *Hangartner* case. The head of the claims department was asked this question and gave this answer:

Q<sub>41</sub>: "Did you develop and put into practice a 'philosophy' concerning claims handling?"

A<sub>41</sub>: "Yes, I did. It consisted of four parts: to insure fair, thorough, and objective evaluation of all claims; to pay legitimate claims promptly; to assist insureds in getting back to work; and to defend the company against illegitimate claims."

This executive and officer of the company then said, roughly, that adjusters at the company were "customer care specialists."

Myself, alone: I would have thought this testimony was wonderful. I would have developed it at great length.

Q<sub>42</sub>: "What is the meaning of *fair* in the context of claims?"

A<sub>43</sub>: "What is the meaning of *objective* when handling claims?"

That testimony is precisely inconsistent with what happened in adjusting Joan Hangartner's claim. A<sub>41</sub> is inconsistent with what other company witnesses said in discovery. When the officer of the company gave this testimony, he basically confessed that the behavior of the adjuster was fundamentally inconsistent with the claims philosophy of the company. If he didn't confess that proposition out-and-out, he certainly implied it.

My approach to the testimony would have been to develop that inconsistency within the company. Bourhis's approach was rather different. He wanted to demonstrate that the company was consistently

guilty of bad faith from its lowest claims-level to its highest. Consequently, his impulse, although not his action, was to stand and say: "Objection. Bullshit!" How I would love to have heard or to have (sometime) made that objection. Naturally, we can't make those objections in court, alas. The reader should not conclude that I am criticizing Bourhis's theory of the case. After all, he won big. Perhaps it is my more limited imagination which is subject to critique. Possibly, my approach would not have generated enormous punitive damages, which his approach did. Then again, in some cases, if the jury can conclude that the adjusters are acting deliberately, even if senior officials of the company assert they have nothing to do with it, punitive damages may flow. Which is to be loved and followed: (i) consistent corporate servility or (ii) apparent corporate inconsistency, itself servile and causative of wicked conduct, which only suggests an explicit (and denied) conspiracy from top to bottom. Perhaps the better choice is determined by the facts and feel of each case.

### Looking for Good Questions

One of the things I have discovered over the years is that lawyers should sit and think about questions to which they do not care what the answer is. If they can find the right ones, they can be extremely damaging.

Consider the following. I was recently involved in a legal malpractice case brought by an insurer against lawyers who represented it in a declaratory judgment action concerning coverage. It was a case involving some liability policies, where there were 25, or so, underlying tort cases. The insurer made a series of very bad decisions, many of which were (or should have been) known to the lawyers who were representing the insurer in the coverage case. The lawyers advised the insurer extensively with respect to a variety of things. The decisions made by the insurer with respect to the underlying tort cases were extremely poor and based upon assumptions, inferences, and reasoning which were quite terrible. The insurer's decision-maker was a senior adjuster. The lawyers never tried to (1) take over and run the cases along with the relevant decision-makers, (2) displace the adjuster, or (3) go around him to more senior and perhaps wiser people.

It seems to me that the failure of the coverage litigation lawyers to do one of these three things was

systematic of malpractice, even if it was not the essence thereof. There were, therefore, a series of questions which could be put to the lawyers in the malpractice case. They could be abstractly formalized as follows:

Q<sub>44</sub>: Did you recognize that A, the claims handler in charge of the underlying cases, had characteristic Z?"

Characteristic Z could then be made into concrete questions by using different words. Here are some examples: incompetence, ignorance, stupidity, idiocy, poor mental faculties, and so forth. The examining lawyer need not care really what the answers are. For some of the questions the answer will take the form of a denial. The witness will say that A did not have that characteristic. That answer can be followed with this question:

Q<sub>45</sub>: So, if A did have Z, you didn't realize it, did you?

If the witness says, "Yes. I did realize it, but I didn't know what to do." or if the witness says, "Yes. I knew there was some problem there, but there was nothing I could do." then that is good for the examining lawyer. In contrast, if the witness says, "No. I didn't realize it." then that too is good for the questioner. One way the lawyer-witness admits he knew there was a problem and didn't solve it. The other way, he confesses to his own ignorance.

There are analogs for insurance bad faith cases. Any lawyer examining an adjuster or a claims executive should try to isolate as many such questions as s/he can. Some of them can be used. Some of them cannot.

### Historic Settlement

There has already been a brief discussion of the Unum California settlement concerning the unfair claims practices of the former. Money changed hands. The *Hangarter* case was obviously influential, so Bourhis and his compatriots get some credit for a shining moment in business history. Furthermore, the settlement involves more than a case for a fund from which injured claimants can seek payment. It involves some significant policy changes. Here the word

"policy" is used in two senses.

It will be the company's policy that rehab provisions will be voluntary. Language in the insurance policy permitting the insurer to determine eligibility for benefits and interpret the language of the contract will change. Social security offsets will apply only to benefits actually received; estimates of benefits due will not be permitted. Language in the insurance policy will be interpreted more liberally and more favorably to the insured. Conditions only contributed to by pre-existing conditions may not be excluded. Benefits for survivors, if any, will have no age limits for surviving children. If there are no eligible survivors, if there are relevant benefits, they will go to the estate.

The most important and controversial change in the settlement agreement is the required change in the definition for the phrase "total disability." It will now read as follows. A policyholder is "totally disabled" if and only if the policyholder is "unable to perform with reasonable continuity the substantial and material acts necessary to pursue his or her usual occupation in the usual and customary way or to engage with reasonable continuity in another occupation in which he or she could reasonably be expected to perform satisfactorily in light of his or her age, education, training, experience, station in life, physical and mental capacity." California officials have said that they will try to make this mandatory for all disability insurance approved for sale in the state.

There is a good deal of controversy about this requirement. First, some say that it will impede employers from invoking alternative—moderated or light-duty—programs for at least some disabled workers. (Commands being more efficient than invitations, persuasion, or begging?) Second, as a consequence of this and other facts, rates may well go up. Third, the settlement is anti-historical. According to the President and CEO of a relevant trade organization, America's Health Insurance Plans, "This [settlement] really [will] turn back the clock on decades of progress. It's an about-face in return-to-work efforts." (See Roberto Cenicerros, *Unum Provident Pact Alters 'Total Disability'*, BUSINESS INSURANCE 1, 42 (October 10, 2005).) (Work being better than rest, idleness, and even vocational incapacity, no matter what?)

From the standpoint of both the coverage and the litigating lawyer, the change in the definition of "total

disability” is far more interesting than save-a-dime no-matter-what ideology. There are a number of problems in this definition. First, it is substantially more complex than the existing definition. Second, it does not cut off the key Bourhis question: Any, some, all? Third, the concepts of *substantial* and *material*, which are each important here, are both obscure. Fourth, the concept of *necessary* has not been either eliminated or simplified. Fifth, what does “reasonable continuity” mean? How is its presence determined? Sixth, what is a *way* of performing an occupation, and how are several ways differentiated? Now turn to the alternative after the second occurrence of “or.” Seventh, whose reasonable expectation is to rule. The person in the street? Eighth, how is satisfactory performance in the future to be measured now? Ninth, how do the relevant criteria intermingle. Should we have equations? Are there to be sociological-economic studies? Tenth, what is “station in life,” and how do we look at it.

Obviously, this extremely complex definition will generate a long list of Bourhisian questions. Whether the definition of “total disability” is met or not will almost always now be a jury issue. These trials will not, however, be fun events.

## Conclusion

As indicated early in this article, Carl Van published a recent book, *THE AWESOME ADJUSTER*. The full title is *THE 8 CHARACTERISTICS OF THE AWESOME ADJUSTER*. There are lots of books about how to be a good adjuster. They all say many of the same things. In some ways, although this one is quite recent, it is not very helpful. Here are the eight characteristics. Awesome adjusters are special people; they have positive attitudes that allow them to see opportunities; they have management skills. They have “great interpersonal skills that allow them to gain cooperation from customers by focusing on how to help the customer instead of hitting them with the

claims hammer.” They are active in raising their level of knowledge; they “understand that they are in the customer service business and never lose sight of that[, so t]hey look at each claim as an opportunity to help.” They have the “deep-rooted desire to do an excellent job[.]” They “understand that they can never really be successful while others around them struggle.” And, they take the initiative. This could also be, of course, awesome (nearly) of any professional—perhaps almost any worker.

I also describe these as not terribly helpful because they will not help the lawyer, by and large, in creating questions for depositions. Part of why this is true is because bad faith avoidance does not require awesome adjusters, it merely requires fairly reasonable ones. (Notice the ambiguity in the word “fairly.”) Nevertheless, there are two categories which are extremely helpful in creating deposition questions for adjusters. One of them is the requirement that the awesome adjuster be cooperative with claimants as the result of interpersonal skills. The other one is that the awesome adjusters realize that they are in the customer service business—that they are there to help.

According to Van, one of the personal characteristics that is essential to customer service in claims, and he could have said that it was also essential to having the right interpersonal skills, is that the adjuster be *empathetic*. Someone has empathy only if they have intuitive insight into the psyches of others. Empathy is obviously an extremely important characteristic of the truly careful and meaningful adjuster.

I therefore leave the reader with two profound and important mysteries. How can adjusters be quizzed in depositions about whether they are truly empathetic? How can the non-empathetic adjuster be exposed to the jury as being closed, shut off, and possibly even cold?