DEFINING AND CONFINING INSTITUTIONAL BAD FAITH IN INSURANCE

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I. INTRODUCTION

Insurers' duty of good faith and fair dealing, and the corresponding tort of bad faith, are recurring subjects in insurance litigation. Indeed, bad faith litigation has long been a prominent feature on the insurance law landscape. Most aspects of bad faith law are now well-understood by courts, lawyers, and insurers. The doctrine or theory of "institutional bad faith," however, is not clearly defined. Essentially, the theory of institutional bad faith allows a plaintiff to expand a dispute over a single loss into a widespread attack on an insurance company's practices and procedures.[1] Plaintiffs' fundamental allegation in institutional bad faith cases is that insurers' policies and procedures related to claim evaluation

1. Michael R. Nelson et al., Extra-Contractual Litigation Against Insurers § 2.11, at 2-59 (2009).

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and resolution, claim adjustment protocols and associated software, and performance and compensation criteria for claims personnel are either individually or collectively intended to unfairly shrink indemnity payments to claimants or deprive insureds of policy benefits to which they are entitled. Allegations of institutional misconduct may relate to an insurer's common law bad faith liability, support the expansion of a single-plaintiff bad faith case into a class action, be said to constitute unfair claims settlement practices under related statutes, or be urged as evidence of reprehensible conduct justifying punitive damages. At the very least, institutional bad faith allegations spawn expensive and time-consuming discovery disputes.[2]

Institutional bad faith claims vex insurers.[3] Claims-related practices and procedures that plaintiffs characterize as being calculated to extort unfair settlements from claimants and to low-ball insureds are to insurers reasonable measures intended to combat fraud, reduce exaggerated claims, eliminate waste, conserve resources for the benefit of all policyholders, and preserve shareholder value. In fact, meritorious institutional bad faith allegations are rare. Insurers correctly reason that bad faith law "has not reached the point where it is wrong for an insurance company to make a profit, much less follow good business practices."[4] Institutional bad faith claims persist nonetheless, as insurers and claimants study the same sets of facts and draw very different conclusions.

Consider, for example, an insurance company that assigns its claims professionals a goal of reducing defense and indemnity costs by five percent in 2010. How well individual adjusters do in meeting this goal will be a factor in their 2010 performance evaluations and, by extension, a compensation criterion. From the insurer's perspective, reducing defense and indemnity costs advances its legitimate goal of generating underwriting profit. The insurer wants its claims staff to fairly and reasonably resolve all claims; however, it also wants its claims staff to pay no more than

2. *See, e.g.*, Saldi v. Paul Revere Life Ins. Co., 224 F.R.D. 169, 175–78 (E.D. Pa. 2004) (involving a discovery dispute over whether the plaintiff was entitled to broad discovery into the insurer's business practices, policies, and procedures to support her argument that the insurer denied her claim as part of a scheme to deny legitimate claims in order to improve the insurer's profits); Pincheira v. Allstate Ins. Co., 190 P.3d 322, 324–38 (N.M. 2008) (involving a dispute over the so-called McKinsey documents and Allstate's effort to shield those documents from discovery as trade secrets).

3. *See, e.g.*, James A. Varner et al., *Institutional Bad Faith: The Darth Vader of Extra-Contractual Litigation*, 57 Fed'n Def. & Corp. Couns. Q. 163, 163 (2007) ("Institutional bad faith is the 'Ebola' virus of extra contractual litigation. . . . It can . . . grow explosively and wreck not only litigation management budgets, but can also seriously deplete corporate equity and shareholder value.").

4. Knoell v. Metro. Life Ins. Co., 163 F. Supp. 2d 1072, 1078 (D. Ariz. 2001).

the company legitimately owes and to manage legal costs prudently. The company expects the five percent savings to be carved from the fat of fraud and inefficiency, not the muscle and bone of meritorious claims. A plaintiff alleging institutional bad faith, on the other hand, will contend that the insurer is forcing its claims staff to deny and discount legitimate claims under penalty of lost income or other adverse employment action. The insurer's stated rationale of reducing needless expense is to the plaintiff pretextual; the insurer's true motive is enhanced profitability at the expense of vulnerable policyholders and claimants. From a plaintiff's perspective, the insurer has subordinated insureds' financial interests to its own, which is the hallmark of bad faith.

Alternatively, assume that an insurer requires that every claim above a set dollar amount be "roundtabled" by a group of senior claims professionals before settlement or payment will be authorized. Not surprisingly, roundtable groups often conclude that the adjuster responsible for a matter has evaluated the claim correctly and approve payment or settlement in the amount the adjuster recommends. In other instances, roundtable members conclude that a claims handler has overvalued a claim, overlooked key facts, or failed to consider defenses, and the group thus declines to pay or settle the claim, or authorizes payment or settlement in a lower amount. From the insurer's perspective, roundtables serve to focus its claim department's collective expertise on serious claims. To the insurer, roundtables are a sound business practice that balances legitimate cost concerns with policyholders' expectations.[5] If anything, roundtables ensure that claims are not *under*valued. But to plaintiffs alleging institutional bad faith, roundtables are intended solely to maximize the insurer's profits at insureds' expense. In plaintiffs' eyes, roundtables frustrate individual adjusters' efforts to pay legitimate claims by conjuring up ways to cheat insureds and lowball innocent third parties.

Next, consider insurance companies' use of computer software programs to value bodily injury or property damage claims. Reputable insurers intend such programs to produce accurate and consistent claim valuations, assuming, of course, that claims professionals enter accurate and complete loss information. These programs are tools to aid claims professionals; they are not intended to be a substitute for experienced adjusters' professional judgment in valuing claims. From plaintiffs' perspective, however, the use of such programs is unreasonable per se because (1) insurers can and do adjust or tune the programs to produce artificially low claim values;

5. *See id.* (stating that "having a round table discussion where more than one person evaluates the status of a claim is not a company acting in bad faith").

(2) the programs have inherent limitations related to the information they process that materially undermine the accuracy of the claim values they produce; and (3) insurers use the programs as arbitrary and inflexible substitutes for experienced adjusters' professional judgment in valuing claims even though the programs are not so designed or intended.[6]

Finally, in a curiously common example of alleged institutional bad faith, assume that an insurance company has either a 401(k) plan or profit-sharing plan in which claims department employees (like all other employees) participate. A bad faith plaintiff alleges that the company's 401(k) or profit-sharing plan creates an incentive for claims representatives to deny legitimate claims in order to boost the company's profits and thus enhance their own financial positions. This is so, a plaintiff will allege, even though 401(k) plans are primarily funded by employee contributions and even if improper claim denials had any effect on the insurer's profitability that might directly benefit employees, the effect would be minimal and impossible to trace back to any particular claim or claims professional.[7] From the plaintiff's perspective, however, the effect or efficiency of the incentives is a fact question for the jury.

This article explores the vague contours of institutional bad faith theory. Part II provides a brief overview of insurance bad faith law in both third-party and first-party contexts. Part III examines the limited case law on institutional bad faith,[8] dividing the few cases on the subject into (a) those discussing institutional bad faith as a theory of liability and (b) those applying the theory in awarding punitive damages. In both contexts, an insurer's alleged institutional bad faith is material only if there is a connection between those policies, practices, or procedures and the insurer's allegedly unreasonable disposition or treatment of the particular claim at issue. Finally, Part IV recommends measures that insurers might consider taking to minimize the risks posed by institutional bad faith allegations.

6. *See*, *e.g.*, Jay M. Feinman, Delay Deny Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It 113–20 (2010) (discussing Colossus®, a software program used by many insurers to value bodily injury claims).

7. This argument is not the same as the theme in *Merrick v. Paul Revere Life Insurance Co.*, 594 F. Supp. 2d 1168 (D. Nev. 2008), discussed *infra* in Part III.B. The insurers in *Merrick* schemed to cheat policyholders out of benefits in order to increase corporate profits. *Id.* at 1178–81. Both the deliberate formulation of dishonest schemes and the beneficiaries of those schemes (the insurers themselves) differentiate the *Merrick* scenario from the theory illustrated here.

8. There is a surprising lack of case law on institutional bad faith given the frequency with which such allegations are made. This disparity is probably attributable to the fact that carriers settle many institutional bad faith cases to avoid discovery costs and potentially severe damage exposure. *See* Varner et al., *supra* note 3, at 163 (asserting that institutional bad faith allegations rarely survive to trial "because of the exposures and the discovery aspect[s]").

II. A BRIEF OVERVIEW OF INSURANCE BAD FAITH

All insurance policies include an implied covenant or duty of good faith and fair dealing.[9] An insurer's breach of this duty is generally actionable in tort. These are opposite sides of the same coin; an insurer's duty to act in good faith and its liability for bad faith refer to the same obligation.[10] Essentially, the duty of good faith and fair dealing requires that neither party to a contract do anything to injure the other party's right to receive the benefits of their agreement.[11] An insurance company is therefore guilty of bad faith if it subordinates an insured's financial interests to its own in handling a claim or suit. Indeed, bad faith liability cannot lie absent such subordination because insurers are clearly permitted to consider their own interests equally with those of their insureds.[12] An insurer's obligation to consider its insured's interests equally does not require it "actively to submerge its own interests."[13]

An insurer found to have committed bad faith faces liability beyond its policy limits. Most jurisdictions require some level of intentional wrongdoing by an insurance company for extra-contractual liability to attach,[14]

9. Allstate Ins. Co. v. Miller, 212 P.3d 318, 324 (Nev. 2009) ("The law, not the insurance contract, imposes this covenant on insurers.").

10. Bosetti v. United States Life Ins. Co., 96 Cal. Rptr. 3d 744, 768 (Ct. App. 2009); Brodeur v. Am. Home Assur. Co., 169 P.3d 139, 146–47 (Colo. 2007); Brown v. Patel, 157 P.3d 117, 121 n.5 (Okla. 2007); Mut. of Enumclaw Ins. Co. v. Dan Paulson Constr., Inc., 169 P.3d 1, 8 n.11 (Wash. 2007).

11. Jackson v. Am. Equity Ins. Co., 90 P.3d 136, 142 (Alaska 2004) (quoting Guin v. Ha, 591 P.2d 1281 (Alaska 1979)); Wilson v. 21st Century Ins. Co., 171 P.3d 1082, 1086–87 (Cal. 2007) (quoting Frommoethelydo v. Fire Ins. Exch., 721 P.2d 41 (Cal. 1986)); Salas v. Mountain States Mut. Cas. Co., 202 P.3d 801, 805 (N.M. 2009) (quoting Watson Truck & Supply Co. v. Males, 801 P.2d 639, 642 (N.M. 1990)); Cathcart v. State Farm Mut. Auto. Ins. Co., 123 P.3d 579, 589 (Wyo. 2005).

12. Wade v. EMCASCO Ins. Co., 483 F.3d 657, 666 (10th Cir. 2007) (quoting Bollinger v. Nuss, 449 P.2d 502, 510 (Kan. 1969)); Acosta v. Phoenix Indem. Ins. Co., 153 P.3d 401, 404 (Ariz. Ct. App. 2007); Jordan v. Allstate Ins. Co., 56 Cal. Rptr. 3d 312, 318 (Ct. App. 2007) (quoting *Frommoethelydo*, 721 P.2d 41); Sharbono v. Universal Underwriters Ins. Co., 161 P.3d 406, 411 (Wash. Ct. App. 2007).

13. Kosierowski v. Allstate Ins. Co., 51 F. Supp. 2d 583, 588 (E.D. Pa. 1999) (applying Pennsylvania law).

14. *See, e.g.*, Royal Indem. Co. v. King, 532 F. Supp. 2d 404, 414 (D. Conn. 2008) ("'Bad faith means more than mere negligence; it involves a dishonest purpose.'") (quoting De La Concha of Hartford, Inc. v. Aetna Life Ins. Co., 849 A.2d 382 (Conn. 2004)); Unum Life Ins. Co. of Am. v. Edwards, 210 S.W.3d 84, 87 (Ark. 2005) (requiring "'dishonest, malicious or oppressive conduct carried out with a state of mind characterized by hatred, ill will, or a spirit of revenge'") (quoting State Auto Prop. & Cas. Ins. Co. v. Swaim, 991 S.W.2d 555 (Ark. 1999)); Ag One Co-op v. Scott, 914 N.E.2d 860, 864 (Ind. Ct. App. 2009) (mandating conscious misconduct by insurer, i.e., "evidence of a state of mind reflecting dishonest purpose, moral obliquity, furtive design, or ill will"); Rinehart v. Shelter Gen. Ins. Co., 261 S.W.3d 583, 591 (Mo. Ct. App. 2008) (requiring evidence that insurer intentionally disregarded insured's

while others allow insureds or their assignees to recover extra-contractual damages for an insurer's simple negligence.[15] Still other states allow recovery on both bad faith and negligence theories, each turning on the proof of different elements.[16] In any event, extra-contractual liability is a significant economic threat to insurers.

In the liability insurance context, most bad faith claims arise out of an insurer's failure to settle a covered claim or suit against its insured within its policy limits despite the opportunity to do so, followed by a judgment against the insured exceeding those limits.[17] The allegation here, of course, is that the insurer's failure to settle within policy limits was unreasonable and thus in bad faith, and that it is accordingly liable for the entire judgment. But the prevalence of such claims does not mean that the duty of good faith and fair dealing assumes that settlement is always the preferred means of protecting policyholders' interests,[18] or that the duty to settle is absolute.[19] To the contrary, insurers are generally free to litigate or settle at their discretion without risking extra-contractual liability,[20] so long as the chance of a defense verdict or verdict within policy limits is "real and

financial interests in hope of escaping full policy obligations) (quoting Zumwalt v. Utils. Ins. Co., 228 S.W.2d 750, 754 (Mo. 1950)); Sloan v. State Farm Mut. Auto. Ins. Co., 85 P.3d 230, 237 (N.M. 2004) (mandating "dishonest judgment" by an insurer for bad faith liability); Lavaud v. Country-Wide Ins. Co., 815 N.Y.S.2d 680, 681 (App. Div. 2006) (requiring "gross disregard" of insured's interests for bad faith liability); Badillo v. Mid Century Ins. Co., 121 P.3d 1080, 1094 (Okla. 2005) (requiring more than mere negligence for bad faith, but less than recklessness required for punitive damages); Zappile v. Amex Assur. Co., 928 A.2d 251, 254 (Pa. Super. Ct. 2007) ("Further, mere negligence or bad judgment is not bad faith; bad faith imports a dishonest purpose and means a breach of a known duty (i.e. good faith and fair dealing), through some motive of self-interest or ill will."); Johnson v. Tenn. Farmers Mut. Ins. Co., 205 S.W.3d 365, 370 (Tenn. 2006) (stating that mere negligence is insufficient; bad faith requires "an insurer's disregard or demonstrable indifference toward the interests of its insured").

15. *E.g.*, Cotton States Mut. Ins. Co. v. Brightman, 580 S.E.2d 519, 521 (Ga. 2003); McKinley v. Guar. Nat'l Ins. Co., 159 P.3d 884, 888 (Idaho 2007); Hein v. Acuity, 731 N.W.2d 231, 235 (S.D. 2007).

16. *See, e.g.*, Mut. Assur., Inc. v. Schulte, 970 So. 2d 292, 296 (Ala. 2007) (noting differences in elements of causes of action).

17. Most jurisdictions require a settlement demand or offer within policy limits as a prerequisite to bad faith liability premised on a failure to settle. *See, e.g.*, Chandler v. Am. Fire & Cas. Co., 879 N.E.2d 396, 400 (Ill. App. Ct. 2007); Phillips v. Bramlett, 288 S.W.3d 876, 879 (Tex. 2009).

18. Dairyland Ins. Co. v. Herman, 954 P.2d 56, 61 (N.M. 1997).

19. Teague v. St. Paul Fire & Marine Ins. Co., 10 So. 3d 806, 820 (La. Ct. App. 2009); *see, e.g.*, Ross Neely Sys., Inc. v. Occidental Fire & Cas. Co. of N.C., 196 F.3d 1347, 1352 (11th Cir. 1999) (discussing Alabama law and enhanced duty of good faith, and stating that insurer has no duty to settle merely to minimize insured's exposure to punitive damages).

20. Eskind v. Marcel, 951 So. 2d 289, 293 (La. Ct. App. 2006); *see, e.g.*, Christian Builders, Inc. v. Cincinnati Ins. Co., 501 F. Supp. 2d 1224, 1229–40 (D. Minn. 2007) (finding no bad faith where insurer did not settle and plaintiff won excess judgment).

substantial" and the decision to litigate is made honestly.[21] Insurers also may decline to settle free from the fear of extra-contractual liability if the plaintiff is unwilling to grant the insured a full release in exchange for a policy limits payment.[22]

First-party bad faith reduces to an insurer's unreasonable refusal to pay a claim or its unreasonable delay in doing so. A plaintiff must establish that (1) the insurer's conduct was unreasonable and (2) the insurer either knew or recklessly disregarded the fact that it had no reasonable basis for denying policy benefits.[23] Some states modify the second prong, requiring that an insurer either knew or reasonably should have known that its actions were unreasonable for bad faith liability to attach.[24] In any event, some form of this two-part test applies no matter the first-party coverage in dispute. The issue then becomes the standard to be applied. Some courts hold that the first element is determined by an objective standard, while the second is subjective;[25] others hold that both elements are measured by an objective standard.[26]

Regardless of the coverage at issue, the unreasonableness of the insurer's conduct is the essence of bad faith.[27] The reasonableness of the insurer's actions or decisions must be judged at the time they were taken or made.[28] An insurer is not guilty of bad faith "just because hindsight shows

21. DeWalt v. Ohio Cas. Ins. Co., 513 F. Supp. 2d 287, 296 (E.D. Pa. 2007); *see also* Johnson v. Am. Family Mut. Ins. Co., 674 N.W.2d 88, 90–91 (Iowa 2004) (discussing insurer's ability to reject demand within policy limits it believes to be unreasonable and instead to try case); Anglo-Am. Ins. Co. v. Molin, 670 A.2d 194, 197–98 (Pa. Commw. Ct. 1995) (stating that an insurer "may reject a settlement offer and insist on litigation if it has a bona fide belief that it has a good possibility of succeeding on the merits").

22. Trinity Universal Ins. Co. v. Bleeker, 966 S.W.2d 489, 491 (Tex. 1998). *But see* Fortner v. Grange Mut. Ins. Co., 686 S.E.2d 93, 94–95 (Ga. 2009) (involving multiple insurers).

23. Acosta v. Phoenix Indem. Ins. Co., 153 P.3d 401, 404 (Ariz. Ct. App. 2007) (quoting Miel v. State Farm Mut. Auto. Ins. Co., 912 P.2d 1333, 1339 (Ariz. Ct. App. 1995)); DeHerrera v. Am. Family Mut. Ins. Co., 219 P.3d 346, 352 (Colo. Ct. App. 2009); Wilson v. Farm Bureau Mut. Ins. Co., 714 N.W.2d 250, 262 (Iowa 2006); LeRette v. Am. Med. Sec., Inc., 705 N.W.2d 41, 47–48 (Neb. 2005); Mudlin v. Hills Materials Co., 742 N.W.2d 49, 51 (S.D. 2007) (quoting Phen v. Progressive N. Ins. Co., 672 N.W.2d 52, 59 (S.D. 2003)); Peerless Ins. Co. v. Frederick, 869 A.2d 112, 116 (Vt. 2004); Farmers Auto. Ins. Ass'n v. Union Pac. Ry. Co., 756 N.W.2d 461, 472 (Wis. Ct. App. 2008) (quoting Anderson v. Cont'l Ins. Co., 271 N.W.2d 368, 376 (Wis. 1978)); Cathcart v. State Farm Mut. Auto. Ins. Co., 123 P.3d 579, 589 (Wyo. 2005).

24. *Wilson*, 714 N.W.2d at 262.

25. *See, e.g.*, Bellville v. Farm Bureau Mut. Ins. Co., 702 N.W.2d 468, 473 (Iowa 2005).

26. *See, e.g.*, Gainsco Ins. Co. v. Amoco Prod. Co., 53 P.3d 1051, 1058 (Wyo. 2002).

27. Nieto v. Blue Shield of Cal. Life & Health Ins. Co., 103 Cal. Rptr. 3d 906, 928 (Ct. App. 2010); Fetch v. Quam, 623 N.W.2d 357, 361 (N.D. 2001).

28. Chateau Chamberay Homeowners Ass'n v. Associated Int'l Ins. Co., 108 Cal. Rptr. 2d 776, 784 (Ct. App. 2001); La. Bag Co. v. Audubon Indem. Co., 999 So. 2d 1104, 1114 (La. 2008); Pitts v. W. Am. Ins. Co., 212 P.3d 1237, 1240 (Okla. Civ. App. 2009) (quoting Hale v.

its employees were wrong" in the handling of a case or claim,[29] or because an adjuster handled a claim in less than ideal fashion.[30] An insurance company cannot be liable for bad faith if it has a reasonable basis for denying a claim.[31] An insurer may deny or dispute a claim that is "fairly debatable" without breaching its duty of good faith and fair dealing.[32] Whether a claim was fairly debatable can generally be determined by the court as a matter of law.[33] The fact that the claim was fairly debatable compels the conclusion that the insurer's denial or delay in payment was reasonable.[34] A claim may be fairly debatable as a matter of fact or law.[35] An insurer must, however, debate the claim fairly; that is, it must investigate the claim reasonably and subject the results of its investigation to reasonable evaluation and review.[36]

Additionally, an insurer accused of bad faith may defend on the basis that there was a genuine dispute with its insured as to the existence of coverage or the value of a claim. This is the "genuine dispute" or "genuine issue" doctrine.[37] The genuine dispute doctrine is equivalent to the fairly debatable rule.[38] If there is a genuine dispute as to an insurer's obligation, a court

A.G. Ins. Co., 138 P.3d 567, 572–73 (Okla. Civ. App. 2006)); Dakota, Minn. & E. R.R. Corp. v. Acuity, 771 N.W.2d 623, 630 (S.D. 2009); Brown v. Labor & Indus. Review Comm'n, 671 N.W.2d 279, 288 (Wis. 2003).

29. State Farm Mut. Auto. Ins. Co. v. Lee, 13 P.3d 1169, 1175 (Ariz. 2000).

30. Windmon v. Marshall, 926 So. 2d 867, 873 (Miss. 2006).

31. United Fire & Cas. Co. v. Shelly Funeral Home, Inc., 642 N.W.2d 648, 652 (Iowa 2002); Murphree v. Fed. Ins. Co., 707 So. 2d 523, 529 (Miss. 1997); Martin v. Allianz Life Ins. Co. of N. Am., 573 N.W.2d 823, 829 (N.D. 1998); Zarrella v. Minn. Mut. Life Ins. Co., 824 A.2d 1249, 1261 (R.I. 2003); Mixson, Inc. v. Am. Loyalty Ins. Co., 562 S.E.2d 659, 661 (S.C. Ct. App. 2002).

32. McGilvray v. Farmers New World Life Ins. Co., 28 P.3d 380, 386 (Idaho 2001); Bellville v. Farm Bureau Mut. Ins. Co., 702 N.W.2d 468, 473 (Iowa 2005); Bentley v. Bentley, 172 S.W.3d 375, 378 (Ky. 2005) (quoting cases); Williams v. Allstate Indem. Co., 669 N.W.2d 455, 460 (Neb. 2003); Villa Enters. Mgmt. Ltd. v. Fed. Ins. Co., 821 A.2d 1174, 1188–89 (N.J. Super. Ct. Law Div. 2002); Imperial Cas. & Indem. Co. v. Bellini, 947 A.2d 886, 893–94 (R.I. 2008) (quoting Skaling v. Aetna Ins. Co., 799 A.2d 997, 1010–12 (R.I. 2002)); *Dakota, Minn. & E. R.R. Corp*., 771 N.W.2d at 630; Young v. Fire Ins. Exch., 182 P.3d 911, 917 (Utah Ct. App. 2008); Pum v. Wis. Physicians Serv. Ins. Corp., 727 N.W.2d 346, 356 (Wis. Ct. App. 2006); Gainsco Ins. Co. v. Amoco Prod. Co., 53 P.3d 1051, 1058 (Wyo. 2002).

33. *Bellville*, 702 N.W.2d at 473; LeRette v. Am. Med. Sec., Inc., 705 N.W.2d 41, 50 (Neb. 2005).

34. *Bellville*, 702 N.W.2d at 473 (explaining the fairly debatable doctrine); Prince v. Bear River Mut. Ins. Co., 56 P.3d 524, 533 (Utah 2002).

35. Rodda v. Vermeer Mfg., 734 N.W.2d 480, 483 (Iowa 2007); *Bentley*, 172 S.W.3d at 378 (quoting cases).

36. Weitz Co., LLC v. Lloyd's of London, 574 F.3d 885, 892 (8th Cir. 2009) (quoting Dolan v. AID Ins. Co., 431 N.W.2d 790, 794 (Iowa 1988)); Trinity Evangelical Lutheran Church & School-Freistadt v. Tower Ins. Co., 661 N.W.2d 789, 795 (Wis. 2003).

37. Wilson v. 21st Century Ins. Co., 171 P.3d 1082, 1089 (Cal. 2007).

38. Other courts hearing bad faith cases use slightly different terminology, referring to "bona fide" disputes, "good faith" disputes, or "legitimate" disputes rather than genuine disputes, genuine issues, or fairly debatable claims. *See, e.g.*, Mansur v. PFL Life Ins. Co., 589

can conclude as a matter of law that the insurer's conduct was reasonable.[39] The genuine dispute doctrine applies to legal controversies, such as policy interpretation, and to factual disputes.[40] In some cases, the genuine dispute doctrine may apply where an insurer denied a claim based on the opinions of experts.[41] To invoke the doctrine in any case, an insurer must have fairly, fully, and thoroughly investigated the claim at issue.[42] "A *genuine* dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds."[43]

III. INSTITUTIONAL BAD FAITH IN CONTEXT

Institutional bad faith allegations surface in two contexts. First, institutional bad faith is often a theory of liability. For example, a plaintiff may allege that institutional factors such as compensation or performance evaluation plans or programs caused an insurance company claims professional to act unreasonably, or that an insurer had an organized plan or scheme for unfairly resolving all claims.[44] In the first-party bad faith context, plaintiffs often rely on institutional bad faith allegations to prove that an insurer either knew or recklessly disregarded the fact that it had no reasonable basis for its actions. Second, plaintiffs frequently allege that institutional bad faith supports punitive damages or an enhanced punitive award.

A. *Institutional Bad Faith as a Theory of Liability*

White v. Continental General Insurance Co.[45] is widely considered to be a leading case on institutional bad faith. *White* arose out of Continental General's rescission of plaintiff Vic White's health insurance policy for failing to reveal his history of depression on his application for coverage and

F.3d 1315, 1322 (10th Cir. 2009) (applying Oklahoma law and referring to "legitimate" disputes); Allstate Ins. Co. v. Fields, 885 N.E.2d 728, 732 (Ind. Ct. App. 2008) (referring to good faith disputes); Spicewood Summit Office Condo. Ass'n v. Am. First Lloyd's Ins. Co., 287 S.W.3d 461, 469 (Tex. App. 2009) (observing that evidence establishing a bona fide coverage dispute does not rise to the level of bad faith). As a practical matter, terminology differences are inconsequential because the principles underlying all the approaches are the same.

39. R & R Sails, Inc. v. Ins. Co. of the State of Pa., 610 F. Supp. 2d 1222, 1230–31 (S.D. Cal. 2009) (applying California law).

40. *Wilson*, 171 P.3d at 1089.

41. McCoy v. Progressive W. Ins. Co., 90 Cal. Rptr. 3d 74, 80 (Ct. App. 2009); *see also*, *e.g.*, Mastellone v. Lightning Rod Mut. Ins. Co., 884 N.E.2d 1130, 1140 (Ohio Ct. App. 2008) (opining that expert reports provided insurer with "reasonable justification" for reserving its rights, conducting claim investigation, and, ultimately, denying coverage).

42. Bosetti v. United States Life Ins. Co., 96 Cal. Rptr. 3d 744, 770 (Ct. App. 2009).

43. Wilson v. 21st Century Ins. Co., 171 P.3d 1082, 1089 (Cal. 2007).

44. *See*, *e.g.*, Hogan v. Provident Life & Accident Ins. Co., 665 F. Supp. 2d 1273, 1281–82, 1283, 1285 (M.D. Fla. 2009).

45. 831 F. Supp. 1545 (D. Wyo. 1993).

its related refusal to pay for his hospitalization for a thyroid cyst.[46] White sued Continental General on several theories, including bad faith. Continental General moved for summary judgment on White's bad faith claim, contending that it rescinded White's policy only after it conducted an investigation into the statements on his application, and that its actions were reasonable as a matter of law because his claim was fairly debatable.[47]

White countered that there were genuine issues of material fact that precluded summary judgment. First, he argued, there was evidence that Continental General practiced "post-claim underwriting," which established that the company lacked a reasonable basis to deny his claim.[48] In the two years before White purchased his policy, Continental General suffered approximately $8.5 million in losses, and from that figure White argued that the company practiced post-claim underwriting to increase its revenues by accepting new policyholders while lowering its costs by denying coverage when claims were submitted.[49] Second, Continental General implemented a bonus plan for underwriters that required them to amass 100 points per day to remain employed. Underwriters received 2.5 points if they either paid or denied a claim, but were awarded 5 points if they could find a preexisting condition on which to deny coverage.[50] White contended that these factors, in combination, demonstrated that Continental General's underwriting practices were prima facie evidence of the company's bad faith.[51]

The court denied Continental General's summary judgment motion on the plaintiff's bad faith claim. The court observed that Continental General had never requested White's medical records during the nineteen months that his policy was in force before his thyroid problem arose despite having the right to do so.[52] When the company did rescind his policy, it was for a mental condition unrelated to his thyroid problem. Finally, White's expert witness on insurance issues had testified that Continental General practiced post-claim underwriting. For these reasons, the *White* court concluded that a genuine issue of material fact precluded summary judgment.[53]

Within the framework of this case, Continental General's bonus program appears to have been misguided at best and intentionally corrupting

46. *Id*. at 1548–49.
47. *Id*. at 1555.
48. *Id*. at 1556.
49. *Id*.
50. *Id*.
51. *Id*.
52. *Id*.
53. *Id*.

and predatory at worst. Couple the bonus program with the company's underwriting losses that precipitated the program and its treatment of White's application and subsequent claim, and the potential for bad faith liability is obvious. It is important to understand, however, what the *White* court did and did not do. First, the court did not recognize a cause of action for institutional bad faith, nor did it find that Continental General committed bad faith based on the institutional factors at issue. All the court did was find that, on the evidence presented, there was a genuine issue of material fact that precluded summary judgment for the insurer.[54] Second, without expressly so holding, the *White* court required a causal link between White's allegations of institutional bad faith and Continental General's disposition of his claim. Although one might question based on the facts stated in the opinion whether White satisfactorily established that link, it is the existence of the link that is critical.

Zilisch v. State Farm Mutual Automobile Insurance Co.[55] is another leading case. There, Kimberly Zilisch sued State Farm for bad faith after the company allegedly refused to pay her the $100,000 limits of her underinsured motorist ("UIM") coverage despite knowing that the value of her UIM claim was nearly four times that amount. At trial, Zilisch introduced evidence that State Farm had a nationwide practice of underpaying claims. The evidence suggested that State Farm set arbitrary payment goals for its claims personnel in order to achieve its goal of having the most profitable claims department in the country.[56] Promotions and salary increases for claims personnel were based on achieving these goals.[57] Not surprisingly, the plaintiff's expert witness opined that State Farm's conduct in handling Zilisch's claim was outrageous and was consistent with its business practices across the country.[58] State Farm countered that its refusal to pay Zilisch the full limits of her UIM coverage was reasonable because the value of her claim was fairly debatable.[59]

A jury returned a $1 million verdict for Zilisch split between compensatory and punitive damages. Both sides appealed and the Arizona Court of Appeals held that even if State Farm engaged in improper claims practices that influenced its conduct, it was nonetheless entitled to judgment in its favor if Zilisch's claim was fairly debatable as a matter of law.[60] The Arizona Supreme Court granted review.

54. *Id*. at 1555–56.
55. 995 P.2d 276 (Ariz. 2000).
56. *Id*. at 279.
57. *Id*.
58. *Id*.
59. *Id*.
60. *Id*.

The supreme court concluded that the court of appeals erred in making the fair debate of the plaintiff's claim both the beginning and the end of its bad faith analysis.[61] In doing so, the *Zilisch* court discussed various evidentiary factors that might persuade a jury that in handling Zilisch's claim State Farm knowingly acted unreasonably, including the fact that (1) State Farm set arbitrary goals to reduce claim payments and (2) claims representatives' salaries and bonuses were influenced by how much they paid to resolve claims.[62] The supreme court vacated the court of appeals opinion and remanded the case to that court for further consideration.[63]

Zilisch is perhaps not as carefully worded as one might like when it comes to institutional bad faith, but to the extent the court recognized the doctrine, it suggested the need for a causal link between the challenged practices and the plaintiff's injury. The plaintiff presumably demonstrated at trial the nexus between State Farm's claim reduction and bonus programs and the mishandling of her UIM claim even if that link was not apparent from the supreme court's opinion. It is now clear that insofar as bad faith liability is concerned, an insurer's institutional practices are relevant only if they actually influenced the insurer's handling of the claim at issue. If there is no causal link, there can be no liability,[64] as *Lopez v. Allstate Insurance Co*.[65] illustrates.

The plaintiff in that case, Mario Lopez, was making a delivery for his employer when he was rear-ended by another motorist in what seemed to be a minor accident. The other driver was uninsured, but Lopez was covered by an uninsured motorist ("UM") policy with Allstate. Soon after the accident, Lopez began experiencing various pains attributable to soft tissue injuries. He incurred just over $3,300 in medical bills. Allstate requested documentation of Lopez's injuries and asked to interview him in order to verify his injuries. Lopez offered to settle his UM claim for $14,500,

61. *Id*. at 280.

62. *Id*.

63. *Id*. at 281.

64. *See, e.g*., Sterling v. Provident Life & Accident Ins. Co., 619 F. Supp. 2d 1242, 1259 n.15 (M.D. Fla. 2009) (referring to several alleged practices that were not shown to have been applied to the plaintiff's claim); Milhone v. Allstate Ins. Co., 289 F. Supp. 2d 1089, 1100–02 (D. Ariz. 2003) (involving computer programs); Young v. Allstate Ins. Co., 296 F. Supp. 2d 1111, 1123 n.21 (D. Ariz. 2003) (noting that procedures allegedly constituting institutional bad faith did not have any effect on the plaintiff's claim); Knoell v. Metro. Life Ins. Co., 163 F. Supp. 2d 1072, 1078 (D. Ariz. 2001) (rejecting institutional bad faith claim where the plaintiff could not show that any of the practices at issue applied to his claim); Yumukoglu v. Provident Life & Accident Ins. Co., 131 F. Supp. 2d 1215, 1227 (D.N.M. 2001) (granting insurer summary judgment where there was no link between allegedly wrongful roundtable practices and insured's claim); Kosierowski v. Allstate Ins. Co., 51 F. Supp. 2d 583, 594–95 (E.D. Pa. 1999) (involving software designed to evaluate claims; the adjuster did not rely on the program but used his own judgment in evaluating the plaintiff's claim).

65. 282 F. Supp. 2d 1095 (D. Ariz. 2003).

but Allstate insisted on interviewing him first. That interview was accomplished after several months of delay for which each side blamed the other. Based on that interview and the medical information provided, Allstate offered Lopez $1,000 to settle.[66] Lopez considered that offer to be insulting and demanded arbitration.[67] The arbitration panel awarded him $14,500, and Allstate promptly satisfied the award.[68] Lopez then sued Allstate for bad faith.

Lopez alleged that Allstate acted in bad faith by (a) failing to settle for a reasonable sum; (b) unreasonably delaying the processing and payment of his claim; (c) forcing him to arbitrate his claim; (d) low-balling him; (e) failing to consider his interests equally to its own; (f) flatly refusing to pay above a certain amount for certain classes of claims, including his; (g) creating additional and unnecessary burdens for him and similarly situated insureds; (h) unreasonably profiling and discriminating against classes of claimants, including him; and (i) failing to pay the undisputed portion of his claim.[69] Allstate moved for summary judgment and aimed part of its motion at Lopez's institutional bad faith claim framed in theories (f), (g), and (h).[70] Those theories were linked to Allstate's "Claim Core Process Redesign," or "CCPR," and the "Minor Impact Soft Tissue" component of that initiative known by the acronym "MIST."[71] Allstate emphasized that Lopez could not connect its alleged institutional bad faith to his claim, nor could he demonstrate that he was harmed by the CCPR or MIST program.[72]

Lopez countered that Allstate had fared poorly in market conduct examinations conducted by insurance departments in Alaska, California, Pennsylvania, and Virginia.[73] The fact that Allstate was found to have acted unreasonably in those states, he argued, was evidence that it acted unreasonably in handling his claim.[74] The court disagreed for two reasons. First, the market conduct examinations were conducted to evaluate Allstate's compliance with state insurance regulations; thus, they had no bearing on this case. Second, and more importantly, Lopez could not connect the findings in the state examination reports and Allstate's alleged misconduct in his case.[75]

66. *Id*. at 1098.
67. *Id*.
68. *Id*.
69. *Id*. at 1099.
70. *Id*. at 1104.
71. *Id*.
72. *Id*.
73. *Id*.
74. *Id*.
75. *Id*.

Outside of the market conduct examinations in other states, Lopez could not demonstrate that Allstate employed any principles or procedures in the CCPR or MIST program in a fashion that harmed him.[76] He therefore relied on a report by his insurance claims expert, Michael Cerf, in which Cerf opined that Allstate had been willfully indifferent to its duty of good faith and fair dealing in handling Lopez's claim, had failed to comply with standard industry claims practices, and had adhered to "'the dogmatic process of MIST'" without reason or basis.[77] Unfortunately for Lopez, the court concluded that Cerf's opinions did not create a genuine issue of material fact sufficient to defeat summary judgment for several reasons.[78] Among other flaws, Cerf admitted that he never fully read the CCPR or MIST program, there was no factual support in the record for his opinions, and Lopez could point to no provision in the CCPR or MIST program that evidenced bad faith.[79]

The *Lopez* court rejected the rest of the plaintiff's bad faith theories as lacking factual support or on the basis that his UM claim was fairly debatable.[80] The court therefore granted summary judgment for Allstate.[81]

Lopez was a fairly simple case because the plaintiff could not tie his treatment by Allstate to the CCPR or MIST program. But what if he had? The police officer who responded to the accident in which Lopez was allegedly injured reported no injuries at the scene.[82] The collision was low-impact. There was evidence from Lopez's doctors to suggest that he was exaggerating his injuries.[83] An Allstate investigator observed Lopez moving normally, which contradicted at least some of his injury claims.[84] This was the sort of case in which an insurer might reasonably question the nature and extent of a claimant's injuries and doubt the amount of medical expenses or lost income.[85] In summary, Lopez's claim was fairly debatable regardless of whether the debate (1) erupted from a single adjuster's objective investigation of the facts or (2) derived from a company-wide systems approach to

76. *Id.*
77. *Id.* (quoting Cerf's report).
78. *Id.* (noting that Cerf's opinions were inadmissible because they were presented in letter form rather than being sworn and that the report did not recite Cerf's expert qualifications).
79. *Id.* at 1105.
80. *Id.* at 1100–03.
81. *Id.* at 1105.
82. *Id.* at 1097.
83. *Id.* at 1102.
84. *Id.*
85. *See also, e.g.*, Yumukoglu v. Provident Life & Accident Ins. Co., 131 F. Supp. 2d 1215, 1227 (D.N.M. 2001) (granting insurer summary judgment on insured's bad faith claim and discussing surveillance that suggested that insured was exaggerating his claimed disabilities; the insurer had the tapes reviewed by medical professionals who questioned the insured's disability as a result, and there was other objective medical evidence of possible exaggeration).

analyzing and investigating categories of claims that were susceptible to overpayment absent careful scrutiny.

The plaintiff in *Kosierowski v. Allstate Insurance Co.*,[86] Barbara Kosierowski, was hurt when her vehicle was rear-ended by an underinsured motorist. Kosierowski had $100,000 in UIM coverage with Allstate. After settling with the motorist, Kosierowski's lawyer, Joseph Mallon, demanded that Allstate pay Kosierowski the $100,000 limits of her UIM policy on the basis that her lost wages and medical expenses totaled $130,000. After Allstate investigated Kosierowski's claim and had a physician examine her, Mallon demanded that Allstate arbitrate her claim. When it took some time to select a neutral arbitrator and schedule the arbitration, Mallon informed Allstate that he was considering bad faith litigation.

The Allstate claims representative responsible for the matter, Huber, ran Kosierowski's claim through the company's Colossus software to calculate its settlement value.[87] The first run produced a settlement range of $11,624–13,824. Huber independently valued Kosierowski's claim at $50,000–60,000, and promptly offered Kosierowski $50,000 to settle.[88] She declined the offer. Two days later, with the addition of different variables, another Colossus analysis produced a settlement range of $50,700–61,060. Allstate then granted Huber $100,000 in settlement authority. He offered Kosierowski $80,000 to settle, which she was willing to accept if the settlement was limited to her UIM claim and did not require her to release her putative bad faith claim.[89] Huber, of course, intended the $80,000 to encompass both the UIM and bad faith claims. Ultimately, he offered her the full $100,000 to settle only her UIM claim, which she accepted. Kosierowski then sued Allstate for bad faith in a Pennsylvania federal court.

Allstate moved for summary judgment. One of the issues at summary judgment was Allstate's pattern and practice of claims-handling. Kosierowski alleged that Allstate's use of Colossus to calculate claim values based on irrelevant variables was an act of bad faith.[90] She also alleged that Allstate engaged in bad faith through a policy of offering settlements of five percent below the value it internally assigned to claims as a means of increasing profitability.[91] Allstate did, in fact, have such a policy; a company handbook stated that Allstate could increase its profits by $34 million per year in its UM/UIM lines by reducing settlements by up to five percent.

86. 51 F. Supp. 2d 583 (E.D. Pa. 1999).

87. Colossus® is a software program that the Computer Sciences Corporation licenses to insurers for use in evaluating bodily injury claims. *See* Computer Sciences Corp., http://www.csc.com/p_and_c_general_insurance/ds/24234/26553-colossus.

88. *Kosierowski*, 51 F. Supp. 2d at 587.

89. *Id.*

90. *Id.* at 594.

91. *Id.*

Furthermore, one of Allstate's Pennsylvania claims offices employed this policy in connection with third-party claims.[92] Unfortunately for Kosierowski, she could not demonstrate that Allstate's allegedly wrongful practices had any effect on her claim.

Although the first Colossus calculation was clearly too low (apparently because it was based on inaccurate information), and even assuming that Colossus was as flawed as the plaintiff alleged, the fact remained that Huber did not rely on the program in making his initial $50,000 settlement offer.[93] Indeed, it was clear that Huber consistently exercised his own judgment in determining the value of Kosierowski's claim. As for the five percent program, Kosierowski had no evidence that Allstate applied it to her claim. In fact, it would have been impossible for her to do so, given that she received the full $100,000 policy limits in settlement of her UIM claim and had been willing to accept $80,000 to settle that claim.[94] Ultimately, the *Kosierowski* court awarded Allstate summary judgment.

Crackel v. Allstate Insurance Co.[95] presents a contrasting view, although the insurer's liability in that case was predicated on abuse of process rather than bad faith. Succinctly, in *Crackel*, an Allstate claims representative regrettably embraced and enforced Allstate's corporate position "that any injury reportedly caused by 'a minor impact' was 'suspect'" in connection with two claims arising out of a single rear-end automobile accident.[96] This position, although illogically asserted and irrationally carried out in this particular case, was in larger context a key component of Allstate's MIST program centered on aggressively litigating minor impact automobile accidents that produced claims of soft tissue injuries. Implementing the MIST philosophy with blind zeal, the Allstate claims representative and the defense lawyer Allstate engaged orchestrated a strategy that involved denying liability even though the insured's fault was crystal clear, making ridiculous lowball settlement offers, hiring a biomechanical expert to contest the plaintiff's claims at a cost far beyond the plaintiffs' settlement offer, requiring the plaintiffs to submit to plainly unnecessary independent medical examinations, unreasonably appealing an arbitration award, and refusing to participate in a settlement conference in good faith.[97] The plaintiffs convincingly characterized Allstate's MIST-related litigation strategy "as a 'club' in an attempt to coerce them, and other similarly situated claimants, to surrender those causes of action that sought only modest damages."[98]

92. *Id.* (citing summary judgment exhibits).
93. *Id.* at 595.
94. *Id.*
95. 92 P.3d 882 (Ariz. Ct. App. 2004).
96. *Id.* at 886.
97. *Id.* at 886–87.
98. *Id.* at 890.

To conclude for now on liability, the fact that an insurance company roundtables claims, establishes a uniform system for evaluating claims, uses software programs to evaluate or value claims, analyzes categories or classes of claims, scrutinizes the payments of certain classes of claims, implements procedures or systems intended to improve claims-handling, or structures employee incentive programs as a means of controlling claim expenses or expediently resolving claims typically does not alone evidence bad faith.[99] Insurance companies are entitled to implement sound business practices fairly and to consider the "bottom line" when structuring claims processes.[100] For these practices or procedures to be relevant from a bad faith standpoint, they must have caused the insurer to behave unreasonably in connection with a particular claim.[101] Although not a bad faith case in the true sense, *Crackel* illustrates how this might happen.[102] Bad faith in the atmosphere, however, will not do.[103] For that matter, because the analytical focus in a bad faith case must always be on the specific claim or loss at hand, the term "institutional bad faith" is something of a misnomer.

B. *Punitive Damages Based on Institutional Bad Faith*

Plaintiffs often allege institutional bad faith as a basis for awarding punitive damages or as a reason to ratchet up a punitive damage award.[104] This

99. *See*, *e.g.*, Santer v. Teachers Ins. & Annuity Ass'n, Civ. A. No. 06-CV-1863, 2008 WL 755774, at **7–9 (E.D. Pa. Mar. 19, 2008) (discussing insurer's bonus program for "resolving" claims in connection with discovery request); Milhone v. Allstate Ins. Co., 289 F. Supp. 2d 1089, 1100–02 (D. Ariz. 2003) (involving the Colossus program and a similar initiative, and stating that the plaintiff "made no effort to explain how the use of a uniform system for evaluating claims is bad faith"); Young v. Allstate Ins. Co., 296 F. Supp. 2d 1111, 1123 (D. Ariz. 2003) (commenting on Allstate's CCPR and MIST programs); Knoell v. Metro. Life Ins. Co., 163 F. Supp. 2d 1072, 1078 (D. Ariz. 2001) (discussing roundtables, keeping claims statistics, and profitability considerations); Miller v. Allstate Ins. Co., No. CV 98-1974-WMB SHX, 1998 WL 937400, at *4 (C.D. Cal. Sept. 21, 1998) (involving Allstate's CCPR and MIST programs); Nager v. Allstate Ins. Co., 99 Cal. Rptr. 2d 348, 353 (Ct. App. 2000) ("There is nothing tortious in Allstate's preliminary use of computerized billing programs as a yardstick to measure the reasonableness of chiropractic bills provided to a litigant by medical lien claimants.").

100. *Knoell*, 163 F. Supp. 2d at 1078.

101. Kosierowski v. Allstate Ins. Co., 51 F. Supp. 2d 583, 594 (E.D. Pa. 1999) (quoting Hyde Athletic Indus., Inc. v. Cont'l Cas. Co., 969 F. Supp. 289, 307 (E.D. Pa. 1997)).

102. *See* Crackel v. Allstate Ins. Co., 92 P.3d 882, 885–87 (Ariz. Ct. App. 2004) (discussing the insurer's conduct in connection with abuse of process allegations tied to defense of two bodily injury claims).

103. *See generally Santer*, 2008 WL 755774, at *3 ("Limiting discovery [in a bad faith case] to the practices applied to the individual plaintiff is the preferable approach, 'as the issue in a bad faith case is whether the insurer acted recklessly or with ill will towards the plaintiff in a particular case, not whether the defendants' business practices were generally reasonable.'") (quoting Mann v. Unum Life Ins. Co. of Am., 2003 WL 22917545, at *10 (E.D. Pa. Nov. 25, 2003)); Condio v. Erie Ins. Exch., 899 A.2d 1136, 1143 (Pa. Super. Ct. 2006) ("Bad faith claims are fact specific and depend on the conduct of the insurer *vis-à-vis* the insured.").

104. Nelson et al., *supra* note 1, § 2.11, at 2-60.

use of institutional bad faith at first might seem inappropriate given the Supreme Court's decision in *State Farm Mutual Automobile Insurance Co v. Campbell*.[105] After all, the Supreme Court in *Campbell* made clear that state courts generally do not have a legitimate concern in awarding punitive damages to punish defendants for lawful conduct occurring outside the state.[106] Indeed, the Court bluntly faulted the Utah Supreme Court for awarding punitive damages against State Farm for conduct that bore no relation to the plaintiffs' harm.[107] The Court explained that a defendant's "dissimilar acts" that were "independent from the acts upon which liability was premised[ ] may not serve as the basis for punitive damages. A defendant should be punished for the conduct that harmed the plaintiff, not for being an unsavory individual or business."[108] Furthermore, the Court stated, courts calculating punitive damages may not adjudicate the merits of other parties' hypothetical claims against a defendant under the guise of reprehensibility analysis.[109]

Importantly, however, the Court in *Campbell* did not impose a blanket prohibition on courts' or juries' consideration of a defendant's conduct in other cases or venues when weighing punitive damages. Rather, the decision mandates a causal link between a defendant's out-of-state conduct and the defendant's allegedly tortious conduct in the case in which punitive damages are sought. Under *Campbell*, "[l]awful out-of-state conduct may be probative when it demonstrates the deliberateness and culpability of the defendant's action in the [s]tate where it is tortious, but that conduct must have a nexus to the specific harm suffered by the plaintiff."[110] Moreover, a recidivist defendant in a civil case may be punished more harshly than a first offender on the basis that repeated misconduct is more reprehensible than a single instance of malfeasance, provided that the court ensures that "the conduct in question replicates the prior transgressions."[111] Thus, *Campbell* substantially limits plaintiffs' ability to recover punitive damages for institutional bad faith, but it does not eliminate the prospect.[112]

In *Niver v. Travelers Indemnity Co. of Illinois*,[113] for example, plaintiff Scott Niver won summary judgment against Travelers on his first-party bad faith claim for failing to pay workers' compensation benefits, leaving only damages for trial to a jury. The parties sought in limine rulings on a variety of

105. 538 U.S. 408 (2003).
106. *Id*. at 421.
107. *Id*. at 422.
108. *Id*. at 422–23.
109. *Id*. at 423.
110. *Id*. at 422.
111. *Id*. at 423.
112. Nelson et al., *supra* note 1, § 2.11, at 2-63 to -64.
113. 433 F. Supp. 2d 968 (N.D. Iowa 2006).

issues, including evidence that Niver intended to offer to support his theory of institutional bad faith liability. Niver alleged that Travelers, as an institution, had enacted policies, programs, or procedures designed to wrongfully deny workers' compensation claims "across the board."[114] Much of the evidence Travelers sought to exclude concerned a South Dakota case, *Torres v. Travelers Insurance Co*., which Niver had mined for documents and information to use against Travelers in his case.[115]

With respect to the *Torres* documents, Travelers argued that the fact that a jury returned a verdict against it in another case was no more relevant to the issues in this case than the fact that it had successfully defended many other bad faith cases.[116] Travelers contended that it was unfairly prejudicial to allow Niver to use documents from other cases to persuade this jury that Travelers had intentionally and wrongfully denied his claim for workers' compensation benefits. Travelers further argued that evidence from the *Torres* case was not admissible to establish reprehensibility for punitive damage purposes because even if alleged recidivism bore on reprehensibility, there was no evidence that it had harmed individuals intentionally as an organization.[117] All that Niver offered to support his institutional bad faith theory, Travelers argued, was conjecture and speculation. Travelers' essential position was that only documents from this case were relevant to Niver's bad faith claim.[118]

Pushing back, Niver argued that evidence from the *Torres* case was relevant to show the reprehensibility of Travelers' actions for punitive damage purposes.[119] He contended that Travelers raised in *Torres* three of the same arguments it used to assert that his claim was fairly debatable. He further argued that Travelers' "Claim Professional Incentive Program," which tied Travelers' employees' bonuses to overall claim payments, was in evidence in the *Torres* case just as it was in his.[120] In short, Niver argued, the district court could instruct the jury that it could not punish Travelers for conduct in *Torres* or any other case, but the jury could punish Travelers in his case for replicating previous misconduct.[121]

The district court doubted whether evidence from *Torres* had "any tendency whatsoever" to prove that Travelers' bad faith proximately caused Niver's actual damages.[122] Were Niver's actual damages the only issue remaining

114. *Id*. at 976.
115. *Id*.
116. *Id*.
117. *Id*.
118. *Id*. at 976–77.
119. *Id*. at 977.
120. *Id*.
121. *Id*.
122. *Id*. at 978.

for trial, the court noted, the evidence would likely be excluded as irrelevant or as unfairly prejudicial or potentially confusing under Federal Rules of Evidence 402 and 403.[123] The admissibility of the evidence for punitive damages, however, was another matter following *Campbell*.[124] As the *Niver* court explained:

> Here, Travelers asserts that, as in *Campbell*, there is scant or no evidence that Travelers's bad faith conduct toward Niver "replicates prior transgressions," while Niver contends that the "replication" of misconduct between the *Torres* case and the present case is apparent from evidence that he has gathered. . . . The apparent "replication" of conduct between the *Torres* case and the conduct on which this court concluded that Travelers had acted in bad faith appears to be close enough—at least as the evidence is characterized by Niver—for the evidence from the prior case to have the tendency to make the existence of "recidivism" in this case more probable. . . . Therefore, Travelers's motion to exclude this . . . category of evidence will be denied.
>
> While this court must "ensure that the conduct in question replicates the prior transgressions" . . . this court believes that it is ultimately for a jury to decide whether the evidence of prior misconduct is sufficiently like the misconduct at issue here to warrant punishing Travelers for "recidivism" in an award of punitive damages. Thus, consistent with *Campbell*, jurors must be instructed that they cannot award punitive damages to punish or deter conduct that bore no relation to Niver's harm, and that they may not consider the merits of other parties' claims, real or hypothetical, against Travelers in determining whether or not to award punitive damages in this case, but may only award punitive damages to punish Travelers for repeated "bad faith" conduct of the same sort that injured Niver. . . .[125]

The court next turned to Travelers' motion to exclude evidence of its compensation and bonus programs, incentive plans, and so on. Travelers argued that there was no evidence that any of the employees responsible for Niver's claim received compensation, bonuses, or incentives as a reward for reducing his payment. Indeed, Travelers argued, the adjusters who handled Niver's claim testified in their depositions that they had never heard of the programs or plans to which Niver referred and that their decisions in Niver's case and other cases were not affected by compensation or bonus considerations.[126] Niver forcefully resisted Travelers' argument:

> [Niver] contends . . . that Travelers has in place a program that provides bonuses or "incentives" to its employees that are tied directly to the payout on

123. *Id*.
124. State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408 (2003).
125. Niver v. Travelers Indem. Co. of Ill., 433 F. Supp. 2d 968, 979–80 (N.D. Iowa 2006) (citations omitted).
126. *Id*. at 980.

> claims they handle. These programs . . . are called the Claim Property Casualty Incentive Program (CIP) and the Claim Professional Incentive Plan (CP). . . . [H]e contends that he will . . . show the amount of bonuses that the employees who were involved in Niver's workers compensation claim received during the years that they were handling Niver's claim, as well as performance reviews that tie[d] their compensation and performance to the "average paid" on claims, as well as documents that explain the "Critical Success Factor" program used in employee reviews. . . . Niver contends that these documents are clearly relevant to punitive damages, because they tend to make more probable that Travelers acted willfully wantonly and that its conduct was reprehensible by showing how and why Travelers acted with reckless disregard of Niver's rights. Niver argues that denials by Travelers's employees that any plans, programs, or incentives influenced their treatment of his claim raise only credibility issues for a jury to decide.[127]

The court agreed with Niver that *why* Travelers adjusters may have handled his claim as they did, especially where there was evidence that they may have been rewarded for minimizing claim payments, was relevant to whether Travelers acted with willful and wanton disregard for his right to fair compensation for his workplace injury.[128] Although the court was not convinced that Niver's evidence was a "smoking gun" demonstrating that the claim-handling decisions in his case were influenced by Travelers' compensation and performance plans or programs, it was no more persuaded by Travelers' denials of any connection.[129] The court determined that the jury should be allowed to consider this evidence, so long as it was suitably limited to protect the Travelers' employees' privacy concerns.

Niver illustrates the difficulty of resolving many institutional bad faith claims short of trial. The claims professionals who were involved with Niver's claim denied being influenced by the policies and practices that Niver contended were evidence of Travelers' institutional bad faith, yet the district court viewed their denials only as creating a fact issue for the jury to decide. The lesson for insurers is obvious: severing the causal link between alleged acts of institutional bad faith and the handling of a particular claim without a trial will frequently require more than mere denials by company witnesses.

Merrick v. Paul Revere Life Insurance Co.[130] is another illustrative case, albeit at the extreme end of the bad faith spectrum. In *Merrick*, the district court was ruling on post-trial motions in a case in which a jury had returned a bad faith verdict against UnumProvident Corporation and Paul Revere

127. *Id*. at 980–81.
128. *Id*. at 981.
129. *Id*.
130. 594 F. Supp. 2d 1168 (D. Nev. 2008).

(which had merged by the time of trial), and had assessed substantial punitive damages. *Merrick* arose out of the insurers' calculated mistreatment of G. Clinton Merrick, a venture capitalist who was insured under "own occupation" disability insurance policies issued by the defendants.[131] The case is illuminating not just because of the defendants' unreasonable conduct vis-à-vis Merrick, but because of the court's extensive discussion of the defendants' (principally UnumProvident's) institutional bad faith.

In the 1990s, UnumProvident realized that claims under its own occupation disability policies were putting the company at risk. As a result, it substantially restructured its claims-handling practices and philosophy. It went from a company that had a philosophy of paying claims to one that managed claims, with "profound" results.[132] UnumProvident began targeting what it referred to as "subjective" claims, meaning claims that were based on mental or nervous disorders, such as chronic fatigue syndrome and fibromyalgia. Because these claims could not be proven by hard medical evidence such as x-rays, UnumProvident reasoned that they had "a large potential for resolution based on the vulnerability of insureds to pressure tactics."[133] In addition, but in a similar vein, UnumProvident developed a practice of "claim objectification."[134] Essentially, UnumProvident required insureds to provide objective evidence of their disability as a condition of receiving benefits, even though its policies contained no such requirement.[135] The company did this solely as a means of denying claims, including perfectly legitimate ones.[136] Furthermore, UnumProvident imposed the claim objectification requirement on insureds who it knew could not meet it given the nature of their disability. That was the case with Merrick, who became disabled as a result of chronic fatigue syndrome.[137]

Another tactic that UnumProvident developed was the use of roundtable reviews of high indemnity claims. These reviews involved claims, legal, management, and medical personnel. It was company policy to destroy all records of these roundtables, including the identities of the participants, the subjects discussed, and the basis for any resulting decision.[138] Unum-

131. "Own occupation" disability policies deem insureds to be totally disabled when they cannot perform the major duties of their regular occupations. A regular occupation is the one in which the insured was engaged when the disability began. Under this type of policy, insureds may be able to work in other capacities and still be entitled to policy benefits if they cannot perform the important tasks of their own occupations in the usual way. Kenneth Black Jr. & Harold D. Skipper Jr., Life & Health Insurance 152 (13th ed. 2000).

132. *Merrick*, 594 F. Supp. 2d at 1170.

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.* at 1170–71.

Provident attempted to cloak the roundtables with the attorney-client privilege to further insulate from scrutiny the claims decisions and bases for them.[139]

UnumProvident also developed a practice of shifting the burden of claims investigation to insureds.[140] Employees were instructed that insureds bore the burden of proving their claims and were told to limit their use of independent medical examinations (IMEs).[141] At the same time, UnumProvident implemented a practice of always valuing the opinions of in-house medical personnel—who never spoke with or examined insureds—over the opinions of insureds' treating physicians or doctors who conducted IMEs.[142] Conjunctively, the insurer's in-house medical personnel cherry-picked insureds' medical records looking for reasons to deny claims regardless of their merit.[143] In-house medical personnel focused on apparent inconsistencies in medical records and other information supplied by claimants rather than trying to understand claimants' medical conditions.[144] In-house medical staff also had a practice of "piecemealing" claimants' medical conditions rather than considering the totality of the medical circumstances.[145]

UnumProvident set targets and goals for terminating claims for its own financial gain and without regard for the merit of the claims being terminated.[146] It established financial targets for closing claims; transmitted those corporate goals to claim units, which then felt pressure to close claims; imposed claim closure quotas on claim units; punished claim units that did not meet their quotas; pressured claims personnel to meet these quotas; and, to further pressure employees, set up stock boards in claim units that were updated daily so that claims personnel were constantly reminded how their activities contributed to the defendants' financial results.[147] These programs were endorsed at the highest levels of the company and were discussed at UnumProvident board meetings.[148]

139. *Id*. at 1171.
140. *Id*.
141. *Id*.
142. *Id*.
143. *Id*.
144. *Id*.
145. *Id*.
146. *Id*. at 1171–72. There was evidence that not every terminated claim was the result of an improper denial. Some insureds returned to work. Policies expired, some policyholders died, and others "aged out," such that benefits are no longer payable. But the evidence established that the defendants set targets and goals well beyond actuarial expectations for claim closures based on these factors. "The evidence established that Defendants went looking for ways and claims to close in order to meet their financial goals." *Id*. at 1171 n.1.
147. *Id*. at 1172.
148. *Id*. at 1173 & n.8.

Paul Revere was also facing significant financial difficulties as a result of its book of own occupation disability insurance policies. When UnumProvident and Paul Revere merged, the former imposed its predatory claim practices on the latter.[149] Evidence introduced at trial in *Merrick* demonstrated that the defendants' unscrupulous claim practices were wildly profitable, bringing in hundreds of millions of dollars that they never would have earned had they handled claims properly.[150] Regrettably, the defendants achieved their astronomical profits "at the expense of physically, mentally, emotionally, and economically vulnerable individuals, through repeated actions systematically applied to deprive them of disability insurance benefits in their time of need."[151]

Long story short, UnumProvident and Paul Revere abused Merrick just as they did many other insureds. The institutional bad faith schemes for which the court faulted the defendants were glaringly displayed in connection with Merrick's chronic fatigue syndrome claim.[152] For example, the defendants (1) insisted that he "objectify" his chronic fatigue syndrome despite knowing that it was impossible to do so; (2) repeatedly refused to tell him what tests they would accept to objectify his claim; (3) attempted to reclassify Merrick's occupation as "unemployed" so that they could determine that he was capable of performing the duties of an unemployed person and therefore was not disabled; (4) attempted to sneak an unfair settlement past him through misrepresentations and a statement on a check, whereby he would have surrendered his full policy benefits in exchange for a single payment of one month's benefits; (5) disregarded the opinions of Merrick's treating physicians and ignored the opinions of their in-house physicians who agreed with Merrick's doctors; (6) rejected all information that Merrick offered to support his claim, always falsely asserting that all available information established that he was not disabled; and (7) threatened to sue him for benefits previously paid if he did not terminate his claim.[153] Although it reduced the punitive damage awards against the defendants from a total of $36 million to slightly more than $26 million to satisfy constitutional ratios,[154] the *Merrick* court's disgust with the insurers was palpable, and its evaluation of the reprehensibility of their misconduct caused it to conclude that they had to be punished "at the highest levels constitutionally permissible."[155]

149. *Id*. at 1173–74.
150. *Id*. at 1185.
151. *Id*.
152. *Id*. at 1176 ("Not only did Plaintiff establish the existence of a corporate scheme to augment profits at the expense of disabled policyholders, [he] established that his claim was mishandled in a manner consistent with that scheme.").
153. *Id*. at 1178–81.
154. *Id*. at 1192.
155. *Id*. at 1189.

Merrick is a disturbing case; fortunately, as suggested earlier, it is also an outlier. First, insurers almost never set out to cheat policyholders as UnumProvident apparently did.[156] The description of the facts in *Merrick* makes UnumProvident look more like the diabolical insurer caricatured in John Grisham's novel *The Rainmaker*[157] than an actual insurance enterprise.[158] Sadly, UnumProvident has a long-standing reputation for predatory and unscrupulous claims practices,[159] which everyone should hope the corporation will ultimately repair through the recognition and restoration of its duty of good faith and fair dealing. UnumProvident has presumably learned from its harsh experiences in litigation and eliminated the practices that spawned many bad faith claims against it. Second, UnumProvident perverted reasonable claims-handling practices, such as roundtables, to unfairly advance its profitability initiative. On the whole, roundtables are a standard insurance industry practice intended to foster responsible claims-handling; as commonly employed they benefit claimants as often as they work against them.[160] Indeed, the fact that an insurer roundtables a claim more likely demonstrates the existence of the insurer's good faith rather than bad. Third, UnumProvident distorted responsible business objectives or practices, such as reducing fraud and waste in categories of claims susceptible to incorrect evaluation or manipulation, into schemes to cheat policyholders. As a general rule, there is nothing wrong with insurers testing claims for exaggeration or inflation.[161]

In closing, *Merrick* illustrates institutional bad faith as plaintiffs ideally script the theory. Although institutional bad faith claims are often properly condemned for being concocted behind a "façade of righteousness"

156. *See also* Greenberg v. Paul Revere Life Ins. Co., 91 F. App'x 539, 542 (9th Cir. 2004) (affirming punitive damage award against Paul Revere for repeated misconduct, including acts of deceit, directed at a financially vulnerable plaintiff); Hangarter v. Provident Life & Accident Ins. Co., 373 F.3d 998, 1014 (9th Cir. 2004) (characterizing UnumProvident's institutional bad faith in relation to another claim); Shepherd v. UnumProvident Corp., 381 F. Supp. 2d 608, 611–12 (E.D. Ky. 2005) (allowing expert testimony by a former UnumProvident claims handler to the effect that UnumProvident's "high-level management . . . emphasiz[ed] that claims for benefits be denied for reasons of offsetting revenue losses, rather than based upon the merits of a particular claim").

157. John Grisham, The Rainmaker (1995).

158. *See* Merrick v. Paul Revere Life Ins. Co., 594 F. Supp. 2d 1168, 1172–76 (D. Nev. 2008) (describing what the court referred to as the defendants' "scheme" to deprive policyholders of their disability benefits).

159. *See* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 Nw. U. L. Rev. 1315, 1317–20 (2007) (describing the UnumProvident claims "scandal" and citing several exemplary cases).

160. *But see Hangarter*, 373 F.3d at 1011 (involving improper use of roundtable process by UnumProvident and criticism of roundtables in general by the plaintiff's insurance expert).

161. *See, e.g.*, Nager v. Allstate Ins. Co., 99 Cal. Rptr. 2d 348, 350 (Ct. App. 2000) ("Not every first party insurance claim is transmogrified into a bad faith suit simply because an insurer questions the amount of a bill before paying it.").

by disingenuous plaintiffs in "a naked effort to put the entire [insurance] industry on trial,"[162] the decision in *Merrick* reveals the unappealing truth that sometimes when one sees smoke there is indeed fire.

C. *Summary*

Regardless of whether institutional bad faith is a theory of liability or an alleged basis for increasing punitive damages on the basis of reprehensibility, there must be a causal connection between the supposed institutional wrongdoing and the particular plaintiff's claim. Absent such a link, a plaintiff's institutional bad faith claim necessarily fails. Bad faith liability does not attach merely because an insurance company is alleged to be unsavory, nor can punitive damages be assessed on that ground. The challenge for lawyers and insurers is figuring out how much or what type of evidence is required to establish the causal connection. It is clearly not sufficient to infer or presume a link between allegedly unreasonable institutional practices and an insurer's treatment of a particular claimant, but at the same time, direct evidence of a connection will often be difficult to come by. To the extent that the establishment of a causal link pivots on witnesses' credibility and circumstantial evidence, these cases frequently cannot be disposed of at summary judgment. That increases settlement pressure on insurance company executives, who must then weigh the often significant cost of continued litigation versus a negotiated resolution and who often disfavor trials in bad faith cases because they perceive jurors to be predisposed against their companies.

IV. RECOMMENDATIONS FOR INSURERS

Insurance companies are in the business of paying covered claims. Claims professionals are charged with fulfilling insurers' promises to their policyholders. At the same time, insurers have an undisputed right to make underwriting profits. Indeed, shareholders in stock companies and policyholders in mutual companies expect insurers to make underwriting profits. Of course, underwriting profit depends in part on responsible claims practices. Incorrect and excessive claims payments reduce underwriting profit and contribute to underwriting losses. Accurate and efficient claims-handling produces opposite results. Prudent insurers continuously look for ways to reduce inefficiencies, fraud, and waste in their claims operations. The long and short of it is that reputable insurers want to timely pay policy benefits that they owe, but they do not want to pay claims or incur expenses that they do not owe. That is good business.[163]

162. Varner et al., *supra* note 3, at 163.

163. Insurers cannot generate underwriting profit simply by increasing premiums. Market forces and state insurance regulation limit insurers' ability to raise premium rates.

It is hardly surprising that insurers striving for accuracy and efficiency in their claims operations implement policies and procedures intended to accomplish these goals. Steps include subjecting certain categories of claims to special scrutiny, evaluating claims professionals' performance against objective cost-control goals, or using software programs to value claims. Principled insurers do not intend such measures to delay or deny the payment of legitimate claims. They do not intend these measures to compromise their duty of good faith and fair dealing. The problem for even the best insurers is twofold: first, bad faith plaintiffs will attack claims practices or procedures that advance their theory of institutional wrongdoing regardless of insurers' actual intentions in implementing challenged measures. For insurers, defeating institutional bad faith claims short of trial, and preventing alleged evidence of institutional bad faith from being introduced at trial, can be difficult. Second, claims handlers may misconstrue or misapply reasonable company initiatives or policies. For example, some claims professionals who are assigned a goal of reducing defense and indemnity payments by a given percentage during a specified period may incorrectly attempt to wring dollars out of every claim rather than exercising the discretion and good judgment that the company expects of them, thus harming legitimate claimants rather than, or in addition to, reducing unnecessary expenses.

Prudent insurers should attempt to guard against institutional bad faith allegations and related causes of action. There are several protective measures or approaches that insurers may wish to consider in doing so.

First, insurers should not try to impose on insureds requirements that are not contained in their policies. For example, some health insurers reportedly refuse to pay claims in any case in which they suspect that a third-party is responsible for an insured's injuries, even though their policies do not permit that approach. In a common scenario, an insured who falls in a store and breaks her arm is told by her health insurer that her claim is being denied because the store is responsible for paying her medical bills—not the insurer. Although the insured may be entitled to make a claim for the store's medical payments coverage, that fact does not permit the health insurer to avoid its contractual obligations. And while the desire to assign responsibility for a loss to a potential tortfeasor is perhaps understandable in the abstract, insureds cannot be forced into litigation with third parties outside of subrogation. This kind of approach to claims invites litigation. So too does any other claim requirement that is not contractually grounded.

Second, insurers should evaluate claims practices, policies, and procedures with an eye toward potential bad faith litigation. How will jurors perceive a policy? Can a policy be easily misconstrued? Can the acronym for a process or program be exploited by a bad faith plaintiff? To the extent that these questions are answered in ways that suggest an insurer's potential vulnerability to allegations of institutional bad faith, what is required

to blunt such charges? Should materials be rewritten? Should important explanations or qualifiers be added? Should internal titles for procedures or programs be changed? These questions must also be asked with respect to internal educational and training materials, and to documents prepared by advisors and consultants. Insurers should in all cases be wary of analogies, metaphors, and attempted levity in materials intended for internal use that plaintiffs can spin to their advantage in litigation. Hindsight often casts a different light on decisions, events, and even language. Does anyone doubt, for example, that the McKinsey & Co. slide purportedly suggesting "that Allstate should treat some of its claimants with 'boxing gloves,' rather than its trademark 'good hands,'"[164] has caused Allstate unwanted expense and distracting aggravation?

Third, insurers should take steps to ensure that their claims staffs do not misapply or misconstrue reasonable policies or procedures and, in doing so, cause the company to breach its duty of good faith and fair dealing to its insureds. In some cases, insurers may do this by how they write policies or explain procedures, while in others specialized training may be required. For example, in written policies concerning expense control or reduction, it may be sufficient to include statements to the effect that the goal of eliminating waste and redundancies should never be achieved through the denial or underpayment of legitimate claims. On the other hand, more sophisticated measures may require substantially more effort to ensure appropriate application. For instance, software programs used to value losses are only as accurate as the data fed into them. Adjusters who use such programs must understand that new information about a loss may yield a new estimate. Moreover, they must recognize that it is incumbent upon them to factor in new information at appropriate times. Here, training is likely required.

Fourth, some policies require careful thought before they are implemented. Returning to an earlier example, assume that a liability insurer's regional vice president of claims assigns all claims professionals in her region a goal of reducing defense and indemnity expenditures by five percent in a particular year. At the end of the year, the regional vice president and her senior staff will evaluate the claims professionals against this goal. Those who met or exceeded the goal will be viewed favorably when awarding raises and bonuses. Those who did not meet the goal will not be foreclosed from receiving raises or bonuses, but their failure may be a factor in their evaluations. In fact, insurers commonly implement similar programs

164. Michael Orey, *In Tough Hands at Allstate*, Bus. Wk., May 1, 2006, *available at* http://www.businessweek.com/print/magazine/content/06_18/b3982072.htm?chan=gl (last visited Dec. 14, 2010).

with the perfectly understandable goal of reducing unnecessary expense and eliminating waste. Insurers want to pay fair settlements rather than inflated ones, and to pay reasonable fee bills from defense counsel rather than bloated ones. They do not intend the desired savings to be carved out of legitimate claims or extracted from appropriate legal fees; they certainly do not intend these goals or programs to breach their duty of good faith and fair dealing. To the extent that claims professionals' raises or bonuses are tied to meeting the five percent target, an insurer would argue that is simply an incentive plan common to many industries.

There is nothing wrong with this sort of cost control initiative.[165] The devil, as they say, is in the details. First, the regional vice president of claims must ensure that the claims professionals she commands understand that savings must be achieved responsibly, meaning that claims must be suitably investigated and evaluated. Legitimate claims must be timely paid and insureds must always be treated responsibly. Claims professionals must remember that they are responsible for upholding the company's duty of good faith and fair dealing even as they look for ways to legitimately reduce claims-related expense. Second, when evaluation time comes, the regional vice president and her senior staff must realize that claims professionals who did not hit their targets may have valid reasons for not doing so. Many factors that influence claim values and legal expenses are beyond individual adjusters' control. Third, claims professionals in the region must have faith that they will be fairly evaluated and compensated regardless of whether they hit their targets. They must be confident that they will not be penalized for exercising sound judgment, or for treating policyholders fairly. Fourth, the insurer should properly communicate and document all aspects of this initiative. When the inevitable institutional bad faith claim arrives, the insurer must be prepared to demonstrate that nothing about its plan to reduce defense and indemnity payments by five percent negatively influenced the handling of the particular policyholder's claim or loss.

Fifth, insurers should make reasonable efforts to educate their claims staffs on the duty of good faith and fair dealing, unfair claims settlement practices, and the like. The amount of education required will probably vary by company, line of business, adjuster background and experience, among other factors. Training may be accomplished online, through continuing education classes required for claims professionals to maintain in-

165. *But see* Feinman, *supra* note 6, at 74 ("For actuaries, underwriters, managers, and other insurance company employees, measures that align the employees' incentives with company goals, including the goal of profitability, are perfectly appropriate. Not so for adjusters. . . . If the adjuster's pay is tied to reducing severity, or cases closed without payment, the company has given the adjuster an incentive to violate accepted practices and break the promise the company made to its policyholders [to pay what is owed on claims].").

surance licenses, through in-house programs, through articles and other materials routed to claims professionals for review, by way of programs presented by outside counsel or consultants, or through some combination of approaches. Most insurance companies do some or all of these things, but documentation of such activities varies widely. Insurers should recognize that not only are educational efforts generally helpful to their staffs, but the alleged *absence* of such efforts is often a component of institutional bad faith claims.

Sixth, insurers should sensitize their claims staffs to the threat of bad faith claims arising out of settlement negotiations. Especially in first-party cases, unreasonably low settlement offers are a recurring bad faith theme. Although as a general rule a first-party insurer may begin negotiations with an insured at the bottom of its own estimated settlement range without committing bad faith,[166] at least one court has held that an insurer must settle a first-party claim for the value or within the range of values assigned to the claim as a result of the insurer's investigation.[167] In the first-party context, an insurer that offers its insured less than what the insurer's own investigation reveals to be the claim's value is guilty of bad faith.[168] That is generally not the case with liability insurance, however, where the other party to the negotiations is a stranger to whom the insurer owes no duties.[169] Of course, a liability insurer that low-balls a plaintiff always risks the possibility that it will accordingly lose the opportunity to settle on the insured's behalf and either (a) incur defense costs that settlement would have avoided or (b) face possible extra-contractual liability if the case proceeds to trial and the plaintiff receives a judgment greater than the policy limits. While the threat of third-party bad faith arising out of failed settlement efforts is well-known, however, fewer claims professionals may identify the negotiation perils in first-party claims.

Seventh, insurers must exercise caution in connection with the use of computer software programs to value claims. There is ample public information available to litigants that can be effectively used to challenge these programs' use and to allege their abuse. As noted above, claims professionals using these programs must be thoroughly trained on them and understand the importance of entering complete and accurate information. Claims professionals must also understand that these programs do

166. Kosierowski v. Allstate Ins. Co., 51 F. Supp. 2d 583, 592 (E.D. Pa. 1999); *see also* Johnson v. Progressive Ins. Co., 987 A.2d 781, 784 (Pa. Super. Ct. 2009) (stating that "bad faith is not present merely because an insurer makes a low but reasonable estimate of an insured's damages").

167. Newport v. USAA, 11 P.3d 190, 196 (Okla. 2000).

168. *Id*. at 197.

169. *See id*. at 196.

not provide absolute answers and they must further appreciate the need to evaluate reasonably competing information provided by policyholders. Insurers must recognize that these programs have substantial limitations and should not use them as substitutes for claims professionals' judgment.[170] These programs may be valuable aids and tools for claims staff, but they are only that.

Eighth, insurers must carefully manage the defense of institutional bad faith litigation. They must make sure that employees designated as corporate representatives are prepared to effectively articulate the rationale for challenged actions or practices. Claims professionals must be ready to either separate their decisions from the corporate conduct at issue or explain why a policy, practice, or procedure was reasonable when applied to a particular claim. Depending on the facts, insurers may wish to consider confidentiality agreements or protective orders in discovery in an effort to prevent plaintiffs in different cases from sharing company information. If institutional bad faith allegations are a form of virus as some observers contend,[171] then insurers ought to attempt to limit its spread.

Finally, and though sometimes frustrating, insurers should attempt to learn from bad faith cases brought against them by practicing self-critical analysis. For example, have particular practices or internal policies proven susceptible to attack? Should those practices or policies be revised or discarded, or is the company not doing an effective job of explaining the reasons for them either internally or in litigation? Have plaintiffs been able to exploit gaps in employees' understanding? If so, what educational efforts are required to remedy confusion or knowledge deficiencies? In a worst case scenario, is the company employing practices or enforcing policies that *are* unreasonable when analyzed objectively? If so, what must be done to correct them?

The areas of inquiry will necessarily vary by insurer and any inquiries will be influenced by the nature of the litigation against the company. In many cases, insurers will conclude that their practices, policies, and procedures are reasonable. In others, insurers may determine that their claims practices merit alteration or improvement. In the end, insurers must remember that it is not sympathy that drives large compensatory damage awards or motivates jurors to award punitive damages—it is anger. Few things fuel jurors' anger like insurance companies that persist in allegedly unreasonable courses of conduct, or that appear as organizations to

170. Steven Plitt & John K. Wittwer, *Colossus Under Attack*, 29 Ins. Litig. Rep. 321, 323 (2007) (discussing the Colossus® program).

171. *See* Varner et al., *supra* note 3, at 163 ("Institutional bad faith is the 'Ebola' virus of extra contractual litigation.").

be bullies or arrogant. Insurance companies that engage in reasonable introspective analysis will be better prepared to develop good faith themes, avoid and correct organizational inadequacies, and defeat thorny allegations of institutional bad faith.

V. CONCLUSION

The theory of institutional bad faith allows a plaintiff to expand a dispute over a single loss into a widespread attack on an insurance company's practices and procedures as a theory of liability or as a means of establishing reprehensibility for punitive damage purposes. Regardless, institutional bad faith litigation poses a substantial challenge for insurance companies. At the lighter or less-threatening end of the litigation spectrum, institutional bad faith allegations spawn expensive and time-consuming discovery disputes. At their worst, institutional bad faith claims can produce sizable compensatory and punitive damage awards. For plaintiffs, the key is to link the insurer's institutional practices to their particular claims. Without such linkage there can be no bad faith liability and no basis for punitive damages. For insurers, the focus ought not be on litigation—although the importance of aggressively and effectively defending institutional bad faith claims cannot be overstated—but on avoiding institutional bad faith allegations through analysis and planning. Here, as in many other situations, prevention is preferable to cure.