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BAD FAITH SUBCOMMITTEE

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IN THIS ISSUE

Michael J. Cawley suggests in this article that insurers should consider exporting their "best practices" policies and procedures to third-parties to whom they delegate underwriting (i.e. MGA's) and claims functions (i.e. TPA's) as a way of insuring that such third-parties do not go "rogue" and in so doing create bad faith exposures for those insurers.

Expanding "Best Practices" to all Aspects of the Insuring Process so as to Avoid Bad Faith Claims

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The specter of a bad faith claim against an insurer is one of the major concerns of any insurance claims department operating in the United States. Over the last twenty five years, insurers have dedicated significant resources in the form of time and money educating their claims professionals in developing comprehensive "best practices" to be employed by claims departments when an insured tenders a claim to the insurer seeking insurance coverage. In order to ensure a uniformity and consistency in claims handling, insurance claims departments apply their "best practices" claims handling procedures to every conceivable type of claim for insurance coverage regardless of the type of insurance policy which is alleged to have been triggered by an insured event (i.e. third-party, first party, life, health and disability, professional liability claims etc.). While outside of the scope of this article, "best practices" in the context of insurance claims departments encompass policies and procedures which are triggered the moment an insurer receives notice of a claim and continue thereafter through the life of a claim.

Naturally, given the resources expended on developing "best practices" in claims handling, which typically includes the creation of and staffing within the insurer of "Extra-Contractual Liability Departments" dedicated to making sure that claims departments execute these best practices procedures and protocols, insurers fully expect their claims departments to religiously follow these protocols and procedures. In short, these best practices are themselves a form of insurance which protect the insurer from the severe consequences a successful bad faith claim can have on an insurer's financials especially since damages awarded against an insurer for bad faith are typically not reinsured.

It is important to understand why insurance claims departments have embraced "best practices" in their claims departments and have mandated that their claims professionals strictly adhere to these procedures: in addition to it being a good business practice that benefits both the insurer and insured, there is also the recognition by insurers that if it is discovered by counsel who represent policyholders that an insurer does not train its claims professionals in "best practices", that insurer is sure to become a target of those lawyers who earn their living by suing insurers for bad faith.

Moreover, the reality is that once the bad faith claim is filed, and the policyholder learns of the absence of any claims handling protocols, the policyholder and the policyholder's counsel are even more emboldened since the failure by the insurer to adopt a "best practices" policy delivers to the policyholder a gift in the form of greater leverage if and when the insurer and policyholder commence settlement discussions. And, of course, the lack of a "best practices" program makes it that much easier for the policyholders expert to

claim that the lack of a "best practices" program , in and of itself, is evidence of bad faith by that insurer.

While not every state recognizes a "bad faith" cause of action, the vast majority of states have either established common law bad faith actions or statutory bad faith causes of action. The most draconian of the statutory bad faith statutes permit an award of punitive damages; an award of attorneys' fees to the policyholder; related costs incurred in prosecuting the bad faith action; and an award of interest on the amount awarded which can be several percentage points above the existing prime interest rate. See, ***PA.C.S.A. Sec. 8371 et. seq.*** In some states, courts have recognized that an insured may obtain compensatory damages against an insurer which is found to have acted in bad faith towards an insured. See, ***The Birth Center v. St. Paul Companies, Inc.*** 787 A.2d. 376 (2001). And, of course, in those states that permit punitive damages against an insurer for engaging in bad faith, the one question no insurer which is found liable for bad faith is going to like to hear in a courtroom is a policyholder lawyer addressing either a judge or jury and asking the following question regarding the amount of punitive damages that need to be awarded: "Now, what percentage of this insurance company's net worth should be taken from it so that it will never engage in this behavior again?"

The above discussion hopefully provides some background on "best practices" and why they have become so important to claims departments which are handling claims in the United States. The main focus of this article is to suggest that there is a need for insurers to look *beyond* their own claim departments when considering the adoption of "best practices". Increasingly, policyholder lawyers are looking to expand the "pool of contestants" who have dealings with insureds and who either intentionally or negligently stumble into engaging in bad faith conduct. These policyholder lawyers then utilize common law agency or respondeat superior theories to attribute or relate back this bad faith conduct to the insurer. As will be discussed, much of the conduct which is increasingly viewed as subject to claims of bad faith involve agents and/or representatives (i.e. Managing General Agents; underwriters) of insurers whose conduct has not traditionally been the focus of bad faith claims.

The typical bad faith claim has generally been based on one of the following alleged omissions or commissions by an insurer: the inadequate investigation of a claim; an inordinate delay in investigating a tendered claim; the unreasonable interpretation of policy language and denial of coverage based on said interpretation; the failure to make a reasonable settlement offer on a case despite demands by the Plaintiff for an amount that exceeds the policy limits; and the failure to defend an insured. These "bread and butter' bad faith claims continue to pervade the landscape and are aggressively being prosecuted by policyholders and defended by insurers. See,

Insurance Claims and Disputes; Windt; Sixth Edition Section 5.1-5.25.

Turning to the main focus of this article-the efforts by policyholders to expand bad faith liability by analyzing the conduct of individuals who have an impact on an insured's insurance coverage or claim but who are not employed by the policyholders insurer's claims department, it is evident that policyholders have, where the opportunity presents itself, turned their attention to the conduct of third-party claims administrators, underwriters and managing general agents as a fertile source of "bad faith conduct" which the policyholder then strives to capitalize upon and attribute to an insurer.

This discussion is not meant to be exhaustive of all possible scenarios where non-claims department insurance professionals create bad faith situations. It is meant, however, to (1.) encourage those that are responsible for handling bad faith claims within an insurer to think about some of the relationships that insurers have which can be the source of potential bad faith claims and (2.) consider requiring the application of "best practices" which insurers have developed for their own internal claims departments to these other important and sometimes overlooked relationships that are part of the insurance industry.

I. WRONGFUL CONDUCT BY INDEPENDENT INSURANCE ADJUSTERS

Typically, large insurers rely exclusively upon their own claims departments to determine if a claim is covered by an insurance policy and whether the insurer has a duty to defend. Once the insurer appoints defense counsel to represent the insured, the insurer will have the duty to control the defense and it must place its insured's interests above its own interests. It will have that duty throughout the life of the case until the case is settled or a judgment is entered at trial. See, ***C. Raymond Davis & Sons, Inc. v. Liberty Mutual Ins. Co.,*** 467 F. Supp. 17 (E.D. of Pa 1979)

However, there are situations where an insurer will determine that it needs to hire an independent adjuster to handle the defense of a third-party or first party liability claim. It is critical for an insurer that decides to delegate its claims function to a third party claims administrator to recognize that the delegation of that function will not insulate it from a claim of bad faith by an insured.

In vetting a third-party claims administrator, the insurer must examine the claims protocols and procedures of the potential third-party administrator to determine whether the same "best practices" that the insurer employs with its own claims staff are practiced by the third-party administrator

under consideration to handle the insurer's claims. Moreover, if the insurer is one which does not have its own claims department and it relies on a third-party claims administrator to handle all of its claims, it is imperative that the insurer have an understanding of "best claims handling" procedures and that it not rely on the third-party administrator's assurances that it has adopted claims handling policies and procedures which will avoid bad faith claims.

An illustration of the major problems that an insurer may face when it elects to delegate its claims function to a third-party administrator can be seen in the case of ***Grigos v. Certain Underwriters at Lloyds, London,*** 2010 Phila.Ct. Pl. LEXIS 383. In that case, the Plaintiff insured, the owner of a popular diner, commenced an action for breach of contract and insurer bad faith based on an insurance policy issued by Defendant. The lawsuit concerned a fire, a covered cause of loss, which occurred at the insured diner. As a result of the fire, the Plaintiff sustained damage to its business property and loss of income while the diner was forced to close. The day after the fire, the insurer's American representative, Walnut Advisory, assigned all claims handling for the fire loss to Raphael & Associates. Underwriters advised Plaintiff that all communications had to go through Raphael & Associates. (hereinafter the "TPA") and the Plaintiff insured was further instructed that it could not contact the insurer directly with respect to the insured's claim..

In adjusting the claim, the TPA opined that the food loss at the diner was covered by the policy's "Enhancement Coverage" up to a "$25,000 limit" of liability. In fact, the "Enhancement Coverage" was not exclusive but actually added $25,000 to the $400,000 primary coverage for food loss for a *$425,000* limit of liability. Time passed and the insured complained of the loss of income he was sustaining due to the diner's closing as a result of the fire. The insured requested an advance to start repairs to the diner. The insured's public adjuster requested $50,000 but the TPA stated that the claim was worth only $10,000. The TPA provided no calculation of how he arrived at a $10,000 loss figure. Nearly four months after the fire, the insured received an advance check in the amount of only $10,000- $40,000 less than what the insured needed.

Other delays occurred including a refusal by the TPA to participate in the required appraisal of the loss. The TPA contended that since there was a "dispute" over the amount of the damages, the loss did not qualify for appraisal. Subsequently, only after the insured retained counsel and filed a "Petition to Compel Appraisal and Appoint Umpire", did the TPA acknowledge that his prior position regarding appraisal was wrong and agreed to go to arbitration. In addition, the insurer later acknowledged that the TPA's claim that the food loss was limited by

the "Enhancement Coverage" was wrong too. The matter went to appraisal where the two appraisers agreed that the business income loss was approximately $200,000; the building damage was $340,221 and the business personal property was $52,818. These claims were all paid by the insurer.

Despite paying these claims, the bad faith claim proceeded. The trial court focused on the TPA's conduct and noted that there was never any explanation offered as to why the insured's initial claim for food loss was not covered. The Court also noted that no offer was forthcoming when the insurer's own investigation revealed that at least $25,000 was due (as opposed to the $10,000 paid by the TPA) because the insurer's own investigation revealed that more money was owed to the insured.

In considering the motion for summary judgment filed by the insured on the bad faith claim, the Court focused on certain facts that it found troubling. First, the Court commented on the TPA's nonsensical refusal to go to appraisal when requested and stated that the TPA knew the Plaintiff was facing financial ruin and needed payment yet delayed making payment "despite no substantive objections". The Court noted further that the virtually all of the actions undertaken by the TPA hired by the insurer were "imbued with bad faith". The Court stated that the insurance policy was knowingly misrepresented to the insured; that there was an intentional delay in resolving the claim through unwarranted refusal to pay monies owed under the policy; and that the TPA acted in an inexcusable manner when it failed to participate in an appraisal which forced the insured to have to hire a lawyer to commence litigation. The Court further noted that after delaying payment of a claim where liability was clear for nearly a year, the TPA admitted that the full food loss claim was owed. The continued and repetitive pattern of delay in resolving the insured's claim by refusing to even process paperwork led the Court to find the insurer liable as a matter of law for bad faith.

Most importantly for purposes of our discussion, the Court noted in a footnote the following in response to the insurer's claim that it should not be held liable for the conduct of the third-party claims administrator that it hired:

> *Defendant has argued that it should not be charged with any of Holmdon's (The TPA) misconduct despite the fact that he dealt exclusively with Plaintiff on the insurance company's behalf. Defendant's contention, that it may insulate itself from bad faith liability by delegating authority to representatives who are malicious, incompetent, or just ignorant, is absurd, and that delegation itself in an appropriate case could be further evidence of bad faith.*

The decision in ***Grigos*** which found the insurer liable as a matter of law for bad faith *despite* the insurer paying 100% of the appraisal award should be a sobering tale to all insurers which utilize third party

administrators as their claims handlers. It is clear from a review of the opinion that the insurer itself did *not* engage in the conduct the Court found abusive and there is nothing in the opinion which suggests that the insurer was remotely aware of the omissions and commissions by the TPA. Unfortunately for the insurer none of that mattered to the Court.

The key fact that the Court focused on in ***Grigos*** was that the insurer chose to delegate its responsibility for claims handling to a series of intermediaries. And while it may have not been involved in the day to day actions which spawned the bad faith claim, the Court concluded that the insurer could not "insulate" itself from conduct which the Court concluded was "imbued" with bad faith. The ruling in ***Grigos*** demonstrates why an insurer must adopt claims handling procedures which incorporate "best practices" and that it insist that any claim handlers to whom it delegates claims handling functions employ those same "best practices" when adjusting claims. Courts are not going to be sympathetic to any insurer which attempts to avoid responsibility for failed claims handling by arguing that the duty was delegated to others.

II. "UNREASONABLE CONDUCT" DURING THE UNDERWRITING PROCESS

The majority of bad faith claims typically involve a refusal by an insurer to acknowledge insurance coverage for a claim. Both common law bad faith and statutory bad faith claims tend to involve those situations where an insurer receives a demand for coverage by an insured and the insurer commences a review of the policy against the claim. The insurer rejects the claim on the basis that the policy does not cover the claim for a variety of reasons (i.e. no occurrence has been alleged; the loss to the property was not the result of a covered peril etc.).

It is incumbent on an insurer, however, to recognize that a bad faith claim can involve not just a dispute about the interpretation of policy language, but, can also involve claims that the underwriting of the policy itself may have been "imbued" with bad faith. While there is not a significant amount of bad faith law addressing these types of bad faith claims, insurers must recognize that it is not just their claims handlers who may be viewed as having engaged in bad faith towards an insured, but underwriters as well may be called to task regarding their actions in underwriting a policy.

One situation that comes to mind is when an insurer purportedly *renews* a policy of insurance. The typical scenario that plays out is where an insured and/or its retail broker requests that a policy be renewed with the same terms and conditions as the expiring policy. During the renewal process, the insurer introduces into the policy a set of terms, conditions, and/or endorsements which materially alter and/or diminish the insurance coverage which was available under the expiring policy. The insurer adds

the new terms and conditions yet the insurer's underwriter stamps the policy as a "Renewal" of the expiring policy and delivers it to the insured.

The insured and its retail broker are not advised that the new terms and conditions are being added in the policy nor are they told how their inclusion will limit or curtail the coverage that the insured had under the expiring policy. Fast forward months later into the new policy year and the insured is confronted with a claim which is now not covered but would have been covered under the prior policy year. The insurer denies coverage to the insured based on the new policy provisions which were not previously disclosed to the insured or its retail broker when the policy was undergoing the "renewal" process.

The insured will likely vehemently oppose the disclaimer of coverage based on the language in the "renewal" policy on the basis that the insurer misrepresented the policy to the insured by identifying it as a "renewal" policy. The insured will argue that the terms which are different from the expiring policy should not be enforced given the "misrepresentation" of the policy as a "renewal" when it was not a renewal. Keep in mind that many jurisdictions hold that when an insurer identifies a policy as a renewal, it means that the insurer is representing that the policy has the same terms and conditions as the expiring policy. See, ***Schlock v. Penn. Twp. Mut. Fire Ins. Ass'n.*** 24 A.2d. 741 (Pa. Super. Ct. 1942); ***American Casualty Co. v. Resolution Trust Corp.,*** 1994 U.S. Dist. LEXIS 9447 (E.D. of Pa. 1994).

The insured is also likely to sue the insurer for either common law or statutory bad faith. The focus of such a bad faith claim will not just be on the claims handlers who reviewed the policy and concluded that the new terms and provisions precluded coverage to the insured, but, the underwriters who were involved in processing the renewal, and who authorized the changes to the "Renewed" policy.

The issues raised in any such bad faith case by the insured in the situation described above will undoubtedly include whether the insurer not only had a set of "best practices" for the claims department but for the underwriting department as well. For example, the question will be asked whether the insurer has any policy or procedure whereby it notifies the insured or its broker about its intent to add a new term or condition which changes the coverage afforded from the prior year's policy? Does the insurer have a definition of the term "Renewal" which is consistent with the legal definition of that term in the state where the policy is being issued? Did the underwriters offer the insured the option of "buying back" the new terms and conditions for an additional premium?

The actions of the underwriting department cannot be considered separate and distinct from the claims function-at least with respect to potential bad faith claims. It is important for insurers to recognize that the

underwriting function is increasingly as important as the claims function when it comes to the areas where policyholders and aggressive policyholder counsel look for conduct which could support a bad faith claim. Underwriters need to have at their disposal a series of protocols and procedures to which they can refer when they are processing renewals; making additions to coverage; and deletions to coverage which can materially change an insured's coverage program. Communication by the underwriting department with the insured and/or its broker regarding changes being contemplated to a renewal policy is critical to protecting the underwriting department to later claims that it acted without the insured's knowledge and that it acted in a way that protected its interests over those of the insured- a key litmus test for "bad faith" claims.

III. MISCONDUCT OF MANAGING GENERAL AGENTS

It is common for insurers to appoint Managing General Agents ("MGA"s") to handle the underwriting function of an insurer (sometimes the MGA will have claims handling responsibilities as well). The insurer drafts a contract whereby the MGA is given a certain level of authority to accept applications for insurance coverage from retail brokers and the insurer extends to the MGA authority to bind the insurer to coverage. However, the MGA is not typically given free reign to underwrite and accept every risk presented by a retail broker. The MGA contract places limits on the MGA with respect to the line of business the MGA may bind; the limits of liability that the MGA may extend; the terms and conditions of the coverages being bound as well as other limitations on the authority being granted. Moreover, the MGA contract will have standard indemnity agreements whereby the insurer receives a promise of indemnity from the MGA if the MGA breaches the contract and, for example, exceeds its authority or violates another condition of the agreement which results in damage to the insurer.

On first glance, it would appear that in light of the contractual indemnification promise between the insurer and the MGA, the insurer is protected from liability for the acts of the MGA. However, as in the ***Grigos*** case referenced above, the acts of an MGA in the placement of an insurance policy can be the basis for bad faith claims against the insurer.

In circumstances where an MGA acts in a way that exceeds its authority, the insurer must recognize that its delegation of authority and its decision to entrust its MGA with underwriting a risk does not provide it any insulation from a claim of bad faith brought by an insured which arises out of the conduct of the MGA. For example, where an MGA underwrites a policy with a $1 million limit of liability but the MGA contract limits the authority to $500,000, the insurer would be wise not to attempt to deny coverage on the basis that the policy exceeded the authority granted to the MGA. From a Court's perspective, the policy was issued by an authorized representative of the insurer

who had, from all appearances, the authority to issue the policy with a $1 million limit of liability. Indeed, the insured bought and paid for a $1 million limit. The fact that an MGA may have gone "rogue" and issued a limit which was beyond the authority granted in the MGA contract should in no way result in the insured being forced, for example, to now accept a $500,000 limit of liability.

The remedy for the insurer confronted with an MGA which has exceeded the authority granted is to pursue the MGA in a separate breach of contract action. The remedy is not to argue that the insured is not entitled to the insurance coverage issued by the MGA.

Similarly, where an MGA accepts an application for coverage which has questions left unanswered or where the answers to the questions are non-responsive, but coverage is issued anyway, it would be a mistake for an insurer to attempt to avoid coverage on the basis that there were misrepresentations in the application for coverage. Again, if the responses to these questions were truly material and should have been responded to by the insured, the insurer's issue is not with the insured but with the MGA that accepted the application in the form it was in and ignored or overlooked the lack of responses.

In the event an insurer decides to deny insurance coverage based on the failure of an MGA to properly underwrite a policy, it can fully expect to find itself not on just the receiving end of a breach of contract/declaratory judgment complaint, but, the denial will be alleged to have been done for no reasonable basis (i.e. bad faith)- other than the MGA's error. Such a bad faith claim will be difficult to defend especially when discovery is undertaken and the insurer is forced to admit that the MGA had authority to bind coverage and that the only thing the insured did wrong was select an MGA who exceeded their authority in writing the coverage in the first place.

The above examples of an MGA which commits errors which degenerate into a bad faith claim when an insurer attempts to avoid the MGA's mistake by denying insurance coverage for a claim that is otherwise covered by the policy, is another example why an insurer must make sure that the MGA's it contracts with are conversant in "best practices" in both the underwriting and claims functions. The insurer cannot take for granted that an MGA-which is paid in part based on the amount of premium it underwrites- has adopted a set of protocols whereby it makes sure that it is acting within the scope of its authority and that it is technically proficient in accepting and underwriting risks (i.e. ensuring that applications have all of the information requested by the insurer).

IV. SUMMARY

The point of this article has been to stress that due to the significant advances that claims departments have made in implementing policies and procedures which have helped to limit the threat of bad faith

claims, policyholders and their counsel have shifted their attention to other components of the insurance industry which are not directly tied to claims departments within insurance companies.

The underwriting departments of insurers, third-party claims administrators and the actions of Managing General Agents have all come under increasing scrutiny by policyholders and courts. For this reason, insurers must be aware of the ever expanding source of bad faith claims and they need to transfer the pro-active approach they have had with their own claims departments to other relationships in the industry which interact with their customers/insureds. Insurers are not insulated from bad faith liability when they delegate to third-party vendors (i.e. TPA's; MGA's) the direct interaction with their insureds.

The "take away" from this discussion can be summarized as follows: Insurers are not insulated from bad faith liability when they delegate to third-party vendors (i.e. TPA's; MGA's, etc.) functions which the insurer has normally provided. For this reason, insurers need to insist that the "best practices" which they employ in their own claims departments be applied to all who come into contact with the insurers customers/insureds or who have the ability through their acts and/or omissions to impact insureds (i.e. MGA's, underwriters.)

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