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Institutional Bad Faith:
Putting the Insurer's Practices, Procedures, and Integrity on Trial

1. Defining Institutional Bad Faith

In broad terms, institutional bad faith (and the allegation of) is that an insurer's policies and procedures related to claim evaluation and resolution, claim adjustment protocols, and performance and compensation criteria for claims personnel are either individually or collectively intended to unfairly drive down aggregate claim payments or deprive insureds of policy benefits to which they are otherwise entitled.[1]

Individual elements baked into the definition:

> intentional or unreasonable conduct,
> as a general business practice,
> to drive down aggregate claim payments,
> in order to lower costs and/or increase profits at the expense of policyholders

Although institutional bad faith may be thought of as occurring when a corporate structure or policies encourage bad faith claim handling, not all institutional business practices to drive down aggregate claim payments, vis-à-vis costs and profits, are inherently bad faith practices.

For example, it is quite reasonable for an institutional practice to be in place to combat fraud, reduce exaggerated claims, eliminate waste, and/or conserve resources for the benefit of all policyholders. In other words, driving down

[1] See, generally, Douglas R. Richmond, "Defining and Confining Institutional Bad Faith in Insurance," Tort Trial & Insurance Practice Law Journal, Fall 2010 (46.1)

aggregate claim payments through better claim practices is not intrinsically bad faith.

2. Commonly Used Examples

Systemic Unethical Conduct:

The work of adjusting insurance claims engages the public trust, and, accordingly, claim adjusters are held to a high ethical standard. In every instance, the adjuster must put a duty of fair and honest treatment of a claimant above his or her own interest or the interest of the insurer.

Consider, for instance, the following:

> "An insurer, in handling the defense of claims against its insured, has a duty to use the same degree of care and diligence as a person of ordinary care and prudence should exercise in the management of his own business. For when the insured has surrendered to the insurer all control over the handling of the claim, including all decisions with regard to litigation and settlement, then the insurer must assume a duty to exercise such control and make such decisions in good faith and with due regard for the interests of the insured."
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> Boston Old Colony Ins. Co. v. Gutierrez, 386 So.2d 783, 785 (Fla. 1980)

It should be fair to say that any systemic claim conduct (as opposed to a particular claim) to deprive a company's insureds of the benefit of the bargain they made when entering into a contract of insurance, is, in practice and effect, institutional bad faith.

Compensation:

The most important measure of an insurer's profitability is the combined ratio, which is the claims expenses, plus the other cost of claims, divided by the total premiums collected. This ratio helps the insurer to measure its performance. Adjuster bonus programs often include the metric of meeting the company's combined ratio objectives.

It is improper within the insurance industry to provide any financial incentive to endorse the underpayment of claims. The adjuster's job is not to turn a profit for the company or max out any incentivized compensation. Thus, a significant conflict is created if claim adjusters are incentivized to reduce claim payments without a reasonable and sound reason for doing so.

Post-Claim Underwriting

Post insurance claim underwriting occurs when an insurance company refuses to pay a claim for a loss that should have been covered on the grounds that the policy should never have been issued in the first place and then cancels or rescinds the policy.

When this occurs, the insurance company ignores its commonly understood obligation to do underwriting when a policy application is made rather than conducting its risk assessment after a claim is submitted. This after-the-fact evaluation effectively rids the company of an insured it contends should never have received coverage in the first place and serves as the pretext for a lower or lowball claim evaluation.[2]

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[2] Example:

Claim manager to claim adjuster: "I received your 12-5-03 report. The engineer's report is not very clear as to what damage was the result of improper construction and what damage was the result of wind damage. I want you to go back to the engineer and request that he identify the damages caused by improper construction versus wind. If this is an example of the quality of his work, we do not need to use him in the future."

Then:

Marketing executive to claim executives: "Since it appears that claims procedure will be to send out an engineer to inspect the structures, we need to give the agent better underwriting guidelines as to what is acceptable and what kind of construction details we are looking for at the time that we insure these. If the engineer or the claims department has more specific guidelines than those I have attached, we need to give those to the agents and train them as to what we are looking for."

3. Discovery in Institutional Cases

At the core of any institutional bad faith case is the allegation that an insurer impermissibly underpaid claims in the aggregate in order to achieve a pre-determined financial objective. For the claimant, the most compelling evidence of institutional bad faith is that which links the unlawful practices with the means by which the insurer ensures claim department compliance: how and why the company engages in systemic abuse.

Common Discovery to the Insurer:

> Compensation programs and employee evaluations
> Internal company financial reporting
> Claim file audits and quality assurance
> Underwriting files
> Home office claim files
> Reserves
> Internal claim metrics

Claim Metrics:

Metrics are measures of data-drive quantitative assessments commonly used for assessing, comparing, and tracking performance or production. Generally, a group of metrics will typically be used to build a dashboard that management reviews on a regular basis to maintain performance assessments, opinions, and business strategies. Some common examples include claims settlement cycle time, claims processed per claims employee, average cost per claim, and components of claim cost.

> "Insurers need to be aware of the potential for metrics to be deemed 'schemes.' Often times Plaintiffs' attorneys use statistical evidence against insurers to show bad faith. For example, they could look for statistical evidence that claims handlers with a higher

> incidence of denied claims have higher scores on reviews. Such could be used to show a pattern and practice of encouraging the declination of claims. When insurers keep these metrics and statistics already, in some respects we are doing the Plaintiffs' attorneys' work for them. The way to avoid this is to make sure your metrics are based on a range of 'successes.' Look at the metrics you keep with a critical eye and make sure they cannot be turned against you in the, hopefully rare, event of an institutional bad faith claim."[3]

Reasonable Use of Claim Metrics:

> Claims projections based on experience, not corporate goals
> Consider not publishing individual adjuster claim statistics
> Don't create incentives for particular claim outcomes
> Be careful of rewarding adjusters for "cost savings"
> Avoid use of quotas
> Measure success by customer satisfaction and superior service
> Conduct frequent training in best practices

John David Dickinson and Chad A. Pasternack of Cozen O'Connor highlighted the following as a practice to further minimize institutional claims:

> "Use statistics cautiously. Insurance is a business and it is reasonable for a business to measure performance or outcomes. But those statistics are likely to become an exhibit at a bad faith trial. Beware of the metrics that are used and how questions are presented. Also consider who has access to the information. Is the information shared with different

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3 **Measure Twice, Cut Once: Different Perspectives on Law Firm Metrics**, CLM 2017 Southeast Conference (Atlanta, Georgia).

> departments (e.g., underwriting and claims)? Is the information given to managerial employees as well as claims adjusters? Prior to collecting and disseminating information, think defensively—how might a bad faith plaintiff argue this information is nefarious?"[4]

4. Keys to Minimize Institutional Claims

Flexibility:

Flexibility is the key to minimizing the risk of institutional bad faith claims: handle every claim on its own merits, give adjusters authority to deviate from the rules where appropriate (in consultation with management), encourage best practices, and proactively find and fix mistakes.

Claim Handling Practices:

> Adopt fair claims practices and procedures
> Train fully on proper practices by merit not outcome
> Review claim procedures to avoid undercutting adjuster authority
> Be prepared to articulate good faith reasoning based on practical realities
> Document and have written explanations for all practices and incentives

Procedural Safeguards and Risk Management:

Quality assurance and claim file audits should be encouraged and not avoided simply because they may give rise to possible information for a claimant to obtain in discovery. While a claims audit is accepted as a systematic and detailed review of claims files and related records to evaluate the adjuster's performance, the insurer can gain more benefit from the process to offset risks incurred – especially when undertaken with a view toward continual improvement of fairness, customer satisfaction and reasonable outcomes.

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4 **Defending Institutional Bad Faith Claims, Part I – A Primer on Institutional Bad Faith**, November 26, 2019 (Mondaq).

5. Recent Case Law

Wenk v. State Farm Fire & Cas. Co., 2020 PA Super 26 (Feb. 7, 2020):

"[T]here is no separate cause of action of institutional bad faith," the Pennsylvania Superior Court recently concluded, stating Pennsylvania's bad-faith statute (42 Pa.C.S. § 8731) authorized certain actions if a court finds an insurer acted in bad faith "toward the insured"— not toward "the world at large." [5]

On appeal, the court affirmed the trial court's judgment for the insurer, concluding that the homeowners "failed to present clear and convincing evidence that [the insurer] acted in bad faith."

The court also affirmed the trial court's rejection of the homeowners' claim for "institutional bad faith" against the insurer, stating that no such claim existed under Pennsylvania law. Although the trial court considered evidence of the insurer's claims-handling policies and procedures, the homeowners "failed to establish a nexus between [those] business policies and the specific claims the [homeowners] asserted in support of bad faith."

Thus, court found no error in the trial court's conclusion that the insurer's policies and procedures, "when applied to the [homeowners] claim," were not improper and could not be used to support a nonexistent claim for "institutional bad faith."

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[5] In Wenk, the homeowners sued their insurer for bad faith arising out of the insurer's handling of a first-party property-damage claim filed following a botched remodeling of their home. "[I]n an attempt to destroy a bee's nest," the homeowners' remodeling contractor "poured gasoline within the framework of [their] home," necessitating remediation. The homeowners filed a claim, and the insurer agreed to remediate the homeowners' property using a contractor of its choice. After deficiencies with the remediation-contractor's work, the homeowners complained to the insurer, which initially declined to review its contractors' work. "[A]s complaints and concerns continued to escalate," however, the insurer hired an engineer to review its contractor's work and ultimately confirmed that some of the work was deficient. During this process, the homeowners relocated to different housing and sought reimbursement of those costs from the insurer, which initially declined to pay the costs, but eventually paid them "as a good will gesture." Later, the homeowners refused to allow the insurer's contractor to continue its remediation work, and retained another contractor—a company owned by one of the homeowner's parents—to do the work. Suspicious of the "close relationship" between the homeowners and their new contractor, the insurer questioned the fairness and reasonableness of that new contractor's remediation estimate. Based on these facts, the homeowners sued their insurer for breach of contract, bad faith, and violation of Pennsylvania's Unfair Trade Practices and Consumer Protection Law (UTPCPL), among other related claims. The trial court conducted a bench trial, and ultimately entered judgment for the insurer on the homeowners' bad-faith and UTPCPL claims, leading to the appeal.