

PROVING INSTITUTIONAL BAD FAITH¹

Introduction

Institutional bad faith cases are won or lost in discovery. This article aims to provide practical advice to counsel who seek an explanation for what appears to be systemic unfair claim handling. In recent years, some carriers have adopted business practices that inexorably conflict with accepted industry standards for good faith claim handling.² Perhaps because of corporate pressure to keep the bottom line myopically in focus, insurance companies have increasingly employed strategies designed to deprive the policyholder of the benefit of its bargain under the insurance contract. As these practices have evolved, carriers have become better at disguising their existence, purpose and effect. Nevertheless, certain records must be internally maintained by the carrier in order to evaluate those charged with driving down aggregate claim payments. Ultimately, the success of an institutional bad faith case hinges on the policyholder's ability to discover information evidencing these unfair business practices and to coherently present that evidence to a jury.

To present a compelling institutional bad faith case, counsel must discover not only the means by which the carrier underpays claims but also the methods employed to ensure the cooperation of the entire claim department. This evidence should then be explained to the jury by an expert qualified to contrast the carrier's actual behavior with accepted industry standards for good faith claim handling. Rest assured, however, that institutional bad faith cases are not

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² See, e.g., DAVID J. BERARDINELLI, ET AL., FROM "GOOD HANDS" TO BOXING GLOVES (2006). See also, JAY M. FEINMAN, DELAY, DENY, DEFEND (2010).

for the faint of heart, and the uninitiated should expect well-funded resistance to any effort to peek behind the industry's curtain.

This article will accordingly discuss methods of proving a carrier's "general business practice," suggest certain information to seek during discovery and, finally, offer guidance on effective use of expert testimony in institutional bad faith cases. Armed with the proper evidentiary foundation, a qualified expert is capable of exposing abusive practices for what they are: a concerted effort to maximize the carrier's profit at the expense of policyholders and claimants.

I. Establishing a General Business Practice

In many jurisdictions, either the enabling statute or common law define the quantum of proof required to establish a general business practice. In Florida, for example, proof of an unlawful general business practice is required for imposition of punitive damages. Not surprisingly, Florida law requires an aggrieved policyholder to demonstrate that the particular unfair practice not only harmed her but also reflects the carrier's standard operating procedure.

The statute provides, in relevant part:

No punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are:

- (a) Willful, wanton, and malicious; [or]
- (b) In reckless disregard for the rights of any insured . . .³

Florida precedent confirms that evidence of "other similar claims" is one way to demonstrate the requisite frequency. In *Howell-Demarest v. State Farm Mut. Auto. Ins. Co.*,⁴ an insured alleged that State Farm's failure to pay her medical bills under her separate medical pay coverage in order to maximize her PIP benefits was an unfair practice committed by State Farm with such

³ FLA. STAT. § 624.155(5) (2010).

⁴ *Howell-Demarest v. State Farm Mut. Auto. Ins. Co.*, 673 So. 2d 526 (Fla. Dist. Ct. App. 1996).

frequency as to warrant punitive damages. As evidence of this “general business practice,” the insured relied upon three other reported decisions where State Farm engaged in similar conduct. In denying State Farm’s motion for summary judgment, the Fourth District Court of Appeal noted:

If in fact State Farm has a “general business practice” of not allocating, i.e., not paying out benefits as they are clearly required to do under the law, that, in our opinion, would be the type of conduct for which the insured could recover punitive damages.⁵

But the appellate court held that the plaintiff’s claim in addition to three other instances were insufficient to establish a general business practice.⁶ Though Florida law is unclear on how many “other claims” would be sufficient, there are alternatives.

In Florida, a plaintiff “need only show evidence of ‘other acts,’ not ‘other claims,’ to show a general business practice.”⁷ *Howell-Demarest* has been interpreted as “standing only for the more limited proposition that, in order to show a general business practice, a plaintiff must establish ‘other acts’ outside his own claim . . .”⁸ The plaintiff must present “evidence of more than just [a plaintiff’s] own claim that would permit a reasonable jury to conclude that the insurer engaged in unfair acts as a general business practice.”⁹ Case law suggests that a general business practice may be proved by the following: (1) testimony of the insurance company through its employees and executives that the handling of a particular claim was in conformity with its general business practices;¹⁰ (2) testimony of company witnesses confirming the existence of

⁵ *Howell-Demarest*, 673 So. 2d at 529.

⁶ *Howell-Demarest*, 673 So. 2d at 529.

⁷ *Jablonski v. St. Paul Fire & Marine Ins. Co.*, 2010 WL 1417063, at *6 (M.D. Fla. Apr. 7, 2010).

⁸ *Jablonski*, 2010 WL 1417063 at *6.

⁹ *Jablonski*, 2010 WL 1417063 at *6 (quoting *Shannon R. Ginn Constr. Co. v. Reliance Ins. Co.*, 51 F. Supp. 2d 1347, 1353-54 (S.D. Fla. 1999)).

¹⁰ See, e.g., *Ingalls v. Paul Revere Life Ins. Co.*, 561 N.W.2d 273 (N.D. 1997) (using testimony from an insurer claim representative concerning a particular practice not being “unusual” as evidence of a general business practice).

company policies or programs that necessarily give rise to statutory violations;¹¹ (3) internal insurance company documents adopting standards for the proper investigation of claims; (4) documents establishing corporate bonus pools tied to claim payout;¹² and (5) expert testimony concerning company practices and procedures.¹³

Cases from other jurisdictions similarly endorse alternative ways for a policyholder to establish the requisite “frequency” of the unfair conduct.¹⁴ In *Dodrill v. Nationwide Mut. Fire Ins. Co.*,¹⁵ West Virginia’s Supreme Court upheld a jury verdict predicated upon a finding that Nationwide had violated certain portions of West Virginia’s Unfair Claim Settlement Practices Act with sufficient frequency to indicate a general business practice.¹⁶ In doing so, the court noted that while “an isolated scenario is not sufficient” to prove a general business practice, other potential methods of showing “frequency” exist without having to present evidence of “other similar claims”:

[S]eparate, discrete acts or omissions, each of which constitute violations of different sub-paragraphs of [the Code] may indeed demonstrate a “general business practice” in the handling of a single claim, the focus of which would tend to show frequent and rather general disregard for the several proscriptions set out by the relevant statute. Or, as may be inferred from the evidence found in the record before us, there may be a series of separate and discrete acts or omissions, indicative of the habit, custom, usage, or business policy or policies regarding the

¹¹ See, e.g., *Dodrill v. Nationwide Mut. Fire. Ins. Co.*, 491 S.E.2d 1, 12-13 (W. Va. 1997).

¹² See, e.g., *Royal Marco Point I Condominium Assoc., Inc. v. QBE Ins. Co.*, No. 2:07-cv-00016-CEH-SPC (M.D. Fla. June 30, 2010) (Opinion & Order on plaintiff’s proffer of evidence) (plaintiff who demonstrated a substantial basis for its punitive damages claim was permitted “to engage in ‘other claims’ discovery as well as net worth, financial incentive, and money-flow discovery”).

¹³ See, e.g., *Ingalls*, 561 N.W.2d 273 (noting three sources of “general business practices” proof: testimony of an expert, an insurer internal memo, and testimony from an insurer’s claim representative concerning a particular practice not being “unusual”).

¹⁴ Unfair Insurance Practices Statutes like Florida’s are typically based on the model act authored by the National Association of Insurance Commissioners. Thus, interpretations from other states are instructive.

¹⁵ *Dodrill*, 491 S.E.2d 1.

¹⁶ The relevant West Virginia statute is similar to FLA. STAT. § 626.9541(1)(i)(3), and states that “no person shall commit or perform with such frequency as to indicate a general business practice any of the following . . .” W. Va. CODE § 33-11-4(9) (2010) (emphasis added).

handling of a particular type or size of claim, which, if found to violate one or more of the sub-paragraphs of the subject statute, would tend to show frequent disregard of the subject statute.¹⁷

The court noted that in a so-called “single claim” case, the finder of fact, viewing the evidence as a whole, should be able to conclude that the practices at issue constitute multiple violations of the statute and are “sufficiently pervasive or sufficiently sanctioned by the insurance company that the conduct can be considered a ‘general business practice’ and can be distinguished by fair minds from an isolated event.”¹⁸

Subsequently, in *Jackson v. State Farm Mut. Auto. Ins. Co.*,¹⁹ the West Virginia Supreme Court expressly rejected the contention that some form of statistical analysis pertinent to other claims would be necessary to show a general business practice.²⁰ Rather, the court approved the common sense view that proof of other violations by the same insurance company could be obtained from “its claims agents, or from any person who is familiar with the company’s general business practice in regard to claim settlement.”²¹

In *Ingalls v. Paul Revere Life Ins. Co.*,²² the Supreme Court of North Dakota affirmed a punitive damage award against Paul Revere. The court pointed to three sources of “general business practices” proof: the testimony of an expert; an internal Paul Revere memo whereby it offered raises and job retention to “finalize” a certain percentage of claims; and, testimony from

¹⁷ *Dodrill*, 491 S.E.2d at 12-13 (emphasis added).

¹⁸ *Dodrill*, 491 S.E.2d at 13.

¹⁹ *Jackson v. State Farm Mut. Auto. Ins. Co.*, 600 S.E.2d 346 (W. Va. 2004).

²⁰ *Jackson*, 600 S.E.2d at 357.

²¹ *Jackson*, 600 S.E.2d at 357 (quoting *Jenkins v. J.C. Penney Cas. Ins. Co.*, 280 S.E.2d 252, 260 (W. Va. 1981)). Under Rule 406, evidence of the routine practice of an organization is relevant to prove the organization’s conduct on a particular occasion was in conformity with the routine practice. FED. R. EVID. 406. “The existence of . . . business custom may be established by a knowledgeable witness’s testimony that there was such a habit or practice.” KENNETH S. BROWN, ed., 1MCCORMICK ON EVIDENCE § 195, at 786 (6th ed. 2006).

²² *Ingalls*, 561 N.W.2d 273.

a Paul Revere claims representative concerning a particular prohibited practice not being “unusual.”

Yet other evidence of a general business practice was considered by the courts in Utah and, ultimately, the United States Supreme Court in *State Farm Mut. Auto. Ins. Co. v. Campbell*.²³ As the original opinion of the Utah Supreme Court made clear, the evidence supporting punitive damages included the testimony of an expert and consideration of State Farm’s “Performance, Planning and Review” policy, which “individually rewarded those insurance adjusters who paid less than market value for claims,” coupled with the destruction of documents relative to incentivizing profits.²⁴

Even though case law elucidating the requisite quantum of “general business practice” proof is scarce, the author suggests the following ways to establish the required frequency of an unfair practice: (1) testimony of corporate witnesses acknowledging that the particular claim at issue was handled appropriately and in compliance with the carrier’s practices and procedures for good faith claim handling; (2) company documents identifying company practices or procedures; (3) testimony of an expert witness concerning the company’s general business practices; (4) testimony by the company’s former employees concerning the same; and (5) evidence of other similar claims.

We now turn to the type of evidence counsel should seek in discovery.

II. The Anatomy of Discovery: Evidence at the Heart of the Institutional Bad Faith Case

At the core of any institutional bad faith case is the shrouded reality that the insurance carrier impermissibly underpaid claims in the aggregate in order to achieve a pre-determined

²³ *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003).

²⁴ *Campbell v. State Farm Mut. Auto. Ins. Co.*, 65 P.3d 1134, 1143, 1148 (Utah 2001), *rev’d*, 538 U.S. 408 (2003). *See also Campbell v. State Farm Mut. Auto. Ins. Co.*, 98 P.3d 409, 420 (Utah 2004).

financial objective. The nature of loss payment is a zero-sum game – every less penny paid on claims improves the carrier’s bottom line. There is necessarily an inverse correlation between payout and profit, incentivizing the unscrupulous to develop claim handling practices designed to part with the least amount of money over the greatest period of time. Unsurprisingly, laws regulating insurer bad faith are designed to penalize carriers who manipulate their claim handling process to reap unearned profit through underpayment or delay. Many such statutes condemn, among other things, an insurance carrier’s failure to adopt and implement standards for the proper investigation of claims; misrepresentation of pertinent facts or insurance policy provisions; failure to acknowledge and act promptly on communications with respect to claims; and denial of claims without conducting a reasonable investigation. The most compelling evidence of institutional bad faith is that which links the unlawful practices (*how* the company engages in systemic abuse) with the means by which the carrier ensures claim department compliance to achieve its financial goals (*why* the company engages in systemic abuse).

A. Carrier’s Compensation Programs and Employee Evaluations

A carrier cannot effectively tether its profit objectives to the manner in which it evaluates and pays claims without the assistance of the individuals directly charged with handling those claims. Institutional bad faith cases involve not only the manner in which the insurer investigated, adjusted, resisted, and litigated the particular claim at issue, but also whether the carrier’s actions are indicative of reprehensible company-wide practices warranting the imposition of punitive damages.²⁵ Insurance carriers often seek to encourage certain desired employee behavior through compensation programs.

²⁵ *BMW of N. Am. v. Gore*, 517 U.S. 559, 575 (1996) (“the most important indicium of the reasonableness of a punitive damage award is the degree of reprehensibility of the defendant’s conduct”).

Personnel compensation and/or human resources manuals (or similar such documents) accordingly play a critical role in exposing the way in which institutional objectives are achieved through incentives. Policyholder counsel should thoroughly explore how claim department personnel, from top to bottom, are evaluated by the company for job retention, promotion, demotion, pay raise, and any incentive compensation. Discovery requests that seek information regarding the job performance and compensation of the employees who handled, or supervised the handling, of the policyholder's claim are permissible in most jurisdictions.²⁶ The Kentucky Supreme Court in *Grange Mut. Ins. Co. v. Trude*, for example, concluded that carrier compensation programs in general, and the manner in which the carrier evaluated the particular claim handlers at issue, are discoverable in an insurance bad faith case:

Other information to be found in personnel files (e.g., related to job performance, bonuses, wage and salary data, disciplinary matters) is relevant to Wilder's claim. Job performance and disciplinary information could help show that the adjusters and their superiors engaged in bad faith practices in adjusting Wilder's initial claim or that they had engaged in bad faith practices at other times. This information could also show Grange's knowledge or even approval of such practices. This makes those portions of the personnel records related to job performance and disciplinary matters discoverable.

Wilder claims that the compensation of Grange's employees could be keyed to obtaining low settlements, which in turn might encourage bad faith practices by adjusters and other employees. Wage, salary, and bonus data as to the employees described in the discovery requests shed light on this subject, as would the discovery requests as to how Grange's overall compensation system works. Thus, insofar as the requested personnel records relate to compensation of the employees involved and the other records relate to how Grange's overall compensation system works, they are discoverable.²⁷

To demonstrate how a carrier's compensation program is designed to motivate unfair claim handling, a policyholder must both discover and decipher the matrix reflected in the

²⁶ See, e.g., *Florida First Fin. Grp., Inc. v. De Castro*, 815 So. 2d 789, 791 (Fla. Dist. Ct. App. 2002). See also *Saldi v. Paul Revere Life*, 224 F.R.D. 169, 184 (E.D. Pa. 2004) (finding evidence concerning compensation and incentives paid by an insurance company to its claims personnel is relevant in a bad faith case.)

²⁷ *Grange Mut. Ins. Co. v. Trude*, 151 S.W. 3d 803, 815 (Ky. 2004).

company's annual performance evaluations. For most carriers, the evaluations are performed for all claim department personnel, including senior management. And, whether an employee receives a raise or bonus, and its corresponding size, is typically tied directly to the employee's ability to meet or exceed certain delineated company expectations. While there is nothing patently improper about using incentive compensation programs to motivate employee production, that is certainly not the case where a claim representative or supervisor is rewarded for lowering "average paid claim," "gross indemnity paid," or for hitting certain pre-determined financial targets. Insurance carriers have, however, become quite adept at camouflaging such evidence and expertise is often required to decode it.

B. Intra-Company Financial Reporting

For budgeting and management purposes, all insurance companies must track and evaluate claim experience in real time. But the manner in which this information is disseminated, especially if a given claim unit is being measured against pre-determined financial objectives, may provide powerful evidence of institutional bad faith. Policyholder counsel should accordingly seek to understand which claim department personnel receive loss ratio and/or combined ratio information, its format, and frequency.

Paired with the performance evaluations, the financial reporting may elucidate the manner in which unit performance is tracked in real time and measured against pre-stated objectives. Most carriers measure their claim department performance by evaluating loss ratios and combined ratios. If the insurer shares that financial information with individuals in the claim department responsible for evaluating or adjusting its policyholders' claims or, even worse, incentivizes those adjusters (or their supervisors) to achieve predetermined financial results, the carrier will have violated a fundamental industry standard. Marrying compensation of claim

handlers to actual financial results impermissibly encourages them to undervalue and delay claims. In that scenario, both the carrier and its employee benefit at the expense of the policyholder who dutifully paid premiums for the promise of fair treatment in the event of a covered loss. Claim department budgets, management reports analyzing loss and combined ratios, methods for sharing this financial information within the claim department, and manuals describing the carrier's incentive compensation programs are all appropriate topics for discovery.²⁸

C. Demonstrating Insurance Carrier Recidivism

The amount of an appropriate punitive damage award is largely dependent upon the reprehensibility of intentional conduct designed to maximize carrier profit at the expense of policyholders or claimants. The reprehensibility of a carrier's conduct vis-à-vis an individual policyholder may be demonstrated through the use of prior cases alleging unfair claim handling and/or seeking punitive damages, attendant settlements or judgments, and the carrier's response (or failure to respond) by taking corrective action. Evidence of prior punitive damage awards, the conduct upon which such awards were premised, and especially whether offending corporate

²⁸ Evidence that a company's unfair claim handling practices were created or condoned to increase profit is probative of the company's culpability, motive, and ultimately, the amount of punitive damages warranted. *See, e.g., Campbell*, 538 U.S. at 415 (evidence of State Farm's "Performance, Planning and Review" ("PP&R") program, a scheme whereby State Farm attempted to meet its corporate fiscal goals by limiting payouts on claims company-wide, was probative of the carrier's reprehensibility); *Goddard v. Farmers Ins. Co. of Oregon*, 120 P.3d 1260, 1280 (Or. Ct. App. 2005) (evidence of insurer's hardball tactics of stonewalling, low-balling, and fraudulently manipulating the claims evaluation process for the purpose of building and maintaining a reputation for "toughness" in claims adjustment was relevant to the punitive damage analysis); *Alexander v. Hartford Life & Accident Ins. Co.*, 2008 WL 906786, at *1-2 (N.D. Tex. Apr. 3, 2008) (insured is entitled to discover "the manner and formula by which [the insurer's claim handling employees] are compensated, or show that these employees had a financial incentive to reduce benefits or deny . . . claims"); *Royal Marco Point I Condominium Assoc., Inc. v. QBE Ins. Co.*, No. 2:07-cv-00016-CEH-SPC (M.D. Fla. June 30, 2010) (Opinion & Order on plaintiff's proffer of evidence) (plaintiff asserting claim for punitive damages permitted "to engage in 'other claims' discovery as well as net worth, financial incentive, and money-flow discovery"); *St. Paul Fire & Marine Ins. Co. v. Jablonski*, No. 2:07-cv-00386-JES-SPC (M.D. Fla. Apr. 14, 2008) (Order on plaintiff's second request for production) (court granting discovery into loss pooling and servicing agreements bearing on claim handling practices and corporate net worth).

policies remained unaltered can be persuasive.²⁹ Moreover, evidence of out-of-state conduct may be “probative [even if the conduct is lawful in the state where it occurred] when it demonstrates the deliberateness and culpability of the defendant’s action in the State where it is tortious, but that conduct must have a nexus to the specific harm suffered by the plaintiff.”³⁰ Where a carrier’s in-state misconduct replicates prior transgressions, it may be punished more severely.³¹ As has been consistently recognized, the existence and frequency of similar past conduct is relevant to a determination of punitive damages.³² Further, the carrier’s awareness of any unlawful practices or procedures, and the steps taken (if any) to remedy any unfair claim handling practices brought to its attention via policyholder complaints, lawsuits, regulatory action, or the imposition of extra-contractual damages, are undeniably relevant to the reprehensibility analysis.³³

²⁹ See, e.g., *Campbell*, 538 U.S. at 426-27 (State Farm’s failure to report a prior \$100 million punitive damages award in Texas to national headquarters was probative of the degree of the carrier’s reprehensible conduct).

³⁰ *Campbell*, 538 U.S. at 422.

³¹ See *Campbell*, 538 U.S. at 423 (a recidivist may be punished more severely than a first offender because repeated misconduct is more reprehensible than an individual instance of malfeasance).

³² See *TXO Prod. Corp. v. Alliance Res. Corp.*, 509 U.S. 443, 462 n.28 (1993) (holding that “evidence of [the defendant’s] alleged wrongdoing in other parts of the country” is relevant in assessing whether “the scheme employed [by the defendant] in this case was part of a larger pattern of fraud, trickery and deceit,” and that such conduct can justify a larger punitive damages award (citing *Pacific Mut. Life Ins. Co. v. Haslip*, 499 U.S. 1, 21-22 (1992))); see also *Cooper Indus., Inc. v. Leatherman Tool Grp., Inc.*, 532 U.S. 424, 434-35 (2001) (holding that, in assessing whether a punitive damages award is appropriate or excessive, one relevant consideration is whether the transgressor has had “sanctions imposed [against him/her/it] in other cases for comparable misconduct”); see also *Saewitz v. Lexington Ins. Co.*, No. 05-21917-CIV-LENARD-KLEIN, slip op. at 4 (S.D. Fla. Apr. 10, 2006) (holding that insureds are entitled to discover whether the carrier’s violations occur frequently, and whether they inform the insurer’s recidivism, warranting punitive damages); *Saldi*, 224 F.R.D. at 176 (where the plaintiff sought information about the carrier’s involvement in other bad-faith cases in order to demonstrate “similar issues of misconduct, . . . establish corporate policies, . . . [and] show Defendants’ recidivism and reprehensibility,” the court overruled the carrier’s objections, allowing discovery into similar cases in which the insurer entered into a non-confidential settlement with value in excess of the present value of contract benefits; documents relating to changes in education or procedures that resulted from such settlements; and a list of civil actions involving similar bad faith allegations but resulting in confidential settlements).

³³ See *Campbell*, 538 U.S. at 419 (the reasonableness of a punitive damages award requires consideration of “whether the conduct involved repeated actions or was an isolated incident . . .”).

D. Claim File Audits and Quality Assurance

An insurance carrier's duty to investigate, evaluate, adjust and pay claims in good faith is non-delegable. The law, as well as established industry practice, accordingly requires carriers to audit open and closed claim files with specified frequency. In certain types of institutional bad faith cases, policyholder counsel may want to discover audit reports concerning the type of claim at issue or with respect to files handled by a particular adjuster. These audits may be performed by an internal claim file audit division or other external entity. Certain insurance companies purport to monitor the quality of claims handling via audits, and these audit reports can provide compelling evidence where the inside or outside adjusters assigned to handle policyholders' claims either lack the requisite technical expertise or frequently violate established standards for good faith claim handling. These reports can be particularly helpful in proving that the insurance carrier failed to adopt and implement standards for the proper investigation of claims. Because the duty to handle claims in good faith does not evaporate when the carrier employs vendors, a carrier's efforts to ensure the competence and fairness of its chosen agents speaks volumes. It is often difficult for a carrier to explain to a jury why it did not even provide these vendors with any written guidelines delineating the carrier's claim handling expectations.

The foregoing are merely suggested areas for discovery in an institutional bad faith case. The topics covered are far from exhaustive and should only be pursued when context permits. As will be discussed in greater detail below, this discovery lays the foundation for appropriate expert testimony distinguishing between accidental behavior that harmed only a single insured and institutional practices designed to achieve certain financial objectives. Before considering the expert's role, however, we briefly discuss typical objections to this sort of discovery.

III. Frequent Carrier Objections to “Bad Faith” Discovery

1. Attorney-Client Privilege and Work Product Immunity

Carriers often contend that the attorney-client privilege and/or work product immunity protect the previously discussed documents from disclosure. The efficacy of these objections will, in many cases, turn on a particular state’s law. Under Florida law, for illustrative purposes, neither the attorney-client privilege nor work product immunity will shield from discovery materials prepared in the ordinary course of business by a person who is an attorney but acting in the capacity of a business advisor or investigator for an insurance company.³⁴ The burden of establishing attorney-client privilege rests on the party asserting the privilege. When the party is a corporation, its claims of privilege are subject to a heightened level of scrutiny “to minimize the threat of corporations cloaking information with the attorney-client privilege in order to avoid discovery.”³⁵ In *Southern Bell Tel. & Tel. Co. v. Deason*, the Florida Supreme Court held that a corporation must demonstrate, at a minimum, that the communication would not have been made but for the contemplation of legal services and that the content of the communication relates to the legal services being rendered.³⁶

³⁴ See, e.g., *Southern Bell Tel. & Tel. Co. v. Deason*, 632 So. 2d 1377, 1383-84 (Fla. 1994). Federal courts have repeatedly refused to recognize attorney-client privilege when an attorney is acting as a claims adjuster or investigator. See also *Western Nat’l Bank of Denver v. Emp’rs Ins. of Wassau*, 109 F.R.D. 55, 57 (D. Colo. 1985) (holding the portions of the file of a law firm retained by an insurer reflecting the factual investigation of a claim by the attorneys are not work product); *Chicago Meat Processors, Inc. v. Mid-Century Ins. Co.*, 1996 WL 172148, at *3 (N.D. Ill. 1996) (“[i]n the insurance context, to the extent that an attorney acts as a claims adjuster, claims process supervisor, or claims investigation monitor, and not as a legal advisor, the attorney-client privilege does not apply”).

³⁵ *Deason*, 632 So. 2d at 1383.

³⁶ See *Deason*, 632 So. 2d 1377; see also *Village Spires Condo. Ass’n, Inc. v. QBE Ins. Corp.*, No. 06-14191-CIV-Martinez-Lynch, slip op. (S.D. Fla. Dec. 6, 2007) (refusing to recognize attorney-client privilege when an attorney is making claims and adjusting decisions).

Florida law holds that the attorney-client privilege only attaches when an attorney performs acts for an insurer in his or her professional capacity or in anticipation of litigation.³⁷

Reversing a finding of privilege by the trial court as to communications between an insurer and its attorney, Florida's First District Court of Appeal held:

The evidence demonstrates that [the attorney] serves as the [insurer's] secretary and general counsel, but the [insurer] presented only argument, and no evidence, that he undertook the investigation of the Department's employee in his professional capacity as general counsel, or that he undertook the investigation in anticipation of litigation in which the [insurer] would be a party.³⁸

To the extent the insurer asserts the privilege with respect to documents that plainly do not constitute confidential communications made for the purpose of rendering legal services, a court should compel production.

Under Federal Rule of Civil Procedure 26, materials assembled in the ordinary course of business pursuant to public requirements unrelated to litigation or for other nonlitigation purposes are not work product protected.³⁹ The question in analyzing a claim of work product immunity is: At what point in time (if ever) did the documents cease to be records kept in the normal course of an insurer's business – underwriting, investigating, adjusting and paying claims, as well as creating the means to accomplish these tasks – and become documents legitimately prepared in anticipation of litigation. The answer ought to be “never” when the discovery at issue includes things such as job descriptions, performance reviews, compensation systems, company philosophies, and codes of conduct. Corporate policies, practices, and

³⁷ *Bankers Ins. Co. v. Florida Dept. of Ins.*, 755 So. 2d 729 (Fla. Dist. Ct. App. 2000) *rev. denied*, 773 So. 2d 54 (Fla. 2000) (holding no privilege exists where the attorney is “a conduit” for the insurer).

³⁸ *Bankers*, 755 So. 2d at 730.

³⁹ See FED. R. CIV. P. 26(b)(3) advisory committee's note (citing *Goosman v. A. Duie Pyle, Inc.*, 320 F.2d 45 (4th Cir. 1963)).

organizational information are by their very nature assembled in the ordinary course of business, and work product immunity should not shield them from disclosure.

2. Confidentiality and/or Trade Secret

Insurance carriers often claim that their claim handling guidelines, job descriptions, performance review policies, and compensation systems constitute trade secrets or, at least, merit protection from disclosure. This assertion is typically inapt. The purpose of trade secret and confidentiality protection is to prohibit a party from gaining valuable information that could be used to its own commercial advantage.⁴⁰ The party resisting discovery carries the burden of showing that the requested material would cause commercial harm if disclosed.⁴¹ The average policyholder presents no such danger to the insurer. This type of discovery is highly pertinent to the prosecution of an institutional bad faith case and, in an overwhelming portion of cases, outweighs any counterbalancing fears by the carrier that the material will serve an improper purpose.⁴²

3. Undue Burden

The Federal Rules allow discovery “regarding any matter, not privileged, that is relevant to the claim or defense of any party . . .”⁴³ This broad grant must be properly leveraged to ensure that the information obtained delineates both the unfair practices and the financial motivations underlying them. Blanket objections of undue burden are unfounded and cannot be sustained. A party has the burden of proving the basis for its objections and cannot shirk its discovery

⁴⁰ See, e.g., *Auto Owners Ins. Co. v. Totaltape, Inc.*, 135 F.R.D. 199, 203 (M.D. Fla. 1990); *Freedom Newspapers, Inc. v. Ely*, 507 So. 2d 1180, 1184 (Fla. Dist. Ct. App. 1987).

⁴¹ See *Empire of Carolina, Inc. v. Hackle*, 108 F.R.D. 323, 325 (S.D. Fla. 1985).

⁴² *Finnegan v. Coll*, 157 A.2d 737, 738 (N.J. Super. Ct. Law Div. 1960) (denying trade secret privilege where information important to disposition of case); *Smith v. BIC Corp.*, 869 F.2d 194, 199 (3d Cir. 1989) (trade secrets do not enjoy automatic immunity; courts must “weigh[] their claim to privacy against the need for disclosure”) (quoting FED. R. CIV. P. 26(c) advisory committee’s note).

⁴³ FED. R. CIV. P. 26(b)(1).

obligations through conclusory, boilerplate statements.⁴⁴ The “undue burden” objection requires that a party raising the objection offer proof of its diligence in attempting to comply with the request.⁴⁵ To merit even consideration, “an objection must show specifically how a discovery request is overly broad, burdensome or oppressive, by submitting evidence or offering evidence which reveals the nature of the burden.”⁴⁶ The mere fact that production would be difficult or expensive is not reason to refuse an otherwise legitimate discovery request in any case.⁴⁷

Overcoming the carrier’s objections, however, merely provides access to the evidence. Equally important to successful prosecution of an institutional bad faith case is how that evidence is presented to the jury. Enter the role of the expert.

IV. Expert Testimony Can Make or Break a Bad Faith Case

The expert is an indispensable piece of the institutional bad faith puzzle. Absent an expert qualified to contrast the carrier’s unfair practices with accepted industry standards, that information is vacuous. The proper expert will not only explain how the carrier’s conduct falls below industry standards but also how the carrier profits financially as a result. Policyholder counsel must accordingly be prepared to articulate the expert’s qualifications and explain to the court how the expert’s specialized knowledge or experience will assist the trier of fact in understanding the evidence.

⁴⁴ See *St. Paul Reinsurance Co. v. Commercial Fin. Corp.*, 198 F.R.D. 508, 511-13 (N.D. Iowa 2000) (rejecting boilerplate objections and holding that evidence or affidavits are required to support objections).

⁴⁵ *Oliver v. City of Orlando*, 2007 WL 3232227, at *2 (M.D. Fla. 2007) (The party resisting discovery bears the burden to demonstrate specifically how the objected-to request is unreasonable or otherwise unduly burdensome).

⁴⁶ *Coker v. Duke & Co.*, 177 F.R.D. 682, 686 (M.D. Ala. 1998). See also *Cutrale Citrus Juices USA, Inc. v. Zurich Am. Ins. Grp.*, 2005 WL 5177325, at *1 (M.D. Fla. 2005) (“[Defendants] have simply advanced a generalized and inadequate assertion that furnishing the proposed discovery would be unduly burdensome . . . [t]his broad and conclusory allegation, by itself, falls far short of satisfying Defendants’ burden of proof”).

⁴⁷ See *Baine v. Gen. Motors Corp.*, 141 F.R.D. 328, 330 (M.D. Ala. 1991) (“The mere fact that producing documents would be burdensome and expensive and would interfere with the party’s normal operations is not inherently a reason to refuse an otherwise legitimate discovery request”).

Under Rule 702 of the Federal Rules of Evidence as explained by the Supreme Court in *Daubert v. Merrell Dow Pharm., Inc.* and *Kumho Tire Co. v. Carmichael*,⁴⁸ expert testimony is admissible when (1) the expert is qualified to testify competently regarding the matters she intends to address; (2) the methodology utilized in reaching conclusions and opinions is sufficiently reliable; and (3) her testimony assists the trier of fact through the application of specialized knowledge or expertise to determine a fact in issue or understand the evidence.⁴⁹ The party offering the expert has the burden of laying a proper foundation for admission of the expert testimony, and it is incumbent on the policyholder to demonstrate that each of these factors is satisfied.⁵⁰

Rule 702 requires that a testifying expert be “qualified as an expert by knowledge, skill, experience, training, or education.”⁵¹ Indeed, the advisory committee notes emphasize a broad conception of expert qualifications, recognizing that “[i]n certain fields, experience is the predominant, if not sole, basis for a great deal of reliable expert testimony.”⁵² Experience fitting this bill may include extensive employment in the insurance industry as an adjuster or supervisor; service as a consultant to insurance companies, government officials, policyholders, or state agencies; prior retention as a national claim handling expert or consultant; a history of offering testimony concerning insurance claim practices in state or federal courts; experience attending or conducting seminars, classes, workshops, and continuing education on various insurance-related topics; and speaking engagements on insurance claim practices. Such experience typically qualifies the expert to opine on the general principles of insurance, the role

⁴⁸ *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579 (1993); *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).

⁴⁹ See *Quiet Tech. DC-8, Inc. v. Hurel-Dubois UK LTD.*, 326 F.3d 1333, 1340-41 (11th Cir. 2003).

⁵⁰ *Allison v. McGhan Med. Corp.*, 184 F.3d 1300, 1306 (11th Cir. 1999).

⁵¹ FED. R. EVID. 702.

⁵² See FED. R. EVID. 702 advisory committee’s note.

of insurance companies in society, claim handling standards and practices in the insurance industry, and the relationship between unfair insurer conduct in claim handling and an insurer's wealth.

Aside from attacking an expert's particular qualifications, carriers also commonly attempt to exclude experts on the ground that the expert has little or no experience with claim handling in the venue state. This objection should fail. First, such experience is irrelevant to the extent that a state's insurance law is significantly based on national best practices and model acts. Second, such a reading of *Daubert* and its progeny would disqualify any professional not licensed to practice in the venue state from testifying at trial despite being a leading expert in the country in the relevant discipline. Third, no case law supports any type of "locality" requirement for insurance claim handling. Claims and "best practices" manuals are not typically provincial, but are by definition intended to guide all claim handlers throughout the United States.

Expert testimony must also be reliable. Rule 702, as amended in 2000, provides general standards for use by district courts in fulfilling their gate-keeping function with respect to the admissibility of expert testimony.⁵³ *Daubert* itself sets forth a non-exclusive list of factors, which were not codified, but pursuant to *Kumho*, "might be applicable to assessing the reliability of non-scientific expert testimony, depending upon 'the particular circumstances of the particular case at issue.'"⁵⁴ But, the mere fact that an expert's methodology is not quantitative, testable by

⁵³ Federal Rule of Evidence 702, as amended, states: "If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case."

⁵⁴ FED. R. EVID. 702 advisory committee's note.

scientific method, or subject to peer review and publication is not grounds for excluding expert testimony that is otherwise sufficiently reliable.⁵⁵

The Ninth Circuit analyzed what, if any, *Daubert* factors apply in the context of an expert on insurance claims practices, and concluded that they do not translate:

Concerning the reliability of non-scientific testimony such as Caliri's, "the *Daubert* factors (peer review, publication, potential error rate, etc.) simply are not applicable to this kind of testimony, whose reliability depends heavily on the *knowledge and experience* of the expert, rather than the methodology or theory behind it."⁵⁶

The Ninth Circuit further explained that the trial court did not abuse its discretion in admitting expert testimony because the expert's analysis was dependent upon his knowledge of, and experience within, the insurance industry and not contingent upon a particular methodology or technical framework.⁵⁷ Where an expert on insurance practices has gained knowledge of the standards applicable in the industry through experience and training, his or her testimony may accordingly be based thereon.⁵⁸ So long as the testimony is relevant to the facts at issue in the case and is based on appropriate experience and a review of the factual record, a court should find the testimony sufficiently reliable.

Expert testimony must, however, also assist the jury in understanding the evidence. Expert testimony about the ordinary practices of a profession or trade is generally admissible since it enables a jury to evaluate the conduct of the parties against the accepted standards in the

⁵⁵ *United States v. Brown*, 415 F.3d 1257, 1267 (11th Cir. 2005) (finding admissible expert testimony based upon application of knowledge, skill, and experience to sufficient facts and data).

⁵⁶ *Hangarter v. Provident Life & Acc. Ins. Co.*, 373 F.3d 998, 1017 (9th Cir. 2004).

⁵⁷ *Hangarter*, 373 F.3d at 1017-18.

⁵⁸ *See, e.g., Geico Cas. Co. v. Beauford*, 2007 WL 2412974 (M.D. Fla. Aug. 21 2007) (recognizing that an insurance claims adjuster with 30 years of claim handling experience is qualified to testify as an expert on claim handling in a Florida bad faith case); *see also Kraeger v. Nationwide Mut. Ins. Co.*, 1997 WL 109582, at *1-2 (E.D. Pa. Mar. 7, 1997) (holding that *Daubert* factors do not apply in this context and that bad faith expert's testimony was admissible based upon the application of his experience to the facts of the case); *Montagne v. Safeco Ins. Co. of Ill.*, 2008 WL 2225770, at *5-6 (D. Alaska May 27, 2008).

industry.⁵⁹ This same rationale has been applied in insurance claim practices litigation.⁶⁰ By establishing a baseline of accepted standards, the expert provides the framework for the jury to evaluate the carrier's practices. Only then can the jury pass judgment on whether the insurer has impermissibly institutionalized a manner of dealing with claims that is below what the industry – and the law – require. Effective expert testimony must accordingly address: (1) industry standards for good faith claim handling; (2) general principles of insurance and risk transfer; and (3) how the carrier's unfair practices bolster profit.

A. Industry Standards for Claim Handling

Without expert testimony, a layperson cannot be expected to comprehend the good faith claim handling standards recognized in the insurance industry or appreciate the financial ramifications flowing from an abuse of those standards. A Florida jury may ultimately be asked to answer intricate questions such as (1) whether the insurer failed to settle the policyholder's claim in good faith when it could and should have done so had it acted fairly and honestly toward the policyholder and with due regard for his interests; (2) whether the insurer violated certain unfair claim settlement practices, such as failing to adopt and implement standards for the proper investigation of claims, failing to acknowledge and act promptly upon communications with respect to claims, and denying claims without conducting reasonable investigations based upon available information; and (3) whether the acts giving rise to the violations occur with such frequency as to indicate a general business practice, in reckless disregard for the rights of the

⁵⁹ See, e.g., *Linkstrom v. Golden T. Farms*, 883 F.2d 269 (3d Cir. 1989) (holding that it was reversible error to exclude the testimony of a farm safety expert regarding the safety practices a reasonable and prudent farmer would follow).

⁶⁰ See *Hangarter*, 373 F.3d at 1017-18 (district court properly admitted expert witness testimony on the practices and norms of insurance companies in the context of bad faith); *Whiteside v. Infinity Cas. Ins. Co.*, 2008 WL 3456508, at *7-9 (M.D. Ga. Aug. 8, 2008) (holding that expert testimony concerning appropriate claim handling practices in an insurance bad faith case “will be helpful to the jury, as lay jurors are not likely to be familiar with the intricacies of insurance claims handling”).

insured. Any intelligent analysis requires that the jury be educated by an expert about insurance industry standards for claim handling.

Certain standards are commonly acknowledged to be fundamental to the insurer's delivery of the promises contained in the insurance contract. For example, insurance carriers generally agree that they must (1) treat their insureds' interest with equal regard as its own interests; (2) assist insureds with claims; (3) disclose all benefits, coverages, and time limits that may apply; (4) fully, fairly, and promptly investigate and evaluate claims; and (5) promptly pay amounts not in dispute. The jury's understanding of whether the carrier adopted and implemented claim handling practices consistent with these industry standards bears directly upon the issues it will be required to decide. The expert assists the trier of fact in understanding the claim handling practices and procedures used by insurance companies to ensure compliance with industry standards. The expert must provide this frame of reference.

B. General Principles of Insurance

The general principles of insurance supply the framework for understanding how insurance works and why there exists a fertile market for insurance products. The trier of fact must understand that by combining a sufficient number of homogenous exposure units, losses are predictable – not individually, but collectively. The jury should also be educated about the purpose of underwriting so that it understands the components that make up the premium charged and how insurance companies are *supposed* to make a profit. It is uniquely the province of an expert witness to explain that insurers make money in two principal ways: (1) through underwriting, and (2) by investing the pooled premiums collected from customers. An insurer's underwriting performance is measured by its combined ratio. The loss ratio ((incurred losses divided by premiums) x 100) is added to the expense ratio ((expenses divided by premiums) x

100) to determine the company's combined ratio. The combined ratio is a reflection of the company's overall underwriting profitability. A combined ratio of less than 100 percent indicates profitability.⁶¹

It is not until the jury understands how profits are properly earned that it is capable of discerning when carriers have impermissibly cheated to earn profits in violation of industry standards. A fundamental standard in the insurance industry is that a claim handler must make claim decisions based on the merits of each claim, without the influence of any monetary reward or penalty. Beyond the realm of insurance claim handling, there may be nothing wrong with marrying incentive compensation to corporate profit. In the insurance industry, however, companies generate income by selling appropriately priced policies and investing those premium dollars. Income is *not* permissibly generated by artificially lowering claim payouts after losses have occurred. When monetary incentives are linked to the amount that is paid out on claims, the insurer has run afoul of industry standards. The claim handler's job is to pay covered claims that are honestly made – without regard to the impact on the bottom line.

Ultimately, if the only way to meet a corporate objective is to increase the number of denials, delay claims, or reduce the amounts paid in claims, the company's performance system runs directly counter to the claim handler's good faith duties – to pay the full and fair value of each claim based upon its merits. The average layperson lacks this industry-specific knowledge regarding the components of an insurer's wealth and the money it stands to (wrongfully) gain through inappropriate claim handling practices.

⁶¹ BARRY D. SMITH & ERIC A. WIENING, *HOW INSURANCE WORKS* 30 (2d ed. 2003).

C. Unfair Claim Handling Impermissibly Bolsters the Insurer's Wealth

The expert should also explain to the jury precisely how the carrier profits from the unfair business practice. The two most commonly used measures of the wealth of an insurance company are admitted assets and surplus as regards policyholders.⁶² An expert is capable of explaining the influence of goal setting on claim handling, how emphasizing lower loss and combined ratios engender wrongful claim practices, and the corresponding effect on written and earned premium. The average layperson is unfamiliar with the ways in which an insurer's wealth may be improperly manipulated by the claim handling process, and the aggregate effect abusive practices have on corporate profitability.

Conclusion

In order to successfully prosecute an institutional bad faith case and recover punitive damages sufficient to deter continued carrier misconduct, policyholder counsel should consider discovery aimed not only at illuminating the unfair practice but also underlying the carrier's financial motivations. The evidence exists because carriers must internally monitor and manage these practices if they are to continue to reap the fiscal benefits. Once discovered, a qualified expert is capable of methodically exposing the carrier's bad faith to a jury that would otherwise be ill-equipped to appreciate impermissible practices and mete out an appropriate punitive remedy.

⁶² These figures are published annually (after they have been verified) in Best's Key Rating Guide.