

18 Am. Jur. Proof of Facts 3d 323 (Originally published in 1992)

Punitive Damages Against an Insurer for the Bad-Faith Handling of a First-Party Claim

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American Jurisprudence Proof of Facts 3d

Database updated February 2013

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### Topic of Article:

Proof, through expert testimony, of outrageous conduct on the part of an insurer toward its insured in administering a claim under underinsured motorists provisions of an automobile policy, to justify an award of punitive or exemplary damages.

This issue ordinarily arises in connection with a bad-faith case for recovery of benefits due under a policy.

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## I. Background

### A. In General

#### § 1. Introduction

#### [Cumulative Supplement]

Litigation by policyholders against their own insurance company for payment of withheld benefits is no longer confined to staid contract remedies. In an increasing number of jurisdictions, the arena is becoming a minefield of emerging torts, generally extracted from the implied covenant of good faith and fair dealing recognized in the Restatement (Second) of Contracts.<sup>1</sup> These emerging tort theories, which have become known as “bad-faith claims,” are attractive because of the availability of consequential or extracontractual damages beyond that measured by the contract. In addition, tort theories permit the recovery of punitive damages in egregious cases. It is particularly the aspect of punitive damages that has resulted in the furor of controversy in this area of the law.

In October of 1991, the United States Supreme Court dashed the expectations of the insurance industry when it declined to find a punitive damage award in a policyholder’s bad-faith case violated any constitutional rights.<sup>2</sup> The court held that punitive damages were firmly grounded in the common law, and that they were properly left to the several states. The high court’s refusal to interfere sent a clear signal that this element of damages will continue to play a dramatic and controversial role in this emerging area of the law.

#### CUMULATIVE SUPPLEMENT

#### Trial Strategy

[Defense of First-Party Bad Faith Claim Action Against an Insurer, 97 Am. Jur. Trials 211](#)

#### Cases:

**Post-payment claims:** Insurer has some duties of a fiduciary nature, including equal consideration, fairness and honesty, and thus, an insurer may be held liable in a first-party case when it seeks to gain unfair financial advantage of its insured through conduct that invades the insured’s right to honest and fair treatment, and because of that, the insurer’s eventual performance of the express covenant, by paying the claim, does not release it from liability for bad faith. [Zilisch v. State Farm Mutual Auto. Ins. Co.](#), 196 Ariz. 234, 995 P.2d 276 (2000); West’s Key Number Digest, [Insurance 1867](#).

An implied duty of good faith exists in all insurance contracts and requires an insurer to act in good faith with its insured; this duty results from the unique nature of the insured/insurer relationship, which may be at varying times arm’s-length, fiduciary, and/or adversarial. [Allen v. Great American Reserve Ins. Co.](#), 766 N.E.2d 1157 (Ind. 2002); West’s Key Number Digest, [Insurance 1866](#).

Standard for awarding punitive damages in first-party insurance actions is strict one and is available only in limited number of instances. [Rocanova v Equitable Life Assurance Soc’y of the United States](#) (1994) 83 NY2d 603, 612 NYS2d 339, 634 NE2d 940.

The insurer’s duty toward the insured is fiduciary in nature, but is something less than a true fiduciary relationship, which would require the insurer to place the insured’s interests above its own. [Mutual of Enumclaw Ins. Co. v. Dan Paulson Const., Inc.](#), 169 P.3d 1 (Wash. 2007); West’s Key Number Digest, [Insurance 1866](#).

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[END OF SUPPLEMENT]

## § 1.5. Consumer protection statutes

[\[Cumulative Supplement\]](#)

### CUMULATIVE SUPPLEMENT

#### Cases:

An award of \$2 million in punitive damages was not excessive for a commercial property insurer's violation of the Unfair Claims Settlement Practices Act (UCSPA) in settling a claim for a fire loss; the insureds presented evidence that any punitive damage award of less than \$4,455,000 made it statistically more profitable for the insurer and adjuster to deal with other insureds in the same manner, rather than in a fair manner. [KRS 304.12-230. Farmland Mut. Ins. Co. v. Johnson, 36 S.W.3d 368 \(Ky. 2000\)](#), as modified, (Feb. 22, 2001); West's Key Number Digest, [Insurance 3376](#).

**Knowledge requirement:** Insurer did not "knowingly" engage in deceptive acts or practices or "knowingly" breach the duty of good faith and fair dealing by delaying payment of water damage and mold remediation claims under homeowner's insurance contract, and thus, insured was not entitled to punitive damages or mental anguish damages under Deceptive Trade Practices Act (DTPA) or Insurance Code; claims adjuster simply forwarded to homeowner letter in which insurer's plumbing contractor stated that contractor had conducted "complete" plumbing test, insurer eventually paid all but one of homeowner's claims, and insurer paid claims according to its own valuation, assisted by contractors' bids. [V.T.C.A., Bus. & C. §§ 17.45\(9\), 17.50\(b\)\(1\); V.A.T.S. Insurance Code, art. 21.21, § 16\(b\)\(1\). Allison v. Fire Ins. Exchange, 98 S.W.3d 227 \(Tex. App. Austin 2002\)](#), reh'g overruled, (1 pet.)(Feb. 13, 2003) and reh'g overruled, (1 pet.)(Feb. 21, 2003) and Rule 53.7(f) motion filed, (1 pet.)(Apr. 3, 2003); West's Key Number Digest, Consumer Protection 40.

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[END OF SUPPLEMENT]

## § 2. Anatomy of a bad-faith award

[\[Cumulative Supplement\]](#)

While actions based on an insurer's breach of its duties of good faith and fair dealing are commonly referred to as "bad-faith claims," the term often is a misnomer. An award of damages in these actions is always in three parts, only the last of which necessarily involves elements of true "bad faith."

The first part of any such award is the contract damages, founded on contract principles, which consists of either the limits of the policy or the defined benefit stated, plus interest, court costs and, as often permitted by statute, attorney fees. The second part of such an award, predicated on a breach of the duty of good faith and fair dealing in tort, consists of consequential (or extracontractual) damages in excess of those available under the policy, to compensate the insured for any additional harm proved to have been proximately caused by the breach. However, proof of the tort does not necessarily involve the existence of true bad faith. It may only involve the absence of good faith.

The last part is the punitive damages. The additional showing required is the existence of sufficient bad faith under the standard required in the forum jurisdiction to justify imposition of punitive damages. It is significant that punitive damages are not intended as additional compensation to an injured claimant, but rather as punishment and deterrence for the harmful

conduct of the insurer. It is also significant that punitive damages are not awarded in private litigation unless there exists a predicate breach and consequent harm to the claimant.

Not every action for recovery under a policy of insurance will involve true bad faith; most, in fact, probably do not. To maximize the progress of litigation, and to avoid derailing the process, plaintiff's counsel must carefully evaluate the case and confine the scope of suit to the elements that are realistically provable.

## CUMULATIVE SUPPLEMENT

### Cases:

Punitive damages award of \$1,150,000 against insurer in bad faith case did not violate due process, where evidence showed that insured and his wife suffered emotional distress as result of insurer, without first conducting adequate investigation, publicly accusing insured of having committed arson, that insured's subsequent uninsurability would affect his ability to continue his farming business, and that insurer was aware that insured was financially vulnerable when it made accusation, and jury awarded insured \$1,150,000 on his bad faith claim. [U.S.C.A. Const.Amend. 14.](#); NDCC § 32-03.2-11.1. [Moore v. American Family Mut. Ins. Co.](#), 576 F.3d 781 (8th Cir. 2009).

**Indicia of insurer bias:** Following factors may indicate an insurer's bias, rather than that insurer was engaged in genuine dispute: (1) insurer may have misrepresented the nature of the investigatory proceedings; (2) insurer's employees lied in depositions or to the insured; (3) insurer dishonestly selected its experts; (4) insurer's experts were unreasonable; or (5) insurer failed to conduct a thorough investigation. [Hangarter v. Paul Revere Life Ins. Co.](#), 236 F. Supp. 2d 1069 (N.D. Cal. 2002); West's Key Number Digest, [Insurance 3337](#).

**Five factors:** In evaluating the conduct of an insurer for purposes of an insured's claim of bad faith, the trier of fact under Virginia law must consider whether (1) reasonable minds could differ in the interpretation of policy provisions defining coverage and exclusions, (2) the insurer made a reasonable investigation of the facts and circumstances underlying the insured's claim, (3) the evidence discovered reasonably supports a denial of liability, (4) it appears that the insurer's refusal to pay was used merely as a tool in settlement negotiations, and (5) the defense the insurer asserts at trial raises an issue of first impression or a reasonably debatable question of law or fact. West's [V.C.A. § 38.2-209](#). [HHC Associates v. Assurance Co. of America](#), 256 F. Supp. 2d 505 (E.D. Va. 2003); West's Key Number Digest, [Insurance 3335](#).

Aid of expert witnesses is often required in order to establish objective evidence of industry standards in insurance bad faith cases. [Goodson v. American Standard Ins. Co. of Wisconsin](#), 89 P.3d 409 (Colo. 2004); West's Key Number Digest, [Insurance 3381\(5\)](#).

Insured's cause of action alleging that insurer engaged in "illegal evasion of insurance claims payment" with regard to disability insurance policy failed to state claim for punitive damages and required dismissal since complaint does not state claim for compensatory or punitive damages by alleging merely that insurer engaged in pattern of bad-faith conduct; complaint must first state claim of egregious tortious conduct directed at insured claimant, and only then does alleged pattern of bad-faith conduct attain legal significance insofar as it shows that public wrong would be vindicated by award of punitive damages. [Rocanova v Equitable Life Assurance Soc'y of the United States](#) (1994) 83 NY2d 603, 612 NYS2d 339, 634 NE2d 940.

**297 dead cows:** Recording of conversation between insurance adjuster and insurer's property supervisor that included attempts to undervalue insured's losses, discussions of how to make insured appear fraudulent, concerns about need to "minimize paper" in case of discovery, and false accusations of extra-marital affairs involving insured's wife, together with evidence that insurer never attempted to count or weigh dead livestock, while disputing both number and weight of dead livestock, and that insured was left with mound of 297 dead cattle in his yard for several months, incurring costs associated with necropsy of each animal, was sufficient to support submitting issue of punitive damages to jury. [Sawyer v. Farm Bureau Mut. Ins. Co.](#), 2000 SD 144, 619 N.W.2d 644 (S.D. 2000); West's Key Number Digest, [Insurance 3382](#).

A bad-faith insurance case potentially can result in 3 types of damages: (1) benefit of the bargain damages for an accompanying breach of contract claim; (2) compensatory damages for the tort of bad faith; and (3) punitive damages for intentional, malicious, fraudulent, or grossly negligent conduct. [Transportation Ins. Co. v Moriel](#) (1994, Tex) 879 SW2d 10.

**Bad faith opinion:** Trial court acted within its discretion, in action challenging insurer's denial of supplemental life insurance coverage for city employee under group policy, in allowing licensed claims adjuster to testify as an expert regarding his interpretation of the policy and to state his opinions on mixed questions of law and fact as to whether insurer's conduct constituted bad faith, unfair dealing, fraud, or violation of statutes; claims adjuster had 48 years' experience in insurance industry, he was also a licensed risk manager, he had taught insurance courses at college level, and he had handled

numerous group health and life claims. Rules of Evid., Rules 702, 704. [Royal Maccabees Ins. Co. v. James](#), 134 S.W.3d 906 (Tex. App. Dallas 2004), reh'g granted, (May 21, 2004) and opinion withdrawn and superseded on reh'g, 146 S.W.3d 340 (Tex. App. Dallas 2004); West's Key Number Digest, [Evidence 540](#).

**Malice opinion:** Insurance expert was not permitted to testify that the conduct of insurer's agents and employees indicated the existence of actual malice in injured driver's unfair trade practices action against insurer; such testimony did not assist the trier of fact in that after the jury was informed of industry practices of claims adjustment and settlement, the nature of insurer's conduct in the instant case, and the applicable law concerning malice, they were as capable as expert to determine whether insurer's conduct indicated the existence of malice. [West's Ann.W.Va.Code, 33-11-4\(9\)](#); Rules of Evid., Rule 702. [Jackson v. State Farm Mut. Auto. Ins. Co.](#), 600 S.E.2d 346 (W. Va. 2004); West's Key Number Digest, [Evidence 506](#).

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**[END OF SUPPLEMENT]**

### **§ 3. Scope of article**

This article examines specific proof that may be offered to support and sustain an award of punitive damages in an action by an insured against the insurer for benefits due under the underinsured motorists coverage provisions of an automobile policy, arising out of a breach of the duty of good faith and fair dealing. The principles discussed are applicable to any first-party insurance claim. The focus of the article is on the presentation of proof through expert witnesses.

This article does not examine in any detail the predicate theories that must be established before the question of punitive damages is reached (see [§ 5](#)). For simplicity, the present discussion is founded on the assumption that the insurer's conduct constitutes a breach of the duty of good faith and fair dealing in tort. Nevertheless, counsel must always bear in mind that if the subject jurisdiction requires a predicate showing in contract, or under theories of fraud, misrepresentation, breach of fiduciary standards or statutory provisions, the specific showing required must, of course, be factored into the analysis. These theories are treated in other articles.<sup>3</sup>

## **B. Preliminary Evaluation of a Potential Punitive Damages Claim in a Bad-Faith Case**

### **§ 4. In general**

[\[Cumulative Supplement\]](#)

Evaluation of a potential punitive damages claim requires a three-tiered analysis. The first tier is an analysis of the amount due under contract; the second tier is an analysis of whether or not the insurer's actions constituted a breach of the duties of good faith and fair dealing; the last tier is an analysis of the existence of sufficient bad faith to justify imposition of punitive damages. This last tier requires an evaluation of whether or not the actions of the insurer were so egregious that punitive damages are available under the standards applicable in the jurisdiction (see [§ 9](#)).

It should go without saying that there is no reason to move to the next tier unless all conditions for recovery are reasonably within reach on the given tier under scrutiny. An insurer may be found liable under its contract, for example, without breaching any duty in tort. It is universally held that an insurer has not breached its duty in challenging a claim that is "fairly debatable," that is, where there is a legitimate difference of opinion over the amount or value of a claim, or where the insurer makes an honest and innocent mistake in the facts concerning the nature of the claim, even where it is ultimately determined that the challenge was wrong or an error had been made. The insured will receive his or her contract damages under the policy, but the insurer is not exposed to additional damages. Further, a breach in tort consisting merely of the absence of good faith does not necessarily indicate punitive damages.

## CUMULATIVE SUPPLEMENT

### Cases:

Under Iowa law, punitive damages may be brought on bad faith claims against insurers. [Feller v. Hartford Life and Acc. Ins. Co.](#), 817 F. Supp. 2d 1097 (S.D. Iowa 2010).

Under South Dakota law, while punitive damages are normally not available for a breach of contract, an insured can seek punitive damages from her insurer when prosecuting a bad faith action. [SDCL § 21–3–2. Berry v. Time Ins. Co.](#), 798 F. Supp. 2d 1015 (D.S.D. 2011).

Under Arizona law, the test for punitive damages on a bad faith claim against an insurer focuses on the insurer's attitude and conduct; the insured may recover punitive damages when, and only when, the facts establish that the insurer's conduct was aggravated, outrageous, malicious, or fraudulent. [Medical Protective Co. v. Pang](#), 606 F. Supp. 2d 1049 (D. Ariz. 2008) (applying Arizona law).

**Arbitration agreement** which stated that matter was resolved when decision on uninsured motorist (UM) claim was rendered and that any award would bar any action arising from the same incident did not release insured's right to sue insurer for vexatious and unreasonable delay in handling UM claim; the arbitration hearing was confined to issues of liability, damages, causation, and comparative fault, "the matter resolved" referred to the accident and injuries, and the bad-faith claim was outside the scope of arbitration. S.H.A. 215 ILCS 5/143a(1), 155. [Smith v. State Farm Ins. Companies, Inc.](#), 369 Ill. App. 3d 478, 308 Ill. Dec. 118, 861 N.E.2d 183 (1st Dist. 2006); West's Key Number Digest, [Insurance 3324\(3\)](#).

Under Mississippi law, claim alleging bad faith refusal of insurance coverage, and a corresponding chance to recover punitive damages, requires insured to prove that there was no arguable or legitimate reason to deny coverage and the insurer acted willfully, maliciously, or with gross and reckless disregard for the insured's rights. [Mitchell v. State Farm Fire and Cas. Co.](#), 799 F. Supp. 2d 680 (N.D. Miss. 2011) (applying Mississippi law).

Commercial property insurer's wrongful denial of coverage under sewer or drain backup provision of commercial property policy did not entitle insured to punitive damages; policy was ambiguous, and insured did not produce evidence of malice, recklessness, or gross disregard of insured's rights or evidence that insurer engaged in willful conduct in bad faith. [United States Fidelity and Guar. Co. of Mississippi v. Martin](#), 998 So. 2d 956 (Miss. 2008).

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**[END OF SUPPLEMENT]**

### § 5. Controversy and variations in the law of punitive damages

[\[Cumulative Supplement\]](#)

The next step in the evaluation of a potential claim for punitive damages in a bad-faith case is an examination of the particular requirements of the forum state with regard to the availability of punitive damages.

Punitive damages have become the singular area of controversy surrounding the explosion of litigation in "bad-faith" insurance cases. They are vilified by the insurance industry as unnecessary and unconstitutional, needlessly increasing the costs of litigation and contributing to skyrocketing premiums. They are defended with equal vigor by the plaintiffs' bar as an essential measure in the regulation of insurance companies, necessary to protect consumers, deter unfair settlement practices, and promote responsible administration of policyholder claims.

The United States Supreme Court's ruling in [Pacific Mutual Life Insurance Company v. Haslip](#)<sup>4</sup> left the matter of punitive damages to state law (see [§ 1](#)), but did little to bring about any uniformity among the states. Because of the polarized views on punitive damages, these cases are flooding into state appellate courts resulting in decisions that vary considerably.

## CUMULATIVE SUPPLEMENT

### Cases:

Oregon's denial of judicial review of size of punitive damage awards was violative of due process. [Honda Motor Co. v Oberg](#) (1994, US) 129 L Ed 2d 336, 114 S Ct 2331, 94 CDOS 4761, 94 Daily Journal DAR 8844, CCH Prod Liab Rep ¶13895, 8 FLW Fed S 341.

Punitive damage award of \$2,000,000 against insurance company under Oklahoma statute allowing punitive damages to exceed actual loss if clear and convincing evidence shows that defendant is guilty of conduct evincing wanton or reckless disregard of rights of another did not violate due process, even though compensatory damages were only \$4,500 since jury's award was reasonable in view of defendant's oppressive conduct and necessity to set example and punish defendant. [Capstick v Allstate Ins. Co.](#) (1993, CA10 Okla) 998 F2d 810.

Limitation of punitive damages in most cases to \$250,000 set forth in [Alabama Code § 6-11-21](#) violates state constitution's guarantee of trial by jury. Under trial by jury provision, [Alabama Constitution, art. I, § 11](#), right to jury trial is to remain inviolate in cases in which right existed at common law, or in which it was used at time of adoption of constitution. In holding unconstitutional earlier statute limiting noneconomic damages in medical malpractice cases, court pointed out that jury is empaneled with expectation that its verdict will have efficacy. Statute does not entirely abrogate right to jury; instead, once jury is empaneled, it is authorized to award every species of damages, including punitive damages. Thus, although right to jury still exists under statute, it does not remain inviolate. Because jury was used in punitive damages cases at time state constitution was adopted, right to jury trial in such cases is protected under § 11, and limitation on punitive damages such as that imposed by [Alabama Code § 6-11-21](#) clearly impairs traditional function of jury. It is improper for legislature to substitute itself for jury and to fix arbitrary limit. [Henderson by & Through Hartsfield v Alabama Power Co.](#) (1993, Ala) 627 So 2d 878.

Despite certain similarities with criminal sanctions, punitive damages arising from common law causes of action are quintessentially civil, which keeps them outside the zone of constitutional protections such as double jeopardy and the ex post facto clause, which are intended to protect citizens against government-imposed sanctions. [U.S.C.A. Const. Art. I, § 10, cl. 1](#); [U.S.C.A. Const. Amend. 5](#); [West's Ann. Cal. Const. Art. I, §§ 9, 15](#). [Roman Catholic Bishop of Oakland v. Superior Court](#), 128 Cal. App. 4th 1155, 28 Cal. Rptr. 3d 355 (2d Dist. 2005), review denied, (July 27, 2005); West's Key Number Digest, [Damages 87\(1\)](#).

**Evidence of actual harm to nonparties** can help to show that the conduct that harmed the plaintiff also posed a substantial risk of harm to the general public; however, a jury may not go further than this and use a punitive damages verdict to punish a defendant directly on account of harms it is alleged to have visited on nonparties. [Rinehart v. Shelter General Ins. Co.](#), 261 S.W.3d 583 (Mo. Ct. App. W.D. 2008), reh'g and/or transfer denied, (July 29, 2008) and transfer denied, (Sept. 30, 2008); West's Key Number Digest, [Damages 91.5\(1\)](#).

The legal justification for punitive damages is similar to that for criminal punishment, and like criminal punishment, punitive damages require appropriate substantive and procedural safeguards to minimize the risk of unjust punishment. [Transportation Ins. Co. v Moriel](#) (1994, Tex) 879 SW2d 10.

The outer limit of the ratio of punitive damages to compensatory damages in cases in which the defendant has acted with extreme negligence or wanton disregard but with no actual intention to cause harm and in which compensatory damages are neither negligible nor very large is roughly five-to-one; however, when the defendant has acted with actual evil intention, much higher ratios are not per se unconstitutional. [Boyd v. Goffoli](#), 216 W. Va. 552, 608 S.E.2d 169 (2004); West's Key Number Digest, [Damages 94](#).

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[\[END OF SUPPLEMENT\]](#)

### § 6. Controversy and variations in the law of punitive damages—Predicate theories

[\[Cumulative Supplement\]](#)

Punitive damages are always considered in connection with an underlying breach and resultant harm to the insured. Without a predicate breach that results in damage to the insured, either in contract or tort, there is no cause of action for punitive damages.

Most states now recognize a tort theory of bad faith, founded on a breach of the duty of good faith and fair dealing, and this predicate theory is assumed in this article. In some states, however, insurance cases are still considered purely matters of contract, and punitive damages are not available unless a separate tort has been committed. Other states confine claims to contract theories, but allow punitive damages where the breach is egregious. Other theories that may be available to lead to an award of punitive damages are fraud, misrepresentation, breach of fiduciary duties, or breach of statutory duties imposed.<sup>5</sup> A few states have statutes defining or limiting punitive damages.<sup>6</sup>

## CUMULATIVE SUPPLEMENT

### Cases:

Evidence that an insurer has violated its duty of good faith and fair dealing does not thereby establish that it has acted with the requisite malice to justify an award of punitive damages. In order to establish that an insurer's conduct has gone sufficiently beyond mere bad faith to warrant a punitive damage award, it must be shown by clear and convincing evidence that the insurer has acted maliciously. [Stewart v Truck Ins. Exchange \(1993\) 17 Cal App 4th 468, 21 Cal Rptr 2d 338, 93 CDOS 5672.](#)

Rule of managerial capacity relates to punitive damages and provides that punitive damages can properly be awarded against a master or other principal because of an act by an agent if the agent was employed in a managerial capacity and was acting in the scope of employment. [Martin-Martinez v. 6001, Inc., 1998 -NMCA-179, 968 P.2d 1182 \(N.M. Ct. App. 1998\).](#)

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### § 7. Controversy and variations in the law of punitive damages—First-party claim practice versus third-party claim practice

[\[Cumulative Supplement\]](#)

In the case of uninsured or underinsured motorists claims, most states view the duty owed by the insurer to its insured to be governed by standards applicable to first-party claim practice. Under this standard, it is held that a special relationship, akin to a fiduciary duty and sometimes recognized as such, is imposed on the insurer toward its insured.<sup>7</sup> The following duties apply: The insurer is required (a) to determine whether or not a claim falls within the coverage provided; the insurer must then (b) evaluate the scope and extent of the claim presented, in order (c) to decide upon the validity of the claim, (d) to assess its monetary value, and (e) to control the manner and time of payment. A breach of duty in any or all of these respects may be willful or negligent; if negligent, it is measured against reasonable standards of acceptable conduct.

A few states view the duty owed by the insurer toward its insured under uninsured or underinsured motorists provisions to be equivalent to the duty owed in the case of a third-party defense claim under the liability provisions of the policy. That is, the insurer steps into the shoes of the uninsured driver and becomes adverse to its own insured. In such cases, the parties are considered adversaries and the insurer is entitled to resist its insured's claim with considerable vigor.<sup>8</sup> It will be liable for punitive damages only in situations tantamount to fraud, callous disregard of the contractual provisions, or intentional obstruction of performance.

While in all cases, something more than a mere breach is required before punitive damages will lie (see [§ 8](#)), the threshold is significantly higher where the insurer is permitted to treat such cases as third-party defense claims.

## CUMULATIVE SUPPLEMENT

### Cases:

Pivotal question, in deciding whether one party to contract may sue another party in tort for negligent performance of contract, is whether allegedly negligent party is subject to standard of care independent of terms of contract. Applying same principles previously applied to physicians, lawyers, architects, and other professionals, when liability insurer undertakes to “defend” insured, relationship carries with it standard of care independent of contract and without reference to specific terms of contract. Thus, “excess claim” brought by insured against insurer for failure to defend case with reasonable care (in this case, alleged failure to settle within policy limits), is cognizable as negligence claim. [Georgetown Realty, Inc. v Home Ins. Co. \(1992\) 313 Or 97, 831 P2d 7](#), on remand [113 Or App 641, 833 P2d 1333](#), reconsideration den (Oct 14, 1992).

No Stowers duty, which provides that insurers must exercise that degree of care and diligence which ordinarily prudent person would exercise in management of his own business in responding to settlement demands within policy limits, was ever imposed or triggered regarding automobile insurer’s handling of passenger’s claim against tortfeasor’s policy where insurer offered policy limits of tortfeasor’s liability coverage, and by terms of tortfeasor’s policy, passenger was not entitled to make claim for tortfeasor’s UIM coverage. [Traver v State Farm Mut. Auto. Ins. Co. \(Tex App Fort Worth, 1996\) 930 SW2d 862](#), rehearing overruled (Oct 10, 1996), application for writ of error filed (Dec 4, 1996).

**Bad faith and duty to defend compared:** The standard for bad-faith claims is the same “fairly debatable” standard as that for duty to defend, but it is the insurer, rather than the insured, that gets the benefit of the doubt. [Liebovich v. Minnesota Ins. Co., 299 Wis. 2d 331, 2007 WI App 28, 728 N.W.2d 357 \(Ct. App. 2007\)](#), review granted, [2007 WI 61, 300 Wis. 2d 191, 732 N.W.2d 857 \(2007\)](#); West’s Key Number Digest, [Insurance 2931](#).

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### § 8. Controversy and variations in the law of punitive damages—Legal standards of requisite misconduct

#### [\[Cumulative Supplement\]](#)

Although standards vary, in order to justify an award of punitive damages the insurer’s breach of the duty of good faith and fair dealing must be shown to have been particularly outrageous.<sup>9</sup> Depending on the jurisdiction, the plaintiff’s proof must demonstrate that the insurer’s conduct under examination, in some combination, met the following criteria:

- The insurer’s conduct was an extreme deviation from acceptable standards; and/or
  - The insurer’s actions were oppressive, fraudulent, wanton, malicious, or outrageous; and/or
  - The insurer acted with an understanding of and a reckless or conscious disregard for the likely consequences; and/or
- or
- The insurer’s actions were carried out with an extremely harmful state of mind with the manifest intent to deliberately or willfully injure another.

Punitive damages are not favored, and in virtually all states the trial judge has considerable discretion to determine whether to allow the issue to go to a jury, and to take the issue away post trial.

#### Standard of proof

One aspect of punitive damages that has been the subject of considerable legal debate in recent years concerns the standard of proof needed to establish the conduct on which punitive damages are predicated. Various contentions regarding the standard of proof that should be required as to conduct underlying punitive damages have been made. In most jurisdictions, the standard of proof required on the punitive damage issue is the preponderance of the evidence. Some states require a higher standard.<sup>10</sup> It may be instructive to note that the Supreme Court ruling in [Haslip](#)<sup>11</sup> recommends a higher standard of proof for



punitive damages, but does not mandate it.

## CUMULATIVE SUPPLEMENT

### Cases:

**Oppressive, fraudulent, or malicious conduct:** Under California law, punitive damages are available on an insured's bad faith claim against an insurer if in addition to proving a breach of the implied covenant of good faith and fair dealing proximately causing actual damages, the insured proves by clear and convincing evidence that the insurance company itself engaged in conduct that is oppressive, fraudulent, or malicious. [Amadeo v. Principal Mut. Life Ins. Co.](#), 290 F.3d 1152 (9th Cir. 2002); West's Key Number Digest, [Insurance 3376](#).

**"Actual malice,"** of kind required for award of punitive damages under Maryland law, may be characterized as the performance of act without legal justification or excuse, but with an evil or rancorous motive influenced by hate, the purpose being to deliberately and willfully injure the plaintiff. [Nestorio v. Associates Commercial Corp.](#), 250 B.R. 50 (D. Md. 2000); West's Key Number Digest, [Damages 91\(1\)](#).

A breach of fiduciary duty alone, without malice, fraud or oppression, does not permit an award of punitive damages. The wrongdoer must act with the intent to vex, injure, or annoy, or with a conscious disregard of the plaintiff's rights. Punitive damages are appropriate if the defendant's acts are reprehensible, fraudulent, or in blatant violation of law or policy. The mere carelessness or ignorance of the defendant does not justify the imposition of punitive damages. Punitive damages are proper only when the tortious conduct rises to levels of extreme indifference to the plaintiff's rights, a level which decent citizens should not have to tolerate. [Tomaselli v Transamerica Ins. Co.](#) (1994, 4th Dist) 25 Cal App 4th 1269, 31 Cal Rptr 2d 433, 94 CDOS 4443, 94 Daily Journal DAR 8129, review den (Sep 8, 1994).

A consistent and unremedied pattern of egregious insurer practices is required for the insurer's bad faith conduct to rise to the level of malicious disregard of the insured's rights so as to warrant the imposition of punitive damages. Evidence that an insurer has violated its duty of good faith and fair dealing does not thereby establish that it has acted with the requisite malice, oppression, or fraud to justify an award of punitive damages. To establish that an insurer's conduct has gone sufficiently beyond mere bad faith to warrant a punitive award, it must be shown by clear and convincing evidence that the insurer has acted maliciously, oppressively, or fraudulently. The malice which must be shown to justify an award of punitive damages when no intent to harm is claimed implies an act conceived in a spirit of mischief or with criminal indifference towards the obligations owed to others. Something more than the mere commission of a tort is always required for punitive damages. There must be circumstances of aggravation or outrage, such as spite or malice, or a fraudulent or evil motive on the part of the defendant, or such a conscious and deliberate disregard of the interests of others that his or her conduct may be called willful or wanton. To justify an award of punitive damages when nondeliberate injury is alleged, the plaintiff must establish that the defendant was aware of the probable dangerous or harmful consequences of his or her conduct, and that he or she willfully and deliberately failed to avoid those consequences. [Mock v Michigan Millers Mutual Ins. Co.](#) (1992, 2nd Dist) 4 Cal App 4th 306, 5 Cal Rptr 2d 594, 92 CDOS 1914, 92 Daily Journal DAR 3014.

**Requisite state of mind:** Finding of bad faith by insurer requires evidence of state of mind reflecting dishonest purpose, moral obliquity, furtive design, or ill will; bad faith determination inherently includes element of culpability. [Colley v. Indiana Farmers Mut. Ins. Group](#), 691 N.E.2d 1259 (Ind. Ct. App. 1998).

**Reasonable investigation:** Engineering firm's report which concluded that an oversized air conditioning system caused mold in house satisfied homeowners insurer's obligation to conduct a reasonable investigation, even though the report did not discover the water leaks or identify the type of mold; the report's purpose was not to determine all possible causes or types of mold present, and the causes and types of mold were irrelevant. West's [N.C.G.S.A. § 58-63-15\(11\)\(d\)](#). [Nelson v. Hartford Underwriters Ins. Co.](#), 630 S.E.2d 221 (N.C. Ct. App. 2006); West's Key Number Digest, [Insurance 3361](#).

If there is reasonable ground for contesting claim, insurer is not guilty of bad faith in doing so. Trial court erred in refusing to grant judgment n.o.v. to health insurer following jury award of punitive damages for bad faith in denying application for health insurance after having received premium payment, and for failure to pay costs of heart surgery undergone by applicant on ground that applicant had preexisting heart condition, where applicant was diagnosed with coronary artery disease day after he made application, and where insurer followed standardized, published procedures in determining that applicant had preexisting condition. [Crossley v State Farm Mut. Auto. Ins. Co.](#) (1992, SC) 415 SE2d 393.

Even if an insurer has "no reasonable basis" to deny or delay payment of the claim, the plaintiff may not recover punitive damages on that basis alone, and an award of punitive damages is justified only when bad faith is accompanied by malicious, intentional, fraudulent, or grossly negligent conduct. [Transportation Ins. Co. v Moriel](#) (1994, Tex) 879 SW2d 10.



**Reasonably clear liability:** An insurer breaches its duty of good faith and fair dealing by denying, or delaying payment of, a claim when the insurer's liability has become reasonably clear. V.A.T.S. Insurance Code, art. §§ 4(10)(a)(ii), 21.21. [Vandeventer v. All American Life & Cas. Co.](#), 101 S.W.3d 703 (Tex. App. Fort Worth 2003); West's Key Number Digest, [Insurance 3336](#).

**Evil intent:** Proof of a bad faith cause of action does not necessarily make punitive damages appropriate in a suit against an insurer; there is a distinction between the intent necessary to maintain an action for bad faith and the intent that must be shown to recover punitive damages. For punitive damages to be awarded there must be a showing of an evil intent deserving of punishment or of something in the nature of special ill-will or wanton disregard of duty or gross or outrageous conduct. W.S.A. 895.85(3). [Trinity Evangelical Lutheran Church v. Tower Ins. Co.](#), 251 Wis. 2d 212, 2002 WI App 46, 641 N.W.2d 504 (Ct. App. 2002), review granted, 2002 WI 121 (Wis. 2002); West's Key Number Digest, [Insurance 3419](#).

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## § 8.5. Controversies and variations in the law of punitive damages—Ratio analyses

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### CUMULATIVE SUPPLEMENT

#### A.L.R. Library

[Constitutional Issues Concerning Punitive Damages—Supreme Court Cases](#), 1 A.L.R. Fed. 2d 529

#### Cases:

A 1:1 ratio of punitive to compensatory damages, which is above the median award, is a fair upper limit in maritime cases with no earmarks of exceptional blameworthiness, such as intentional or malicious conduct, or behavior driven primarily by desire for gain. [Exxon Shipping Co. v. Baker](#), 128 S. Ct. 2605, 171 L. Ed. 2d 570, 66 Env't. Rep. Cas. (BNA) 1545, 2008 A.M.C. 1521 (2008).

**State Farm vs. Campbell:** A jury's punitive damage award of \$145 million for an automobile liability insurer's bad-faith failure to settle for the insured's policy limits, where the compensatory damages were \$1 million, was neither reasonable nor proportionate to the wrong committed and, therefore, violated the due process clause; harm was economic rather than physical, jury was allowed to award punitive damages to punish and deter conduct that occurred out-of-state and bore no relation to the insureds' harm, and punitive damages, to extent that they were for distress caused by outrage and humiliation, were duplicative of compensatory damages. [U.S.C.A. Const.Amend. 14. State Farm Mut. Auto. Ins. Co. v. Campbell](#), 123 S.Ct. 1513; West's Key Number Digest, [Constitutional Law 303](#).

Ratio of 8.18:1 between award of punitive damages and the actual and potential harm caused in insurance bad faith case was not constitutionally excessive in insurance bad faith case where insurer's conduct was highly reprehensible without substantial ameliorative behavior, the conduct was engaged in for profit and targeted thousands of vulnerable individuals and put hundreds of thousands at risk, it was repeated, and involved malice, trickery and deceit and was not the product of accident; appropriate denominator consisted of first trial judgment brought to present value to which would be added the post-trial benefits paid to insured under reservation of rights. [U.S.C.A. Const.Amend. 14](#); West's [NRSA 42.005\(2\)\(b\)](#), 42.007(2). [Merrick v. Paul Revere Life Ins. Co.](#), 594 F. Supp. 2d 1168 (D. Nev. 2008).

Ratios between punitive and compensatory damages greater than a single digit may comport with due process where a particularly egregious act has resulted in only a small amount of economic damages, but when compensatory damages are substantial, then a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process guarantee. [U.S.C.A. Const.Amend. 14. Jet Source Charter, Inc. v. Doherty](#), 148 Cal. App. 4th 1, 55 Cal. Rptr. 3d 176 (4th

[Dist. 2007](#)), as modified on denial of reh'g, (Feb. 28, 2007); West's Key Number Digest, [Constitutional Law](#) 303.

Requiring homeowners insurer to pay punitive damages of \$660,000 for delaying payment of property damage claim for approximately two years would violate due process, but reduction to \$74,600 in four to one ratio to compensatory damages of \$18,650 was permissible; although nothing indicated that delay tactics occurred on numerous occasions and insureds were compensated to the maximum extent that their policy permitted, the insurer would have an incentive to delay payment without an award of punitive damages, and they were thus needed for deterrence. [U.S.C.A. Const.Amend. 14. Hall v. Farmers Alliance Mut. Ins. Co., 145 Idaho 313, 179 P.3d 276 \(2008\)](#); West's Key Number Digest, [Insurance](#) 3376.

The “comparable sanctions” guidepost for determining whether punitive damages award is excessive under due process requires three steps: first, courts must identify comparable civil or criminal sanctions, second, courts must consider how serious comparable sanctions are, relative to universe of sanctions that legislature authorizes to punish inappropriate conduct, and third, courts must then evaluate punitive damage award in light of relative severity of comparable sanctions. [U.S.C.A. Const.Amend. 14. Williams v. Philip Morris Inc., 340 Or. 35, 127 P.3d 1165, Prod. Liab. Rep. \(CCH\) P 17452 \(2006\)](#), cert. granted in part, [126 S. Ct. 2329, 164 L. Ed. 2d 838 \(U.S. 2006\)](#); West's Key Number Digest, [Constitutional Law](#) 303.

Requiring automobile insurer to pay punitive damages of \$2.8 million, representing a 10 to 1 ratio over the compensatory award of \$278,825, for bad faith did not violate due process; the trial court found deliberate indifference and, in some cases, blatant dishonesty, the insurer misrepresented the amount of underinsured motorist (UIM) coverage, established an arbitrary reserve, discounted projected wage loss without supporting medical or vocational evidence, and refused to contact insured's employer to determine the extent of her inability to complete assigned tasks, the compensatory damages were limited to attorney fees, costs, and interest, and the insurer faced potentially harsh statutory penalties. [U.S.C.A. Const.Amend. 14; 40 P.S. §§ 1171.1 et seq. Hollock v. Erie Ins. Exchange, 2004 PA Super 13, 842 A.2d 409 \(2004\)](#); West's Key Number Digest, [Insurance](#) 3376.

**State Farm vs. Campbell on remand:** Automobile liability insurer's bad faith failure to settle for policy limits warranted punitive damages of \$9,018,780.75, nine times the compensatory and special damages for emotional distress, and that amount was consistent with due process, even if a \$10,000 fine for fraud was the most applicable civil penalty; the insureds' injuries were not limited to economic loss, the insurer had assured them that their assets would not be placed at risk by the negligence and wrongful death lawsuit, but later withdrew its expressions of assurance and told the insureds to place a “for sale” sign on their house, and the insurer's obdurate insistence that its treatment of the insureds was proper clearly called out for vigorous deterrence. [U.S.C.A. Const.Amend. 14. Campbell v. State Farm Mut. Auto. Ins. Co., 2004 UT 34, 98 P.3d 409 \(Utah 2004\)](#), cert. denied, [125 S. Ct. 114 \(U.S. 2004\)](#); West's Key Number Digest, [Constitutional Law](#) 303.

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**[END OF SUPPLEMENT]**

## **§ 9. Circumstances indicating viability of claim**

[\[Cumulative Supplement\]](#)

Punitive damages are clearly indicated in cases of deliberate, willful, or intentional misconduct. These instances are generally obvious, and little analysis is required.

The difficult questions come from conduct that is not intentional, but merely indifferent or negligent. Although these cases are all commonly referred to as “bad-faith” cases, it is not always correct to conclude that every breach of the duty of good faith and fair dealing is “bad faith.” Simple indifference or negligence may indicate only the absence of good faith.

On the other hand, conduct that is not only indifferent but is also calculated to work to the advantage of the insurer elevates the circumstances considerably. If, in addition, the insured is placed at a special disadvantage by the indifferent conduct, and the insurer is made aware of the disadvantage and still persists, the circumstances are elevated even further.

In assessing a potential claim for punitive damages, a determination in favor of alleging punitive damages ordinarily will require the presence of the following circumstances:

- (a) The conduct under examination breached a duty owed;
- (b) As a result of the breach, the position of the insurer was advanced at the expense of its insured;

(c) The insured was harmed or placed at a disadvantage by the conduct, of which the insurer was aware and yet still persisted; and

(d) The circumstances demonstrate an egregious breach, under the standards applicable for punitive damages.

A common example of cases in which punitive damages may be alleged involves delay in payment of the loss. The insurer is entitled to a “reasonable” time to determine and pay losses due. However, if it takes an excessive amount of time, it has breached its duty. Delay in payment works to the advantage of the insurer; this is elementary economics. If the insured has been forced to forego an opportunity or endure a hardship during this interim, the delay works to the disadvantage of the insured, and if the insurer is or should be aware of this harm, conditions (a), (b), and (c) are satisfied.

The final test, (d), is one of common sense. Taken as a whole, are the circumstances such as to constitute an outrageous affront to the sensibilities of the ordinary person? In answering this question, the adjectives embedded within the punitive damage standards are instructive: “extreme” deviation, “reckless” disregard, “callous” indifference, “gross” negligence, and the like. If these adjectives do not come readily to mind as appropriate to describe the circumstances of the case, rhetoric and bombastic argument will seldom create them in the minds of a jury.

It is crucial to the analysis to remember that punitive damages are not assessed to compensate the claimant, but to punish and deter the defendant. Thus, while the existence of harm to the insured may be important, the critical element is the conduct of the defendant. In other words, a slight breach causing significant harm may not justify punitive damages, while an egregious breach that only causes slight harm may. This is illustrated by a case in which an insurer was sued in bad faith for mishandling a trivial property damage claim. At trial, the proof established that the company had consistently and arbitrarily “clipped” thirty-five dollars from every property damage claim submitted, and had been doing this for many years. The explanation was that the company thought this thirty-five dollars would not be material enough to cause legal action from individual insureds, but would make a significant difference in the overall loss rate of the company. A jury awarded \$3.5 million in punitive damages, which was affirmed on appeal.<sup>12</sup>

## CUMULATIVE SUPPLEMENT

### Cases:

**Strong-arm settlement tactics:** Evidence was sufficient to support an award of punitive damages under Oklahoma law on insured’s bad faith claim against uninsured/underinsured motorist (UIM) insurer, which conditioned payment of an undisputed amount on release of all disputed claims; a jury could properly view insurer’s refusal as a strong-arm tactic that was in blatant disregard of insurer’s duty to its insured. [23 Okl.St. Ann. § 9.1\(B\)\(2\)](#). [Hatfield v. Liberty Mut. Ins. Co.](#), 98 Fed. Appx. 789 (10th Cir. 2004); West’s Key Number Digest, [Insurance 3381\(5\)](#).

A finding of bad faith by an insurer does not necessarily make the award of punitive damages appropriate; the intent necessary to maintain an action for bad faith is distinct from what must be shown to recover punitive damages. [W.S.A. 895.043](#). [Miller v. Safeco Ins. Co. of America](#), 761 F. Supp. 2d 813 (E.D. Wis. 2010), judgment amended, (Mar. 11, 2011).

Punitive damages award of \$155,000 was appropriate in motor vehicle owners’ bad faith action against insurer; the reprehensibility of insurer’s misconduct in deciding to repair vehicle, rather than total vehicle, due to profit concerns was low to, at most, moderate, jury’s \$155,000 compensatory damages award was substantial, and civil penalties for unfair claims settlement practices were capped at \$50,000 per six-month period. [U.S.C.A. Const. Amend. 14](#); [A.R.S. § 20-461\(A\)](#). [Nardelli v. Metropolitan Group Property and Cas. Ins. Co.](#), 277 P.3d 789 (Ariz. Ct. App. Div. 1 2012).

**Subsequent remedial measures:** Property insurer’s letter recommending transfer to a new adjuster after the insureds hired an attorney, a report on the status of the claim, and a memo to the file discussing possible problems in the negotiation process, and response to the memo were not evidence of subsequent remedial measures and were admissible in insureds’ bad faith suit; the documents did not describe measures that would make an event less likely to occur. Rules of Evid., Rule 407. [Columbia Nat. Ins. Co. v. Freeman](#), 347 Ark. 423, 64 S.W.3d 720 (2002); West’s Key Number Digest, [Evidence 219.20\(1\)](#).

Jury’s finding that commercial property insurer acted with “oppression, fraud, or malice” in its handling of claim for flooding of business premises was supported by substantial evidence, in awarding punitive damages on insured’s claim of bad faith, including evidence that insurer never advised insured about the available coverages, insurer twice immediately told insured that certain coverages were unavailable and only looked into the matter when insured pressed the issue and pointed out the applicable policy provisions, insurer expressly denied coverage for a tenant-improvements claim and stated that its investigation showed that no tenant improvements had been damaged when in reality no such investigation had been

undertaken, and insurer effectively put insured out of business by failing for two years to replace a printer and scanner which were the key pieces of equipment insured needed to run its business. [West's Ann.Cal.Civ.Code § 3294. Amerigraphics, Inc. v. Mercury Cas. Co., 182 Cal. App. 4th 1538, 2010 WL 1038675 \(2d Dist. 2010\).](#)

Court, reversing punitive damage award against insurer which had denied uninsured motorist (UM) claim, concluded that facts of present dispute did not warrant award of such damages. Adjuster eventually concluded that insured was more than fifty percent at fault and therefore UM benefits were not payable. Court held that insurance companies have duty of good faith to refrain from making unfounded refusal to pay policy proceeds, causing unfounded delay in making payment, deceiving insured, and exercising unfair advantage to pressure insured into settling; and that punitive damages may be awarded for breach of good faith duty if insurer acted maliciously, fraudulently, grossly negligently, or oppressively. Court ruled that here, although jury ultimately disagreed with insurer's determination that insured had been more than fifty percent at fault, record contained evidence of rational principled basis for insurer to have denied her claim, and that no basis existed for finding of malice, oppression, or like on insurer's part. [Erie Ins. Co. v Hickman \(1993, Ind\) 622 NE2d 515.](#)

Punitive damages were not recoverable from automobile insurer due to its alleged bad faith in not fulfilling its obligations under policy when insured's vehicle was stolen; complaint did not show that insurer's conduct constituted an independent tort, that it rose to sufficient level of egregiousness, or that alleged egregious conduct was part of pattern directed at public generally. [Rodriguez v. Allstate Ins. Co., 931 N.Y.S.2d 462 \(Sup 2011\).](#)

Building owners failed to make showing that insurer lacked good faith in denying claim based on fire in building, and thus punitive damages were not available to building owners under Ohio law. [Corbo Properties, Ltd v. Seneca Ins. Co., Inc., 771 F. Supp. 2d 877 \(N.D. Ohio 2011\) \(applying Ohio law\).](#)

Punitive damages prayer for relief would not be dismissed for lack of an underlying claim where plaintiff insured had sufficiently pleaded her bad faith claim. [SDCL § 21–3–2. Berry v. Time Ins. Co., 798 F. Supp. 2d 1015 \(D.S.D. 2011\) \(applying South Dakota law\).](#)

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**[END OF SUPPLEMENT]**

## **§ 10. Tactical consideration against alleging punitive damages**

[\[Cumulative Supplement\]](#)

Too often, the prevalent pleading and trial practice is to present all conceivable theories, including a claim for punitive damages, without thoughtful analysis of what the circumstances will actually support. The apparent argument is that a claim for punitive damages increases the insurer's exposure, thus enhancing the likelihood of a higher or swifter settlement; that arguing the proposition of punitive damages to the jury may increase the stature of the case in the jury's eyes; and that the strategy cannot hurt—the worst that can happen is that punitive damages will be denied or eliminated by the court.

If the circumstances of the case do not warrant imposition of punitive damages, this is a strategically unsound series of arguments. If punitive damage allegations are advanced in a case where the circumstances do not warrant, there are at least five probable consequences, all bad.

First, the cost of pretrial preparation is dramatically increased. Discovery will be more expensive and time consuming; expert witnesses must be retained and prepared; local consultants, willing to testify on contract issues, may be unwilling to become involved in combat over punitive damages; and counsel will have to defend and brief extra motions for summary judgment. When the plaintiff prevails on the predicate claim but loses on the punitive damage issue, the court may strip the excess costs associated with the punitive damage allegations from any award of costs and attorney fees, thus diluting the compensatory damages awarded.

Second, the impositional burdens invariably fall more heavily on the plaintiff. The defendant insurer is in a far better position to sustain the paper war of discovery and motion practice. It is a universal fact that time is the plaintiffs' enemy, and that anything that derails, hinders, obstructs, or delays the progress of litigation works to the advantage of the defense. Raising any issue not warranted by the facts plays straight into this defense strategy.

Third, advancing an unwarranted theory may weaken the structure of the entire case in the eyes of the judge. The lawyer

loses credibility and the client loses sympathy. In federal court and some states, the worst-case result of advancing unwarranted theories can be an award of attorney fees against the plaintiff and his or her counsel, even where the plaintiff otherwise prevails.<sup>13</sup>

Fourth, the jury may perceive the arguments for punitive damages as an overreach and an indication of greed. If a jury detects greed as a motivating factor in any facet of the case, the entire verdict will inevitably plummet to the minimum.

Finally, if the issue is allowed to go to the jury, and it awards punitive damages where the circumstances do not warrant, this may lead the trial judge or appellate court to decide that the jury was inflamed with passion or prejudice and set aside the entire verdict for retrial.

Any expectation that the mere unsubstantiated allegation of punitive damages will inherently enhance the value of a claim is pure sophistry. The risks far outweigh any conceivable potential for gain. A superior strategy is to plead entitlement to punitive damages only in those cases where counsel is satisfied that proof does exist demonstrating the required level of egregious conduct, under the standards applicable in the jurisdiction.

## CUMULATIVE SUPPLEMENT

### Cases:

**Arbitration restrictions:** Insured's common-law right to punitive damages on claim of fraud was not based on law enacted by state, and, thus, the McCarran-Ferguson Act which requires reverse preemption of federal law by law enacted by any state for the purpose of regulating the business of insurance did not preclude application of the Federal Arbitration Act (FAA) to validate arbitration clause which prohibited award of punitive damages. [9 U.S.C.A. § 2](#); McCarran-Ferguson Act, [§ 2](#), [15 U.S.C.A. § 1012](#). *American Intern. Group, Inc. v. Siemens Building Technologies, Inc.*, 881 So. 2d 7 (Fla. Dist. Ct. App. 3d Dist. 2004); West's Key Number Digest, [Insurance 1107](#).

Tort of breach of duty of good faith and fair dealing and standard for recovery of punitive damages are distinguishable; former requires only that defendant act intentionally, while latter requires more than intentional action, and encompasses intent to do an act, or an intent to not do an act, in reckless disregard of the consequences, and under such circumstances and conditions that reasonable person would know, or have reason to know, that such conduct would, in high degree of probability, result in substantial harm to another. *Farmers Ins. Exchange v. Shirley*, 958 P.2d 1040 (Wyo. 1998), reh'g denied, (June 5, 1998).

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[END OF SUPPLEMENT]

### § 11. Amount of punitive damages available

[\[Cumulative Supplement\]](#)

With few exceptions, punitive damages are left to the discretion of a properly instructed jury, subject to the power of the court to intervene if it determines that the jury has gone awry.<sup>14</sup>

Awards range from nominal to staggering, with each case depending on the particular facts. Juries are typically given only general guidance for their deliberations. The pattern jury instruction used in Idaho, for example, reads:

Punitive damages are not a matter of right, but may be awarded in the jury's sound discretion, which is to be exercised without passion or prejudice. The law provides no mathematical standard by which such damages are to be calculated, other than that any award of punitive damages must bear some relation or proportion to the actual damages, to the causes thereof, to the conduct of the defendant, and to the primary objective of deterrence.

From an evidentiary standpoint, it is generally relevant to offer proof of the financial net worth of the defendant, and it is

appropriate to argue that the jury can take the financial capacity of the defendant into consideration in determining the amount of punitive damages to award.<sup>15</sup>

## CUMULATIVE SUPPLEMENT

### Cases:

**Exacting appellate review** ensures that an award of punitive damages is based upon an application of law, rather than a decisionmaker's caprice. [State Farm Mut. Auto. Ins. Co. v. Campbell](#), 538 U.S. 408, 123 S. Ct. 1513, 155 L. Ed. 2d 585, 60 Fed. R. Evid. Serv. 1349 (2003); West's Key Number Digest, [Federal Courts 504.1](#).

Award of punitive damages in the amount of \$2.4 million was not excessive, under Arizona law, in insured's action against disability insurer for bad faith termination of disability benefits; evidence against insurer included acts of deceit towards an insured who was financially vulnerable, ratio between punitive and compensatory damages awards was approximately four to one, and possible civil sanctions for insurer's conduct could include suspension of insurer's licenses, which could be worth hundreds of millions of dollars to insurer. [Greenberg v. Paul Revere Life Insurance Co.](#), 91 Fed. Appx. 539 (9th Cir. 2004), cert. denied, 124 S. Ct. 2918 (U.S. 2004); West's Key Number Digest, [Insurance 3376](#).

In insured's action against his automobile insurer to recover breach of contract and bad faith damages, court, applying Oklahoma law, affirmed judgment for insured awarding \$1,500 in breach of contract damages and \$3,000 compensatory and \$2,000,000 punitive damages for bad faith, where insured's automobile had been completely destroyed by fire while he was repairing it, after gasoline escaped, came into contact with hot engine and ignited; insured submitted claim for damage to vehicle, which was worth approximately \$1,500; and insurer rejected claim, on basis that insured had set fire, after perfunctory investigation that essentially assumed from beginning that fire was result of insured's arson. [Capstick v Allstate Ins. Co.](#) (1993, CA10 Okla) 998 F2d 810, 26 FR Serv 3d 425.

There was sufficient evidence to support award of punitive damages against insurer, and award of \$1,000,000 bore rational relationship to legitimate goals of punishment and deterrence, where it appeared that insurer had established pattern of accepting premium payments after expiration of contractual 31-day grace period, although insurer purported to consider policy terminated at that point. Evidence supported view that insurer intentionally accepted overdue payments with intent to deny coverage when claim was made. [Intercontinental Life Ins. Co. v Lindblom](#) (1992, Ala) 598 So 2d 886, cert den (US) 121 L Ed 2d 142, 113 S Ct 200.

Jury's award of \$3 million in punitive damages for insured, based on commercial property insurer's handling of claim for flooding of business premises, was excessive in violation of federal due process clause to the extent it exceeded \$500,000, even though insurer removed equipment insured needed to keep its business going and never replaced it, and insured's letters to insurer clearly explained that insured needed the money to survive, where insured's compensatory damages were only \$130,000, insurer's conduct did not cause physical harm and did not show a disregard for health or safety, and the evidence fell short of demonstrating that insurer's conduct constituted intentional malice; although evidence showed several discrete acts of misconduct involving insured's claim for coverage under various policy provisions, insurer's conduct ultimately involved only one insured and one claim. [U.S.C.A. Const.Amend. 14](#); West's [Ann.Cal.Civ.Code § 3294](#). [Amerigraphics, Inc. v. Mercury Cas. Co.](#), 182 Cal. App. 4th 1538, 2010 WL 1038675 (2d Dist. 2010).

Evidence was sufficient to support award of \$150,000 in punitive damages, which was two times the amount of general damages, to homeowners for homeowner's insurer's breach of duty of good faith and fair dealing, where insurer took nearly four months to send homeowners the \$23,224.66 amount it considered due for hurricane damage, insurer ignored two damages estimates, and insurer also ignored appraisal award of \$181,929.05. [LSA-R.S. 22:1220\(C\)](#). [Farber v. American Nat. Property & Cas. Co.](#), 999 So. 2d 328 (La. Ct. App. 3d Cir. 2008).

In insureds' action to recover from its homeowner's insurer for insurer's bad faith in denying claim for total fire loss of insureds' house on ground that insureds had set fire, judgment for insureds, including \$2,000,000 punitive damages award, was supportable, where insurer's entire investigation of fire was directed to establishing that insureds set fire, and insurer completely failed to pursue any evidence suggesting that this had not occurred. [State Farm Fire & Casualty Co. v Simmons](#) (1993, Tex App Beaumont) 857 SW2d 126.

Insurer breached its duty of good faith to insured, and court of appeals would reform trial court's judgment to award damages for insurer's breach, including \$115,000 in exemplary damages, where insured's home was accidentally burnt down, and chemist's report found no residues that suggested arson, but where insurer relied, without reasonable basis, on chemist's report to deny coverage, claiming insured set his home on fire. Insurer knew or should have known it had no reasonable basis to deny coverage based on chemist's report. Punitive damages were justified because insurer acted with conscious indifference to insured's rights by relying on chemist's report and arson investigator's report without comparing insured's



statements concerning the fire. [St. Paul Ins. Co. v Rakkar \(Tex App Dallas, 1992\) 838 SW2d 622.](#)

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**[END OF SUPPLEMENT]**

## **§ 12. Defense considerations**

[\[Cumulative Supplement\]](#)

It must be stressed that tort theories of recovery in first-party insurance cases, including punitive damages, are not available in all jurisdictions. Some states do not recognize tort theories, some states do not permit punitive damages in first-party insurance cases, and some states permit punitive damages recoveries only in particular circumstances.<sup>16</sup> In the area of uninsured motorists claims, some states hold that implied covenants of good faith and fair dealing do not apply, as the relationship is considered as adversarial.<sup>17</sup> There are significant variations among the states in this area, and the specific case law and statutory authority relevant to the forum jurisdiction must be consulted.

Where tort theories including punitive damages are available to an aggressive plaintiff, the defense of a full-featured bad-faith action is a multifaceted task. These cases are invariably fact-driven from the defense standpoint, and a complete itemization of defense strategies is beyond the scope of this article. The discussion here highlights only the general considerations pertinent to the task.

The front line of defense, if available, is to defeat the underlying policy claim. If there is no coverage, or if there is a policy defense to the claim—such as untimely or defective notice—an insurer will cut off any consideration of consequential or punitive damages by defeating the insured’s right to recover in contract. It is universally held that there can be no recovery in tort for bad faith, and therefore no recovery of punitive damages, unless there is a predicate right to recovery under the policy.<sup>18</sup> This requires the claimant to prove that the policy was in full force, that the loss was a covered occurrence, that the claimant is an insured or otherwise entitled to benefits under the policy, and that all conditions of the policy for payment—such as timely notice and proof of loss—have been met. If the insurer can defeat the claim on any of these foundational issues, the bad-faith case will collapse at the gate.

Even if the insurer ultimately loses on the contract issue, liability in tort leading to punitive damages may still be eliminated if the insurer can demonstrate a legitimate basis to debate the contract issue.<sup>19</sup> The key to this defense is that the basis to challenge liability under the contract must be legitimate; it must be based on truly disputed facts, or truly uncertain points of law. If an insurer continues to advance a theory in defense of the foundational contract issue that is untenable, the strategy may boomerang. The very fact of advancing the untenable defense may be considered further evidence of bad faith.

If a breach in the underlying contract has occurred, an insurer may cut off consequential and punitive damages by demonstrating that the breach was the result of an “honest mistake” in its handling of the claim.<sup>20</sup> Admittedly, there is a fine line between tortious indifference and an honest mistake. If the circumstances are egregious, the contention of good faith may have a hollow ring. This strategy, too, may backfire if it is demonstrated that the claimed honest mistake was the result of an inadequate investigation, violation of company procedures in the administration of the claim, or other obvious and preventable failing. Nevertheless, it has been held that an insurer is not liable in punitive damages for failure to pay claims based on honest mistakes.

If it develops that the policy has been breached and the front-line defenses are not available, the focus of the defense must be on damage control. The objective is to confine the damages to the policy, and to exclude consequential and punitive damages if possible. It is essential that the defenses advanced not make a bad situation worse. This generally means that an insurer must choose among the possible defense strategies; it may not continue to advance alternative but inconsistent defenses, for the inconsistencies may be thrown back at it as an example of continued bad faith. Defense counsel should exercise care from the outset in determining the defenses to include in the initial pleading. The defense tactic of filing a “kitchen sink” answer, loaded with every conceivable defense, is a risky practice. Even though inapplicable theories may be abandoned along the way, any excess baggage in the initial pleading may return to haunt the insurer upon plaintiff’s contention that it is a further indication of bad-faith stonewalling.

Theoretically, it is possible for a principal or corporate employer to avoid a punitive damage claim by arguing that it neither ratified nor authorized the allegedly wrongful conduct of its employee. The vicarious liability of the principal or employer

will depend on local law. Where the potential for punitive damages exposure involves only the actions of a field claims agent, the company may distance itself from the conduct of its employee. When attempting to dissociate the employer from the misconduct of the employees involved in disposing of the claim, the issue is whether such individuals are “managerial personnel” so that their acts within their scope of employment or authority are attributed to the corporate employer for purposes of imposing liability for punitive damages on the employer.<sup>21</sup>

However, this defense is difficult to sustain in practice, for if the company does contend that its line adjuster was off on his or her own, the plaintiff may then argue that the company’s management was still culpable for not adequately supervising the line adjuster, or not having policies and procedures in place to prevent the misconduct.

Where the claim is founded in both contract and tort, the statutes of limitation may be prominent, since the time framework may vary. In most jurisdictions, the statute of limitations for tort claims is shorter than that allowed for contract actions. An ill-timed complaint may be allowed on the contract counts but barred on the tort claims and punitive damages aspects.

The defense may eliminate or reduce exposure to consequential and punitive damages by showing that the insured was guilty of bad faith—or at least an absence of good faith—in any element of the claim. It has been held that the measure of bad-faith damages arises out of what are equitable principles derivative of the contractual relationship, calling for good faith and fair dealing on the part of both parties. Other cases appear to accept a defense of comparative bad faith, which operates as a set-off to any recovery against the insurer.<sup>22</sup>

The last-ditch defense is to plead poverty. Inasmuch as the wealth of the insurer is one criterion for the amount of punitive damages allowable (see § 11), the defendant’s lack of financial resources may be shown as a matter in mitigation of the award.<sup>23</sup>

A particularly pesky feature of the defense of a bad-faith case is in the area of settlement strategies. In a bad-faith case, settlement overtures, frequently even those made after the bad-faith litigation is instituted, may be admissible in evidence. In some states, the insurer’s duty of good faith and fair dealing continues, with respect to its obligations under the policy, even after a lawsuit for nonpayment has been instituted.<sup>24</sup> Since the gravamen of a bad-faith claim is in the process, and settlement overtures are an inherent part of the process, counsel may not rely on the general rule of evidence that statements made in connection with settlement are inadmissible.<sup>25</sup> This means that counsel must proceed cautiously in any statements made or position taken in settlement negotiations—at least with respect to statements made or positions taken as to the company’s liability under the policy. Any overreach by counsel may well be offered at trial as further evidence of the insurer’s insouciance.

An alternative tactic to consider, in the event it is determined that there are not valid defenses to the foundational contract issues, is to immediately and unconditionally pay over the amount of policy benefits due—with interest and without quibble. Counsel may wish to concede the contract issues completely, and focus the case only on the tort and punitive damages aspect. If this is done at the outset of the bad-faith litigation, it will lend some credence to a good-faith argument, and may well deflate the punitive damages exposure considerably.

In all events, defense counsel must concentrate on the distinction between the concepts of liability under the policy, liability for consequential damages flowing from a simple breach of duty in tort, and the excesses that must be shown to justify imposition of punitive damages. While adroit plaintiff’s counsel will endeavor to blur the distinction in the eyes of the jury, it must be emphasized that a mere breach of contract, or even a breach of duty in tort, does not ipso facto entitle the insured to punitive damages. Rather, to justify an award of punitive damages there must be an additional showing meeting the criteria for such damages in the forum jurisdiction (that is, outrageous conduct, extreme deviation, harmful state of mind, malice, and the like; see § 8). Clear separation of these concepts is vital to sustain a separate and distinct attack on each component.<sup>26</sup>

## CUMULATIVE SUPPLEMENT

### Cases:

**Constitutional limitations on punitive damage awards:** Factors court considers in determining whether punitive damage award against tortfeasor is grossly disproportional to gravity of offense, and thus violative of due process, are: (1) degree of defendant’s reprehensibility or culpability; (2) relationship between penalty and harm to victim caused by defendant’s actions; and (3) sanctions imposed in other cases for comparable misconduct. [U.S.C.A. Const.Amend. 8, 14](#). [Cooper Industries, Inc. v. Leatherman Tool Group, Inc.](#), 532 U.S. 424, 121 S. Ct. 1678, 149 L. Ed. 2d 674 (2001); West’s Key Number Digest, [Constitutional Law](#) 303.



**Insurer had an arguable basis** for denying insureds' claim under homeowners policy for the destruction of their home during hurricane on the grounds that home was destroyed by water, rather than wind, and thus excluded from coverage under the policy, and, thus, under Mississippi law punitive damages instruction was not warranted on grounds that insurer acted in bad faith in denying claim; insurer's claims adjuster who recommended denying the claim examined the position of the home seaward of the debris line and the condition of trees on and around the insureds' property and concluded that the damage to the trees was more consistent with flooding than with tornadic winds. [Broussard v. State Farm Fire and Cas. Co.](#), 523 F.3d 618 (5th Cir. 2008); West's Key Number Digest, [Insurance 3376](#).

**Defense expert testimony—five qualifications:** Under California law, expert testimony does not automatically insulate insurers from bad faith claims based on biased investigations under genuine dispute rule; biased investigation claims may present jury questions when, for example: (1) the insurer is guilty of misrepresenting the nature of the investigatory proceedings, (2) the insurer's employees lie during the depositions or to the insured; (3) the insurer dishonestly selects its experts; (4) the insurer's experts are unreasonable; and (5) the insurer fails to conduct a thorough investigation. [Guebara v. Allstate Ins. Co.](#), 237 F.3d 987 (9th Cir. 2001); West's Key Number Digest, [Evidence 571\(1\)](#).

**ERISA preemption:** Tort of bad faith refusal to pay insurance claims under Alabama law did not regulate insurance, and therefore, savings clause of ERISA did not apply to preclude preemption of ERISA plan participant's claim against disability insurer alleging bad faith refusal to pay disability claim. Employee Retirement Income Security Act of 1974, § 514(a), (b)(2)(A), 29 U.S.C.A. § 1144(a), (b)(2)(A); Ala.Code 1975, § 27-12-24. [Walker v. Southern Co. Services, Inc.](#), 279 F.3d 1289 (11th Cir. 2002), reh'g and reh'g en banc denied, 34 Fed. Appx. 393 (11th Cir. 2002) and cert. denied, 123 S. Ct. 111 (U.S. 2002); West's Key Number Digest, [Insurance 1117\(4\)](#).

**ERISA preemption of insureds' bad faith claims:** Alabama statute governing insurers' bad-faith refusal to pay or settle claims did not "regulate insurance" within meaning of ERISA savings clause; statute had its roots in general principles of tort and contract law rather than developing specific scheme to govern insurance, did not effect spreading or transfer of policyholder risk, and did not define terms of insurer-insured relationship but only declared that breach of insurance contract may in certain circumstances allow for punitive damages; abrogating [Hill v. Blue Cross Blue Shield of Alabama](#), 117 F.Supp. 2d 1209. Employee Retirement Income Security Act of 1974, § 514(a), (b)(2)(A), 29 U.S.C.A. § 1144(a), (b)(2)(A); Code 1975, § 27-12-24. [Gilbert v. Alta Health & Life Ins. Co.](#), 276 F.3d 1292 (11th Cir. 2001); West's Key Number Digest, [States 18.41](#).

**Reliance on independent adjuster:** Insurer did not recklessly or intentionally fail to properly investigate claim under homeowner's policy by allegedly not beginning investigation until after insured filed suit for damages due to Hurricane Katrina, as required for extraordinary bad faith investigation of claim, under Alabama law, where insurer relied on independent insurance adjuster's investigation which was completed prior to both insurer's denial of claim and insured's initiation of suit, and insured failed to articulate how laundry list of perceived imperfections and anomalies of insurer's handling of claim constituted bad faith investigation. [Preis v. Lexington Ins. Co.](#), 508 F. Supp. 2d 1061 (S.D. Ala. 2007); West's Key Number Digest, [Insurance 3361](#).

Insurer's refusal to offer payment for underinsured motorist (UIM) claim was made in good faith, precluding insured's claim for punitive damages under Indiana law. [Balzer v. American Family Ins. Co.](#), 805 F. Supp. 2d 618 (N.D. Ind. 2011).

In insureds' action to recover breach of contract and punitive damages from their homeowner's insurer for insurer's failure to determine whether insureds' claim for fire loss to premises would be honored, court, applying Indiana law, granted insurer's summary judgment motion with respect to punitive damages claim. Under Indiana law, insureds were required, in order to establish entitlement to punitive damages, insurer's commission of conduct amounting to independent tort; establishing insurer's commission of conduct that was essentially tortious was insufficient to constitute predicate for punitive damages. Insureds did not establish independent tort, where (1) insureds asserted that insurer's year-long delay in deciding whether to pay claim was intended to cause insureds to lose right to sue insurer, as policy contained one-year litigation limitation provision, but insurer had unilaterally granted 90-day extension of contractual provision; (2) insureds had declined, for extended period of time, to provide insurer with requested financial information; (3) insurer did not deceive insureds, as insurer acknowledged at early point in investigation that insurer was concerned that fire was result of arson; and (4) insureds had not been prejudiced by insurer's delay. [Gray v. American Family Mut. Ins. Co.](#) (1993, SD Ind) 825 F Supp 203.

There was no evidence that insurer of pickup truck acted outrageously, with an evil motive, or with reckless indifference to driver's rights by delaying its offer of the policy limit amount to driver whose vehicle was hit by trailer attached to pickup truck, so as to justify an award of punitive damages, as required to support driver's claim against insurer under Kentucky Unfair Claims Settlement Practices Act (KUCSPA), alleging that insurer acted in bad faith by failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim in which liability had become reasonably clear. [KRS 304.12-230\(6\)](#). [Scott v. Deerbrook Ins. Co.](#), 714 F. Supp. 2d 670, 82 Fed. R. Evid. Serv. 795 (E.D. Ky. 2010).

**Good faith basis for arson investigation:** Insureds under homeowners policy failed to establish that insurer breached implied covenant of good faith and fair dealing in its handling and investigation of fire claim; evidence showed that fire at insured house was caused by arson, and thus insurer had a good faith basis for conducting investigation of claim in order to

determine whether insureds had a motive to commit the arson. [Yerardi v. Pacific Indem. Co.](#), 436 F. Supp. 2d 223 (D. Mass. 2006); West's Key Number Digest, [Insurance 3361](#).

Punitive damages are not available where a defendant acted in good faith reliance on the reasonable but erroneous advice of counsel. This is so because the malice necessary to support a punitive damages claim requires intentional conduct or a willful and conscious disregard of the plaintiff's rights, and those states of mind are inconsistent with conduct pursued in good faith reliance on an attorney's reasonable advice that the conduct is lawful. [Greenwood & Co. Real Estate v C-D Investment Co.](#) (1993, 2nd Dist) 12 Cal App 4th 1459, 93 CDOS 873, 93 Daily Journal DAR 1786, mod, reh den (Cal App 2nd Dist) 93 Daily Journal DAR 2759.

**Claim preclusion:** Treating evidence of insured's bad faith claims against her automobile insurer and her underinsured motorist (UIM) benefits claim as a unit conformed to parties' expectations, such that claim preclusion barred insured's bad faith claim filed after she obtained judgment in UIM case; when insured was informed that insurer refused to arbitrate UIM claim, she knew facts necessary for bringing bad faith claims, and, thus, it was reasonable to expect insured to amend her UIM benefits claim to include any bad faith claims. [Restatement \(Second\) of Judgments § 24](#). [Salazar v. State Farm Mut. Auto. Ins. Co.](#), 148 P.3d 278 (Colo. Ct. App. 2006), as modified on denial of reh'g, (Aug. 17, 2006) and cert. denied, 2006 WL 3479331 (Colo. 2006); West's Key Number Digest, [Insurance 3557](#).

In case of alleged breach of insurance contract and bad faith by disability insurer, arising from insurer's refusal to pay disability benefits to insured who became psychiatrically disabled only days after inception of coverage, jury award of \$209,000 for breach of contract and \$915,000 for bad faith was reversed where trial court made numerous errors. In particular, trial court erred in excluding "other acts" evidence proffered by insurer to effect that insured had made false representations on other applications for insurance, where that evidence was offered to show insured's plan to defraud, intent, and absence of mistake. Trial court also erred in admitting under residual exception to hearsay rule unverified documents from Egyptian businessman evidence purporting to document insured's income, which was otherwise unproven, particularly where insured's only other evidence of his income was his copies of his tax returns, which bore irregular date stamps, and where insured had withdrawn authorization for insurer to acquire IRS records. Trial court also erred in permitting cross-examination of insurer's expert concerning other case, while at same time allowing expert to refuse to answer, where expert was under court order not to reveal information concerning that case as to matters under protective order; under circumstances, permitting cross-examination was tantamount to permitting expert to be harassed. [Abdelsamed v New York Life Ins. Co.](#) (1992, Colo App) 857 P2d 421.

Resort to judicial forum is not per se bad faith or unfair dealing on part of insurer regardless of outcome of suit. Rather, insurer may challenge claims that are fairly debatable and it will be found to have acted in bad faith only if it has intentionally denied or failed to process or pay claim without reasonable basis. The burden is on the insured to establish insurer's knowledge or reckless disregard of a claim's validity. In the instant case evidence in the form of expert opinions that the insurer had virtually no chance to prevail in its appeal of an administrative award was insufficient to prove that the insurer engaged either knowingly or unknowingly in unreasonable conduct, and was thus insufficient as a matter of law to support the jury award for bad faith. [Brandon v Sterling Colorado Beef Co.](#) (1991, Colo App) 827 P2d 559.

If the insurer had an arguable basis on which to deny the claim, the insured's bad faith cause of action fails as a matter of law regardless of the manner in which an investigation was or was not conducted. [LeRette v. American Medical Sec., Inc.](#), 270 Neb. 545, 705 N.W.2d 41 (2005); West's Key Number Digest, [Insurance 3336](#).

**Comparative negligence** by the insured does not conclusively defeat a claim for bad faith; rather, it is a factor that may give rise to a reasonable basis to deny benefits. [Skaling v. Aetna Ins. Co.](#), 799 A.2d 997 (R.I. 2002); West's Key Number Digest, [Insurance 3339](#).

**After acquired evidence:** Evidence that the insured had consumed several alcoholic beverages before he attempted to rescue car passenger after fall from railroad bridge was irrelevant and inadmissible in insured's suit alleging bad faith failure to pay underinsured motorist (UIM) benefits; the insurer acquired the information well after it denied claim and thus could not rely on it to show that the claim was fairly debatable. [Skaling v. Aetna Ins. Co.](#), 799 A.2d 997 (R.I. 2002); West's Key Number Digest, [Insurance 3381\(4\)](#).

**An insurer's reliance on an expert report**, standing alone, will not necessarily shield the insurer from liability for bad faith, if there is evidence that the report was not objectively prepared or the insurer's reliance on the report was unreasonable. [State Farm Lloyds v. Hamilton](#), 265 S.W.3d 725 (Tex. App. Dallas 2008), rule 53.7(f) motion granted, (Nov. 3, 2008); West's Key Number Digest, [Insurance 3335](#).

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[END OF SUPPLEMENT]

### C. Discovery Considerations

#### § 13. Necessity of proof outside immediate resources of client

[\[Cumulative Supplement\]](#)

Once it is determined from the overview analysis suggested in the preceding discussion (see §§ [4](#) – [11](#)) that the circumstances may warrant punitive damages, the next step is the assembly of evidence to prove the point. While in the general case, evidence within reach of the client may be sufficient to establish the predicate breach, this evidence is seldom sufficient to establish punitive damages. Direct proof of indifference, callous disregard, or even willful misconduct is not required to prove a straight breach of contract in the first instance, and may often be inferred in measuring simple absence of good faith in tort.

Investigation into the existence of bad faith, necessary to sustain punitive damages, and however measured or defined, requires inquiry into the specific actions and reactions of the defendant insurer, and into the specific conduct of the individuals responsible for the administration of plaintiff's underlying claim. Proving the predicate breach may only require proof of what happened; proving entitlement to punitive damages requires evidence of why. This proof is seldom within the immediate resources or knowledge of the client, and must be found within the files of the defendant and from the testimony of defendant's employees for later analysis by expert witnesses.<sup>[27](#)</sup>

### CUMULATIVE SUPPLEMENT

#### Cases:

A substantial punitive damages award against a health insurer was sustained as not violative of due process where the insurer's conduct was particularly egregious and a smaller award would have had little deterrent effect against a corporation of insurer's size. In so ruling the appellate court took notice of a smaller punitive damages award against the same insurer that had been entered in an unrelated case involving similar conduct on the part of the insurer. [Eichenseer v Reserve Life Ins. Co.](#) (1991, CA5 Miss) 934 F2d 1377.

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[END OF SUPPLEMENT]

#### § 14. Assembling documentary evidence from insurer

[\[Cumulative Supplement\]](#)

It is essential that the plaintiff secure for examination the entire claims file pertaining to the claim and the underwriting file pertaining to the policy, as well as any other documents bearing on the insurer's conduct in handling the claim. These should be obtained at the earliest possible moment in the litigation. If permitted by local rule, the discovery requests should be served on the defendant with the complaint.<sup>[28](#)</sup>

#### Claims file

It is important that the insurer and defense counsel be placed on notice at the outset that the entire claims file is subject to discovery, including all the handwritten notes, telephone slips, miscellaneous writings, and loose papers, without any opportunity to purge the files in any way. Plaintiff's attorney should insist that all parts of the claims files are produced, wherever located. Some insurance companies maintain a duplicate file at the home office, which may contain additional notations concerning the internal handling of the claim which are not always revealed in the field office or line adjuster's file. The home office file may contain management-level memoranda directing the policy or tactics to be employed, management's evaluation of exposure, reports to reinsurers, information pertaining to loss reserves, and correspondence with counsel.

The line adjuster's file may contain all that is necessary to establish the predicate breach, but the home office file may reveal the "smoking pistol" to the punitive damage claim. For example, in the case presented in the model proof (see §§ 31–63), a senior vice president penned a note on the bottom of a field office claims report to the company secretary: "Where do we get these insureds? Lets pull out all the stops on this one." While a copy of the report itself was in the field office file, the executive's memo was contained only on the copy in the home office duplicate. "Pulling out all the stops" was proved to mean "take all tactics necessary to drive the claim down," and this memo became the centerpiece of plaintiff's argument for punitive damages.

The critical part of any claims file is the daily log or chronological notations of activity. These notes, often in longhand, will detail all of the activity on the file at each step as the claim progresses. While these are usually maintained as part of the file, either written on the file jacket or on separate sheets within the file, in some situations they might be maintained separately, by each individual, in separate diaries. If the claims file offered for inspection does not include a daily log or chronological notations of this type, counsel should immediately press for the identification and production of any individual diaries or records.

#### **Other documents in insurer's possession**

In addition to the claims files, the following additional documents should be requested from the defendant insurer in early discovery:

- The company claims manual and all policy guidelines and memoranda governing administration of claims.
- All training materials required or available to adjusters and claims supervisors.
- The minutes or records of any claims committee action on the subject claim.
- Correspondence and reports to and from reinsurers pertaining to the claim, if not included in the claims file.
- Documentation on the loss reserves maintained throughout the processing of the underlying claim, if not included in the claims file.
- Identification of other bad-faith claims that have been filed against the company.
- Advertising or promotional material utilized in marketing policies which make representations concerning the manner in which claims will be handled.

Claims manuals and policy guidelines are obviously valuable to establish the company's position on how the claim should have been handled. Training materials may be especially revealing. Again, this is aptly illustrated by the case presented in the model proof, in which the insurer promulgated a directive that all line adjusters were required to work through a series of tape cassettes on negotiating techniques. After requiring production of these training materials, plaintiff's counsel discovered that one of the lessons included in the series was titled "The Vise Technique: How to Squeeze People," and another was titled "Manipulate Time to Your Advantage: Bring Time Pressure on the Other Side." These two lesson titles figured prominently in the presentation of the punitive damage aspects of the case.

#### **CUMULATIVE SUPPLEMENT**

##### **Cases:**

**Ownership of insurance claim files:** Genuine issues of material fact as to whether automobile insurer breached its fiduciary duty to insureds and acted with evil motive and reckless indifference by refusing to provide insureds with unrestricted access to their claims file following automobile accident precluded summary judgment on issue of whether insureds were entitled to

punitive damages, in insureds' declaratory judgment action against insurer seeking contents of insurance claims file; Missouri Supreme Court made it clear in action that the insurance claims file belonged to the insureds, and despite such decision insurer subsequently still refused to release to insureds copies of certain file documents. [Grewell v. State Farm Mut. Auto. Ins. Co.](#), 162 S.W.3d 503 (Mo. Ct. App. W.D. 2005); West's Key Number Digest, [Judgment 181\(23\)](#).

In an action for bad faith against an insurer, the general procedure involved with discovery of documents contained in an insurer's litigation or claim file is as follows: (1) the party seeking the documents must do so in accordance with the reasonable particularity requirement; (2) if the responding party asserts a privilege to any of the specific documents requested, the responding party shall file a privilege log that identifies the document for which a privilege is claimed by name, date, custodian, source and the basis for the claim of privilege; (3) the privilege log should be provided to the requesting party and the trial court; and (4) if the party seeking documents for which a privilege is claimed files a motion to compel, or the responding party files a motion for a protective order, the trial court must hold an in camera proceeding and make an independent determination of the status of each communication the responding party seeks to shield from discovery. Rules Civ.Proc., Rule 34(b). [State of West Virginia ex rel. Allstate Ins. Co. v. Madden](#), 601 S.E.2d 25 (W. Va. 2004); West's Key Number Digest, [Pretrial Procedure 403](#).

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**[END OF SUPPLEMENT]**

## **§ 15. Assembling documentary evidence from insurer—Examination of documents**

[\[Cumulative Supplement\]](#)

It is impossible to catalog all of the useful evidence of bad faith giving rise to punitive damages that might be revealed from the documents discovered from the insurer. The examples presented in the following discussion, which are pertinent to the sample case presented in the model proof, are illustrative only. In any event, it is important that all of the core documents be examined, analyzed, and thoroughly understood before any depositions of company employees are scheduled. When the depositions are taken after the necessary analysis, they can then be utilized to fasten down the company's explanation on every item of relevant material discovered. This, then, can be factored in to the expert witness's analysis and testimony which will be offered to connect the ends together.<sup>29</sup>

**Inordinate, unexplained, and repeated delays in responding to communications** from the insured, as revealed in telephone logs or message slips, chronological notes to the file, interoffice and home office memoranda, and correspondence to and from the insured. A week to return a phone call, or a month to reply to a letter, with no file indication of activity in the interim, is persuasive indication of foot-dragging.

**Requests for additional information** from the insured, with no indication that anything was done with the material supplied. When an insurer is pressed for a decision on a claim it wishes to delay, a tactic that is sometimes employed is to counter with continual demands for further information. An indication that this tactic is being employed is the absence of any evidence that any analysis or examination of this additional information was ever performed. In the sample case presented in the model proof, the insurer stalled the insured for over two years with repeated requests for additional medical reports. When the claims file was disclosed, it revealed that the claims supervisor did nothing with the information received; there was no indication that the medical reports had been referred to a consulting physician for review, or even discussed with the home office. The claims supervisor admitted during deposition that he had not even read some of the reports.

**"Stair-stepping" reserves.** Insurance companies are required to establish loss reserves as soon as practicable after a claim is presented. The reserves are expected to be an accurate estimate of the company's exposure under each claim; they are an essential index of the financial stability of the company, and are regularly subject to audit by the regulatory agencies of the states involved. If the file indicates that these reserves are being "stair-stepped" up as events unfold, this may indicate inadequate investigation and evaluation. Unless an increase in reserves is based on new information, it is an indication that the company may be reacting to its inability to pick the claim off cheaply, rather than a reasoned evaluation after adequate investigation.

**Settlement offers that are significantly lower than the reserve established for the claim.** In first-party coverage, the insurer is obligated to fairly evaluate and promptly pay the amount justly due. Generally, this should approximate the amount of the loss reserve established. If the company's settlement offers are substantially below this reserve figure, it is an indication that the company is consciously attempting to avoid its obligation. However, if measurement of the insurers' duty is under third-party claims standards, the strategy of "reserve salvage," or starting with a low offer and moving up only when

forced, may be an acceptable practice.

**Settlement offers that are significantly below the authority granted.** Again, there is a difference in the significance of this tactic between third-party claim standards and first-party claims. The difficulties of negotiating a third-party claim with an adverse insurance company, and trying to figure out what the adjuster's actual authority is and how much play there might be from the last offer are well understood by seasoned plaintiffs' counsel. In a first-party claim, however, the insurer is duty bound to lay its cards on the table; if the company has authorized payment at a given level, there is good argument that the claims representative should convey that offer to the policyholder. While he or she may be excused for withholding a minimal amount, to be able to cement a settlement with a minor concession if necessary, withholding a significant amount from the authorized figure in communicating an offer to the insured is an indication of unfair practice.

**Correspondence and reports from the writing company to its reinsurers** may be particularly revealing. In the sample case presented in the model proof, the insurer was stair-stepping its reserves, which had been maintained well below the figure recommended by the line adjuster. (The claims supervisor and home office overruled him.) The adjustments were clearly in reaction to unsuccessful attempts to obtain a low settlement, and not in response to any new information. However, a company officer reported to its reinsurer that the increases were occasioned by the receipt of new information on the extent of the loss, which was false. The company officer was obliged to admit the deception at trial, which demolished his credibility and had a devastating effect on the defense case before the jury.

**Awareness of insured's special circumstances.** The claims file should be scrutinized for indications that the company was aware of any financial distress or special disadvantage being experienced by the insured during the delay. Proof of the predicate claim for consequential damages and as an element of the foundation for punitive damages is considerably stronger if the plaintiff can demonstrate actual knowledge of the developing harm, rather than relying on the circumstantial argument of what the company should have known. Especially important in this area are any notations made to the file by company personnel regarding this information indicating indifference or disregard toward the plight of the insured. In the sample case presented in the model proof, the line adjuster wrote in a status report to his supervisor that the insured was experiencing severe financial pressure, and may be nearing bankruptcy. The supervisor replied that since the insured was now in desperate straits, perhaps he was ready "to get on with his life" and accept a low-ball offer that had already been rejected. As is illustrated in the model proof, the plaintiff's expert witnesses considered this knowledge of the plight of its insured, and the response of the claims supervisor, to be significant in measuring the egregiousness of the circumstances.

In developing these lines of proof, what is not contained in the claims file and other documents may be as significant as what is. The absence of internal memoranda and reports from the line people to supervisors and home office executives, the absence of directives from the home office to the field, and the absence of any indication of investigation, damage calculations, or review of information submitted by the insured may be of considerable significance.

## CUMULATIVE SUPPLEMENT

### Cases:

**E-mails from insurer to insurer's managing agent**, which expressed frustration with insured's failure to cooperate on loss control and suggested "getting stubborn" and "tough" about paying certain high value fiberboard drum shipments, were probative of whether agent breached alleged fiduciary duty to insured by following insurer's instructions, if insured demonstrated that agent owed fiduciary duty to insured, in insurer's action for declaration that it properly denied insured pharmaceutical manufacturer's claims for coverage under transit insurance policy. [Fed.Rules Evid.Rules 401-403](#), 28 U.S.C.A. [American Home Assur. Co. v. Merck & Co., Inc.](#), 462 F. Supp. 2d 435 (S.D. N.Y. 2006); West's Key Number Digest, [Insurance 1673](#).

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**[END OF SUPPLEMENT]**

## § 16. Overcoming insurer's resistance to production

[\[Cumulative Supplement\]](#)



Despite the argument that the claims file, or portions thereof, are privileged material assembled in contemplation of litigation, it is becoming widely accepted that the entire claims file of an insurer is subject to discovery in a first-party, bad-faith claim.<sup>30</sup> The gravamen of a bad-faith claim is the process, and the proof of the process is particularly within the claims file.

Most states that permit discovery of the claims file will do so up to the point where the claim is denied or the bad-faith litigation is initiated. The rationale is that from that point forward, the parties are clearly adverse; additional information in the file is, in fact, in contemplation of litigation, and the privilege should therefore apply thereafter.<sup>31</sup> Even in states where the claims file is still considered presumptively privileged, the courts will permit discovery upon a showing of substantial need and undue hardship, under standards similar to [Federal Rule of Civil Procedure 26\(b\)\(3\)](#).<sup>32</sup>

## CUMULATIVE SUPPLEMENT

### Cases:

**Work product protection:** Handwritten note by employee of insurer which requested opinion from counsel on possible bad faith claim by insured qualified for work product protection, although it did not fall within attorney-client privilege, in insured's bad faith action against workers' compensation insurer; insured made bad faith an issue before note was written, therefore handwritten note could fairly be said to have been prepared by insurer in anticipation of litigation. [Fed.Rules Civ.Proc.Rule 26\(b\)\(3\)](#), 28 U.S.C.A. [Brennan v. Western Nat. Mut. Ins. Co.](#), 199 F.R.D. 660, 49 Fed. R. Serv. 3d 604 (D.S.D. 2001); West's Key Number Digest, [Witnesses](#) 204(2).

Trial court properly exercised its discretion in striking answer of defendant insurer in bad-faith action by insured arising from handling of claim on totaled automobile, and in entering default as to liability, where insurer repeatedly failed to comply with court's order to produce entire claim file, twice promising to produce form which it ultimately admitted never existed. [Viking Ins. Co. v. Jester](#) (1992) 310 Ark 317, 836 SW2d 371.

**Regular course of business vs litigation preparation:** Payment or rejection of claims is a part of the regular business of an insurance company and, consequently, reports which aid it in the process of deciding which of the two indicated actions to pursue are made in the regular course of its business, and reports prepared by insurance investigators, adjusters, or attorneys before the decision is made to pay or reject a claim are not privileged and are discoverable, even when those reports are "mixed/multi-purpose" reports, motivated in part by the potential for litigation with the insured. [McKinney's CPLR 3101\(d\)](#). [Bombard v. Amica Mut. Ins. Co.](#), 11 A.D.3d 647, 783 N.Y.S.2d 85 (App. Div. 2d Dep't 2004); West's Key Number Digest, [Pretrial Procedure](#) 381.

**Evidence that insurer's employees attempted to "minimize paper":** Finding that actions of insurer in failing to pay insured's claim for 297 cattle that died in winter storms were "vexatious and without reasonable cause," for purposes of statute allowing for attorney fees in actions against an insurer for failing to pay a claim, was not clearly erroneous; taped telephone conversation between insurer's employees included attempts to undervalue insured's losses, discussions of how to make insured appear fraudulent, and concerns about need to "minimize paper" in case of discovery, and evidence also showed that insured failed to conduct a good faith investigation and evaluation of claims. [SDCL 58-12-3](#). [Sawyer v. Farm Bureau Mut. Ins. Co.](#), 2000 SD 144, 619 N.W.2d 644 (S.D. 2000); West's Key Number Digest, [Insurance](#) 3381(5).

Where insureds sued an insurer for bad-faith handling of a claim, and the insurer was ordered by the court to permit discovery of the performance evaluation of employees who had allegedly participated in the company's handling of the claim, the employees whose records were to be produced had standing to seek relief from the order by filing a writ of mandamus on the basis of a constitutional right to privacy, because the terms "party," "a party to discovery," and "any person against or from whom discovery is sought," in [Texas RCP 166b\(4\), \(5\)](#), which permits objections to, and protective orders against, discovery, are broad enough to include such employees even though they are not parties to the underlying suit. [Kessell v. Bridewell](#) (1994, Tex App Waco) 872 SW2d 837.

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**[END OF SUPPLEMENT]**

## § 17. Overcoming insurer's resistance to production—Claim of attorney-client privilege

### [Cumulative Supplement]

If an outside attorney has been retained by the insurer, a special case may exist with respect to the discoverability of correspondence and communications between the attorney and insurer. If the attorney has been retained for legal consultation, the communications are generally considered privileged. However, if the outside counsel has been retained in advance of the bad-faith litigation for the purpose of evaluating or investigating the underlying case, and has provided that evaluation, there is a good argument that this communication is not within the privilege. The basis for argument would be that the attorney is not acting as counsel, but is functioning as an adjuster or investigator, which is a duty the company owes to its insured.<sup>33</sup>

In the sample case presented in the model proof, the company retained outside counsel to evaluate the underlying case. Outside counsel then retained an economist to examine the wage loss claims of the insured. The economist's conclusions were reported orally to the outside counsel, and by counsel to the company. In response to discovery, the company contended that it had no written reports and therefore no documents to produce; that the oral report on the consultant's conclusions from its counsel was privileged; and that counsel would not be required to divulge the information, since the consultant was a nontestifying expert, thus immune from discovery under the state's equivalent to [Federal Rule of Civil Procedure 26\(b\)\(4\) \(B\)](#). However, the court ruled that the expert had been retained in connection with the obligatory evaluation of the underlying claim and not in anticipation of the bad-faith litigation, and thus the discovery exclusion did not apply; that the company was obligated to disclose the expert's conclusions, regardless of how communicated to the company, as part of its duty to deal fairly with its insured; and finally, that the company could not shield the evidence from discovery by filtering it through its counsel under the guise of attorney-client privilege.

The point is not to accept too readily a defense contention that communications with counsel are privileged. If the defense counsel was involved in the evaluation process of the underlying claim before the bad-faith litigation was initiated, there may well be information in the communications which is not shielded by privilege. The scope and limitations on attorney-client privilege vary somewhat from state to state, and the specific rules applicable to the jurisdiction must be consulted. If a question still exists, counsel may generally be able to obtain an in camera inspection by the court.

## CUMULATIVE SUPPLEMENT

### Cases:

Client may implicitly waive the attorney-client privilege by putting "in issue" an attorney's advice. [Harter v. University of Indianapolis](#), 5 F. Supp. 2d 657, 127 Ed. Law Rep. 827 (S.D. Ind. 1998).

Internal insurance company memoranda were not protected work product since it was apparent that insurer's actions leading to generation of documents involved only preliminary activities in anticipation of receiving claim of loss from plaintiff; insurer was only initiating process, undoubtedly followed in other cases, of determining whether it had provided coverage for loss set forth in plaintiff's proof of loss which it anticipated receiving shortly. [Video Warehouse v Boston Old Colony Ins. Co.](#) (1994, SD W Va) 160 FRD 83.

The general rule governing discovery in third-party bad-faith actions against insurance companies applied, and the insurer owed a fiduciary duty to the insured, where the rule requires the production of documents over the objection of the insurer that the work is protected by the attorney-client privilege and rules governing work product, but the insurer contended that the rule did not apply since its relationship with the insured was adversarial from the time the claim was first made, because the issue of coverage was resolved in favor of the insured, and once coverage was determined to exist, the fiduciary obligation existed from the time the insurer received notice of the claim. [General Accident Fire & Life Ins. Corp. v Boudreau](#) (1994, Fla App D5) 658 So 2d 1006, 19 FLW D 1843, review den (Fla) 650 So 2d 989.

In action by insured alleging insurer breached a contract and acted in bad faith by failing to defend insured and refusing to pay \$50,000 toward a settlement and court costs in suit that insured was named as a defendant, court did not err in compelling insurer to release to insured all letters of opinion from insurer's counsel to insurer concerning the insurance coverage provided to the insured, where such opinions were not intended to be confidential because the insurer waived any attorney-client privilege when it reported part of the contents of their counsel's opinion to the insured in a letter, and therefore the entire communication made by the insured's counsel is discoverable. [Mid-American Nat. Bank & Trust Co. v Cincinnati Ins. Co.](#) (Wood Co) 74 Ohio App 3d 481, 599 NE2d 699.



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**[END OF SUPPLEMENT]**

### **§ 18. Regulatory agency documents**

The state regulatory agency may have records of complaints and investigation into claims practices, and where state law includes provisions drawn from the Model Unfair Claims Practices Act, records of past violations and administrative sanctions imposed. State laws vary as to public access to these records, but inquiry should be made where access is available. If resources are not limited, inquiry may be made to all states in which the defendant company is qualified to do business.

As a practical matter, the emphasis of state regulatory agencies is on the solvency and financial stability of the insurers operating within the state rather than with policyholder grievances. The utility of information gleaned from agency files may be limited, unless evidence of a clear course of conduct is revealed. Isolated grievances will generally be of no real help in developing the case, other than the solace of suspicions confirmed, but may become relevant for impeachment if a defense witness opens the door (see [§ 19](#)).

The state regulatory agency will also have the audit reports on the financial stature of the company—its earnings and net worth—which is relevant for the assessment of punitive damages.

### **§ 19. Use of written interrogatories**

The essential proof in a bad-faith case will generally come from the documents obtained through requests for production of documents, and the inability of company witnesses to explain or justify actions taken. On the punitive damage aspects of the case, written interrogatories or requests for admission intended to force concessions on affirmative elements of proof are not particularly useful. The elements surrounding punitive damages are all subjective, and responses drafted by defense counsel invariably cast answers to subjective questions in an unhelpful light.

Interrogatories or requests for admissions are useful to establish that all relevant documents have been produced and that all individuals with any knowledge of the claims processing or procedures of the company have been identified. In the area of punitive damages, interrogatories can be used to develop information on other bad-faith claims made against the company, and to identify former employees of the company who may be familiar with claims-handling procedures. Based on that information, further inquiry may develop collateral evidence or additional witnesses.<sup>34</sup>

#### **Caution:**

Isolated incidents of prior bad faith may not be admissible in the plaintiff's case-in-chief; they may become relevant in rebuttal or for impeachment, however, if the defendant claims mistake or accident. If the number of prior incidents is sufficient to demonstrate a pattern or course of conduct, knowledge, or the existence of a plan, the prior acts may be admissible in the plaintiff's case-in-chief.<sup>35</sup> Admissibility may be denied in the discretion of the trial judge under the balancing of probative value versus unfair prejudice.<sup>36</sup>

### **§ 20. Deposition of company employees**

[\[Cumulative Supplement\]](#)

Clearly, the claims representative with whom negotiations were conducted should be deposed. Then, depositions should go right up the chain of command within the company to every person with supervisory or policy authority. Depositions should include not only those directly responsible for the handling of the subject claim, but also management-level executives responsible for overseeing or establishing general policies and guidelines.

Each deposition inquiry will be fact-specific, and only generalities can be offered here. As they pertain to the development of punitive damages, the primary objective of the depositions should be to fasten down the company's version of each event as the claim negotiation unfolded, to determine the company's interpretation or explanation for every item in the claims file, and to explore any inconsistencies between different levels of management. A second, and equally important, objective is to determine the company's standard procedures and policies for claims administration, in order to compare what should have happened to what did.

While it may be sufficient in the predicate case to demonstrate a breach of duty only at the line adjuster level, it will dramatize and maximize the applicability of punitive damages to demonstrate that the egregious conduct permeated the entire company. If the plaintiff can show that the branch claims manager, regional supervisor, and home office executives were aware of the circumstances and did nothing, or should have been aware of the circumstances and intervened, or actively directed the tactics and strategies employed by the line adjuster in communicating with the insured, the argument for significant punitive damages is much stronger.

The inquiry in this area, then, becomes an examination, at each level of management, into what did the witnesses know, when did they learn it, and what did they do about it. The company may become trapped in a three-cornered situation with no escape possible: either (a) high-level management knew what was going on and openly concurred in the strategies or did nothing to correct them; or (b) high-level management did not know what was going on but, according to specific company policies and standard operating procedures, should have known and should have intervened; or (c) high-level management did not know what was going on, and, contrary to accepted industry standards, there were no company policies or standard operating procedures controlling the company's internal administration of the claim. A final trap in which the company may be caught is the existence of marketing or advertising promotions that are inconsistent with the actual policies and practices of the company.

It is naive to expect that company witnesses will candidly admit to any instance of bad faith, or that clever examination will force a dramatic confession. What may develop, if the witnesses are industriously working to keep the shiny side out, are inconsistencies in the rationalizations offered for company actions. As any prosecutor knows, if two or more witnesses are fabricating their stories, they will invariably trip themselves up on the details. This may not be apparent within the testimony of any given witness, but will be revealed upon comparison.

Therefore, it is important that each witness be required to explain and interpret the same set of circumstances and all of the documents, and this requires that the examiner carefully prepare. If possible, the same examiner should take all of the depositions in this series. The examiner should be thoroughly familiar with the entire claims file, and with the detailed tactical plan necessary to establish the case. If the examiner is not personally knowledgeable about industry practices for proper claims handling, the entire process should be reviewed with an expert consultant before the first deposition is taken. It may be wise to retain a consultant who will not be called upon to testify, so that open discussions of tactics and strategy are possible without exposure to adverse discovery.<sup>37</sup>

Witnesses who are trying to conceal something often say things that appear reasonable in context, but are incredible when measured against the full details available. While even close interrogation seldom results in a witness actually crumbling during the testimony, so long as the examiner is well prepared and familiar with all of the nuances of the case, each witness can be boxed into his or her story. The incredibility of it can later be dissected and analyzed by the plaintiff's own experts.<sup>38</sup>

#### **Caution:**

It is important that all of the core documents be examined, analyzed, and thoroughly understood before any depositions of company employees are scheduled. If the depositions proceed before the central documents are fully produced and examined, there is the substantial chance of gaps between the documents and the deposition testimony of company employees. This may leave holes in the expert's conclusions and offer the opportunity for the defense to shape its explanations.

### **CUMULATIVE SUPPLEMENT**

#### **Cases:**

**Evidence of the salaries** of health insurers' executives was marginally relevant in suit alleging bad faith denial of claim and seeking punitive damages; the jury needed to look at what was needed to send a message to the insurers. [Dardinger v. Anthem Blue Cross & Blue Shield](#), 98 Ohio St. 3d 77, 2002 -Ohio- 7113, 781 N.E.2d 121 (2002); West's Key Number Digest, Insurance 3381(4).

**[END OF SUPPLEMENT]**

**D. Expert Witnesses**

**§ 21. Necessity of expert proof**

Expert proof is essential in all but the most obvious of bad-faith cases, if punitive damages are in issue. The subject abounds with technical standards and procedures that will require explanation to the jury. Further, the true impact of the company's conduct, as it pertains to the punitive damage analysis, usually must be developed by the exploration of a series of events or a number of isolated episodes. Any single act, event, or episode may not appear egregious, standing alone, and the company witnesses can be expected to vehemently defend their actions at every step. It is only when all of the details are examined through the eyes of an expert that the results become apparent.

An expert witness, or a team of expert witnesses, will be essential to connect the ends together and demonstrate the full impact of the company's actions. The areas amenable to expert proof begin with the intricacies of the operation of an insurance company with particular regard to claims administration, and include the following:

- The relationship between the duties of an insurance company to its insured versus the duties it owes to protect against excessive or invalid claims.
- The difference in methods and acceptable tactics between resolving third-party claims and first-party claims.
- Acceptable methods and techniques for the investigation and evaluation of various damage elements.
- Explanation of the function and responsibility of the various levels of management within the company which are involved in the claims process.
- Explanation of technical insurance procedures such as reinsurance and loss reserves.
- The impact and importance of punitive damages on the insurance industry.<sup>39</sup>

**§ 22. Sources for expert witnesses**

[\[Cumulative Supplement\]](#)

There are five probable sources where counsel may find qualified expert proof:

- A forensic consultant, meaning an individual from the growing breed of consultants who offer their services to the legal profession exclusively for the purpose of analysis and testimony. If truly qualified, forensic consultants can be exceptionally valuable. They are knowledgeable about legal procedures, and usually well skilled in offering understandable testimony to juries on technical points. However, as is discussed below, a degree of caution should be exercised.
- An independent adjuster or insurance executive with actual industry experience in claims adjusting, administration and supervision, and actual industry experience in the inner workings of an insurance company. This witness, or the forensic consultant, would be the cornerstone of the expert proof.
- An insurance manager or risk manager from private industry or government who has broad experience in the administration, negotiation, and settlement of claims from a policyholder's standpoint. This witness would augment the industry expert from the viewpoint of the consumer, offering proof in the area of justifiable policyholder expectations with respect to reasonable investigative demands, reasonable time standards for the evaluation of a claim, and reasonable limits on the tactics and strategies that are tolerated in the negotiations for settlement.
- An administrator from the state regulatory agency, particularly where the agency is involved with policyholder

grievances. Local law may prevent sitting administrators from testifying in private litigation; in such event, a retired administrator, or one who has left the agency for private employment, may be found. The expert with regulatory experience may be qualified to offer testimony on acceptable claims standards under state law, particularly where the state has adopted some version of an unfair claims practices act.

- A college professor with academic credentials in the teaching and writing on the subject of insurance. Academic experts are especially appealing because of their apparent neutrality. Industry consultants, particularly from competitor companies, and risk managers may be viewed as having axes to grind; forensic consultants may be viewed as hired guns. A college professor usually escapes these stigmas. Further, those with solid classroom experience are particularly well suited to explain complex or technical subjects to a jury. Depending on the academic credentials and comfort level of the witness with the subject matter, a professor can be utilized to offer proof in virtually any area.

#### **Attorneys: a resource to avoid**

Unless desperate, counsel should refrain from relying on an attorney to provide expert proof. Universally, lawyers make lousy witnesses. The best expert is one who is neutral, objective, nonargumentative, and nonadversarial, and lawyers are inherently incapable of conforming to this mold. Unless exceptionally disciplined, the lawyer-witness is impossible to control on direct examination, and becomes a loose cannon on cross.

While it may be necessary to call a prior lawyer of the claimant for some feature of the case, it may invite catastrophe to permit the lawyer to wander into any of the subjective elements of proof. If the lawyer-witness should decide to blow his or her own horn, for example, and emphasize the skill and abilities manifested in his or her handling of the case, it might suggest that the underlying case contained difficult legal issues requiring special expertise. If the jury then gets the notion that there were legitimate issues to debate in the underlying claim, the bad-faith case will sail out the window.

### **CUMULATIVE SUPPLEMENT**

#### **Cases:**

Fact that an expert witness routinely testified in bad faith insurance cases did not prevent him from testifying in a particular bad faith case. [Vining on Behalf of Vining v. Enterprise Financial Group, Inc.](#), 148 F.3d 1206 (10th Cir. 1998).

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**[END OF SUPPLEMENT]**

#### **§ 23. Selection of experts**

[\[Cumulative Supplement\]](#)

The importance of charisma and presence cannot be overemphasized. Experience, credentials, and technical competence are wasted unless the witness is convincing; the witness must be able to communicate with the jury in a manner that is completely objective and nonadversarial to be of value to the case. Arrogant witnesses who lose their cool on the stand, who rise to the bait offered in cross-examination and become overly defensive of their opinions, or who decide that their mission is to help the lawyer advocate the client's cause instead of just offering objective technical expertise, will do more harm than good.

Counsel should be especially skeptical of independent consultants who are not actively involved in industry work, but rather offer themselves exclusively to the legal community for purposes of testifying. While well-qualified professionals are available for forensic engagement, and many derive significant portions of their income from this work, their credibility is promoted by demonstrating that they also maintain an extensive practice within the industry. The dregs of business may try to follow the path of legal consultation, and if no one but the lawyers are using their services, it may be an indication that the so-called expert has been discarded by the industry. Counsel should insist on references and make an independent inquiry into

the work of any proposed expert without strong credentials within the industry.

## **CUMULATIVE SUPPLEMENT**

### **Cases:**

Independent consultant, proffered by insured as expert witness in action against individual disability insurance carrier of own-occupation policy, alleging tort and contract claims arising from termination of benefits, was qualified based on his 25 years of experience in dealing with insurers and insureds, to testify regarding whether insurance carrier's handling of insured's claim comported with industry standards, and such testimony would not impinge on province of either court or jury. [West's Ann.Cal.Ins.Code § 790.03](#); 10 CCR § 2695.1-2695.17. [Hangarter v. Paul Revere Life Ins. Co.](#), 236 F. Supp. 2d 1069 (N.D. Cal. 2002); West's Key Number Digest, [Evidence 506](#).

Proposed expert's extensive background and experience in insurance industry qualified her to testify as expert in insured's action alleging that insurer acted in bad faith in denying her claim under "own occupation" disability policy, despite expert's lack of formal education in field of insurance, where expert worked for insurer for seventeen years, including time period during which changes to oversight and management of how individual disability claims were adjusted was allegedly implemented, she had provided expert testimony in several cases involving challenges to how insurance claim was handled, and she had testified for insurer on claims practices and procedures. [Fed.Rules Evid.Rule 702](#), 28 U.S.C.A. [Shepherd v. Unumprovident Corp.](#), 381 F. Supp. 2d 608 (E.D. Ky. 2005); West's Key Number Digest, [Evidence 540](#).

Attorney who had received degrees from respected schools and had practiced for 17 years with primary emphasis in the insurance area was qualified to give expert testimony about claims handling in an insured's suit against his automobile insurer for bad faith denial of a claim for uninsured motorist (UM) benefits. [Ohio Evidence Rule 702\(B\)](#). [Furr v. State Farm Mut. Auto. Ins. Co.](#), 128 Ohio App. 3d 607, 716 N.E.2d 250 (6th Dist. Lucas County 1998); West's Key Number Digest, [Evidence 540](#).

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**[END OF SUPPLEMENT]**

### **§ 24. Preparation of witness**

The experts selected to testify should be provided with everything obtained in discovery and all of the depositions. They should be given free reign to conduct their own inquiries if indicated. While they may be given copies of relevant pleadings to frame the issues to be examined, counsel's own theories or thoughts on the case should not be disclosed.

Competent defense counsel will require that the complete basis for the experts' conclusions be disclosed in discovery, including all communications between counsel and the expert. Any deficiencies in information supplied, any restrictions on the methods of analysis, or any indication of coaching by counsel on the results desired will offer ammunition for cross-examination.

While counsel should not instruct his or her expert on how to conduct the analysis, counsel should ensure that the witness is current on any technical literature in the field. This is important in all cases, but is especially important if the witness is retired or has otherwise been removed from the industry for any length of time.

The expert should be provided with the relevant principles of law pertaining to the areas on which he or she will be examined. Preferably, this should be accomplished by providing copies of reported cases, law review articles, or extracts from the text of leading treatises rather than counsel's own explanations. If motion briefs are offered for the expert's review, the briefs on both sides should be included.

If the legal principles are not well settled, or are open to interpretation, it is essential that the expert be fairly apprised of all sides of the legal issues. Counsel should refrain from any thought of concealing adverse legal authority from the expert; if the expert is not prepared to face hypothetical questions based on adverse legal theories prior to trial, the result may be devastating at trial. If the expert's opinion is only valid under plaintiff's legal theory, but not under the defense theory, so be it; it is up to the lawyer to persuade the court to accept the plaintiff's authorities. But the expert should be fully advised of all

relevant legal theories that may bear on his or her conclusions.

It is particularly recommended that the expert be given the jury instructions that counsel expects the court to give, covering the specific elements of the case on which the expert will be expected to testify. The expert can then be prepared to state his or her explanations and opinions in the precise language of the instructions.

## **§ 25. Presentation of expert testimony**

### **[Cumulative Supplement]**

The expert witnesses must not only be technically accurate and complete, but they must be convincing in the conclusions they offer. There are three ways to enhance the convincing force of expert testimony.

First, while the experts must be convincing and should be expected to fully support their conclusions and opinions, they should not be permitted to become advocates for the plaintiff's cause. They should not be invited in any question to argue the case on direct examination, and should be cautioned not to do so on cross. Unless directly material to the basis of a specific opinion, the client's particular predicament should have no bearing on the experts' assessment of the defendant's conduct. If the jury perceives an expert to be overly partisan to the plaintiff's cause, the validity of the opinion testimony will be tarnished. The experts will be most convincing if it is perceived that they are offering their testimony in order to let the chips fall where they may, without any interest or stake in the outcome.

Second, the experts should be prepared so that their critical opinions and conclusions will be couched in the precise words of the legal standards to be contained in the instructions. The impact on the jury of having critical points stated in exactly the same language by the witness and the judge, with this feature emphasized by counsel in summation, is significant. Of course, counsel can translate the expert's language into the language of the instructions, but the impact will not be the same.

Finally, counsel should let the expert be the expert. Too often, counsel will attempt to "out-expert" his witness by loading questions up with technical terms and conditions, and with the conclusion counsel thinks is necessary to the case, then simply ask the expert to agree. Skilled adversaries will seldom object when expected testimony comes in through leading questions; they are aware that the testimony will carry less force if it comes from the mouth of the lawyer instead of in the expert's own words. It is measurably more convincing and persuasive to have the technical information and explanation come from the expert, not the lawyer.

## **CUMULATIVE SUPPLEMENT**

### **Cases:**

Expert in insurance bad faith may reasonably rely on the application of statutes in determining the reasonableness of a company's actions; it would be reasonable for experts in bad faith insurance practices to look to the relevant statutory and regulatory requirements in examining the reasonableness of an insurer's actions. [Hangarter v. Paul Revere Life Ins. Co.](#), 236 F. Supp. 2d 1069 (N.D. Cal. 2002); West's Key Number Digest, [Evidence 555.7](#).

Expert's report, and jury's award of punitive damages against property insurer, supported conclusion that insurer engaged in willful unfair claims practices and could be held liable for attorney fees; the report stated that the insurer engaged in an inquisition-style examination and documentation process without justification or support, accused the insured of intentional concealment and misrepresentations without any credible evidence, intentionally and maliciously misinterpreted the policy, coverages, and duties of the insured, and ignored the terms of the policy, and the jury necessarily found that the insurer's actions were malicious, reckless, or wanton. [NMSA 1978, § 59A-16-30](#), subd. B. [O'Neel v. USAA Ins. Co.](#), 131 N.M. 630, 2002 -NMCA- 028, 41 P.3d 356 (Ct. App. 2002), cert. denied, 131 N.M. 737, 42 P.3d 842 (2002); West's Key Number Digest, [Insurance 3375](#).

### **[Top of Section]**

### **[END OF SUPPLEMENT]**

## II. Elements of Proof<sup>40</sup>

### § 26. Checklist of elements indicating punitive damages—Proof of existence of a predicate claim under the policy

#### [Cumulative Supplement]

The following facts and circumstances tend to show the existence of a predicate claim under the policy. The existence of a legal or factual dispute over any of these foundational issues probably eliminates any consideration of bad faith or punitive damages; thus, there may be no basis for a claim of punitive damages unless all of these issues are clearly resolved in favor of the insured.

- ☐ Policy is in full force and effect [<sup>§ 12</sup>]
- ☐ Claimant is an insured under the policy [§§ <sup>31</sup>, <sup>32</sup>]
- ☐ Entitlement to benefits is clear, without room for legitimate debate [§§ <sup>36</sup>, <sup>57</sup>]
- ☐ Insured is in full compliance with all conditions under the policy for payment, including specifically a timely and complete proof of loss [§§ <sup>38</sup>, <sup>45</sup>, <sup>57</sup>]
- ☐ The company has wrongfully denied payment, has offered an inadequate amount in settlement, or has delayed a decision on payment for an inordinate period of time [§§ <sup>34</sup>, <sup>49</sup>]

#### CUMULATIVE SUPPLEMENT

##### Cases:

**Clear and convincing evidence:** Requirement of clear and convincing evidence to recover punitive damages for bad faith delay in paying automobile insurance benefits could be explained by example that burden of proof was not met, if jurors had to ask themselves whether insured had met burden. *Brown v. Alfa Mut. Ins. Co.*, 727 So. 2d 95 (Ala. Civ. App. 1998), writ quashed as improvidently granted, 727 So. 2d 99 (Ala. 1998); West's Key Number Digest, *Insurance* 3379.

#### [Top of Section]

#### [END OF SUPPLEMENT]

### § 27. Checklist of elements indicating punitive damages—Proof of absence of good faith

The following facts and circumstances tend to show an absence of good faith on the part of the insurer. The presence of some of these elements do not necessarily indicate the existence of “bad faith”; they may be attributable to simple negligence or indifference. If the circumstances of any given instance rise to the level of extremes, however, this is an indication of bad faith. Further, if many of the circumstances exist, this alone may raise the inference that the handling of the file, viewed as a whole, rises to the level of extremes, even though any single element may appear innocuous.

- ☐ Unusual delay in responding to communications [<sup>§ 15</sup>]
- ☐ Repeated demands for additional information [§§ <sup>38</sup>, <sup>53</sup>]
- ☐ Denial of claims without explanation [<sup>§ 34</sup>]

- Absence of explanations or reasons for positions taken [§§ 34, 36]
- Unusual delays in the processing and delivery of checks or drafts after a promise or commitment to pay is made [§ 45]
- Discrepancies between the actual amounts paid and the amounts promised or committed [§§ 15, 58]
- Repeated refusals to make a decision; constant referrals to other departments or supervisors [§ 35]
- Unwarranted suspicion or challenge to veracity of claim [§ 41]
  - Surveillance of insured without reasonable cause
  - Intrusive investigation through neighbors, employers, family members, or acquaintances
  - Insistence on an examination under oath without reasonable cause
  - Rude, abusive, or unwarranted accusations
- Unexplained “disappearance” of material submitted by insured, especially of complicated or detailed documentation, with insistence that insured redo and resubmit the entire work [§ 53]
- A claims file that is disorganized (e.g., not maintained in chronological order, or with loose contents not fastened down or in logical sequence) [§ 42]
- Failure to follow company policies and procedures as set forth in claims manuals or policy guidelines [§§ 14, 45, 52]

## § 28. Checklist of elements indicating punitive damages—Proof of bad faith

### [Cumulative Supplement]

The following facts and circumstances tend to show the insurer’s bad faith in handling the claim in question.

- Any indication of a deliberate breach of contract [§§ 34, 40, 42, 49, 58]
- Any indication of a conscious violation of company policy or standards [§§ 14, 36, 45, 52, 58]
- Patterns of deliberate stalling when responding to communications from insured [§ 15]
- Demands for further information, without any indication of what is done with the information when supplied [§§ 38, 39, 53]
- Disparaging or derogatory notes or memoranda in file [§ 14]
- Failure to investigate or make a timely evaluation of the extent of plaintiff’s losses [§ 37]
- Complete absence of any analysis or calculations related to the actual value of the loss claimed [§§ 49, 57]
- Inability of claims personnel to articulate a rational method of calculation used in arriving at the evaluation made [§§ 34, 49]
- Existence of analysis and evaluations that appear to be based solely on tactical considerations (i.e., what the company might be required to pay, or what the insured might be persuaded to accept, rather than what an objective



evaluation would indicate is actually due) [§§ 54, 55]

- Assertions of fact without any indication of investigation or inquiry to substantiate the assertion; refusal to acknowledge corroboration of facts offered by insured [§ 36]

- Absence of any indication of a reasoned evaluation or calculations of the parts of plaintiff's claim, where loss may be divisible into a number of parts [§ 57]

  - Refusal to separate the claim into component parts, and discuss or explain the evaluation of each part

  - Insistence on presenting settlement offers in terms of gross dollars for the entire claim

- Grossly inadequate offers made to satisfy the liability of the company [§§ 34, 45, 49, 55]

- Arbitrarily “clipping” amounts off fixed dollar claims without explanation (especially where a pattern appears) [§ 9]

- Refusal to advance or tender payment of portions of the loss that are not in dispute [§§ 45, 58]

  - Delays in making advance payments for medical expenses, despite the existence of separate voluntary medical pay provisions of the policy

  - Inadequate and slow advance payments under policy for other items, despite clear policy guidelines to the contrary

- Statements (orally or in writing) discouraging insured from seeking counsel [§ 14]

- Statements (orally or in writing) that misstate or misinterpret provisions or rights available under the policy [§ 51]

- Arbitrary and inadequate procedures in establishing and adjusting the loss reserve maintained on the claim [§§ 15, 43]

  - “Stair-stepping” loss reserves

  - Adjustments that are not connected to developing information but appear to be reactions to tactical developments in negotiations

- Untimely, incomplete, or misleading reports to reinsurers [§ 44]

- Absence of any indication of review of claims file by supervisors [§§ 38, 42, 53]

- Inadequate supervision of claim by home office; absence of guidance or delegation of authority from home office to field [§ 42]

- Indication that supervisory review is focused on minimizing company exposure or protecting company interests rather than reviewing the investigation and evaluation of the claim from the policyholder's standpoint [§ 52]

- Absence of any company policy or guidelines governing claims procedure [§§ 14, 15]

- Interoffice and interdepartmental memoranda that focus on limiting the exposure of the company rather than determining the extent of the insured's loss [§§ 14, 15, 54]

- A claims file that appears incomplete; indications of missing documents or reports [§§ 14, 15]

- Refusal or inordinate delay of permission for plaintiff to accept the policy limit offer from the adverse carrier (of underinsured adverse driver) [§§ 45, 56]

- Delay in investigating the financial capacity of the adverse driver to determine potential subrogation interests [§

40]

□ Entangling plaintiff in unnecessary lawsuits with the adverse driver and the (underinsured) adverse driver's insurer [§ 45]

□ Unnecessary, annoying, and harassing requirements on plaintiff during the investigation [§§ 38, 39, 53]  
— Demands for redundant medical examinations

— Demands for unnecessary medical procedures (e.g., unnecessary independent medical examination)

— Other unethical practices of field investigator

□ Overall patterns of settlement tactics and practices indicating the application of economic coercion and pressure on the insured to accept a low-ball offer of settlement [§§ 45, 54, 55]

□ Overall patterns of settlement tactics and practices indicating that company was utilizing delay for delay's sake to drag out the claim process, despite the known desperate financial straits of the plaintiff and his or her family [§§ 34–40, 45, 50–58]

The following facts and circumstances tend to show significant indicia of bad faith based on evidence in collateral sources. While isolated incidents of prior bad faith may not be admissible in the plaintiff's case-in-chief unless they are part of a pattern or course of conduct, they may become relevant in rebuttal or for impeachment. (See § 19.)

□ Claims and grievances from policyholders contained in state regulatory files [§ 18]

□ The existence of other lawsuits against the company for bad-faith refusal to pay [§ 19]

□ Complaints or grievances to consumer protection agencies, better business bureaus, or similar community organizations [§§ 18, 19]

□ Empirical or anecdotal experiences related by others concerning negotiations with subject insurer [§§ 18, 19]

## CUMULATIVE SUPPLEMENT

### Cases:

**Circumstantial evidence:** Bad faith by an insurer is a state of mind indicated by acts and circumstances and is provable by circumstantial as well as direct evidence. *Truck Ins. Exchange v. Prairie Framing, LLC*, 162 S.W.3d 64 (Mo. Ct. App. W.D. 2005), reh'g and/or transfer denied, (Mar. 29, 2005) and transfer denied, (May 31, 2005); West's Key Number Digest, *Insurance* 3381(5).

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[END OF SUPPLEMENT]

## III. Model Discovery

### § 29. Written interrogatories—Plaintiff insured to defendant insurer

The interrogatories in this section are addressed to an insurance company that allegedly acted in bad faith in handling the

plaintiff's first-party claim for benefits under the uninsured motorists coverage of an automobile insurance policy, in an action in which the plaintiff is seeking an award of punitive damages against the defendant insurer.<sup>41</sup>

*Caution:* A number of states and federal district courts have numerical restrictions and form requirements for interrogatories. Although the interrogatories in this article are intended to provide a generic set of interrogatories that can be used in most jurisdictions, the practitioner is cautioned to consult the discovery statutes or rules in the appropriate jurisdiction.<sup>42</sup>

#### **DEFINITIONS:**

A. PLAINTIFF means \_\_\_\_\_[name], and any agent or employee of \_\_\_\_\_[name].

B. DEFENDANT means \_\_\_\_\_[name], and any agent or employee of \_\_\_\_\_[name].

C. IDENTIFY a person means to state his or her full name, address, and telephone number; his or her occupation; the name, address, and telephone number of his or her employer, if known; and any family, social, recreational, professional, or employment relationship you have with the person.

D. IDENTIFY a business entity means to give that entity's full name; principal addresses of the business; telephone numbers; type of entity (corporation, partnership, etc.); place of incorporation (where applicable); names, addresses, and titles of principal executive officers; and names, addresses, and titles of all individuals or entities owning more than a \_\_\_\_\_ percent interest in the entity.

E. DOCUMENT includes reports, compilations of data or information, or records made in any form, such as by writing, typewriting, printing (including computer printouts), photography, and electronic memory, regardless of how the matter is stored.

F. IDENTIFY a document means to describe briefly the form of the document; describe generally the subject of its contents; state the date and place of preparation; state the purpose of its preparation; state the date and place of its mailing or submission to the person or firm who received it; and IDENTIFY the person or firm who prepared the document, the person or firm who received it, and the person or firm who has possession or control of the original copy of the document, or an appropriate custodian who would have a complete copy available for inspection.

G. POLICY means the automobile insurance policy described in paragraph \_\_\_\_\_ of PLAINTIFF'S complaint.

H. CLAIM means the claim under the policy described in paragraph \_\_\_\_\_ of PLAINTIFF'S complaint.

#### **INTERROGATORIES:**

1. IDENTIFY each person in the employ of DEFENDANT who has any knowledge or has taken any action on behalf of DEFENDANT with regard to handling the CLAIM. This interrogatory seeks the name of every employee of DEFENDANT who had anything to do with the CLAIM, including the adjusters, branch claims representatives, regional or home office claims auditors or claims examiners, all claims managers and claims supervisors at any level, executive officers of the company, and all members of any review committee or claims committee.

2. For each person identified in the answer to Interrogatory 1, state the person's title or position within the company, current branch or office location, the name and title or position of the individual's immediate supervisor, and the nature of the function or service performed by that person in connection with the CLAIM.

3. If any person identified in the answer to Interrogatory 1 has been promoted, demoted, or transferred during the time relevant herein, describe in detail the change in employment status of each such individual, including the circumstances of the person's employment before and after the change in status.

4. If any person identified in the answer to Interrogatory 1 is no longer employed with DEFENDANT, please state the date of separation, and the last-known residence address and telephone number or place of current employment of each such past employee.

5. IDENTIFY each person not in the employ of DEFENDANT who has any knowledge or has taken any action on behalf of or at the request of DEFENDANT with regard to the CLAIM. This interrogatory seeks the name of every person, firm, or company with whom DEFENDANT had any contact, including independent adjusters or independent adjusting firms, private investigators, accident reconstructionists, engineers, physicians or medical consultants, economists, accountants, attorneys, or any other person, firm, or company, concerning the CLAIM.

6. For each person identified in the answer to Interrogatory 5, state the person's professional title, and the nature of the function or service provided by such person in connection with the CLAIM.

7. IDENTIFY any DOCUMENT relating to the CLAIM submitted to DEFENDANT by each person identified in the answer to Interrogatory 5.

8. Describe each file that was opened, created, or maintained by DEFENDANT relating in any way to the POLICY or the CLAIM, including the complete name or title of the file, its complete file number or other identifying designation, its present custodian and physical location within DEFENDANT, and its general purpose or business classification. This interrogatory seeks the identification of each "claims file" and each "underwriting file," under whatever designation or description, and every copy or duplicate thereof which may exist within DEFENDANT.

9. State whether or not any information or data of any kind pertaining to the POLICY, the CLAIM, the claims-handling or underwriting activities of DEFENDANT, or any reports, communications, or data of any kind, are maintained on any electronic media, such as computer data files, electronic mail, or any equivalent.

10. If the answer to Interrogatory 9 is yes, describe the contents of such electronically stored information, whether or not hard copies of such material exist, the custodian of such data, and the appropriate location within the company for the retrieval of such data.

11. Has DEFENDANT secured a policy or policies of reinsurance on any portion of the coverage written on PLAINTIFF with any reinsurer?

12. If the answer to Interrogatory 11 is yes, state the name, business address, telephone number, policy identification number, and liability limits of each such reinsurance.

13. IDENTIFY the individuals in DEFENDANT, including title and function, who are responsible for determining, promulgating, and overseeing company policies and standard procedures for the administration, evaluation, determination, and payment of insurance claims by DEFENDANT.

14. IDENTIFY every DOCUMENT containing statements of policy, policy guidelines, administrative bulletins, intercompany memoranda or other DOCUMENT of any kind, promulgated by DEFENDANT and disseminated or distributed to its employees, relating to the standard, recommended, or expected procedures for the administration, evaluation, determination, and payment of claims.

15. Does DEFENDANT maintain a manual or handbook containing standard procedures or guidelines for the administration, evaluation, determination, and payment of claims?

16. If the answer to Interrogatory 15 is yes, state the complete title of such manual, the year of publication, the author or the department or individual responsible for its contents, and an appropriate custodian within the company who would have a current edition available for inspection.

17. IDENTIFY the individuals in DEFENDANT, including title and function, who are responsible for devising, implementing, and overseeing the training of adjusters, claims representatives, claims supervisors, or any other individuals involved in the claims-handling process within DEFENDANT.

18. Describe all training materials of any kind used by DEFENDANT in training adjusters, claims representatives, claims supervisors, or any other individual involved in the claims-handling process within DEFENDANT.

19. In the case of training materials described in the answer to Interrogatory 18 prepared specially for DEFENDANT or by its employees, describe each item, including the complete title and date of preparation, and IDENTIFY an appropriate custodian within the company who would have the materials available for inspection.

20. In the case of training materials described in the answer to Interrogatory 18 used by DEFENDANT that are commercially available, describe each item, including the complete title, author, publisher, address of publisher, and year of publication.

21. Describe all advertising published in any magazine, newspaper, or other publication, and all promotional brochures or material provided to or intended for use by insurance agents, brokers, and sales representatives, which were in use during the period \_\_\_\_\_[date] through \_\_\_\_\_[date], and which in any way relate or pertain to automobile insurance policies, uninsured or underinsured motorists coverage, or the claims-handling policies or reputation of DEFENDANT.

22. IDENTIFY an appropriate custodian within the company who would have complete copies of all promotional brochures or material described in the answer to Interrogatory 21 available for inspection.

23. With respect to any advertising material described in the answer to Interrogatory 21 published in magazines or newspapers, state at least one reference to a national or regional publication, by name, date of publication, and page, for each advertisement used (or designate an appropriate custodian within the company who would have tear sheets of each such advertisement available for inspection).

24. Name each state in which DEFENDANT is qualified to do business.

25. Has any person or entity filed a lawsuit against DEFENDANT alleging either in whole or in part any breach of duty of good faith and fair dealing, or alleging any tortious claim of bad faith, in the handling of any uninsured or underinsured motorists claim, from \_\_\_\_\_[date] to the present?

26. If the answer to Interrogatory 25 is yes, describe each such lawsuit, including the complete name of each plaintiff, the complete name of each defendant, the jurisdiction in which the action was filed, the court docket number or other identifying designation, and the ultimate disposition of the lawsuit.

27. IDENTIFY every person who was employed by DEFENDANT during any of the years \_\_\_\_\_ to the present in any capacity as an adjuster, claims representative, claims adjudicator, claims examiner, claims supervisor, or claims manager, who is no longer employed by DEFENDANT, including the office or branch where last employed, position or title, date of separation from the company, and last-known residence or current business address.

28. IDENTIFY each person, including title and function, who assisted in the preparation of answers to these interrogatories and responses to the request for production of documents that accompany these interrogatories, and in the assembly of documents to be produced.

29. For each person identified in the answer to Interrogatory 28, state the nature of the assistance the person provided or the subject matter of information the person supplied.

### § 30. Requests for production of documents—Plaintiff insured to defendant insurer

Documents in the defendant's possession are ordinarily crucial to proving circumstances warranting the recovery of punitive damages in a bad-faith case against an insurer. It is therefore good practice to obtain as soon as possible all relevant documents from the defendant by way of requests for production of documents.<sup>43</sup> Despite the argument that the claims file, or portions thereof, are privileged material assembled in contemplation of litigation, it is becoming widely accepted that the entire claims file of an insurer is subject to discovery in a first-party bad-faith claim.<sup>44</sup>

#### DEFINITIONS:

A. PLAINTIFF means \_\_\_\_\_[*name*], and any agent or employee of \_\_\_\_\_[*name*].

B. DEFENDANT means \_\_\_\_\_[*name*], and any agent or employee of \_\_\_\_\_[*name*].

C. DOCUMENT includes reports, compilations of data or information, or records made in any form, such as by writing, typewriting, printing (including computer printouts), photography, and electronic memory, regardless of how the matter is stored.

D. POLICY means the automobile insurance policy described in paragraph \_\_\_\_\_ of PLAINTIFF's complaint.

E. CLAIM means the claim under the POLICY described in paragraph \_\_\_\_\_ of PLAINTIFF's complaint.

#### REQUEST FOR DOCUMENTS:

1. Produce all claims files in their entirety maintained by DEFENDANT on the CLAIM. Included in this request are all copies or duplicates of the claims files maintained in branch, regional, or home offices.

2. Produce all committee reports, committee minutes, or written notes prepared or taken in connection with any claims committee meetings held on the CLAIM.

3. Produce a copy of each report, writing, or other DOCUMENT supplied by any person outside DEFENDANT to whom any matter concerning the administration of the CLAIM was referred (unless such report is already contained within the claims files to be produced). This request calls for the production of each document identified in your response to Interrogatory 7.

4. Produce all underwriting files in their entirety maintained by DEFENDANT on the POLICY.

5. Produce all correspondence between DEFENDANT and any reinsurer identified in your response to Interrogatory 12 pertaining to the CLAIM, including specifically all status reports and all reports on changes to loss reserves.

6. Produce a copy of the claims manual or handbook containing the standard or recommended procedures of DEFENDANT for the administration, evaluation, determination, and payment of claims, and in use during the period \_\_\_\_\_[*date of accident*] through \_\_\_\_\_[*date of filing of complaint*].

7. Produce a copy of each memorandum, written statement of policy, written policy guideline, administrative bulletin, or other writing prepared and disseminated to employees involved in claims administration, on any subject related to procedures in the administration, evaluation, determination, or payment of claims. This request calls for the production of all items described in your response to Interrogatory 14.

8. Produce a copy of all training materials used by DEFENDANT in the training of adjusters, claims representatives, claims

adjudicators, claims examiners, claims supervisors, or claims managers. This request calls for the production of all materials described in your response to Interrogatory 18.

9. Produce a copy of the annual report filed with the Department of Insurance for the State of \_\_\_\_\_ for the fiscal year ending \_\_\_\_\_[*date*].

10. Produce a copy of all promotional material or brochures provided to insurance sales representatives, agents, or brokers, and in any way pertaining to DEFENDANT'S standard automobile policy \_\_\_\_\_[*plaintiff's policy type*], uninsured or underinsured motorists coverage provided under such policies, and the practices, procedures, and reputation of DEFENDANT in the administration, evaluation, determination, and payment of policyholder claims. This request calls for the production of material described in your response to Interrogatory 21.

#### **IV. Proof of Bad Faith of Insurer in Handling Underinsured Motorist Claim Warranting Recovery of Punitive Damages**

[The following model proof is based on an actual trial in the author's court. While some editorial license for emphasis and clarity has been exercised, the testimony is largely verbatim, drawn from the transcripts. The trial resulted in a verdict for the plaintiff for the limits of the policy, compensatory damages for emotional distress and consequential losses, and punitive damages in excess of \$1 million. It was not appealed. The plaintiff was severely injured in an auto accident caused entirely by the negligence of the adverse driver and without any element of comparative fault. The jury ultimately determined his total damages from the accident to be \$770,000. The adverse driver was inadequately insured, carrying a policy with a limit of only \$50,000, which was promptly offered. The plaintiff carried underinsured motorists coverage with the defendant insurance company, with policy limits of \$300,000. The insured claimed from the outset that he was entitled to the policy limits. Despite clear liability and substantial documentation of loss, the company refused to make any significant offers. After over two and a half years of delay, the plaintiff instituted a bad-faith action against the defendant, claiming entitlement to the policy limits in contract, consequential damages in tort for bad faith and intentional infliction of emotional distress, and punitive damages. Plaintiff's predicate case in contract and tort was well made through his own testimony, that of his doctors and family, and the callous testimony of company witnesses. In establishing his claim for punitive damages, and to demonstrate the egregiousness of the defendant's conduct, the plaintiff relied on three experts: (1) an industry consultant with extensive experience in claims administration; (2) a risk manager with extensive experience in negotiating first-party claims for the state; and (3) a college professor of insurance. Their testimony is extracted in the sections that follow. It is also important to note that in the forum jurisdiction, the instruction to the jury on the punitive damage issue was as follows:

If you find that the defendant's acts which caused injury to the plaintiff were an extreme deviation from reasonable standards of conduct, and that the actions or omissions of the defendant were oppressive, fraudulent, wanton, malicious, or outrageous conduct, and that the defendant acted with an understanding of and disregard for the likely consequences of those actions or omissions, you may, in addition to all other damages to which you find the plaintiff entitled under these instructions, award to the plaintiff an amount that will punish the defendant and deter it and others from engaging in similar conduct in the future.

It is instructive to note how plaintiff's counsel and the witnesses couched the critical opinions expressed in the precise language of this instruction.]

##### **A. Testimony of Industry Consultant**

[After introduction, identification, and qualification of witness. The witness was qualified as an expert by his credentials as a prior insurance executive with over thirty years of experience in all levels of management. His consulting experience included engagements with several major domestic companies, as well as foreign insurers and state regulatory agencies. As to the use of industry consultants as expert witnesses, see [§ 22](#).]

#### **§ 31. Establishing the basis for the expert's opinions**

**Q.**Are you familiar with the circumstances surrounding the accident in which \_\_\_\_\_[*plaintiff*] was injured on October 9,



1986 and matters flowing from that injury as far as claim he has made against \_\_\_\_\_[defendant] Insurance Company?

A.Yes, I am.

Q.How did you become familiar with these circumstances?

A.Basically, from a review of the claims file including the home office duplicate and the underwriting file on the policy. These files contain the entire history of the claim, from the standpoint of the defendant company. I also examined the company's claims manual and all claims bulletins issued by the company. Most of my review has come out of that information.

Q.How about the medical records?

A.While I'm not medically oriented, I do understand a little bit of medical matters and I have looked at those documents, but I haven't gone into them in depth. I did compare generally the contents of the medical charts with what material had been submitted to the company for the claims files. What I was looking for was to see if the company had enough medical information in the claims file to make a reasoned determination of the claim.

Q.Have you reviewed any other materials in reaching your conclusions on this case?

A.I have examined the depositions of \_\_\_\_\_[line adjuster], \_\_\_\_\_[branch claims supervisor], \_\_\_\_\_[regional claims manager], \_\_\_\_\_[home office vice president responsible for claims], and \_\_\_\_\_[secretary of company].

Q.And who do you understand these individuals to be?

A.I understand these people to be all of the individuals within the company who were responsible for the administration of this claim, from the field adjuster who dealt with the insured right up the chain of command to the senior officer of the company.

Q.Were you present in court during the testimony of \_\_\_\_\_ and \_\_\_\_\_?

A.Yes, I was.

#### **Testimony of witnesses as basis for expert's conclusions.**

It may be appropriate to have the expert listen to the testimony of certain witnesses during trial. If the expert is not available to listen to the actual testimony, counsel may consider arranging for daily transcripts of such testimony, and provide these to the expert for review. If witnesses have been excluded, however, counsel must obtain the court's permission before providing trial testimony to any subsequent witness.

Q.Anything else?

A.You provided me with copies of certain legal documents that have been filed with the court in this case. I have the complaint and answer, answers to interrogatories, copies of the pretrial briefs and copies of the requested jury instructions.

Q.Are those the materials that you used in reaching your conclusions in this case?

A.Yes.

#### **§ 32. Difference between first-party coverage and third-party coverage**

Q.Can you give the jury a description of the difference between first-party coverage and third-party coverage?

A.First-party coverage consists of those provisions or coverages in any insurance policy whereby the company has promised to pay its own insured the benefits in the event of a loss. Third-party coverage consists of those provisions in the policy where the company promises to defend its insured against the claim of another, and to pay any damages its insured might owe to that other person. In insurance language, the policyholder or named insured is always the first party, and anyone else is a third party. The third party is also referred to as the "adverse" party.

Q.Can you explain this in the context of an automobile insurance policy, such as the policy in this case—and you may refer to the actual policy, if you wish, which is in evidence as Exhibit \_\_\_\_\_.

A.The policy that the defendant issued to the plaintiff in this case has a number of provisions and coverages. The first part of the policy, for example, contains coverage for collision and comprehensive loss. This is first-party coverage. If the policyholder's vehicle is damaged in a collision or from any of the occurrences listed under the comprehensive damage section of the policy, then the company will pay to the policyholder the loss sustained, regardless of fault. The second part of the policy contains the liability coverage. This is third-party coverage. Here, the policy says that if a claim is made against the insured by a third party, the insurance company will defend the insured, and if it is determined that the loss was the fault of the insured, the company will pay to the third party any damages which the insured might be responsible for, up to the limits of the policy.

Q.What about coverage for uninsured or underinsured motorists?

A.This is included in the policy, and is described in sections \_\_\_\_\_ through \_\_\_\_\_ of the exhibit. Here, the policy is saying that the company will pay to its named insured any damages caused by a third party, or adverse party, arising out of an automobile accident, which the insured is unable to recover from the third party or adverse party by reason of that party not having adequate insurance to cover the loss.

Q.Is this coverage first-party coverage or third-party coverage?

A.In this state, it is considered first-party coverage.

### **First- or third-party coverage.**

A few states permit an insurance company to treat uninsured and underinsured claims as third-party claims, treating their insured as the adverse party. In most states, the insurer is required to consider claims as first-party claims. Counsel must verify local law on this aspect. As to first-party claim practice versus third-party claim practice, see § 7.

**Q.**In both first-party and third-party situations, who does the insurance company owe its obligation to?

**A.**To the first party, to their own insured.

**Q.**To the person they're dealing with?

**A.**That's correct.

**Q.**Now, for instance in this case, \_\_\_\_\_[adverse driver's] Insurance Company, provided insurance to \_\_\_\_\_[adverse driver]. Who did it owe its obligation to and who did it have to take care of?

**A.**It had to take care of \_\_\_\_\_[adverse driver].

**Q.**And how about \_\_\_\_\_, the defendant insurance company in this case—whom did it have to take care of?

**A.**They had to take care of their own insured, \_\_\_\_\_[plaintiff].

### **§ 33. Difference between first-party coverage and third-party coverage—Industry standards in handling first-party claim**

**Q.**Are there recognized industry standards expected of an insurance company when it is presented with a first-party claim for damages by its own insured?

**A.**Yes.

**Q.**What are those standards?

**A.**There are five steps in the handling of any claim, and it is required that each of these steps be handled fairly and in good faith. First, the company must determine whether or not a claim falls within the coverage provided. Second, it must evaluate the scope and extent of the claim. Third, it must decide upon the validity of the claim. Fourth, it must assess its monetary value. And finally, it should pay the claim, or amount of claim that is justly due, as soon as possible under the circumstances.

**Q.**What does the phrase “fairly and in good faith” mean?

**A.**It means that the company cannot place its own interests ahead of its insured. The company does have a responsibility to its shareholders and other policyholders not to pay too much, and to properly investigate claims to ensure that they are properly brought under the terms of the policy. But it has a contract with its insured, which the insured bought and paid for in the payment of premiums, and it must act in such a manner that it is not taking advantage of its insured by reason of its size, experience, or the economic pressures it can bring to bear by undue delay.

### **§ 34. Overall conclusions of the expert**

**Q.**Taking into account your examination of all of the materials you just indicated, and taking into account your experience in the insurance industry generally and in the evaluation and administration of insurance claims specifically, do you have an opinion as to whether or not the defendant in this case carried out its obligations under the contract in accordance with recognized and accepted industry standards?

**A.**I have an opinion.

**Q.**What is your opinion?

**A.**That the handling of this claim by the defendant company did not meet accepted industry standards in a number of significant respects.

**Q.**Do you have an opinion on whether or not the defendant acted fairly and in good faith in its handling of the claim of the plaintiff in this case?

**A.**I do.

**Q.**What is your opinion?

**A.**In my opinion, \_\_\_\_\_[defendant insurance company] did not deal fairly or act in good faith in the handling of this claim, both in the overall context and in a number of specific elements.

**Q.**Please identify for the jury each of the areas in which you observed an act or omission in reaching your conclusion.

**A.**Well, there are several major failings that I observed. First, the defendant company has unreasonably delayed, denied, and withheld insurance benefits from plaintiff. Second, they unreasonably failed to investigate the claim on three different occasions. Third, they have used unjustifiable economic coercion toward the plaintiff to better their own financial interest. The fourth area is in their dealing with the plaintiff based on the filing of a lawsuit or the forced filing of a lawsuit against the adverse driver, which was totally unnecessary, and in delaying their decisions for so long with respect to allowing the plaintiff to accept the offer of the adverse driver's insurance company that the plaintiff became entangled in yet another lawsuit. All of these elements, and others, constituted a complete failure on the part of the defendant insurance company to handle this claim in a responsible manner.

**Q.**How would you characterize the methods used by the defendant company, in terms of first-party coverage versus third-party coverage in this case?

**A.**They treated \_\_\_\_\_[plaintiff] as an adversary. They have treated him as a third party and not a first party under the contract. They have no explanation as to why they have not paid the full value of the claim up to this point. They have continually maintained that the damages were lower than they actually were or what is actually on the records of the company. Even when their own records and loss reserves indicate that they placed a significantly higher value on the claim, they continued to offer a miserly amount to their own insured.

**Q.**Can any of these elements be attributed to mere negligence or inadvertence?

**A.**Yes, some of them. But in others, and especially as the claims file grew, the conclusion is inescapable that the company was deliberately and intentionally attempting to drive the claim down and force a settlement at a figure far below the actual value of the claim, and far below even what the company had indicated in its records.

**Q.**How would you characterize the degree by which the defendant's actions in this case deviated from the accepted standards in the industry?

**A.**They were an extreme deviation.

**Q.**Would you consider the actions to be oppressive, fraudulent, wanton, malicious, or outrageous?

**A.**I cannot say they were fraudulent or malicious. I can't read the minds of the individuals responsible. But certainly the economic coercion employed in this case was oppressive, certainly the callous disregard for the consequences that the delay was causing their insured could be considered wanton, and several of the elements—particularly their refusal to permit the plaintiff to accept the \$50,000 offer from the adverse insurance company for over thirteen months, and some of their tactics used during the course of this claim—were outrageous.

### **§ 35. Unwarranted delay in concluding claim as an element of bad faith**

**Q.**Let's talk about each of those specifically. You indicated there had been delay in this case. Could you tell the jury, please, about the delay?

**A.**The way I approached this is I put myself in every position I could put myself in the company: the senior officers at the home office, the regional claims supervisor, the branch claims manager, and the line adjuster. I determined two different dates when this claim should have been reasonably concluded. The first date I came up with is based on what should have happened if the company had opened a claim file when it should have. The second date is what could have happened, even with a late opening of the claim file, if the company had proceeded properly from that point onward.

First, I took the date of October 10, 1986, which is the day after the accident, and the date the defendant company first received a report on the accident, and I tried to determine when this claim could have been fully investigated and analyzed if it had been handled appropriately from that date on. And on that basis, I think, based on the information that had been provided, and moving it back through the claims process and doing the investigation in an appropriate way, I determined that this claim really could have been fully examined and evaluated by February 1st of 1988.

Then I had to redo that whole idea and start from July 8th of 1987—the date the claims file was actually opened—and go through the same process again and decide what could have been done, what should have been done, and how this claim would have been handled, and when it should have been paid. And I came up with the fact that with all the information now available and which had been put into \_\_\_\_\_[defendant insurance company's] possession, that the claim should have still been fully examined and evaluated by June 1st of 1988.

**Q.**Now, that's giving them credit for that period of time when the file wasn't open, when it was reported to them a second time, is that correct?

**A.**Yes. I felt that I had to do it both ways just to see where the delays developed.

**Q.**Are you familiar with the memorandum in the claims file to the home office from \_\_\_\_\_[branch claims manager], which refers to the failure of the branch claims office to open a claims file on this matter immediately after the accident, and instead delaying the opening of any formal claims file until July of 1987, as "a blunder"?

**A.**Yes.

**Q.**Do you agree with \_\_\_\_\_[branch claims manager's] characterization of that as "a blunder"?

**A.**Yes, I would have to agree with it. It's a very serious blunder.

**Q.**You are aware that after the accident the insured's wife, \_\_\_\_\_, told them the other insurance company would be handling the matter?

**A.**Yes.

**Q.**Then why was it a blunder—why should a claims file have been opened on this case immediately after the accident, where \_\_\_\_\_[plaintiff's wife] told them the other insurance company would be handling the matter?

**A.**The other insurance company was the company for the adverse driver. It owed its duty to the adverse driver, not the plaintiff. As we have already discussed, the plaintiff here was the third party to that company. The company here, \_\_\_\_\_[defendant company], had first-party coverage all over the place. They had collision coverage on the car, they had medical payment coverage on the driver and passengers and there were serious injuries involved, and they had underinsured motorists coverage. Clearly, they should have opened a file immediately, as soon as they learned of the accident, so that they could follow along with what was happening with the other company, and be prepared to step in if necessary. That was their obligation, in my opinion, as part of their responsibility under the policy to their own insured.

**Q.**And what was the consequence of not opening a file right then, that is, right after the accident in October of 1986?

A.The result is that nothing happened for almost a full year. There was no accident investigation or analysis of the plaintiff's injuries or damages at all for almost a full year. When the defendant company was notified in July of 1987 of how serious the accident really was, and that it was likely to exceed the limits of the other insurance and bring into play its own coverage, they were caught completely flat-footed. They had not even begun the preliminary workup on the file, and it was already over nine months post accident.

Q.How would you characterize this blunder in terms of deviation from the standards—was it an extreme deviation?

A.Well, I think I would be charitable and characterize it as just negligent. The company could have recovered from this error if they had moved quickly. The problem was, they did not move quickly. They continued to stall and delay, and this continuation was what pushed the case far over the line, in my opinion.

Q.And why do you say that?

A.Based on my examination of the file, and beginning with the July 1987 date, the company could have gathered everything it could possibly have needed within twelve months. They could have had this claim fully investigated and analyzed by June of 1988 at the latest. Instead, they continued to stall and delay, and never did make any reasoned analysis of the plaintiff's claim, until finally this lawsuit was filed.

Q.If I understand, this claim should have been resolved by February of 1988, if the company had promptly opened a claim file in October of 1986, and followed through with its responsibilities, right?

A.Correct.

Q.And it still could have been resolved by June of 1988, if the company had moved with dispatch after it discovered its blunder and opened a claim file in July of 1987, right?

A.Correct.

Q.And if the company had done this, where would you put this in terms of adhering to the acceptable standards of the industry?

A.This would have been at the outer limit. It think it would demonstrate negligence and perhaps indifference toward their insured, but these things do happen.

Q.And how would you characterize the company's actions after June of 1988, in terms of the acceptable standards of the industry?

A.In my opinion, there is no question but that the company crossed the line. As the delays continued throughout 1988 and into 1989, coupled with the other tactics employed by the defendant company, the actions constituted an extreme deviation from accepted standards. The delay was having a devastating effect on the insured, and the company knew it.

### **§ 36. Assertion of unsubstantiated defense to liability**

Q.How about investigation into the liability for the accident, is that important?

A.Absolutely. Under this type of coverage, the insurance company is only obligated to pay what the plaintiff could recover from the adverse driver. This means that the accident must be the adverse driver's fault. Further, the claim is reduced by law if the plaintiff himself is negligent. Under comparative negligence laws, the amount recoverable in any accident is reduced by the percentage of fault attributable to the plaintiff. So it is very important to ascertain the facts of the accident, and to determine who was at fault.

Q.How does a company do this, in the ordinary case?

A.First, by obtaining the police reports; second, by interviewing and taking statements from the drivers and all witnesses to the accident; third, by inspecting the scene and taking photographs or preparing scale diagrams; and, in complicated cases, referring the circumstances to an accident reconstructionist.

Q.Was this a complicated case?

A.It does not appear to be—it appears to be a straightforward case of an improper turn and failure to yield on the part of \_\_\_\_\_[adverse driver]. She turned left directly in front of the plaintiff.

Q.What did you find in the claims file with respect to accident investigation?

A.The police report and a statement from the plaintiff.

Q.Was this sufficient, in your mind?

A.It is sufficient in my mind to establish that the adverse driver was one hundred percent at fault. The police report so indicated, and further indicated that a citation was issued.

Q.Were any interviews or statements taken from witnesses?

A.No.

Q.Any photographs or scale diagrams?

A.No.

Q.Any reports from an accident reconstructionist?

A.No.

Q.Any indication whatsoever of any negligence or comparative fault on the part of \_\_\_\_\_[plaintiff]?

A.None in the file whatsoever, and no indication of any additional investigation steps to develop this if it was of true concern.

Q.I hand you Exhibit \_\_\_\_\_, and ask if you recognize that document.

A.Yes, it is a letter from \_\_\_\_\_[branch claims manager] to \_\_\_\_\_[plaintiff's lawyer] replying to a settlement demand made on \_\_\_\_\_[date], which was well before the filing of this lawsuit. A copy of this letter is contained in the claims file that I examined.

**Q.**Directing your attention to the third paragraph of that letter, where the writer says, “Furthermore, your demand does not adequately take into account the comparative negligence component which must be borne by your own client, and which we believe reduces the amount of the claim significantly.” Do you see that language?

**A.**I do.

**Q.**In your opinion, based on the evidence of accident investigation in the claim file and the statements made by the defendant’s people in deposition, is there any basis for that assertion?

**A.**None whatsoever.

**Q.**Based on your experience and examination of the claims file and other documents, in your opinion is there any basis for an insurer to contend that there exists room to debate or that there is a legitimate dispute over this issue?

**A.**None. An insurance company has the duty to make a reasonable investigation of the circumstances of the accident, and the company is expected to have the means and expertise to do this. Unless it has made such an investigation, and has uncovered facts or found witnesses who indicate that there is an issue over whose fault the accident was, there is no justifiable basis to even raise the question as a possibility.

**Q.**When an insurer is dealing with its own insured, in a first-party case, is it an accepted practice to make an assertion such as this, without any basis?

**A.**Absolutely not. Furthermore, it is a violation of the company’s own policy guidelines and is contrary to the provisions of the claims manual to do so.

**Q.**I was just going to get to that. Handing you Exhibits \_\_\_\_\_ and \_\_\_\_\_, do you recognize these documents?

**A.**Yes, Exhibit \_\_\_\_\_ is a copy of a policy guideline dated \_\_\_\_\_, and Exhibit \_\_\_\_\_ is the company claims manual.

**Q.**Can you identify for the jury the specific policy statements contained in the guidelines and manual which prohibit making assertions about defenses or liability issues which are not supported by adequate investigation?

**A.**Yes. \_\_\_\_\_[Witness identifies, and reads if appropriate, the relevant sections of the exhibits].

**Q.**Going back to the accepted standard recognized in the industry that we have been talking about all along, how would you characterize this tactic?

**A.**I would say that it is an extreme deviation from accepted standards.

### **§ 37. Delays in investigation of claim**

#### **[Cumulative Supplement]**

**Q.**You mention failure on the part of \_\_\_\_\_[defendant insurance company] to investigate this matter. To what were you referring in that regard?

**A.**Well, in the first instance is the failure to fully investigate this claim from the very beginning. It was reported by \_\_\_\_\_[plaintiff’s wife] on the 10th of October in 1986, by telephone, and if you go by the diary, or the summary sheets contained in the file, the claim actually appears not to be handled at all by \_\_\_\_\_[line adjuster] until October 27th of 1986. That’s seventeen days after it was reported. Then, nine days after that it was closed without payment. So in that respect it was a failed investigation. There was no investigation of the occurrence whatsoever at that point. There should have been, because based on the report there were passengers involved, even a young child, and there were indications of head injuries and fractures. These should have raised red flags all over the place, even though the initial report indicated that the adverse insurer was on the risk. So there immediately should have been some action taken by the company.

The second delay comes when we start on July 8th of 1987, when the company clearly learned that the adverse insurance probably was not going to be sufficient. The company did pay some medical bills under the medical pay provisions of the policy, but it still did not begin any efforts in connection with the overall damages until October. It does not appear that a claims file under the underinsured motorists coverage was opened until October 27, 1987. There’s indication in correspondence, the internal memos, that the file was not opened until October 27, 1987. That’s over a hundred days from the date that \_\_\_\_\_[plaintiff’s wife] called on July 8.

I understand there were certain things done, such as medical payments were made in that period of time preceding opening the file. But in effect not much was done at all in those hundred days that should have been done. This file should have been put on an emergency basis—if they have red folders, or anything that indicates this file should be handled promptly and speedily, they should have done it at that point. Because after nine months and finding out what they were in at that time, they had to move on this claim as quickly as possible.

### **CUMULATIVE SUPPLEMENT**

#### **Trial Strategy**

[END OF SUPPLEMENT]

**§ 38. Tactics in investigation of medical condition**

**Q.**Is it important to investigate and analyze the medical history of any claim?

**A.**Of course. The primary indication of the extent of injury, any impairment or disfigurement suffered, any permanent loss, and indications of probable pain and suffering experienced, both present and future, will be reflected in the medical records and reports. This information is essential to the evaluation of any claim.

**Q.**What was done in this case?

**A.**There are extensive reports from Drs. \_\_\_\_\_, \_\_\_\_\_, and \_\_\_\_\_, the plaintiff's treating physicians, which were supplied to the defendant throughout the course of communications between the parties.

**Q.**In your mind, are these reports adequate?

**A.**I am not a doctor, but I have read hundreds, if not thousands, of these reports over the years in connection with adjusting and supervising the administration of insurance claims. From the standpoint of an insurance claims examiner, the reports fully substantiate all of the medical claims and conditions which have been made in this case.

**Q.**If there was any question over these reports, what should have been done?

**A.**The reports and medical charts could have been referred to a consulting physician for review, or the plaintiff could have been required to submit to an examination by a physician designated by the company. This is referred to as an IME, or independent medical examination.

**Q.**What was done in this case, with respect to further investigation of the medical condition of the plaintiff?

**A.**A number of things, but nothing that appears productive. First, after receiving the extensive summaries from the plaintiff's doctors, the company insisted that the plaintiff provide it with medical release forms permitting the company to obtain copies of the complete medical charts from the hospitals and medical providers involved in the case. But when these were provided, and it did take some time to assemble them, the company didn't do anything with them. It did not inquire of any of the hospitals or actually obtain copies of the charts.

**Q.**What else did the company do as time passed?

**A.**The company continually requested updated medical reports from the plaintiff's doctor. Each time this request was made, and it happened on several occasions, the plaintiff was obliged to go back to his doctor, submit to an examination, and then his doctor was obliged to write a report to the company. These requests all came after the doctor had written what he termed his discharge summary, in which he stated that the plaintiff's condition had fully stabilized, and that he was as good as he was going to get. This report was dated \_\_\_\_\_, and is in the claims file.

**Q.**What did the company do with these update reports?

**A.**This is what makes the circumstances of this case unusual. As far as the claims file, diary notes, and intercompany correspondence indicates, nothing. There is no indication that these update reports were examined or summarized or reported to the home office, or that they figured into the evaluation of the medical condition of the plaintiff in any way. In fact, \_\_\_\_\_ [branch claims manager] admitted in his deposition that he had not even read the last report from Dr. \_\_\_\_\_.

**Q.**What does all of this indicate to you, in your experience in handling claims?

**A.**That these were just delaying tactics.

**Q.**Why is that?

**A.**It appears that these requests for further information came only when \_\_\_\_\_ [plaintiff's lawyer] was pressing the company for a decision. Instead of giving him an answer, the company would insist on further information. Since they didn't do anything with this information when it was supplied, it appears that they were only buying time.

**Q.**Is this practice an acceptable practice, according to recognized industry standards in handling a first-party claim?

**A.**No, it is not.

**§ 39. Tactics in investigation of medical condition—Independent medical examination**

**Q.**What about an IME—was that requested in this case?

**A.**Yes, on \_\_\_\_\_ [date].

**Q.**Anything unusual about this request?

**A.**The file indicates that early on, the company made an inquiry of its local adjuster concerning an IME, and was advised that Dr. \_\_\_\_\_, the doctor who was treating the plaintiff and who had already submitted a detailed report, was considered a conservative and competent physician, and that an IME might be a waste of time and money. Further, the medical problems of the plaintiff in this case all consisted of objective injuries—that is, injuries that were readily apparent and measurable by

objective means. They showed up on X-rays and lab reports, they required surgical treatment in hospitals, they involved a number of doctors, and the reports of the doctors already in the file all corroborated each other. This was not a situation where the injuries were subjective, like soft tissue injuries that don't show up on X-rays or in lab reports, or a situation where all of the medical evidence was to come from a single source. In the situation here, there really did not appear to be any necessity for an IME.

**Q.**In terms of the reasonable standards of the industry, how would you characterize the request for an IME?

**A.**Taken in isolation, there would be nothing wrong with the request. It is a normal request to make in serious cases. However, when the request is taken in context with all of the other tactics in the case, it appears to me that the request was only for the purpose of delay.

**Q.**And as a delaying tactic, what is your opinion?

**A.**That it did not comply with the expected and reasonable standards of the industry.

#### **§ 40. Delay in investigating adverse driver's assets**

**Q.**All right. Any other items regarding failure to investigate on this matter?

**A.**Another element would be relative to an investigation into the assets of \_\_\_\_\_[adverse driver].

**Q.**Why is this important?

**A.**When an insurance company makes a payment under the uninsured or underinsured motorists coverage, it has what is termed subrogation rights to take action against the adverse driver to recover its losses. In this case, the insurer for the adverse driver offered the insurance limits of its policy, which was \$50,000, providing that \_\_\_\_\_[plaintiff] signed a release. Now, taking a release is a standard thing, and would have released \_\_\_\_\_[adverse driver] from any further liability. The defendant insurance company instructed the plaintiff that he could not accept this money or sign a release until the company had investigated the adverse driver's personal financial resources, and determined whether or not she had any substantial assets, over and above the insurance coverage, that could be obtained to cover any payments made under the underinsured motorist coverage. The company is entitled to do this, and this type of investigation is perfectly proper.

**Q.**What is involved in this type of investigation?

**A.**For an individual or family not in business, usually you can get a commercial credit report, make a few telephone calls to verify home ownership and employment, and check credit references. This will give you a reasonably predictable picture of the assets available. If something more is necessary, you can arrange an interview or deposition of the adverse driver, and ask him to supply bank financial statements, tax returns, or other documents. Unless there is some indication of hidden assets, this is usually sufficient. The object is not to measure net worth precisely, or determine exact assets, but just to get a picture of whether or not he has substantial assets. Homestead laws, exemptions, and bankruptcy protection make it virtually impossible to recover significant amounts from an individual unless he or she has substantial assets.

**Q.**How long should it take?

**A.**Unless the individual is hiding something, for an ordinary middle-class family it can be done in under thirty days.

**Q.**How quickly should it have been done in this case?

**A.**The assets investigation here could have been done in thirty days, as I think \_\_\_\_\_[branch claims manager] indicated in his testimony. I would have to agree with him totally on that. It could have been and should have been done in thirty days. Furthermore, if you're concerned about assets of someone who's a wrongdoer, you don't wait to find out what they are. Assets move, and you just don't sit there waiting.

If you take both scenarios I gave you before, that means that by the end of November of 1986 \_\_\_\_\_[adverse driver's] assets should have been searched and found and they should have known what they are if they had handled the claim properly at that time. Second time, beginning on July 8, 1987, if they had handled the claim properly, certainly by the time they had the file open on October 27th, they should have known what the assets were.

**Q.**How long did it actually take in this case?

**A.**It only took three weeks when they finally got around to it. The problem, of course, is that they waited until the end of August of 1988 to even make the inquiry. Then, when they had the information in their hands, which they received in the middle of September, for no reason I can find in the file, the company still delayed making any determination of the subrogation interests until after November of 1988.

**Q.**What effect did this delay have on the resolution of the claim with the plaintiff?

**A.**It had a significant impact. Since \_\_\_\_\_[adverse insurance company] had tabled its limits in September of 1987, and was willing to pay this amount to the plaintiff just as soon as he signed a release, and since the defendant refused to permit the plaintiff to sign the release until it had determined its subrogation interests, this meant that the plaintiffs were deprived of this \$50,000 for over thirteen months.

**Q.**How would you characterize this delay in terms of the accepted standards of the industry?

**A.**It was an extreme deviation from any reasonable standards.

#### **§ 41. Use of private investigator to harass plaintiff**

**Q.**Let's talk about the use of private investigators in the handling of an insurance claim. Are you familiar with this practice?



A. Yes, I am. I have used them many times.

Q. Why is this necessary?

A. Companies have a responsibility, as part of their investigation of any claim, to try to prevent insurance fraud. Also, there are many times when it is necessary to verify by actual observation facts which are stated in a claim. While most claims are legitimate, there are some that are exaggerated in one respect or another. A few may be total fiction. Even the documents may be invented. A claimant may contend that his back is injured to the point where he cannot work, for example, and he may produce what appears to be doctor's statements to back this up. We'll send a private investigator to watch him for a few days, and find out that he is engaged in strenuous activity around the home, or has gone back to work on the side and not reported it to us. I remember one case some years ago where the fellow claimed that his back was injured so badly that he could not lift more than ten pounds. We took movies of him helping his brother build a house, and he was carrying around a hundred sacks of concrete, climbing up and down ladders, and swinging a hammer—all completely inconsistent with his own statements. That sort of thing.

Q. Are you aware that the company utilized a private investigator and placed the plaintiff under surveillance in this case?

A. Yes, there is reference to that in the claims file.

Q. Anything wrong with that, in your opinion?

A. No, not in principle. I do have a problem, however, with the manner in which it was accomplished in this case.

Q. What is that?

A. The plaintiff's injuries were severe, and he was claiming significant impairment or limitations in his physical ability to raise his arm above shoulder level—this was the basis for the contention that he could not return to his old line of work, which required him to reach over his head. This had significant impact on the value of the claim, because it would significantly affect the future damages for lost earnings. Even though the physical limitations were documented in the medical reports from more than one doctor, it was still appropriate in my mind for the insurance company to quietly verify this, watch him for a few days, and see exactly how his physical limitations affected his ordinary life-style. But the company had no real reason at this point to suspect that there was anything wrong with the claim.

But instead of quietly watching the plaintiff, the insurance investigator began questioning his neighbors and openly hanging around the neighborhood. The neighbors talked to \_\_\_\_\_ [plaintiff], of course, and he complained to the company, wanting to know what was going on. Even after the company knew that the plaintiff knew he was being watched, they still left the surveillance in place for another full week. This was a total waste, since the whole idea is to observe the claimant when he does not know he is being watched. Another thing. I understand from a deposition I reviewed, that when the investigator was inquiring of one of \_\_\_\_\_ [plaintiff's] neighbors, he told the neighbor that he was investigating a potential fraud claim. This, too, got back to the plaintiff, and he was quite upset. Understandably so.

Q. What specifically did \_\_\_\_\_ [defendant insurance company] do wrong, in your opinion?

A. The inquiry of the neighbors should have been much more tactful and diplomatic. There was no reason whatsoever to suggest that the investigation was into a fraud claim. The investigator should have been cautioned that there was no suspicion of fraud, and that the company only wanted an independent verification of the claim. And the minute it appeared that \_\_\_\_\_ [plaintiff] knew he was being watched, the surveillance should have been called off. There was no reason to continue it beyond that point.

Q. Did the investigators' report indicate anything of concern with respect to the plaintiff's claim?

A. No. According to their report, their observations and door-to-door inquiry confirmed his disabilities. They observed nothing inconsistent with his claims.

Q. What was done with this report?

A. Nothing. It was simply placed in the file.

Q. Is there any indication that \_\_\_\_\_ [plaintiff] or his lawyer were ever advised that the investigators' report confirmed plaintiff's condition?

A. None.

Q. From a negotiating standpoint, would there be any purpose to what was done in this case?

A. Only to harass or embarrass or annoy the plaintiff, and to bring pressure on him.

Q. Is this an appropriate tactic for a company to employ, in your opinion?

A. Absolutely not.

## **§ 42. Home office involvement**

Q. Let's turn to another area. I think you've indicated that you are familiar with the handling of claims at the home office level, that is, at a level above the branch office handling, is that correct?

A. Yes.

Q. Have you actually sat on claims committees yourself?

A. For approximately ten years, yes.

Q. Did you reach any conclusions as to whether or not \_\_\_\_\_ [defendant insurance company] adhered to accepted industry standards in the manner in which this case was handled at the home office level?

A. Yes, I did reach a conclusion.

Q. What is your opinion in that regard?

A. In my opinion, the company failed to follow any of the accepted standards normal to the industry from the time they were

advised of this claim pretty much throughout, and the home office people, the senior officers of the company, had their hand into the claim pretty much throughout.

**Q.**What was done or not done at the home office level that you believe constitutes a breach of duty in this regard?

**A.**First of all, the company failed to delegate sufficient authority to the people responsible for handling this claim in order for them to do their job. As I understand it from previous testimony, or depositions, \_\_\_\_\_[line adjuster] had \$15,000 authority in \_\_\_\_\_[city], \_\_\_\_\_[branch claims manager] had \$25,000, and \_\_\_\_\_[home office claims supervisor], who was in \_\_\_\_\_[home office city], only had \$40,000 authority. With that small amount of authority delegated to the field, at least at the home office level the authority should have been larger, or there should have been some other way of handling a claim than what they apparently did with this claim. As was explained in the depositions, any time the company has a claim above \$40,000, it has to be resolved by a claims committee at the home office. But there is no indication in the claim file of who is on the claims committee, what they do at their meetings, or how they arrive at their decisions. They leave that meeting with no notes, nothing at all that registers what the decision was on that particular file. So there is no guidance that comes out of these meetings back to the field people to explain what the home office's thinking is on a claim, how they arrived at any decisions, or where the field people are to go from there with respect to further communications with their insured.

If the claims committee meets once a week, as \_\_\_\_\_[home office supervisor] indicated they do, I believe you should have a lot of information coming out of that committee with respect to this claim, and a lot of guidance and instructions to the field people with respect to the future handling of the claim. In this case, there was none of this.

You're also dealing with a claims committee that's comprised of five, six or seven people—it varied from week to week—not all of whom are claims people. One is house counsel, another is vice president in charge of casualty, and there's the indication in some other testimony that maybe even the president might sit in at times on different claim problems.

So there really should have been much more activity, much more involvement to make sure this claim was handled correctly, and there wasn't. At least, there is no indication in the claims file in the way of interoffice memoranda to the claims committee, or from the committee to the people at the branch level who were actually working with the plaintiff and his lawyers.

If the home office people knew what was going on, and approved, they were wrong for all of the reasons we have already discussed. If they didn't know what was going on, they should have, and they should have been issuing instructions and guidance to the field people to get this claim back on track.

**Q.**Did you find any specific indication of mishandling of this claim at the home office, other than the operation of the claims committee and inadequate authority to the field?

**A.**I noted two glaring instances which, although they did not bear directly on the claim of the plaintiff in this case, did indicate the methods being utilized by the company in the handling of the claim.

**Q.**And what were those?

**A.**The first was in the method by which the loss reserve on this claim was adjusted up as the claim progressed, and the second was in the reporting of this claim to the reinsurers.

### **§ 43. Home office involvement—Arbitrary adjustment of loss reserves**

**Q.**Lets take up the loss reserves first. You're familiar with the term "reserves," are you not?

**A.**Yes, I am.

**Q.**Having dealt with all the companies you've dealt with, are you familiar with the way in which insurance companies reserve claims?

**A.**Yes, I am.

**Q.**And from your review of the files and depositions in this case, are you aware of how the reserves were set on this claim by the defendant?

**A.**Yes, I am.

**Q.**First of all, please tell the jury how insurance companies establish a loss reserve on a claim and why.

**A.**How they're supposed to is by fair evaluation of the claim, so everyone is put on notice of what the potential liability is. It's important not only for the stockholders of the insurance company, it's important from the state insurance department's standpoint, from the underwriting and actuarial standpoint, and from everybody else's standpoint, to know what the probable liability under the claim will be.

**Q.**So proper reserving is important to a lot of different agencies and to the company itself, is that correct?

**A.**That's correct.

**Q.**Why is it important from the company's standpoint?

**A.**In order for the company to know where it stands financially at any given point in time, is it important for them to have a good grasp on what their actual or probable liability is in the cases they have pending. It's really absolutely necessary for them to do that.

**Q.**Is that true also for the various insurance commissioners in the states that they have to report to?

**A.**Yes, it is, because they have to verify by affidavit that these reserves are fairly set forth and fairly and properly noted. The Internal Revenue Service is also very interested in whether insurance companies over-reserve or under-reserve their pending claims.

**Q.**Did you do an examination of the reserving practice in this particular case?

A.Yes. In fact I reviewed and prepared separate sheets on it because I wanted to follow the reserves through to see what was done within the company.

Q.Could you explain to the jury what you found?

A. \_\_\_\_\_[Witness traces the history of adjustments to the loss reserve from the reserve reports contained in the claims file].

Q.Does that final figure now constitute the policy limits under the uninsured motorists coverage in this policy?

A.The remaining policy limits, yes.

Q.You indicated how low the reserves were set right at the outset. Did someone in the company actually recommend substantially higher reserves right at the outset of this claim?

A.Yes, they did. \_\_\_\_\_[Line adjuster] recommended \_\_\_\_\_ dollars.

Q.Was he successful in getting the company to accept this?

A.No, he wasn't.

Q.Did you draw any conclusions from how these reserves were adjusted as it pertains to the handling of the claim of the plaintiff in this case?

A.Yes.

Q.What conclusions did you draw?

A.I note that the line adjuster recognized at the outset that this was a serious case, and recommended a substantial reserve, but was overruled by management. He didn't have much information at that time, certainly not as much as he should have, but he did have enough to recognize that it was going to be a big claim. When they adjusted the reserve in January of 1988 to \_\_\_\_\_ dollars, they had virtually all of the base information from the plaintiff that they needed to set the reserve. Maybe they had not digested all of it yet, although as I indicated earlier, they should have. Nevertheless, they knew the medicals and past wages for certain. Further, they knew the plaintiff was going to have permanent impairments and was not going back to his old line of work, and they had an economist's report indicating his future wage losses. With only \_\_\_\_\_ dollars in limits, less advances and the underlying insurance available, I think it was absurd to set the reserve at only \_\_\_\_\_ dollars.

Q.Is there any indication of how that reserve figure was arrived at?

A.As far as the file indicates, it was the wishful guess of \_\_\_\_\_[home office vice president responsible for claims]. There is no indication in the file of any calculations, no breakdown of damages, no indication of how this value was arrived at.

Q.What event occurred, if any, that caused them to finally increase the reserve to the remaining policy limit available?

A.Nothing other than the filing of this lawsuit.

Q.Do you draw any conclusion from this?

A.Yes.

Q.What conclusions do you draw?

A.Once the lawsuit had been filed, it had to be reported to the reinsurers and to the state regulatory agency. They must have realized at last that the previous low reserves would no longer stand audit after the suit was filed, so they finally increased them.

Q.If the reserves had been properly set before, would there be any reason to increase them just because a lawsuit is filed?

A.No, none.

#### **§ 44. Home office involvement—Misleading reports to reinsurers**

Q.Let's turn to the area of reinsurance. I think you've already explained to us what that is. I wonder if you would look for a moment at Exhibits \_\_\_\_\_ and \_\_\_\_\_ and tell me if you are familiar with those two exhibits.

A.I am.

Q.Have you looked at both of those exhibits?

A.Yes, I have.

Q.Now, both of those are reports from \_\_\_\_\_[defendant insurance company] to the its reinsurer, is that right?

A.That's correct.

Q.When is the company required to report to their reinsurer?

A.When it appears that a claim may reach the level where the reinsurer would be possibly involved in any loss payment.

Q.Have you examined those two documents for the accuracy of the information that was given to the reinsurer?

A.Yes, I have.

Q.Can you tell the jury whether or not those reports were accurate to the reinsurer?

A.I have examined the statements in there and I do find some rather large discrepancies.

Q.Okay. Are those factual discrepancies?

A.Yes.

Q.What do the inaccuracies pertain to?

A.The times at which the loss reserves were adjusted, the reason for the adjustments, and the status of the claim at the time of the report.

Q.And at the time that those were reported to the reinsurer do you find documentation in the claim file that indicates exactly the contrary to what they're reporting?

A.Yes.

Q.What does it tell you—that in these reports to their reinsurer, they have given inaccurate facts?

A. Well, first you have to understand that they owe the same duty to their reinsurer that they owe to their insured; that is, they owe a duty to investigate a claim promptly and thoroughly, and to fairly assess the amount of the claim and determine the probable liability under the policy. They had to deal with them fairly and honestly and give them the information that was accurate to the best of their knowledge at the time.

And they should give it promptly. I was required in my times of reporting to give that report within thirty days. I have understood recently that those time limits have been revised down—reinsurers want it faster than thirty days. Some of this information did not get to them in that thirty-day period. Plus, it was inaccurate.

What this tells me is that the mishandling of this file was not just at the field level, it was throughout management. The top-level management people knew what was going on, and were concealing it from their reinsurers.

Q. With regard to the inaccuracies that were reported to the reinsurer, and the manner in which the loss reserves were handled, how does that reflect on the way that \_\_\_\_\_ [defendant insurance company] was handling this claim of \_\_\_\_\_ [plaintiff], in your opinion?

A. I think this makes the conclusion inescapable that it was not a case of simple neglect or indifference, nor was it a mistake or accident. It was a deliberate course of tactics by the company intended to drive the settlement down, which was either condoned or directed by top management of the company.

#### § 45. Economic pressure and coercion

Q. Now, you made reference to the fact that you determined that there was economic coercion used on \_\_\_\_\_ [plaintiff]. Could you explain that to the jury, please?

A. In my mind this goes throughout the handling of the whole claim. You have a very serious problem. There is a horrendous injury here. When the company finally woke up and opened this file in the summer of 1987, the plaintiff was already close to his third surgery. He had not been able to work since the accident, and was not going to be able to work for many more months. By the fall of that year, 1987, it was clear that he was not going to be able to go back to his old line of work—that's in a report that was submitted to the company at that time. He was either going to have to be retrained, or was going to have to accept a cut in pay. He was going to have permanent injuries—a permanent impairment—and this is fully documented. By the spring of 1988, the situation was desperate. You proceed along through the file and it's indicated that \_\_\_\_\_ [defendant insurance company] knows that the plaintiff and his family are virtually destitute. A mortgage foreclosure is coming on top of them. They have medical bills that aren't being paid, and you have a scenario where you see people who are under a tremendous, tremendous pressure to just get by day to day. This claim could have been fully resolved by early 1988. We've talked about that. At the latest, it should have been resolved by the early summer of 1988. We have talked about that. Every day of delay added to the tremendous economic pressure on the plaintiff and his family.

Q. Was the defendant aware of all of this?

A. Absolutely. The financial distress these people were suffering was fully disclosed and explained by the lawyers in letters to the company, and by the plaintiff and his wife in telephone calls pleading for help.

Q. Under accepted industry standards, is there any justification for allowing this economic pressure to continue any longer than absolutely necessary to properly administer the claim?

A. No. In first-party coverage, people buy insurance for the express purpose of avoiding this type of financial pressure. This is what the insurance is for, so that people do not have to suffer this pressure.

Q. Are there any particular instances where the defendant in this case applied special coercion on the plaintiff, from an economic standpoint?

A. I think there are at least three instances of tactics employed by the defendant that demonstrate the intentional application of coercion. First is an unreasonable refusal to allow the plaintiff to accept the \$50,000 from the adverse insurance carrier for over thirteen months. Second is in the manner in which requests for advances were handled. And third is the tactic of coupling an offer to permit the plaintiff to accept the \$50,000 from the adverse carrier only if the plaintiff would take \$25,000 from the defendant in satisfaction of the entire claim.

Q. Let's take them up one at a time. This might seem obvious, but explain to the jury why you believe defendant's withholding permission to settle with the adverse carrier constituted coercion in this case.

A. \_\_\_\_\_ [Adverse carrier] offered \$50,000 in September of 1987. The defendant would not let plaintiff take this money, on the pretext that they had to determine their subrogation interests first. They could have determined this in thirty days, and they now admit this. But they stalled for over a year. So for all of this period, the company not only would not pay the plaintiff what was due under his own policy, they would not let him have the money that had been offered by the other company. The only reason I can think of for this tactic would be to increase economic pressure on the plaintiff, so that he would eventually accept a lower settlement from the defendant in desperation. To my mind, this is pure coercion, and it is inexcusable.

Q. Were there any other costs or pressure applied to the plaintiff as a result of the company's refusal to allow him to accept this offer?

A. Yes. Remember that the plaintiff's wife and child were injured in this accident, along with the plaintiff, although not severely. A lawsuit was filed on behalf of the plaintiff, his wife, and his child for these injuries, against \_\_\_\_\_ [adverse driver]. Her insurance company, \_\_\_\_\_ [adverse carrier], took on the defense and hired a lawyer. The lawyers quickly worked out a settlement for the injuries to the wife and child, and these amounts were paid. It wasn't much, something under \$20,000. By September of 1987, \_\_\_\_\_ [adverse carrier] determined that the losses to the plaintiff exceeded the remaining

limit of the adverse driver's policy, and they made a policy limits offer. If that offer could have been accepted, it meant that the first lawsuit was all over; it could have been dismissed. Instead, because of the delay forced upon the parties by the \_\_\_\_\_ [defendant insurance company], the plaintiff and his lawyer had to continue the preparation of that lawsuit right up until the pretrial conference. This meant extra time and money and worry to these people, who were not familiar with litigation or legal matters, for months. And it all turned out to be completely unnecessary.

If this wasn't bad enough, \_\_\_\_\_ [adverse carrier] got fed up with the delay after \_\_\_\_\_ [defendant insurance company] had stalled around making a decision for three months, and filed its own lawsuit, called a declaratory judgment action, to try to force a decision. While the primary target in that lawsuit was \_\_\_\_\_ [defendant insurance company], the plaintiff was also named as a defendant, because he was the real party in interest. It was him they were trying to pay the money to. This meant that his lawyers had to represent him in yet another lawsuit, running up legal bills and court costs, and subjecting him to yet another set of worries and concern over being tangled up in court.

**Q.** Would you characterize it as oppressive, wanton, fraudulent, malicious or outrageous?

**A.** All of those.

**Q.** The second instance was in the handling of requests for advance payments. Would you explain that to the jury?

**A.** According to company policy, as stated in the claims manual and policy guidelines issued by the home office, when it is adjusting a loss with its own insured under first-party coverage, the company is supposed to pay to the insured those parts or portions of any loss which are not disputed, and to make payment of these amounts as soon as it is determined that there is no dispute.

**Q.** Let me interrupt—would you refer the jury to the sections in the claims manual and guidelines which you are referring to? They are Exhibits \_\_\_\_\_ and \_\_\_\_\_, which are on the table there.

**A.** Yes. [Witness identifies language from exhibits.]

**Q.** Please continue.

**A.** In this case, there could be no dispute over the medical expenses; the bills were all in. There could be no dispute over the lost wages of the plaintiff; he was out of work from the time of the accident until the late spring of 1988, and this was fully documented in the medical records. These amounts alone totaled over \$70,000. And there was no dispute that he was going to get \$50,000 from the adverse carrier. This offer had been on the table since September of 1987. Yet when \_\_\_\_\_ [plaintiff's wife] telephoned the company in tears in February of 1988, begging for help to stop a mortgage foreclosure on their home, the company advanced only \_\_\_\_\_ dollars. This was the amount to the penny that was required to stop the foreclosure. The company did not even consider advancing an extra dollar to these people, despite the fact that the company was sitting on at least \$70,000 which was indisputably their money, and was unreasonably refusing to allow them to pick up \$50,000 more.

Then, when they did agree to make this advance of \_\_\_\_\_ dollars, they still let these people worry for almost another month, right up until the day before the foreclosure was to occur, before releasing the money. They insisted on verifying the amount due the mortgage lender, and stalled around until the last minute.

That's coercion in my mind, even though the payment was made. It was made very late and it was made with money I believe already belonged to the plaintiff. And at that time it was made only in part. In other words, only to fulfill the absolute basic needs that they had at that time. The money still did not take the plaintiff out of being in a very tight, very difficult, very worrisome situation, with a lot of mental anguish and mental distress connected with it.

**Q.** Would this advance payment be any indication of good faith on the part of the defendant?

**A.** In no way. It was like offering a teaspoon of water to a man dying of thirst. It prolonged the agony.

**Q.** Finally, you mentioned the offer made in the summer of 1988 as being an instance of economic coercion. Would you explain that to the jury?

**A.** In June of 1988, the company made its first and only offer to the plaintiff prior to the filing of this lawsuit. The branch claims manager, \_\_\_\_\_, told plaintiff, through his lawyer, that he could accept the \$50,000 from the other company if, and only if, he would accept an additional \$25,000 from the defendant in full settlement of his underinsured motorist claim. Now, the \$25,000 was a meager offer by any standards, given what the company knew by that time. This alone made the offer unreasonable. But coupling this offer to the offer already made by the adverse carrier made the whole business unconscionable, in my opinion. If they were willing to let him accept the money from \_\_\_\_\_ [adverse insurer], they should have let him have it with no strings attached.

Furthermore, the fact that they were willing to allow him to accept the \$50,000 is further indication that the only reason they had previously denied him permission to accept this settlement from \_\_\_\_\_ [adverse insurer] was to use it as leverage in their own negotiations. The only conclusion that can be drawn from this tactic is that the company was using every means of economic pressure available to drive the claim down and force the plaintiff to accept a lower settlement.

**Q.** Do you have an opinion as to how defendant's conduct in all of this measured up to the accepted standards of the insurance industry with respect to the handling of first-party claims?

**A.** Yes, I do.

**Q.** What is your opinion?

**A.** In my opinion, these tactics were an extreme deviation from accepted practices, they were an extreme deviation from the written policies of the defendant company, as set forth in the claims manual and policy guidelines, and they constituted oppressive, wanton, and outrageous conduct on the part of the defendant toward its own insured.

**Q.** And do you have an opinion as to how deeply into the company management this tactic of economic coercion penetrated?

**A.** Right to the very top. You have the early memorandum of \_\_\_\_\_ [senior vice president] which says, "Let's pull out all the stops on this one." That's in the exhibits and was talked about yesterday. You have the fact that a duplicate claims file was maintained at the home office, and the fact that nobody in the field had any authority to go above \$40,000, so everything had

to go through the top management claims committee. Everything in this file indicates that the stonewalling and delaying tactics were being directed by the senior management of the company.

Q.Is there any justification for this?

A.None whatsoever, in my opinion.

## **B. Testimony of Insurance Risk Manager**

[After introduction, identification, and qualification of witness. The witness was qualified as an expert by his credentials as the insurance risk manager for the state. Prior to his state position, he had been employed with a private insurance company for a number of years, working his way up from line adjuster to vice president of claims. Prior to this, he had been employed with an independent adjusting firm. As to the use of insurance managers or risk managers from private industry or government as expert witnesses, see § 22.]

## **§ 46. Introduction**

Q.What is your current position?

A.I am the insurance risk manager for the state of \_\_\_\_\_, under the department of administration.

Q.How long have you been so employed?

A.For the last \_\_\_\_\_ years.

Q.Would you outline for the jury your experience in the insurance industry prior to your employment with the state?

A. \_\_\_\_\_ [Witness details his experience].

Q.What are your responsibilities as risk manager for the state?

A.I am responsible for administering all of the casualty and property insurance for the state, for all of the state agencies and bureaus throughout the state. My concern, in my department, is with public liability insurance—generally anything that falls within the category of casualty, personal injury, or property damage, both from the standpoint of liability insurance and first-party coverage. We evaluate the risks that should be insured against throughout the state agencies, determine the amounts of insurance that should be carried, put out requests for bids, secure the insurance and ensure that all policies are properly maintained, and then handle the administration and negotiation of all claims in the event of a loss under any of the policies.

Q.In your capacity as risk manager for the state, have you handled personal injury claims?

A.Yes, in the case of claims against the state for personal injury made under the tort claims act. Our department is responsible for handling these claims directly, where the state is self-insured, and for overseeing the handling of these claims where there is insurance.

Q.Would these be considered third-party claims?

A.Yes.

Q.How about first-party claims for personal injury—have you handled any of these in your capacity as risk manager for the state?

A.Not really. First-party claims for personal injury are generally for the individual's benefit, and the individual himself or herself usually handles these claims directly, usually through his or her own attorney. The only way our department becomes involved is if there is a subrogation interest to the state for the recovery of benefits advanced to an employee of the state that might be recoverable from a third party, but that is probably the only case.

Q.Are you involved in the handling of any first-party claims?

A.Yes, in the area of property damage. Our department administers and negotiates all property losses for the state, from minor fender benders to state vehicles to multimillion-dollar fire losses.

Q.In terms of handling a claim, is there any difference between a personal injury claim and a property damage claim?

A.Not significant, from the standpoint of claims administration. In both cases, the objective is to determine the loss, document the damages, evaluate the amount of money necessary to pay the damages, and get it paid as quickly as possible.

Q.How many personal injury claims have you been involved with during your time as risk manager for the state?

A.Hundreds.

Q.How about property damage claims?

A.That is probably in the thousands, if you take into account all the minor fender benders.

Q.And how many insurance companies do you, or have you dealt with over the years?

A.Insurance is let on a bid basis, and is very competitive. I don't have exact figures, but I am sure that we have written policies with most of the major companies qualified to do business in the state, and probably many of the smaller ones.

Q.Does the state have any policies written through \_\_\_\_\_ [defendant insurance company]?

A.I did check on that. No, we do not. And according to our bid files, they have not bid on any state business during the last \_\_\_\_\_ years.

Q.Have you ever negotiated any claim against this company on behalf of the state?

A.No. At least, I cannot recall any, and I could find no indication of any claims against \_\_\_\_\_ [defendant insurance company] in our claims files.

Q.So you have no claims against this company on behalf of the state, nor any claims against the state which they are

insuring?

A.None.

Q.Do you know any of the individuals from the company?

A.No, I have never met any of them.

Q.Do you know the plaintiff or anyone from his family?

A.No.

Q.Do you know of any connection between the plaintiff or any member of his family and any agency of the state?

A.To my knowledge, there is none.

#### **§ 47. Establishing the basis for the expert's opinions**

Q.In your capacity as risk manager for the state, and from your prior insurance industry experience, have you become familiar with the recognized standards accepted in the industry for the administration, evaluation, and payment of insurance claims, from the policyholder's standpoint?

A.Yes. That is what I do, day in and day out.

Q.How would you characterize the state from the standpoint of its position as a policyholder?

A.I suspect we are the largest consumer of insurance services in the state. The state has over \_\_\_\_\_ million dollars of insurance in force, spread among \_\_\_\_\_ companies. We are in the constant process of evaluating this coverage, and evaluating the performance of the companies that write the policies from the standpoint of services provided. The state is frequently named as a codefendant or additional defendant in all manner of tort claims, and we are continually working with our codefendant's insurance companies in connection with the administration of these claims. Finally, we are often a claimant ourselves, in property damage claims with our own companies and against third parties in tort situations, where we deal with the adverse party's insurance carrier. So I would say that I am extremely familiar with the handling of insurance claims from every facet.

Q.How did you become involved in this case?

A.I was contacted by your office, and asked to review information relative to the handling of an underinsured motorists claim against \_\_\_\_\_ [defendant insurance company].

Q.And did you do so?

A.I did.

Q.What information did you review?

A. \_\_\_\_\_ [Witness discusses the documentation reviewed as the foundation for his conclusions].

#### **§ 48. Difference between first-party and third-party claim practice**

Q.Is there a difference between the handling of a third-party claim and a first-party claim, from a policyholder's standpoint?

A.Yes.

Q.Can you explain the difference?

A.When I am making a first-party claim, I am dealing with our own insurance company. We have paid the premium for the coverage, and we expect the insurance company to cooperate with us in determining the loss, evaluating the damage and paying the state what is due. I have to be open and aboveboard with the company, and tell them everything that I know that bears on the loss. I expect them to be open and aboveboard with me, and tell me quickly of any problems that they have with the claim, so that we can work it out and get it settled. The company is obligated to pay the state the fair value of the loss sustained—that's what we bought the insurance for, and that's what the contract says we're entitled to.

On the other hand, when I am making a third-party claim, I am dealing with the other guy's insurance company. It doesn't have to pay me anything, it just has to protect the other guy. If it can protect his interest by paying just a little bit on a claim, and I am willing to accept it, so be it. While I might hope that the other guy's insurance company will deal with the state fairly and in good faith, I don't have any legal reason to expect it.

Q.You are aware, are you not, that underinsured motorist coverage is considered to be first-party insurance.

A.Yes, it is. It is coverage the insured purchased to protect him and his family or passengers in his automobile.

#### **§ 49. Overall conclusions of the expert**

Q.Now with that in mind, and based on your experience and on your examination of the documents and information supplied to you concerning the handling of the underinsured motorists claim of the plaintiff, \_\_\_\_\_, against the defendant, \_\_\_\_\_, do you have an opinion as to whether or not this claim was handled in accordance with the standards accepted in the insurance industry for the administration of first-party claims, from the standpoint of the policyholder?

A.I have an opinion.

Q.What is your opinion?

A.The company did not conform to the accepted standards in many of the significant respects. There was gross delay in the



handling of the claim at virtually every step. The damages were never analyzed or evaluated in a competent manner, and as a consequence the dollar value that the company placed on the claim was grossly inadequate. The plaintiff was required to become entangled in two totally unnecessary lawsuits, which increased his costs and further delayed matters. The defendant utilized tactics of economic coercion and pressure to drive the claim down that are intolerable under first-party coverage.

**Q.**How would you characterize the degree by which the defendant company deviated from the accepted standards of the industry?

**A.**I would characterize it as a total disregard of any accepted practices.

**Q.**Would you say it was an extreme deviation?

**A.**Certainly. That and more.

**Q.**Would you say that the actions or omissions of the defendant were oppressive, wanton, fraudulent, malicious, or outrageous?

**A.**Yes, all of those come to mind in describing this situation.

**Q.**Can you state whether or not, in your opinion, the company acted with an understanding of and a disregard for the likely consequences of its actions?

**A.**It is clear to me from the file and information I have examined that the company knew exactly what it was doing, and that it had no regard whatsoever for the consequences to anyone else. It was attempting to act for its own best interest, with a calculated and callous disregard for the interests of anyone else.

#### **§ 50. Delay in opening claim file**

**Q.**You have indicated that in your opinion there was, I think the words you used were “gross delay” in this case. Is that correct?

**A.**That’s correct.

**Q.**Could you explain what you mean by that to the jury?

**A.**When this case was originally reported to the company on the day following the accident, the company was made aware of a serious injury to the plaintiff, and less serious injuries to his wife and child. Immediately upon that notice, the medical payments portion of the policy is committed, regardless of fault. They owe the money up front up to the limit of those medical bills that are related to that accident. Secondly, even though they were advised that the adverse carrier was on the risk, they had an obligation, in my opinion, to assist their insured, if the insured desired, in the handling of the physical damage portion of the case, the collision damage to the vehicle. Finally, because of the seriousness of the injury and the possibilities of the case, they should have instituted their own investigation to make sure there was no liability which they may have owed to the adverse driver, and no liability to the passengers of their insured’s vehicle. I believe they should have immediately undertaken an investigation and I believe that their own procedures would require them at that point to at least get the facts whether they were instructed to or not. These were duties they owed to the policyholder, under the terms of their contract.

**Q.**Did you identify any documents where \_\_\_\_\_[defendant insurance company] itself recognized having erred in that regard?

**A.**Yes, I did. There is a memo in the claims file containing an admission from the branch claims manager to the home office supervisor that the closing of the case from October of 1986 to July 1987 was, in his words, “a blunder.”

**Q.**Is that memo Exhibit \_\_\_\_\_?

**A.**[Looking] Yes, that’s it.

**Q.**Do you agree with that characterization—“a blunder”?

**A.**I certainly do.

#### **§ 51. Failure to inform plaintiff of coverages available**

**Q.**Did the company do or fail to do anything else, with regard to this insured, when the original report was made in October of 1986?

**A.**According to the deposition of \_\_\_\_\_[line adjuster], all he did was tell \_\_\_\_\_[plaintiff’s wife] to let them know what happened. But, as I just mentioned, there was first-party coverage involved, as well as the uninsured motorists matter. In my opinion, the adjuster should have asked \_\_\_\_\_[plaintiff’s wife] if she was aware of these coverages—medical pay, collision and so forth—and made sure in his own mind that she knew what her policy covered. He didn’t do this.

**Q.**Are you saying that he misrepresented the coverage in force?

**A.**No, but he didn’t explain or offer to explain what was available under the policy. Now, I know this business pretty well, and when I call in a claim, I can say this is covered under this provision, and that is covered under that provision. But the average person, when they call in, they typically say this is what happened, am I covered? And they expect the company to tell them. That didn’t happen in this case.

## § 52. Breach of policy conditions

**Q.**Did the company's handling of this claim, and particularly the delay in allowing acceptance of the other insurance company's limits, violate or interfere with any of the policy conditions for payment?

**A.**In my opinion, yes. The insurance policy has a precondition that says the insured is not entitled to any proceeds under the underinsured motorists coverage until the limits of any insurance on the adverse driver have been exhausted. Then there is another condition in the insurance policy that prohibits the insured, in this case \_\_\_\_\_[plaintiff], from settling with the adverse insurance company, or with anyone else, without the company's permission. This is to protect their subrogation interests against the adverse driver, if any. The defendant's actions interfered significantly with the plaintiff's ability to satisfy these conditions.

**Q.**Please explain.

**A.**In this case, the defendant could have made its determination with respect to any subrogation interest within thirty days—that has been talked about. Then it could have given the insured permission to accept the other company's policy limits, but it delayed for over thirteen months before making any decision at all. During this whole period of time, their insured was caught between these two conditions of the policy. He couldn't press his claim under the coverage until he settled up with the other company, and he couldn't settle up with the other company because the defendant wouldn't let him.

**Q.**When you speak of subrogation interest, whose interest is it?

**A.**Clearly, the interest being advanced was that of \_\_\_\_\_[defendant insurance company]. The financial condition of the adverse driver was really not of concern to \_\_\_\_\_[plaintiff]. That is why you carry underinsured motorist coverage, so you don't have to worry about the other guy's financial condition. On the other hand, company memoranda and correspondence in the claims file are chock full of references to "protect our subrogation," and "protect our interest." This indicates clearly that the company knew that a timely determination was for their own benefit. They knew they had a contractual interest but they didn't bother to take the time or go to the effort to find out what that contractual interest was worth for over thirteen months.

**Q.**Who benefited, if anyone, from the delay in giving \_\_\_\_\_[plaintiff] permission to accept the other company's policy limits?

**A.**Now, as to who benefited from the delay, it could only be \_\_\_\_\_[defendant insurance company]. They had \_\_\_\_\_[plaintiff] caught in a catch-22 situation. He couldn't make a claim against them under the provisions of his policy until he had exhausted the provisions of the adverse driver's insurance, and he couldn't accept the money from the other carrier until they gave him permission. As long as they stalled in giving permission to accept the other insurance, they were preventing him from proceeding with any claim against them.

**Q.**Was anyone harmed by this delay on the part of the defendant?

**A.**Yes. The plaintiff, certainly, was harmed. He was deprived of \$50,000 for over a year, which caused the family considerable financial distress. Further, they were tied up in two unnecessary lawsuits with the other driver and her insurance company. In addition, the delay certainly caused additional expense and probably additional stress to \_\_\_\_\_[adverse driver]. She and her husband were left hanging for over thirteen months wondering if \_\_\_\_\_[defendant insurance company] was going to force them into bankruptcy over this claim. And the delay certainly caused additional and unnecessary expense to \_\_\_\_\_[the adverse carrier]. They had to continue to defend their insured for over a year after they had offered the full insurance limits, waiting for a decision from the defendant, and they even filed their own lawsuit trying to force a decision from the defendant, unnecessarily running up their bills for legal fees and costs.

**Q.**Can any of this be explained or justified under acceptable claims-handling practices for first-party coverage?

**A.**It can be explained, but not justified.

**Q.**How can it be explained?

**A.**In my opinion, the delay was calculated to enable the company to use the other insurance limits for leverage in its negotiations with the insured in this case. This is exactly what they attempted to do in making their early offers in the case. Even in third-party claims, this is a risky practice. In first-party coverage situations, it is intolerable.

**Q.**Was this a deviation from accepted claims practices, in your opinion?

**A.**It was.

**Q.**Would you say it was an extreme deviation?

**A.**An extremely extreme deviation. I have never seen anything like it in my entire experience. When you consider the pressure this put on their insured, it was absolutely outrageous.

**Q.**Was it a deviation from any stated policy guideline of the defendant company?

**A.**It was. The company has an express policy guideline that covers this situation.

**Q.**Please look at Exhibit \_\_\_\_\_. Is that the policy guideline you are referring to?

**A.**Yes. It's item number five in \_\_\_\_\_[defendant insurance company's] policy guidelines for avoiding punitive damages. It says, "Do not require the insured to take unreasonable steps when the policy has a precondition to payment."

**Q.**What were the unreasonable steps in this case, if any?

**A.**Waiting thirteen months for permission to take the money from the other company. Requiring the insured to continue his lawsuit against the other driver after her company had made a full limits offer. Forcing him to become tied up in the third lawsuit. This wasn't just unreasonable, it was unconscionable.

### **§ 53. Requests for redundant or unnecessary information**

**Q.**What, if anything, did you observe in the handling of this claim with respect to requests for information?

**A.**There are requests to the plaintiff for employment and wage verification from his employer, as well as requests for medical records and reports.

**Q.**What, if anything, did they tell the plaintiff about the necessity for employment and wage verification?

**A.**There is a note in the adjuster's daily log that in responding to a telephone inquiry from plaintiff's lawyer as to payments the plaintiff was entitled to under the policy, the lawyer was told an answer could not be provided until the company had verified plaintiff's employment and wage losses.

**Q.**Is that the entry dated \_\_\_\_\_ which appears on Exhibit \_\_\_\_\_?

**A.**[Looking] Yes, it is.

**Q.**What specifically was plaintiff requested to do insofar as providing employment and wage verification?

**A.**He was requested to sign various authorization forms and return them to \_\_\_\_\_[defendant insurance company].

**Q.**Did plaintiff comply with that request?

**A.**Yes.

**Q.**When \_\_\_\_\_[defendant insurance company] received the signed authorizations back from \_\_\_\_\_[plaintiff], can you tell us what the company did with those authorizations?

**A.**It appears that they put them in the file and forgot about them. I cannot see that they were ever used by the company.

**Q.**Any other instances of requests for additional information?

**A.**There are several requests, later in the file, for updated medical reports from the plaintiff's physician. In each case, it appears that a medical report was submitted.

**Q.**Was it usual for the company to request these updated reports from a claimant in this kind of case?

**A.**In this case the requests were unusual.

**Q.**Why do you note this as unusual?

**A.**These requests all came after the company had received a complete summary from the doctor, indicating that the plaintiff's medical condition had stabilized. While it might have been appropriate to request one more update, the extra requests appear to be a negotiating tactic.

**Q.**Why do you say that?

**A.**Because there is no indication that anything was done with the updated reports—they were not analyzed or sent out for review, and \_\_\_\_\_[branch claims manager] even indicated in his deposition that he had not even read them all. Further, it appears that these requests for additional medical information were made in response to demands from the plaintiff's lawyers for a decision on the file.

**Q.**Is there anything wrong with requesting further information, in your opinion?

**A.**Not if the information is necessary to the investigation or evaluation of the claim. But it is wrong if it is just a negotiating tactic to stall and buy time. Sometimes we see this in third-party claims, where the adverse insurer will keep responding to demands with requests for further information. It's a risky tactic, and a sharp adversary can turn it against you. But the tactic is not appropriate at all in a first-party case. Here, delay works only to the benefit of the company, and prevents the insured from getting what he paid for under the policy. In addition, the requests put unnecessary burdens and stress on the insured.

**Q.**How so?

**A.**Each time the company requested a medical update, \_\_\_\_\_[plaintiff] had to make a doctor's appointment, go see his doctor, and submit to an examination. Now he had already been picked and poked at by doctors for over eighteen months. To subject him to unnecessary examinations, just to buy time for the insurance company, is pure torture.

**Q.**You indicated that this was not acceptable claims practice in accordance with recognized industry standards.

**A.**Correct.

**Q.**Did it violate any specific policy guideline of \_\_\_\_\_[defendant insurance company]?

**A.**In my opinion, it did.

**Q.**And what is that?

**A.**Item six of Exhibit \_\_\_\_\_, the guidelines on avoiding punitive damages, says, "Promptly communicate the company's position on all claims as soon as the investigation is complete." In this case, instead of stating what their position was and clearly stating the reasons for this additional information, they kept waffling. They never told him, or his lawyer, what their evaluation was or why. They never explained anything. Ordinarily, if a company has a problem, they will say, "According to the information we have, it will only support a claim of X dollars. If you think it's worth more, we will need this and this and this." Then you go find this and this and this, and submit it, and they take another look. Nothing like that happened here. The plaintiff couldn't get any answers from the company. In my opinion, this all constituted a breach of this policy guideline.

### **§ 54. Economic coercion**

**Q.**You made reference to the fact that \_\_\_\_\_[defendant insurance company] used economic coercion on the plaintiff. Could you explain to the jury what you meant by that?

**A.**Yes. I think that it all ties together. In their training materials there's a course on negotiating skills that talks about things

like “The Vise Technique,” “How to Squeeze People,” and “How to Use Time.” These are meant to show how to use financial leverage and how to use time to the company’s advantage. The claims file is also full of the word “destitute.” That’s a financial term I think that everybody is familiar with. It’s in the file. They’re destitute yet the company is not doing anything to resolve the issue in a timely fashion. Instead, they are bringing every tactic available to bear on these people to drive the amount of the claim down.

**Q.** From your study of the file, do you have an opinion as to whether they tried to squeeze \_\_\_\_\_ [plaintiff] and use this time pressure on him to try to get him to settle this case?

**A.** I think those titles are an apt description of what happened in this case. I believe that they used both of those techniques and it’s hard for me to believe that was an accident.

**Q.** Is application of the vise technique or squeezing people an acceptable claims practice for a company to employ, in your opinion?

**A.** Absolutely not. I think that just having these titles listed in their training materials for some claims person to read is outrageous, regardless of what the courses actually teach.

#### **§ 55. Economic coercion—Inadequate offer**

**Q.** Are you aware of the fact \_\_\_\_\_ [defendant insurance company] made a \$25,000 offer in late June of 1988 to get a release for themselves of the balance of their obligation on the contract?

**A.** Yes, I am.

**Q.** Do you have an opinion as to whether or not that was an attempted use of economic coercion on the plaintiff?

**A.** There is no question about it. If you look at it in context you have a claim that has dragged out now for almost two years. You have people who are destitute, who are in dire need of money, and you offer them \$25,000 on a claim they know is worth considerably more, which may sound like a lot of money, in hopes they’ll take it in desperation. I can’t imagine why they would offer \$25,000 in a case like this, especially when you’ve got \$50,000 authority.

**Q.** The home office actually authorized \$50,000 at that time?

**A.** That’s correct. There is a memorandum to the branch claims manager from the home office supervisor, saying [reading from exhibit], “Perhaps they are ready to get on with their lives; offer 50K for a full release.”

**Q.** And that is the memorandum dated \_\_\_\_\_ in Exhibit \_\_\_\_\_?

**A.** Yes.

**Q.** How do you interpret the phrase, “Perhaps they are ready to get on with their lives”?

**A.** It is a cliché that I have seen frequently over the years in the insurance field. It literally is a signal that the offer is too low, but that perhaps the recipient will accept it just to be done with the hassle.

**Q.** Is this acceptable in first-party claims practice?

**A.** Certainly not where it is the company that is responsible for the hassle, as is the case here.

**Q.** Was the offer a reasonable offer in this case?

**A.** It was a ridiculous offer, in terms of what should have been the evaluation in this case.

**Q.** How about if the offer had been the full \$50,000 that was authorized?

**A.** It still would have been a ridiculously low offer.

**Q.** Why would any company think that the plaintiff would accept such a low offer?

**A.** The only reason would be that things had dragged on for so long, and the plaintiff was under such financial pressure, that he would have to accept it just to survive. Remember, this offer was tied to releasing the money from the other company. To a man who doesn’t have any money at all, \$100,000 can look awfully big—even if he is entitled to hundreds of thousands more.

**Q.** Is there any indication that the company in this case was aware of this?

**A.** Yes. There is no question about it. \_\_\_\_\_ [Branch claims manager] said it in his deposition, when he was asked why the company only authorized \$50,000. Can I read it? It’s a classic.

**Q.** Please do.

**A.** [Witness looks] Here it is, page \_\_\_\_\_. You had just asked him how the company came up with that figure, and he said, “Well, gee. We just thought that a hundred thou’ would look like a lot of money to \_\_\_\_\_ [plaintiff].”

#### **§ 56. Economic coercion—Insistence on release of claims**

**Q.** Was anything else unusual about this offer?

**A.** It was coupled to permission to accept the \$50,000 from the other company, which we have already talked about, and also it was conditioned upon the insured signing a release to the defendant, releasing them from all further liability under their policy.

**Q.** Why is this unusual?

**A.** An insurance company ordinarily does not need a release when it is paying an obligation due under first-party coverage. It is a different situation where the company is settling a third-party claim—there, the company will obtain a release as part of its duties to protect its insured. But where the company is paying money to its own insured, a release is not necessary. In fact,

it is inappropriate. If someone has made a mistake, and there is really more due under the policy than was paid, there is no reason not to reopen the file and correct the mistake. Requiring a release in this case is another indication that the company was placing its own interests ahead of those of its insured.

**Q.** Does the insistence on a release of claims indicate anything about the adequacy of the offer?

**A.** It is an indication that the offer is too low, and that the company knows it, and that the company was expecting the offer to be accepted out of desperation.

**Q.** From a policyholder's standpoint, what's wrong with insisting on a release in a first-party claim?

**A.** As a policyholder, I have bought and paid for all the coverage available up to the limits of my policy. If I present a claim, and make a mistake, or the company makes a mistake, and I don't get what I paid for at the time I submit the claim, when I discover the mistake I should still be entitled to the rest of the claim. It's like if you buy a set of dishes and forget to take home the cups. You go back to the store and say, "Hey, I forgot my cups." But if you have signed a release, the store owner can say "Too bad," and it doesn't make any difference whose mistake it was.

**Q.** Would this be a violation of any policy guideline?

**A.** I think it violates the guideline about not imposing any unreasonable requirements as a precondition to payment.

### **§ 57. Evaluation of plaintiff's underlying claim**

**Q.** Utilizing your experience as risk manager for the state, and your many years of experience as an adjuster and claims supervisor in the private sector, I would like you to evaluate this case for us, if you would, as the case stood by the summer of 1988. To do that, I would like you to work on that chartboard please [directing the witness to an easel and chartboard]. In your job with the state and your past experience, have you ever had occasion to evaluate personal injury cases?

**A.** Yes, sir, hundreds of them. Probably thousands.

**Q.** On a major case like this, is it important to break the case into its component parts in order to reach an appropriate value on the case?

**A.** It's the only way it can be done.

**Q.** What are the parts of the claim in this case?

**A.** I think there are five distinct parts. First is the medical expenses incurred as a result of the accident. Second is the wages lost while the plaintiff was recuperating and completely unable to work. Third is the future wages the plaintiff will lose by reason of his permanent impairment—by the fact that he cannot go back to his old line of work, but has had to take a job in a lower-paying line. And fourth is the probable cost of future medical expenses he is likely to incur. These are all hard numbers. You can calculate them almost to the penny.

**Q.** Let me interrupt you. Was there sufficient information in the claims file to determine these first four elements?

**A.** Ample information. All of them were fully documented.

**Q.** And what is the fifth element?

**A.** That can be the hard one. The fifth element is the component for general damages—the pain and suffering endured, any future pain and suffering, the disfigurement, the permanent impairment. These are very subjective.

**Q.** Can you place a value on these elements?

**A.** It's done every day. It's what insurance companies do.

**Q.** Let's take these elements one by one.

[The witness is then taken through a complete evaluation of plaintiff's underlying claim. After his final number is on the chartboard, the examination continues:]

**Q.** Should this analysis have been made, in your opinion, by the defendant in this case?

**A.** They didn't need to go nearly as far as we have done here today. The limits of the policy were only \$300,000 less the amount available from the other company. The special damages alone exceeded the limits available. When you add any consideration for general damages, you are so far above the limits available that further analysis is pointless. I would simply have reserved the policy limits and quit.

**Q.** And from your experience, once you went through that calculation and once you reached those figures yourself and that conclusion, can you tell us what the defendant should have done once it came to that realization at that point, as to where the case was?

**A.** They should have paid him the policy limits.

**Q.** So it's your opinion they should have paid policy limits in June of 1988?

**A.** Well before then, really, but certainly at that time, yes.

### **§ 58. Partial advances made under the policy**

**Q.** Let's talk about the advances that were made in this case. You're aware that there were some advances made in this case, is that correct?

**A.** Yes, sir.

**Q.** Do you think that those advances were made properly in this case?

**A.** I think the advances were paid properly. There just weren't enough of them, and they weren't soon enough.

Q.Are you aware that there was a \_\_\_\_\_-dollar payment made in early 1988 to cure a mortgage foreclosure?

A.Yes.

Q.Are you aware of what \_\_\_\_\_[plaintiff's wife] had to go through to get that payment?

A.She had to go through hell.

Q.Do you think an insured should have to go through what she went through to get an advance payment like that?

A.No. Not in a situation like this. The money is, in my opinion, committed and really belonged to the plaintiffs at that time. There's no reason, other than a financial advantage and ultimate settlement pressure advantage, to withhold advance payment from your own insured.

Q.Now, the home office actually suspended advances, were you aware of that?

A.Yes. There is a note in the file. I have that note right here. It's part of Exhibit \_\_\_\_\_.

Q.Why did the home office direct that advances be suspended?

A.The note says, "What are we doing making advances on a case where there is an attorney involved? Doesn't \_\_\_\_\_[line adjuster] know of our policy?"

Q.What was that note referring to—can you tell from the file?

A.Actually, it wasn't even an advance. The line adjuster had made a payment against the voluntary medical pay coverage, which was absolutely due at the time it was made.

Q.Is there anything in the written policies of the company that you found that said the company would suspend advances if a lawyer was involved?

A.Nothing in any of the written policy guidelines.

Q.Would this be a reasonable policy, in your opinion?

A.No. In a case of this size, there is absolutely no reason not to expect that the claimant will have an attorney. It would make no sense at all to have a policy that says you are going to make advances as soon as they can be determined, and at the same time say, but not if a lawyer is involved.

Q.What should have been done as far as advances are concerned in this case, if the case had been handled properly?

A.Had the case been handled properly—truly properly—when it was reported on the 10th of October, 1986, there probably wouldn't have been any need for advances. They could have evaluated the case in very short order and made a full settlement. But if they were going to draw the case out, they should at least have been paying plaintiff's medical bills in full as they were incurred, and they should have been paying the plaintiff his monthly lost wages every month as this thing dragged on. That would be the minimum. They knew the loss, knew it was due, and could have made these payments immediately.

Q.Are there recognized industry standards in this area?

A.Yes.

Q.What are they?

A.You try to make liberal advance payments in first-party claims, within the amounts of the reserve, just as soon as the amounts can be verified as being due.

Q.Were these general industry standards adhered to in this case?

A.No.

Q.Did you look at the defendant's policy guideline on advances, Exhibit \_\_\_\_\_?

A.Yes.

Q.Did \_\_\_\_\_[defendant insurance company] follow its own standards on making advances in this case?

A.No.

Q.How did it violate its own standards?

A.The guideline states that the company is to pay on an advance basis all parts of a claim that are determined to be due, as soon as determined. Not to wait for a final settlement.

Q.Was \_\_\_\_\_[plaintiff] made aware of this policy?

A.There is no indication that he was. In fact, the company acted like it was doing him a favor. When \_\_\_\_\_[branch claims manager] wrote to the plaintiff's lawyer advising that the company would finally advance funds to cure the mortgage foreclosure, he starts out, "As a gesture of our good faith, we are advancing funds to \_\_\_\_\_[mortgage lender] on \_\_\_\_\_[plaintiff's] behalf."

Q.Is that in Exhibit \_\_\_\_\_?

A.[Looking] Yes.

Q.Are the company's stated policy guidelines on advances as set forth in Exhibit \_\_\_\_\_ in accordance with accepted industry standards?

A.Yes, and if they had been followed we would not be here.

Q.Is it possible the people handling this claim were unaware of these policies?

A.No way. The claim file was maintained on a duplicate basis at the home office. Every note in the branch claims file was copied and sent to the home office. The company's senior claims supervisor, \_\_\_\_\_, was following the negotiations throughout, and he is the one who caused these guidelines to be prepared.

Q.How would you characterize the deviation from the industry standards, and from the company policy as set forth in its guidelines?

A.As an extreme deviation. These advances did not accomplish the company policy objective or industry standard of getting the money to the insured as quickly as possible, but rather the method of handling advances was another step in the overall tactic of stonewalling the claim, delaying any attempt at a final resolution, and trying to pressure the plaintiff into accepting a low settlement.

### C. Testimony of Academic Expert

[After introduction, identification, and qualification of witness. The witness was qualified as an expert by her credentials as a professor of insurance at a state university, who had written a recognized textbook on insurance together with numerous articles for academic and industry journals. As to the use of college professors with academic credentials in the teaching and writing on the subject of insurance as expert witnesses, see § 22.]

#### § 59. General explanation of the insurance industry

Q.Can you generally explain to the jury how insurance companies operate and how they make internal decisions?

A.Certainly. While there are many different kinds of insurance, and different companies are organized differently, they're all in the same basic industry. The insurance business has a long history. It developed as means or method to allow people who face financial risks that are bigger than they can afford to assume on their own, to pool their resources with others, and thereby share the risk. Using a statistical concept called the law of large numbers, if you get enough people averaging their results together, the results become predictable. And you can estimate what the total is going to be even though you can't estimate what any one individual's car insurance claim, or fire loss, would be in a particular year. The total loss factor can be predicted, and divided among all members of the pool. Instead of any one member taking the risk of a huge loss, all of the members chip in a little bit to maintain the pool, and individual members' losses are paid out of the pool. The premiums we pay for insurance are established in this fashion, plus a factor for administration, overhead, and profit. This is very simplistic, but it is illustrative of the basic principle. So pooling together the experience of a large number of people is the primary function of the insurance business.

Q.What about the product or service the insurance industry sells? Could you explain to the jury how that works?

A.Well, the product is a contract. It's a piece of paper—what I would consider intangible goods. It is not something you can look at and know that it's worth "X" number of dollars. It's the service or the promises backing up that contract that makes it a valuable commodity, or product. Many people may go through life never knowing exactly what their insurance is really worth. Many people will have a minor claim from time to time, but few have losses which really draw upon the full range of the insurance they carry—whether it's fire insurance, homeowners insurance, or automobile insurance. People buy the policies and pay the premiums on the strength of the promise of the company.

Q.Is the insurance industry motivated by economic considerations?

A.Yes. I think the business for the most part is very competitive. The laws of supply and demand apply.

Q.Are insurance companies profit-oriented?

A.Yes.

Q.Professor, is it financially advantageous for an insurance company to delay payment of claims?

A.We cover this in introductory finance classes. It's financially advantageous for anyone to hang on to their money as long as possible, and the insurance industry is no exception to that general rule.

Q.Why is that?

A.The large pools of money which the company collects out of premiums for payment of the predicted losses are kept invested by the companies until they are needed. It is a basic economic fact that the longer you can keep a dollar or a hundred dollars or a thousand dollars in the bank earning interest, the better off financially you will be in the long run. So the longer you could hold onto a thousand dollars the more you're going to have. When you finally pay that thousand dollars out you will still have something left, which is the interest it earned. Its called the time-value of money.

Q.Is there more incentive to delay a large claim as opposed to a small claim?

A.In the case of a small claim, say \$300, the time-value will be a very small amount—perhaps only a few dollars a month. The administrative costs involved in handling a file may outweigh any earnings which can be derived from delaying payment. So very small claims are routinely handled as quickly as possible, not to maximize the time-value of retaining the claim, but to minimize the administrative expense. On very large claims, however, the amount of interest to be earned may be substantial, and the administrative overhead is not such a dominant factor.

Q.So, is it more financially advantageous to insurance companies to delay on larger claims?

A.Yes, where there's interest to be earned.

Q.Aside from being financially advantageous, is it proper for an insurance company to delay payment of claims?

A.Some delay is necessary and unavoidable. The company must have time to investigate and evaluate claims, and make sure that the claim is proper and fair. The company has a dual responsibility in this area. They owe the claiming policyholder the fair amount of his loss up to the limits of the policy, but they also owe a duty to all other policyholders to protect the pool, and not to waste the pool money by paying claims that are improper or too high.

Q.How about if a company continues to delay beyond the point of adequate investigation and evaluation—it will earn more money and thereby make the pool stronger, right?

A.Yes, but even though the rest of the policyholders might benefit somewhat from this, if in fact this resulted in a lowering of future premiums, it is contrary to the promise the company made to the policyholder who suffered the loss. That policyholder is entitled to be paid in accordance with the insurance contract just as soon as the company has made its determination. And



since all policyholders would expect the same treatment, and since that is all that the company is selling when it sells an insurance policy, this obligation must take precedence. It would not be proper for a company to delay payment longer than necessary, just to maintain funds in the pool.

## **§ 60. Relative bargaining power of parties**

**Q.**Professor, from an economic standpoint, can you tell the jury the difference between the bargaining power of two parties in a situation where you have an insurance company on one side and an individual who suffered a financial catastrophe on the other side? Can you explain to the jury, from an economic standpoint, what the difference in bargaining power is between these two parties?

**A.**I think there are two important factors involved. First, any time you're negotiating, the person with the money always has more power than the person without the money. It's easier to hold on to it than to get it. Second is the relative value of the amount of money involved. If you're talking about a particular sum of money, say \$1,000, this could be very important to the individual claimant and yet be just barely past the nuisance claim category to an insurance company. Even what may appear to be very large sums of money to an individual will usually constitute a very small measure of an insurance company's resources. From a negotiating standpoint, the person who needs the money is in a much weaker position than the person or entity who is indifferent to the question of whether or when the money is paid. So from these principles, one can generally conclude that insurance companies are in a significantly greater bargaining position than is an individual claimant.

**Q.**When a person who is financially stressed has a claim, what motivates that claimant at that time from the economic standpoint?

**A.**Economically, a claimant's first concern may be survival. This may be as basic as getting food on the table, paying bills, and getting through the month—not having the car repossessed or house foreclosed on, and so forth. If these concerns are satisfied or alleviated, then the claimant can focus on other things. But if these basic elements are not covered, they become very significant in negotiations.

**Q.**Do those things that you've just described for us play a part, then, in the final result that's reached?

**A.**I think without a doubt that if those basic survival concerns are the overriding factor in your life, you become predisposed to accept whatever is made immediately available rather than to hold out for a greater sum later on. You can become more anxious about getting any payment at all than holding out for the most or the best payment that you might otherwise receive.

## **§ 61. Regulation of insurance companies**

**Q.**Professor, let's move to another area. Can you tell the jury from your experience and studies how insurance companies are regulated in America?

**A.**Insurance is the biggest industry in this country that's still regulated at the state level. The federal involvement with insurance companies is for the most part limited to things like the Securities and Exchange Commission making sure stock offerings are handled correctly, and the IRS making sure it collects the appropriate taxes. As a historical development, the United States Supreme Court determined many years ago that insurance wasn't interstate commerce, and therefore did not come within the purview of congressional regulation. And that decision has stood for about seventy-five years, during which time the states developed their own regulatory structure. Even though some of the early historical cases have been overturned, the structure of state regulation is still in place. So every state has a department or agency that regulates the insurance business in that state.

**Q.**Is there any federal agency that does regulate insurance?

**A.**Not in the area of things like consumer complaints and company solvency, no.

**Q.**That's left to the states?

**A.**Yes.

**Q.**What is the primary object of state regulation?

**A.**There's a little diversity from state to state but most state insurance regulators have five or six different things they're charged with doing. The most important one is to make sure these insurance companies are solvent—to make sure the company selling insurance to the general public within the state is backed up by enough financial wherewithal to pay claims if called upon to pay up. So solvency, I would say, is the number one priority in every state regulator's office. Other duties include licensing agents and brokers, liquidating insolvent companies, and administering the statutory provisions of state law. State laws can vary considerably in this area.

**Q.**Where does regulation or overseeing of claims practices fall, then, on that scale?

**A.**Generally, not high. The priorities are solvency first, and then the licensing and policing of agents and brokers.

**Q.**Are states particularly effective in regulating claims practices?

**A.**Not in individual cases, no. The state regulators do have some remedies available to them if they hear about a company that is becoming a real problem. If numerous complaints are made, they may investigate and even hold hearings. For the most part, though, that is not going to happen as a result of one claim or one incident. That will happen when the complaint file gets so thick in the insurance department's office that it's screaming for somebody to do something.

**Q.**What about jury verdicts? Do they play an important part in regulating the insurance industry, in your opinion?

A.Jury verdicts do change the behavior of the insurance industry. They sort of regulate, with a small “r,” if you will.

Q.Do insurance companies pay attention to what juries tell them?

A.Yes, they do.

Q.Are juries sending them messages?

A.Most definitely.

## **§ 62. Impact of punitive damages**

Q.Now, do punitive damages have any impact in regulating an insurance company, with a small “r,” if you will?

A.Yes.

Q.How is that?

A.The regular or compensatory damages the company might be called on to pay as a result of a jury verdict are factored into the loss analysis. The actuaries take them into account in determining premiums and loss experience, and it’s all part of the business they’re in. Punitive damages are different. Here, it’s hitting them closer to home and it’s not something they can pass off to someone else. Punitive damages are not factored into the loss pool, and generally cannot be recovered out of premiums. Punitive damages go straight to the bottom line of the company—the company’s profits. And that hurts.

Q.Professor, you just made mention of the fact that if insurance companies get hit with a verdict for punitive damages they can’t really pass this loss off onto someone else. Why is that?

A.I was referring to the responsibility factor, but there’s an economic factor in there as well. Insurance is highly competitive. The laws of supply and demand do apply. If a particular company’s price is higher than the market, people leave, go elsewhere. So if a company tries to recover punitive damages through higher premiums, it will quickly find that it is losing customers.

Q.Is that what keeps punitive awards from being spread out among the policy-purchasing public?

A.Yes, it should.

Q.Does that mean that in the case of an award of punitive damages against a particular company, that company is going to have to take care of it themselves?

A.Correct.

Q.In your opinion, does an award of punitive damages play a role in keeping insurance companies attentive to their responsibilities?

A.Yes, very much so.

Q.Professor, have you reviewed Exhibits \_\_\_\_\_ and \_\_\_\_\_ in this case? Exhibit \_\_\_\_\_ is titled “File-Handling Standards to Avoid Punitive Damages” and Exhibit \_\_\_\_\_ is titled “Advance Payment.”

A.Yes, I have.

Q.And can you tell us whether or not those exhibits relate in any way to the testimony you’ve given about punitive damages having an effect on how insurance companies do business?

A.Yes. Exhibit \_\_\_\_\_, the document titled “File-Handling Standards to Avoid Punitive Damages,” indicates that on February 1, 1988, \_\_\_\_\_[defendant insurance company] was concerned enough about the possibility of punitive damages to issue a special policy guideline.

Q.How about Exhibit \_\_\_\_\_, titled “Advance Payment”—is that also a reaction to jury verdicts?

A.Yes. That document is issued from \_\_\_\_\_[defendant insurance company’s] casualty claims department and the second paragraph on the page says, “As a result of companies being held in bad faith in certain situations where the company mishandled advance payments to the claimant, we are revising our controls.” So they’re modifying their behavior, or changing their standards, actually changing their policy and practices here, in response to jury verdicts.

Q.From an economic standpoint, is this something you would expect when juries tell a company through a punitive damages award that the company has got to be more attentive to its duties?

A.In my class I would call it risk control—making sure that it doesn’t happen to you.

## **§ 63. Financial worth of defendant**

### **[Cumulative Supplement]**

Q.Professor, have you become familiar with the financial condition of \_\_\_\_\_[defendant insurance company]?

A.Yes.

### **Information as to defendant’s financial worth.**

The financial net worth of most insurance companies, other than independent stock companies which publish annual financial statements for stockholders in standard form, is found within the annual reports filed with the state regulatory agencies. These are cumbersome, technical documents that are not readily understandable to a lay person. The expert witness may be asked to

extract information on the financial worth of a defendant company from these reports. The validity of the figures can be confirmed with a request for admission.

**Q.**And how have you done that?

**A.**I have reviewed the somewhat sizeable report that they file with the state insurance department, as well as checking in Best's Insurance Reports, which summarizes and rates every insurance company in the country. It's been doing this annually for seventy-five or a hundred years, and is the recognized resource in the industry.

**Q.**Professor, have you had occasion to examine Exhibit \_\_\_\_\_, which is the \_\_\_\_\_[date of most recent report] annual report of \_\_\_\_\_[defendant insurance company] filed with the state of \_\_\_\_\_?

**A.**Yes, I have.

**Q.**And can you tell the jury what the reported value of the assets owned by the defendant was as of \_\_\_\_\_[date]?

**A.**Assets totaled \_\_\_\_\_million dollars.

**Q.**Can you tell us please, what was the amount of the liabilities which the company owned or which the company was responsible for at that time?

**A.**Liabilities were \_\_\_\_\_million dollars.

**Q.**The difference between those two would be the net worth of the company?

**A.**That's correct.

**Q.**Have you done that calculation?

**A.**They've done it for me.

**Q.**I see. Okay. What is the net worth?

**A.**\_\_\_\_\_million dollars.

**Q.**Out of all of the liabilities, what is the largest liability they are holding?

**A.**The largest liability is for losses—that is, their loss reserves.

**Q.**What are their loss reserves?

**A.**\_\_\_\_\_million-plus dollars.

**Q.**Okay. Would that be money they have set aside to pay claims, the reserve money?

**A.**Yes. There's another approximately \_\_\_\_\_million for expenses of adjusting those claims.

**Q.**What was the net profit of the company in that year?

**A.**Net income was \_\_\_\_\_million dollars.

## **CUMULATIVE SUPPLEMENT**

### **Cases:**

In insured's bad faith settlement action against insurance company, court did not err in entering judgment on jury verdict of \$2 million in punitive damages, despite fact that insured received only \$1,500 on his contract claim and \$3,000 in consequential damages, where jury was instructed that insurance company had a net worth of over \$4.5 billion, and where this was a significant factor that justified the amount of verdict. The purpose of punitive damage award is to punish and deter wrongdoer, and the award must be sufficient to attract the attention of a defendant in order to assure that oppressive practices do not continue. [Capstick v Allstate Ins. Co. \(1993, CA10 Okla\) 998 F2d 810, 26 FR Serv 3d 425.](#)

In an action by insureds against their homeowners insurer for breach of contract and bad faith based on defendant's denial of coverage for losses arising from the cracking of plaintiffs' foundation slab, the award of punitive damages to plaintiffs was defective and subject to reversal, where the only evidence of defendant's financial condition introduced by plaintiffs was an annual report of defendant's corporate parent that had no separate information on defendant's corporate parent that had no separate information on defendant's financial status. Defendant and its parent could not be regarded as the same entity under the alter ego doctrine, since that issue was not litigated or decided in the trial court, there was no significant showing of unity of interest, and there was nothing to show how and injustice would befall plaintiffs if the punitive damage award were limited to a percentage of defendant's value rather than that of the parent company. Further, the requirement of evidence as to a defendant's financial condition cannot be waived by the defendant's failure to object to the inadequacy of the plaintiff's proof. [Tomaselli v Transamerica Ins. Co. \(1994, 4th Dist\) 25 Cal App 4th 1269, 31 Cal Rptr 2d 433, 94 CDOS 4443, 94 Daily Journal DAR 8129, review den \(Sep 8, 1994\).](#)

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**[END OF SUPPLEMENT]**

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Footnotes	
*	Judge D. Duff McKee is a trial judge from Boise, Idaho, and has been a judge since 1985. Prior to his appointment to the bench, he was engaged for twenty-one years in a private practice centering on business and business litigation. He is a graduate of the University of Idaho (B.S., 1961; J.D., 1964).
1	<a href="#">Restatement (Second) of Contracts § 205 (1981).</a>
2	<a href="#">Pacific Mut. Life Ins. Co. v Haslip (1991, US) 113 L Ed 2d 1, 111 S Ct 1032, 91 CDOS 1626, 91 Daily Journal DAR 2599, 18 Media L R 1753.</a>
3	<a href="#">See Automobile Insurer's Bad Faith in Responding to First-Party Claim, 3 Am. Jur. Proof of Facts 3d 751; Civil Conspiracy to Deny First-Party Insurance Benefits, 49 Am. Jur. Proof of Facts 2d 473; Fire Insurer's Bad Faith in Responding to Claim by Insured, 49 Am. Jur. Proof of Facts 2d 1; Insurance Bad-Faith Actions—"Advice-of-Counsel" Defense, 16 Am. Jur. Proof of Facts 3d 419; Insurer's Breach of Covenant of Good Faith and Fair Dealing—First-Party Claims, 31 Am. Jur. Proof of Facts 2d 323; Insurer's Liability for Emotional Distress, 32 Am. Jur. Proof of Facts 2d 99.</a>
4	<a href="#">Pacific Mutual Life Insurance Company v Haslip (1991, US) 113 L Ed 2d 1, 111 S Ct 1032, 91 CDOS 1626, 91 Daily Journal DAR 2599, 18 Media L R 1753.</a>
5	15A Couch on Insurance (2d ed.) § 58:11.
6	For example, <a href="#">Idaho Code § 6-1604</a> . As to exemplary or punitive damages where breach of contract amounts to independent tort, see, generally, <a href="#">22 Am. Jur. 2d, Damages § 752</a> .
7	See, for example, <a href="#">White v Unigard Mut. Ins. Co. (1986) 112 Idaho 94, 730 P2d 1014</a> .
8	See, for example, <a href="#">Spencer v Aetna Life &amp; Casualty Ins. Co. (1980) 227 Kan 914, 611 P2d 149</a> .
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12	<a href="#">Hawkins v Allstate Ins. Co. (1987) 152 Ariz 490, 733 P2d 1073, cert den 484 US 874, 98 L Ed 2d 177, 108 S Ct 212, reh den 484 US 972, 98 L Ed 2d 414, 108 S Ct 477.</a>
13	See <a href="#">Federal Rule of Civil Procedure 11</a> and its corollaries in some states.
14	See, for example, <a href="#">Cheney v Palos Verdes Invest. Corp. (1983) 104 Idaho 897, 665 P2d 661</a> .

15	<p><b>A.L.R. Library</b></p> <p>Punitive damages: relationship to defendant's wealth as factor in determining propriety of award, 87 A.L.R. 4th 141.</p>
16	15A Couch on Insurance (2d ed.) §§ 58:2, 58:11.
17	See, for example, <a href="#">Baxter v Royal Indem. Co. (1973, Fla App D1) 285 So 2d 652</a> , cert dismd (Fla) 317 So 2d 725.
18	15A Couch on Insurance (2d ed.) § 58:1.
19	Id., §§ 58.7, 58:8.
20	<a href="#">White v Unigard Mut. Ins. Co. (1986) 112 Idaho 94, 730 P2d 1014</a> .
21	See <a href="#">Defense of a First-Party Extra-Contract Claims Action Against a Life, Health, and Accident Insurer</a> , 29 Am. Jur. Trials 481 § 19.
22	2 Freedman, Richards on the Law of Insurance (6th ed.) §§ 9:10, 9:11.
23	<p>See <a href="#">Defense of a First-Party Extra-Contract Claims Action Against a Life, Health, and Accident Insurer</a>, 29 Am. Jur. Trials 481 § 18.</p> <p><b>A.L.R. Library</b></p> <p>Admissibility on defendant's behalf, as matter in mitigation of punitive damages, of evidence as to his lack of financial resources, 79 A.L.R. 3d 1138.</p>
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27	As to model discovery, see §§ <a href="#">29</a> , <a href="#">30</a> .
28	As to model requests for production of documents, see § <a href="#">30</a> .
29	As to deposing company employees, see § <a href="#">20</a> .
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31	<a href="#">Brown v Superior Court of County of Maricopa (1983) 137 Ariz 327, 670 P2d 725</a> ; <a href="#">Silva v Fire Ins. Exchange (1986, DC Mont) 112 FRD 699</a> .
32	See, for example, <a href="#">Ex parte Bozeman (1982, Ala) 420 So 2d 89</a> ; <a href="#">Maryland American General Ins. Co. v Blackmon (1982, Tex) 639 SW2d 455</a> .
33	<a href="#">National Farmers Union Property &amp; Casualty Co. v District Court for Denver (1986, Colo) 718 P2d 1044</a> .
34	As to model interrogatories, see § <a href="#">29</a> .
35	See, for example, <a href="#">Federal Rule of Evidence 404</a> .
36	See, for example, <a href="#">Federal Rule of Evidence 403</a> .
37	See <a href="#">Federal Rule of Civil Procedure 26(b)(4)(B)</a> .

<a href="#">38</a>	For checklists of facts to cover in depositions in tort actions, see <a href="#">Pattern Deposition Checklists</a> (2d ed.).
<a href="#">39</a>	For checklists and discussion of the use of expert witnesses, generally, see <a href="#">Danner, Expert Witness Checklists</a> .
<a href="#">40</a>	The checklists in §§ <a href="#">26–28</a> should not be considered exhaustive. Counsel should proceed with caution, however, unless at least some of the elements in the lists are present in the case under examination.
<a href="#">41</a>	As to the use of written interrogatories in a bad-faith case seeking punitive damages, see <a href="#">§ 19</a> .
<a href="#">42</a>	On state court practice with respect to interrogatories, see <a href="#">Discovery—Written Interrogatories</a> , <a href="#">4 Am. Jur. Trials 1</a> . On written interrogatories in federal district court, see <a href="#">Federal Rules of Civil Procedure 26, 33</a> ; see also <a href="#">Federal Procedure</a> , L. Ed. §§ 26:290 et seq..
<a href="#">43</a>	As to assembling documentary evidence from the insurer in a bad-faith case seeking punitive damages, see §§ <a href="#">14</a> , <a href="#">15</a> . On state court practice with respect to production of documents, generally, see <a href="#">Motions for Production and Inspection</a> , <a href="#">4 Am. Jur. Trials 223</a> .
<a href="#">44</a>	As to overcoming resistance to production, see §§ <a href="#">16</a> , <a href="#">17</a> .