

LIABILITY FOR BAD FAITH AND THE PRINCIPLE WITHOUT A NAME (YET)

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In this article, Kenneth Abraham examines the concept of liability for bad faith practices on the part of insurers. Abraham asserts that liability for bad faith is a concept that has existed for roughly half a century despite its inability, as of yet, to be recognized as part of the formal body of insurance law. Abraham details what has been, to some extent, a transmutation with respect to the bad faith claim handling practices of the insurance industry. What once could be dismissed as nothing more than the occasional isolated incident, or “screw up,” can now be characterized by incidences of systemic bad faith. Abraham provides four examples, each one highlighting some form of systemic bad faith practice undertaken by an insurer. Abraham closes with a discussion of the uniqueness of the insurer-consumer relationship and how that relationship creates obligations of fair dealing for insurers which simply do not exist for other private enterprises.

In 1994 the TEXAS LAW REVIEW devoted an entire Symposium issue to the developing law governing insurers’ liability for bad faith.¹ My contribution to that Symposium was called “The Natural History of the Insurer’s Liability for Bad Faith.”² The organizers of this Conference have asked me to revisit my piece, and to make some observations about the

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¹Symposium, *Law of Bad Faith in Contract and Insurance*, 72 TEX. L. REV. 1203 (1994).

² Kenneth S. Abraham, *The Natural History of the Insurer's Liability for Bad Faith*, 72 TEX. L. REV. 1295 (1994). Robert H. Jerry, II, wrote a piece for that Symposium commenting on my Article, entitled *The Wrong Side of the Mountain: A Comment on Bad Faith's Unnatural History*, 72 TEX. L. REV. 1317 (1994). Dean Jerry has been generous in preparing a piece commenting on this Article as well. See Robert H. Jerry, II, *Bad Faith at Middle Age: Comments on Abraham, “Liability for Bad Faith and the Principle without a Name (Yet),”* 19 CONN. INS. L.J. 13 (2012).

development of liability for bad faith in the eighteen years since then.

I will do exactly that. But I also want to try to situate the developments in bad faith law over the past two decades within a larger context. I want to suggest that liability for bad faith reflects a broader principle. This is a principle that, as my title suggests, does not yet have a name, but that treats insurers as having obligations that are more demanding than those imposed on ordinary contracting parties, though not as demanding as those we impose on governments. An obligation to handle claims fairly is one of the obligations that flows from this principle, though it is not the only one.

In the modern state, insurance often falls in between these two poles of private contract and governmentally-provided entitlement. Insurance is brought into being by private contract, but our political system relies on insurance to promote economic well-being and to serve as a social safety net. In a series of separate doctrines and practices insurance law recognizes this, but it has not yet articulated a single principle that reflects what connects them.

I. THE RISE OF SYSTEMIC BAD FAITH CLAIMS

In my 1994 Article I argued that liability for bad faith had by then become a mature field. I suggested that, whereas the field had been much in the flux of early development during the preceding several decades, it was by then becoming stable. I cited a number of reasons for this conclusion, in addition of course to the fact that the field was at that point over thirty years old, and arguably older.³ Thirty or more years seemed to me to be about the amount of time it takes most sub-fields of law to reach at least the beginning of maturity.

In an Article published a decade later, Douglas Richmond chastised me in the opening sentence of his piece for what he took to be my implication that liability for bad-faith was not a severe threat for insurers.⁴ To that charge I would reply here that there is a difference between an unstable threat and a stable one. My point was that the field had matured from early instability to the point where it was now merely posing a stable threat to insurers. After all, insurers are in the business of dealing with stable problems. In fact, they sell protection against stable, predictable problems. So what I took to be increasing stability in the field of liability

³ See Abraham, *supra* note 2, at 1295-1308.

⁴ Douglas R. Richmond, *Bad Insurance Bad Faith Law*, 39 TORT TRIAL & INS. PRAC. L.J. 1, 1 (2003).

for bad faith seemed to me to be a salutary development for insurers.

To continue the metaphor, I would say that the field is now in middle age, and like many who are at that stage of development, unanticipated difficulties have arisen, some of one's own doing and some the fault of others. From the vantage point of 2012, the most striking feature of the field as it stood in 1994 was that it was almost entirely concerned with claims for what I would call "sporadic" or "isolated" bad faith. A single claim person or group of claim personnel had allegedly misbehaved. Sometimes it was alleged that this misbehavior had violated the standards of the insurer in question, and sometimes it was not. And it may well be that at trial the plaintiff made an effort to blame not only the individual claims personnel who had misbehaved, but also to blame their employer, the insurer. But the unstated premise that hung over the majority of bad faith claims in the years running up to 1994 was that these were isolated incidents; that they departed from what ordinarily occurred; and that they reflected a divergence between what the insurer as an entity intended to occur and what had actually occurred. In short, these cases involved, or were thought to involve, screwups.

There still are a lot of these cases. To draw an analogy to products liability, most of the reported cases involved allegations of what appeared to be something like "manufacturing defects." Long ago the law of torts decided that there should be liability for injuries caused by manufacturing defects—departures of an individual product unit from the manufacturer's intended design. Claims for sporadic bad-faith handling of a claim are analogous. It is true that in many instances manufacturers' design specifications are more precise and more detailed than an insurer's prescribed claims handling practices. But the logical structure of manufacturing defect suits and of sporadic bad-faith claims is parallel.

A new type of claim, however, has emerged in the last two decades. These claims have been based on what some observers have called institutional, or systemic, bad faith.⁵ These are more like design defect claims in products liability. They do not involve allegations that there was a single screwup in the handling of a particular claim. Rather, these are cases in which the insurer is alleged to have adopted a company-wide policy of handling claims in a manner that the plaintiff argued constituted bad-faith, even if there was only one actual plaintiff in the bad-

⁵ See, e.g., Douglas R. Richmond, *Defining and Confining Institutional Bad Faith in Insurance*, 46 TORT & INS. PRAC. L.J. 1 (2010); James A. Varner, Tiffany R. Drust & Debra T. Herron, *Institutional Bad Faith: The Darth Vader of Extra-Contractual Litigation*, 57 FED'N DEF. & CORP. COUNS. Q. 163 (2007).

faith suit.

II. FOUR EXAMPLES

I want now to give you four examples. Several, but not all, involve claims for bad-faith claims handling, and one does not involve claims handling at all. But each of them involve what might be called bad faith, and help to make the point that I will develop after I describe them.

In *State Farm v. Campbell*, the nation's largest auto insurer was alleged to have had a national scheme of taking cases to trial in order to meet the corporate fiscal goal of capping payouts on claims, nationwide.⁶ This scheme was referred to as State Farm's Performance, Planning and Review or "PP& R" policy. The suit alleged bad faith against a State Farm liability insurance policyholder after State Farm refused to settle a tort suit against him and the jury returned a verdict in excess of his policy limits.⁷ He sued State Farm, and the jury in his bad-faith case returned a verdict of \$2.6 million in compensatory damages and \$145 million in punitive damages.⁸ These verdicts were reduced, in part by a decision of the U.S. Supreme Court, but in the end they were still substantial.

Based on my conversations with them, I can say that the people at State Farm continue to deny that the company had the particular policy that was found to have led to the bad faith claims handling in that case. They have engaged in at least one retreat that I know of in which they brainstormed about how to ensure that the actions that took place in that case do not happen again. They think of what happened as a screwup, as a misapplication of company policy rather than as an application of policy. That will often be the insurer's perception in these institutional, or systemic bad-faith cases. But what makes these cases different from sporadic bad-faith cases is that the institutional bad-faith cases are not litigated only about whether an acceptable policy was misapplied in a particular claimant's case. They are litigated, at least in part, over the question whether there was a company-wide policy that was rotten to the core.

My second example comes from the first-party side and involves UNUM Provident, a disability insurer. UNUM apparently, or at least allegedly, had a policy of what can plausibly be called cheating in the handling of what it referred to as "subjective" disability claims.⁹ These are

⁶ *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 415 (2003).

⁷ *See id.* at 414.

⁸ *Id.* at 415.

⁹ For an account, see *Merrick v. Paul Revere Life Ins. Co.*, 594 F. Supp. 2d

claims based on mental or emotional disorders whose existence cannot be proved by concrete medical evidence. Basically, UNUM allegedly decided not to pay these claims but instead to require insureds to provide objective medical evidence that they had a disability, which they ordinarily could not do. UNUM set targets for resolving these claims based on its own profit goals and regardless of the merits of the claims themselves. They allegedly did this, among other things, by setting claim closure targets that were endorsed by high level management and the Board of the company.

A third example hasn't resulted in any damages claims that I know of, although there may have been a few. This is the contingent commission controversy of 2003 and 2004. As you will recall, certain insurers, AIG among them, were revealed to have been secretly paying brokers commissions that were contingent on the subsequent claim and loss experience of the brokers' clients – the policyholders to which the insurers issued policies. There is now a literature addressing whether contingent commissions should or should not be permitted, but no one that I know of has argued that it was okay to keep them secret.¹⁰ The issue is whether an obligation on the part of brokers to disclose the existence of a contingent commission arrangement is sufficient, or whether, instead, such commissions ought to be prohibited outright, at least for the consumer segment of the market, or for all applicants, whether consumer or commercial.

This is not an example of bad-faith claims handling. But it is an example of a practice that at least arguably was in bad faith. It was a secret deal between the broker and the insurer to whom the broker was steering applicants for insurance. I have cited this example, not because I necessarily want to argue that there should be a cause of action of some sort against either the broker or the insurer for damages caused by the wrong, but to suggest that there is a broader principle underlying bad-faith claims than may appear. Liability for bad-faith claims handling is about more than bad-faith claims handling. But first, on to my fourth example.

In the early 1990s, Allstate Insurance Company became concerned about its profit levels. It hired McKinsey & Co., and (to oversimplify a bit) these consulting geniuses had the deep insight that Allstate could increase its profits if it paid less for claims. McKinsey recommended the redesign of

1168 (D. Nev. 2008).

¹⁰ See, e.g., J. David Cummins & Neil A. Doherty, *The Economics of Insurance Intermediaries*, 73 J. RISK & INS. 359 (2006); Daniel Schwarcz, *Differential Compensation and the "Race to the Bottom" in Consumer Insurance Markets*, 15 CONN. INS. L.J. 723 (2009).

a number of different claim processes. Jay Feinman described this whole process and the different redesigns very effectively in his book, *DELAY, DENY, DEFEND*.¹¹ One of the claim process redesigns, with the acronym “MIST,” standing for “minor impact soft tissue”¹² – mostly whiplash – had as its purpose cutting down on payments for this kind of claim, and taking cases to trial if a satisfactory settlement could not be negotiated. This policy applied to both Allstate’s own policyholders making Uninsured Motorists claims, and to third-party suits against Allstate’s own liability insurance policyholders. Some of the guidelines for claim valuation were computerized and some claims personnel allegedly adhered slavishly to what the computer told them to do.

Now there is nothing necessarily wrong with using computer programs to guide claim valuation, and nothing wrong with trying to cut back on claim payments if they are too high. It certainly is unwise, and it might even be bad faith, to rely only on what a computer tells you a claim is worth. But that was not what was fundamentally wrong with what Allstate is alleged to have done. If you have an acceptable metric for deciding whether you are currently paying too much for a given category of claims, then that metric might appropriately be used to guide claim valuation. I’m not sure what an acceptable metric would be, since it is not as if there is some objective, freestanding value to a tort claim. But let’s suppose hypothetically that in principle there could be such a metric. For example, if Allstate could have gotten the data, the average of what GEICO and Nationwide paid for these claims in analogous cases *might* have been an appropriate metric for Allstate.

But that’s not what Allstate allegedly did. It didn’t use some acceptable metric for valuing claims. Its metric allegedly was how much less it needed to pay in order to make its desired profit. An insurer can certainly set premium rates on this basis. It can decide how much to charge you for coverage based in part on how much it needs to charge in order to make an acceptable profit. Once you have paid for coverage, however, you’re entitled to have the Uninsured Motorist claims you make, and lawsuits that are brought against you, settled based on some kind of principle other than how much profit your insurer wants to make.

Now I’m well aware that many of the victims of this practice by Allstate were not its own policyholders, but people who brought suit against Allstate’s policyholders. And we know that the question whether a

¹¹ JAY M. FEINMAN, *DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON’T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT* 56-103 (2010).

¹² *Id.* at 31.

liability insurer is liable for bad faith to a party who brings suit against the insurer's policyholder is largely settled. This is what is sometimes referred to as the *Royal Globe* problem, after the 1979 California case holding that there is such a duty.¹³ But the *Royal Globe* rule is dead, and with the exception of a very few isolated cases, that is not the law. It might be that conduct like Allstate's violates a state's Unfair Claim Practices Act and warrants a regulatory fine, but it would be a stretch to imagine that there could be a cause of action by a non-policyholder against Allstate for damages resulting from its practices.

III. A BROADER PRINCIPLE?

Those are my four examples. Now let's take stock. All involve institutional, or systemic bad faith. One case – *State Farm v. Campbell*, is a third-party bad-faith case in which the conventional bad faith remedy was available. A second, UNUM Provident, was a set of first-party bad faith cases in which the conventional bad-faith remedy was available. A third, the contingent commission controversy, did not directly involve claims at all, and while the conduct in question might generate civil liability, it is more likely to be restitutionary liability than the kind of liability for extracontractual damages that is threatening enough to deter misconduct. An insurer or a broker won't be deterred from capturing an undeserved gain through a contingent commission if the only remedy for doing so is that it has to refund the commission or pay it to the policyholder. So fines were necessary in that situation. My last example did involve misbehavior in the claims process, by Allstate, but many of the victims were third parties who did not have a cause of action for any damages they may have suffered as a result of the misbehavior.

What links these examples together, I think, is not merely that each involved something that we would be willing to describe as "bad faith." There are two additional links. First, the bad-faith behavior in all these examples involved, or allegedly involved, something systematic or institutional rather than being an isolated screwup. And second, the bad-faith behavior in each instance is something that we probably would tolerate, and have the common law tolerate, if it were a different sort of business enterprise that engaged in this behavior. If a building contractor adopted a systematic policy of charging for every minor change from an architect's working drawings, because it had decided that its profits were insufficient, we would not consider this an occasion for legal intervention.

¹³ *Royal Globe Ins. Co. v. Superior Court*, 592 P.2d 329 (Cal. 1979).

If an auto parts retailer had a secret deal with some manufacturers that it would be paid an annual rebate that increased if products liability suits against the manufacturer decreased, we would consider this no business of those who purchased the auto parts in question, even if this affected which customers were influenced to buy which kinds of parts. These would be examples of harsh, slightly unsavory dealing, but that's about it.

On the other hand, suppose that the government engaged in these kinds of behaviors. Then we would probably consider them to be constitutional violations. Suppose the government decided to adopt a more stringent test for disability under the Social Security Act, not because it had been misapplying the statute, but because it concluded that it was paying too much out in benefits. That would almost certainly violate beneficiaries' right to due process of law. Or suppose that the U.S. Army secretly paid its own recruiters higher bonuses for recruits who signed up for the Corps of Engineers rather than for Artillery training, because the costs of providing medical care for the former were lower than for the latter. We would think that the due process rights of the recruits had been violated, because they had a right to know whether they were being steered to the Corps of Engineers by the recruiters' financial interest in the particular enlistment choice they made.

If some of you disagree with my admittedly shallow constitutional analysis, I hope that at least you agree that we would find the government's actions in these hypotheticals far more blameworthy than the analogous behavior in the hypotheticals involving private enterprise. We expect far less of most private enterprises in the way of fair dealing and fair process than we expect of government. Customers deal with private enterprises in arms-length transactions where self-interest is expected to be operative. People deal with government as constituents or citizens where government is expected to be concerned with the welfare and fair treatment of those whom its actions and decisions affect.

By now it should be obvious where I am headed. Insurance companies do not fit into either of the categories we have for determining how much fairness we expect from an enterprise or institution. We expect more of insurers than we expect of ordinary private enterprises, though we may not expect as much of insurers as we expect of government. That is what links the four different examples of bad faith that I offered earlier, even though some are governed by the law of bad faith and some are not. In each instance our sense of what makes an insurer's behavior wrongful turns in part on the core nature of insurance and insurance companies. Insurers owe, or ought to owe those with whom they deal, a higher obligation of fair dealing than ordinary private enterprises typically owe

those with whom they deal. As critical legal theory taught us decades ago, the public-private distinction tends to break down in such instances.¹⁴

This notion is already reflected, though somewhat selectively and only partly expressly, at various places in the law governing insurance. First and foremost, of course, the law of bad faith is a reflection of the notion that insurers owe their policyholders higher duties than ordinary contracting parties owe their customers. There is also the occasional judicial assertion, which typically doesn't go very far or is rejected on appeal, that insurers are fiduciaries or quasi-fiduciaries. And of course there is the very practice of administrative regulation of the terms of insurance policies. In my view the justification for insurance regulation must not only be the typical one that is given for economic regulation – market failure or market imperfections. In addition, I think that we regulate insurance, and that there is support for regulation, so that regulators will have the opportunity to ensure that the requisite level of fair dealing occurs, whether or not it would be provided by a perfectly operating market.

For example, we place limits on the characteristics that insurers can use in creating premium classifications,¹⁵ and to me that looks for all the world like a version of equal protection's prohibition of legislation that employs suspect categories. In fact, that kind of insurance regulation actually goes farther than constitutional equal protection would require. Similarly, in at least a few cases, the courts may be on the lookout for coverage defenses that insurers assert as subterfuges, when the insurers cannot prove their actual basis for denying the claim. For example, defenses based on exclusions or conditions that obviously do not apply, but which the insurers assert anyway when they suspect but cannot prove fraud in the application for coverage or deliberate wrongdoing such as arson.¹⁶

¹⁴ See, e.g., Duncan Kennedy, *The Stages of the Decline of the Public/Private Distinction*, 130 U. PA. L. REV. 1349 (1982).

¹⁵ See KENNETH S. ABRAHAM, *INSURANCE LAW & REGULATION* 144-56 (5th ed. 2010).

¹⁶ That may well be what happened in *Heller v. Equitable Life Assurance Society of U.S.*, 833 F.2d 1253 (7th Cir. 1987), where a disability insurance policy covered lost income resulting from the “complete inability of the Insured, because of injury or sickness, to engage in the Insured's regular occupation.” *Id.* at 1255. The policyholder was a cardiologist who specialized in invasive procedures and contracted carpal tunnel syndrome, a condition affecting the dexterity of his hand and fingers, nine months after he purchased the policy. *Id.* The insurer denied coverage on the ground that, because the insured refused to consent to have surgery for the condition, he had violated the policy requirement that he be under the “regular” care of a physician. *Id.* at 1257. But it might just as easily have

This looks to me to be an awful lot like a common law version of a due process requirement.

If I am correct, then the law governing liability for bad-faith handling of insurance claims is not an isolated exception to the law of insurance contracts, but just one manifestation of a broader and deeper principle that runs through this entire body of law: the notion, partly embodied in legal doctrine, partly in administrative regulation, and partly in a more general legal ethos, that more in the way of regularized and consistent treatment of applicants and insureds, and more in the way of fair process, can be expected of insurers than we have a right to expect of most other private enterprises.

Admittedly, this is only an underlying principle or value, what I have elsewhere called a “regulative ideal.”¹⁷ There is not a body of legal doctrine that systematically reflects the principle. Indeed, I would have to say that at present the principle is only selectively reflected in legal doctrine. For example, we don’t have a body of legal doctrine that protects all those who were disadvantaged by Allstate’s conduct, and administrative regulation doesn’t completely fill the gap either. Some might say that I am therefore misidentifying a principle, or seeing a principle where it doesn’t exist. Fair enough. I am not trying to close debate about this, but to open up debate by offering a conceptual insight to be tested against our intuitions and against the law as it stands. If I am capturing our intuitions correctly but I am not accurately describing the law as it stands, then we can either adjust our intuitions or we can consider changing the law.

Moreover, I have been painting with a very broad brush. It seems pretty clear that we should expect the law governing the two forms of insurance that are most essential to individual well-being, health insurance and consumer auto insurance, to more systematically reflect the principle than the law governing other, less essential forms of insurance. There is also room for distinguishing generally between consumer and commercial insurance. Sizable corporate policyholders’ dealings with their insurers are in many respects identical to their dealings with other private enterprises, and do not need as much legal regulation of the sort that I have been

denied coverage on the ground that the insured was still able to “engage” in his “regular occupation”. The insurer’s stated basis for denying coverage was so likely to fail that the alternative of suspected fraud is a far more plausible explanation for the insurer’s fighting the claim all the way to its unsuccessful appeal to the Seventh Circuit.

¹⁷ Kenneth S. Abraham, *The Expectations Principle as a Regulative Ideal*, 5 CONN. INS. L.J. 59, 63 (1998).

describing. If insurance law could manage, predictably and inexpensively, to distinguish between individuals and small businesses, on the one hand, and large enterprises, on the other hand, that might make sense. But that's an issue for another day.

IV. CONCLUSION

To sum up, I think that we should more frequently be thinking about insurers as distinctive enterprises with a set of obligations that are neither those of private parties nor those of government. Some scholars have called this conception, or something like this, “insurance as governance.”¹⁸ That is not right, however, among other reasons because it implies an element of democratic or participatory control – as in labor unions or homeowners associations – that is not present in insurance and that we probably don't want to be present in insurance. I'm not talking about turning stock insurance companies into mutuals. Nor am I talking about the coercive power of insurers, their capacity to “govern” the behavior of their policyholders. I am not talking about negative rights against insurers, but positive rights. Not freedom from something, but freedom for something. And also I don't think that conceiving of insurance as a product gets us very far on this score, though it may be a useful construct for some purposes.¹⁹ The fair process that we expect from insurers we don't expect and should not expect from the makers of chain saws.

The character of the principle I discern in insurance law is one of obligation resting on the nature and contemporary importance of insurance, not resting on the consent and trust that are part of governance. Few individuals trust their insurers or consent to anything meaningful in connection with their purchase of insurance. What might we call the obligations reflected in this principle? *Quasi-constitutional*? *Good faith*? *Fair treatment*? I don't think that any of these names fit, but I don't have a better one. Maybe we should have a naming contest. In any event, I do know this: although the principle may not have a name yet, the principle is lurking in our law, and recognition of the principle's existence will enhance

¹⁸ See, e.g., RICHARD V. ERICSON, AARON DOYLE, & DEAN BARRY, *INSURANCE AS GOVERNANCE* (2003).

¹⁹ See Daniel B. Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389 (2007); Jeffery W. Stempel, *The Insurance Policy as Thing*, 44 TORT TRIAL & INS. PRAC. L.J. 813 (2009).

our understanding of what insurance law is, and what insurance does.