The hunt for institutional bad faith: How to bag a big'un

By E. Gerard Mannion and Kelly M. Mannion

One of the best ways to prove that a carrier has acted unreasonably, maliciously or fraudulently is through evidence of institutional "bad faith" practices. These practices either create false justifications for denying a claim and/or result in the company violating standards imposed by case law and/or the Unfair Claims Practices Regulations which are set forth in California Code of Regulations, Title X, Chapter 5, Subchapter 7.5, §§ 2695.1-2695.14, and Insurance Code § 790.03. This article identifies three different examples of institutional bad faith practices.

Where to find pattern and practices of carriers

There are many sources to explore in determining whether the company systemically acted in bad faith. These include:

1. Claims manuals

These are manuals setting forth the practices and procedures for the handling of a claim. Sometimes they are a goldmine. Other times, the carriers take the position that their claims handling practices are set forth in Insurance Code § 790.03 and the California Fair Claims Practice Regulations. A little more digging usually reveals that this is only a partial truth. Carriers generally have specific guidelines, instructions, and/or practices that apply to particular aspects of claims and which the carriers do not consider to be a claims "manual." It takes some digging to get to these documents, but it is worth it. In addition, you can turn to trial lawyer organizations to see if other attorneys have discovered documents which contain such information. The list servers that have been set up by AAJ, CAOC, and local trial lawyer organizations (such as the San Francisco Trial Lawyers Association and the Consumer Attorneys Association of Los Angeles) are excellent places to search for this information.

2. Colonial Life discovery

In the case of *Colonial Life & Accident Insurance Company v. Superior Court of Los Angeles* (1982) 31 Cal.3d 785, the Supreme Court ruled that it was proper for a plaintiff to ask for discovery concerning the names, addresses, and files of other claimants whose claims were handled by the same claims adjusters, and/or involved the same claim handling problems. This is another way to find a bad faith pattern and practice. If you intend to engage in *Colonial Life* discovery, your requests should be made early because it is a battle to get the carrier to agree to an appropriate letter to be sent to the other claimants.

3. Internet research

With the advent of blogs, discussion groups, etc. on the Internet, it is common to find information posted by other insureds about claims handling practices which are relevant.

4. Cases

A surprising number of cases against particular defendants contain information about claims-handling practices which can be used to show a pattern or practice. The cases can also be a fertile ground for information concerning witnesses, experts, and other discovery.

The information obtained through these avenues, and the discovery in the case itself, will allow you to begin the groundwork for getting a "Big'un."

Car theft claims

Insurers use The Insurance Frauds Prevention Act as an excuse to harass insureds and delay the claim until they can come up with an excuse to deny the claim. The carrier will generally deny these theft claims based on a manufactured "material misrepresentation" or after it has manipulated the insured into a failure to cooperate.

The bad faith claims practice begins with fraud on the part of the insurer. When a claim for a theft comes in, the insurer confirms that the insured had all the keys to the vehicle at the time of the theft.

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Establishing possession of the keys is important because insurers have two experts that will say that there is no way to steal a car without the keys and therefore the theft must have been an inside job.[1] By taking this false and easily disprovable position, the insurer feels they can safely put the claim into special investigations.

Once the claim is in special investigations, special rules apply to the claim. Instead of 40 days to process the claim, the limit is 80 days, and that can be extended with a simple letter stating that more time is required. During the investigation, the insurer will demand an enormous and burdensome number of records, including tax documents, bank records, phone records, and records of employment. If an insured is uncomfortable providing some or all of these records, the insurer claims it is justified in denying for failure to cooperate. However, serious questions develop as to whether the number and scope of the documents requested is reasonable. If the insured complies with all requests, often the insurer will push for far more in order to push the insured to not cooperate.

While the insured is forced to spend time and money gathering records, the special investigator is canvassing the neighborhood, looking for disgruntled neighbors or anyone that is willing to speak poorly of the insured or contradict their statements. The insured's friends and family will be harassed and *any* discrepancies between information provided by the insured and others will be seized upon. If the investigation does not cause the insured to give up, the insurer will demand an Examination Under Oath (EUO). Minor discrepancies between the EUO and the insured's recorded statement will be used to deny the claim on the basis of the insured's "misrepresentations."

Invariably, the insurer commits multiple acts of fraud or misrepresentation during the claims handling process, and violates the Fair Claims Practices Act. The following are some of the most common violations.

1. Delay in violation of California Code of Regulation § 2695.7 and 790.03

Insurers fail to deal with the insured in a timely fashion. These delays are often costly and difficult for the insured and can cause them to give up during the claims process. Section 2695.7 provides:

> (b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part.

If the insurer has a documented reason for believing that it may be a fraudulent claim, the time for denial or acceptance of the claim is increased to eighty (80) calendar days. However, instead of sticking to this 80-day limit, insurers repeatedly claim that they need more and more information to process the claim (they do not) and often keep the claim open for six months to a year.

Even though an insured has provided banking statements, phone records, and appeared for recorded statements or EUOs, the insurer will keep the claim open. This is a violation of Section 790.03(h)(4) (Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured).

2. Failure to act fairly and consider favorable facts in violation of California Code of Regulation § 2695.7

Section 2695.7 provides:

> (d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

Once an insured's claim is referred to the fraud investigator, the insurer treats this as *carte blanche* to look only for fraud and to ignore any evidence to the contrary. Often an insured will provide evidence that the insured had plenty of money and had no financial incentive to commit fraud, but insurer refuses to consider this evidence. Or, the insured provides evidence that the insured was not anywhere near the vehicle at the time of theft, but the insurer persists in the fraud investigation.

A practice of ignoring favorable evidence and only looking for support for the fraud allegation can be an institutional problem. "An insurance company may not ignore evidence which supports coverage. If it does so, it acts unreasonably towards its insured and breaches the covenant of good faith and fair dealing." (*Mariscal v. Old Republic Life Insurance Co.* (1996) 42 Cal.App.4th 1617, 1624.) If evidence supporting the claim is later presented by the insured or obtained from other sources, the insurer owes a duty to investigate that new evidence: "The insured may recover damages for (the carrier failing to investigate) where the recovery is not predicated upon injury due to a report [of fraud], but upon other injuries." (*Frommoethelydo v. Fire Ins. Exch*. (1986) 42 Cal.3d 208 at 219 -220. [The insured had witnesses

who verified his version of the events but the insurer refused to interview them. This was evidence of bad faith.])

3. Misrepresentations regarding the nature and scope of the investigation

Throughout this process, insurers make misrepresentations to the insureds in violation of Section 790.03(h) (1) by misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

Insurers lie about the scope of the inquiry, looking into years and data that have no bearing on the investigation. They will tell the insured that they have waived privacy rights and an assertion of privacy will lead to denial of the claim.

Section 790.03 prohibits pretextual interviews. These are defined as interviews where the true purpose or identity of the interviewer is withheld. Insurers will claim that EUOs and recorded statements are merely to "establish the facts of loss" when in fact, these interviews are being used to build up a fraud case against the insured.

Insurers misrepresent the materiality of the alleged misstatements when they deny claims. "Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries." (Ins. Code § 334.)

There are no cases on what is immaterial. However, minor discrepancies cited as the bases for denial do not match with the kinds of facts that have been considered material.

Repeatedly lying about causation or value were material. Where an insured homeowner admitted during her EUO that she had lied about the cause of damage to her home in her recorded statement, that was a material misrepresentation justifying denial. (*Cummings v. FIE* (1988) 202 Cal.App.3d 1407, 1417.) Lying about the value of a damaged vehicle multiple times constitutes a material misrepresentation justifying denial. (*Hodjat v. State Farm Auto* (2012) 211 Cal.App.4th 1, 3.)

Denial based on minor "misrepresentations" is bad faith.

Home losses and the Unfair Claims Practices Act

In the context of homeowner's claims, the insurance industry has been engaging in fraud in assessing repair cost with Xactimate, unfairly calculating Loss of Use, deducting depreciation, and selling replacement cost coverage.

Insurers frequently make the following misrepresentations:

- Whether a field adjuster is required to investigate the loss and when this investigation must take place. (*Chodos v. INA* (1981) 126 Cal.App.3d 86, 102-103.)
- Insurers will lead the insureds to believe that they had to use insurer-designated contractors and that the bids had to be approved by the insurer before the insureds could even see them. Instead, insureds can have a bid done by a non-insurer contractor.
- That a lack of a kitchen does not make a home uninhabitable. This is not supported by policy language or common sense.
- That the insureds can only get reimbursement for food receipts and not a hotel or similar home.

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- Insurers do not like to explain that Loss of Use coverage can allow insureds to collect Fair Rental Value of their home, at a rate relevant to the time before the loss occurred. They often misrepresent the availability of homes or the value of the home that an insured is entitled to rent.
- Extended Replacement Cost Coverage. It is sold as full replacement without deduction for depreciation. However, the insurer will deduct depreciation until work is completed.

Insurers knowingly violate California Ins. Code § 2695.9:

- The regulation provides that "(a)(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible." Despite this language, insurers always take a deduction for depreciation based on the age and quality of the material that is being repaired.
- The insurer tells its insureds that the definition of Actual Cash Value is the *cost of the repair materials, minus depreciation*. Often, a policy defines Actual Cash Value as the fair market value of the material. This is also the definition under California case law.
- Cal. Ins. Code § 2695.9 (f) states that "Any adjustments for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property and apply only to property normally subject to repair and replacement during the useful life of the property." Many adjusters have admitted they do not know if the depreciation deduction accounts for the difference to market value attributable to the age and condition of the property.
- This is particularly true when an insurer relies on Xactimate because they do not know how Xactimate calculates depreciation. They therefore cannot actually comply with the insurance regulations.
- The Xactimate software that calculates depreciation cannot be modified or otherwise affected by the adjusters. The adjusters do not know how the depreciation is calculated and do not know what factors are considered.

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Misrepresentation in coverage/denial letters

Many coverage and/or denial letters contain a recitation of various portions of the insurance policy which the carrier claims restricts coverage, or justifies a denial of coverage.

Many times the claims adjuster lists out many more provisions of the policy to justify denial of the claim than actually applied to the particular circumstances of the claim. This is actually *fraud* under the punitive damage statute.

Civil Code § 3294(c)(3) defines fraud as: "an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury."

It is important to note that this definition of fraud does not require "reliance" on the part of the insured. It only requires that there be a misrepresentation, deceit, or concealment with the intent of depriving someone of property, etc. A denial letter which cites as the basis for the denial irrelevant or inapplicable provisions of the insurance policy is just that: An attempt to misrepresent that certain provisions of the policy are applicable to justify denying the claim, when they are not, and/or is an attempt to conceal which provisions of the policy actually apply.

The way you establish that this is fraud is the following. Take the denial letter. Identify those provisions of the policy cited in the denial letter which do not apply to the claim in whole, or in part. Identify any other provisions of the policy which would apply to benefit the insured, and which have not been cited in the denial or coverage letter. In depositions of the claims person, and their superiors, ask them to admit that they are supposed to be truthful in what they write to the insured, that the insured is entitled to rely upon what they write, and that it is expected that the insured will make financial and other decisions based upon the representations in the denial letter. Then have the claims personnel admit that the inapplicable portions of the policy cited in the denial letter are indeed inapplicable. If there are provisions of the policy which were not cited that should have been listed in the letter, have the claims personnel admit that they should have included references to those portions of the policy. At this point, you can either leave the testimony stand as it is, or ask the witness to agree that the references to inapplicable provisions of the policy as a basis for denial of the claim were misrepresentations which the company intended the insured to rely upon and/or the failure to list relevant portions of policy was also intended by the carrier to be relied upon by the insured. If, after conducting *Colonial Life* discovery you find that the carrier has done this in other situations, you can prove that it is a company pattern and practice to misrepresent to insureds throughout its claims handling.

Conclusion

Looking for pattern and practices of the like identified above should help any plaintiff's attorney get a nice win. ■

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[1] The carriers' own claims handling guidelines will often state that there are multiple ways to steal a car without the keys. Furthermore, this kind of expert is easily debunked.

Insurance Broker

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v. Membrila Ins. Services, Inc. (2004) 118 Cal.App.4th 462.) This may include costs of defending a legal action brought by a third party where insurance coverage otherwise would have provided for such a defense. It can also include settlement costs for or costs of a judgment in such a third party action. If a broker failed to obtain clear coverage due to negligence and this leads to a dispute between the insured and insurer then the insured can potentially recover attorneys' fees and costs in litigating that dispute from the broker. The trier of fact can apportion such damages between the insurer and the broker as it sees fit.

Conclusion

An understanding of the duties that agents and brokers owe to their insured and for which insureds can hold them responsible, provides a source of possible compensation in circumstances when an insurer refuses to cover all or some of a loss that was or should have been insured. ■

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