TAIBF

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Some Liability Insurers Act In Bad Faith As A General Business Practice

I. Many liability insurance companies have secret business practices that place systematic pressure on people within the claim department to pay as little as possible on all liability claims.

By way of example, one major insurance company implemented "Average Loss Payments" ("ALP") metrics when evaluating the claim department's performance. ALP (which is sometimes referred to as "average severities" or "average claim payments") is the average of the insurance policy proceeds paid by the insurance company to settle liability claims made against its insureds within a certain time frame.

Every insurance company *tracks* ALP; it is an important factor to know for underwriting purposes. But using ALP when setting *performance targets* for the claims department and its personnel takes it one step further. Directors' and managers' raises, bonuses, and eligibility for promotion are often based, at least in part, on how low they can keep ALP. Sometimes, ALP is weighted more heavily (upwards of 30%) than any other metric in the annual performance evaluation. And to ensure they are meeting their annual targets, the directors and managers pressure (or require) the front-line insurance adjusters to make low-ball settlement offers across the board.

Insurance companies are *supposed* to evaluate a liability claim "from the perspective of a reasonable insured facing unlimited exposure." When settlement decisions are influenced by ALP targets, that is evidence of bad faith. *See Gonzalez v. GEICO Gen. Ins. Co.*, 2016 WL 2759130 (M.D. Fla. May 12, 2016); *Hines v. GEICO Indem. Co.*, 2016 WL 688050 (M.D. Fla. Feb. 19, 2016).

II. Liability insurers force claims into litigation to try to decrease the average claim payments.

In the past decade, at least one insurance company was **intentionally provoking lawsuits against their insureds to attempt to decrease its ALP**.[1] As one former regional claim manager explained:

- The insurer should "hold the line" and refuse to settle whenever the insurer believed it had any "rational basis" for its valuation of the liability claim.
- Paying more on one claim "simply because an attorney asked for it" could "set the value of the next 100, 1,000, 5,000 claims" higher. So, even where the insurer's "evaluation" of a claim was only a "couple of grand" less than the claimant's settlement offer, the

insurer would force the injured claimant's attorney to file a lawsuit against the insured, without regard for the exposure its insured faced.

• The manager believed his unit of claim managers and adjusters should encourage more cases to go to trial to "send a very strong and clear message to the plaintiff's bar about [the insurer's] attitude and capabilities."

> This was an extreme disappointment for me because I firmly believe that for every time we take a case to trial, we send a very strong and clear message to the plaintiff's bar about our attitude and our capabilities. This, in and of itself, is a tremendous deterrent to filing new suits from those BI attorneys that may not be as aggressive as others, or to those that deep down know their demands/ expectations may be unreasonable. We will never know how many suits were not filed because of our known willingness and ability to try cases.

• The hope was that over the long run, the insurer's refusal to accept pre-suit settlement offers which the insurer deemed too high would have a "dampening effect" on increasing Average Loss Payments.

But when the insurer's strategy failed and the injured claimant refused to accept the insurer's low offer and elects to file a lawsuit against the policyholder instead, the insured is responsible for paying the excess judgment. **Insurance companies are using their policyholders as human shields to try to increase their profits.**

[1] *In most insurance bad faith cases, there is a restrictive "confidentiality agreement" which prohibits the insurance company's internal business policies, guidelines, performance reviews and claim-handling manuals from being disclosed to the public.* HOWEVER, *no such agreement prohibits the sharing of this information.*

III. Insurance adjusters are trained to make lowball settlement offers.

This is how one insurance company taught their insurance adjusters to negotiate:

"Question everything"

> One theme throughout my talk today is to "question everything." Develop a healthy skepticism. Keep in mind no two negotiations are the same. What you did two weeks ago may not work today. How you handled yesterday's claimant may not necessarily apply to the one today.

"Start negotiation with 'insultingly' low offers."

> The second theme is to "think big." Now I do not mean to "think big" by giving away "big" money. What I do mean is that people should shoot for the moon on every deal to get the best situation from your side of the negotiation table. Strong positions, whether it means quoting an "outrageously" high price or making an "outrageously" low offer, in our situation that is the lower end of our authorized range. From our side of the table, I urge you to start negotiations with "insultingly" low offers.

"Start at the 'bargain basement'."

> Once again, if we view this as the seller/buyer transaction you are the buyer. Thus, always start low. I have touched on this before. Do not be afraid they will not like you when you make an outrageously or insultingly low offer. Remember this is the low end of your authorization range. You can never go back down unless there is a drastic change of circumstances. You only go in one direction that is up. So start at the bargain basement.

IV. What's wrong with the insurance company being aggressive and offering less than the claimant requests?

Nothing, so long as the exposure to the insured person does not exceed the liability policy limits. But when the claim presents an exposure greater than the policy limits (meaning that the policyholder may owe money out of their own pocket), the insurer is gambling with its insured's livelihood.

If the insurance company's aggressive strategy is successful, the insurer saves money. If the insurer's strategy is unsuccessful, the policyholder bears the consequences. Heads the insurer wins, tails the policyholder loses.

This is why the common law duty of good faith exists. Insurance companies are not allowed to put their own financial interests above their policyholder's interests. They owe a *fiduciary duty* to their insureds and are *supposed* to act reasonably to protect the insureds from an excess judgment.