Strategies for Defending First Party Bad Faith Litigation

J.S. “Chris” Christie, Jr.

Bradley Arant Boult Cummings LLP

1819 Fifth Ave. N.
Birmingham, AL 35203
(205) 521-8387
jchristie@bradley.com
J.S. “Chris” Christie, Jr., represents his clients as a Birmingham, Alabama, partner of Bradley Arant Boult Cummings LLP. He serves as the leader of Bradley’s Insurance Practice Group and as co-chair of its Pro Bono Committee. The American College of Employee Benefits Counsel selected him as a fellow in 2012. The Best Lawyers in America lists him in five insurance or litigation related areas of law. Before joining Bradley in 1988, Mr. Christie taught law at the University of Yaoundé in Cameroon (West Africa) as a Peace Corps volunteer.
Strategies for Defending First Party Bad Faith Litigation

Table of Contents

I. Introduction ...................................................................................................................................................5
II. Background and History of the First Party Bad Faith Tort ........................................................................6
   A. Insurance Policies and Tort Damages .................................................................................................5
   B. Development of Insurance Bad Faith ...............................................................................................5
   C. Bad Faith Tort Variations ..................................................................................................................6
III. Steps Insurers Should Consider Before a Policy is Sold ......................................................................6
IV. Steps Insurers Should Consider When Handling a Claim ........................................................................7
V. Steps Insurers Should Consider When a Lawsuit is Filed ....................................................................9
VI. Steps an Insurer May Take Involving ERISA Preemption ..................................................................12
   A. Why Insurer’s Want ERISA to Apply ...........................................................................................12
   B. How an Insurer Can Help Have ERISA Apply ..............................................................................13
   C. ERISA Preemption When the Employer Did Not Intend for ERISA to Apply ...............................14
VII. Conclusion ................................................................................................................................................14
Strategies for Defending First Party Bad Faith Litigation

I. Introduction

The risks from plaintiffs’ actions against insurers alleging bad faith, including the extra-contractual and punitive damages sought, continue to trouble insurers. Life, health and disability insurers, and lawyers representing these insurers, need to consider taking a comprehensive approach to managing these bad faith risks. An insurer's strategies should include steps taken before selling the policy, precautions when considering a claim under the policy, and carefully considered approaches when defending a lawsuit brought based on the policy. Life, health and disability insurers should also separately consider ERISA preemption, which can eliminate the risks of bad faith claims for many policies.

II. Background and History of the First Party Bad Faith Tort

A. Insurance Policies and Tort Damages

Insurance policies are contracts. Contracts normally define the parties' relationship. For an insurance policy, the relationship between the insured and the insurer includes if, when and what the insurer is to pay the insured. For an insurer’s alleged breach of contract, an insured as a plaintiff would thus have alleged damages based on the policy’s contract benefits and a court could award, if the insurer breached the policy, the insurance benefits as damages.

In most states, “bad faith” is a tort claim that an insured may have against an insurer, based on the insurer's claim denial, for damages in addition to the policy benefits. If a plaintiff recovers for the tort of bad faith, an insurer would pay extra-contractual damages not defined by the policy, including possibly mental distress and punitive damages, in addition to the insurance benefits.

B. Development of Insurance Bad Faith

The development of the bad faith tort has been justified based on the insurer’s duty of good faith and the insurer’s power when handling claims, compared to the insured’s lack of power. The theory is that the bad faith tort permits insureds to recover tort damages in addition to policy benefits if claims are improperly denied, thereby seeking to protect insureds with valid claims against being abused by insurers.

The bad faith tort primarily developed through common law decisions by state courts, with a handful of states having statutes that define a bad faith tort claim. Since 1945, under the McCarran-Ferguson Act, 15 U.S.C. §§1011-15, federal law has expressly left the regulation of the business of insurance to the states. States generally regulate insurance through an “Insurance Code.” In what amounts to insurance regulation through litigation, however, most states have judge-made case law creating and defining the bad faith tort.

California first recognized the first party bad faith tort. In Grunberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973), the California Supreme Court held that an insured who can show that benefits due under the policy were withheld and that the reason for withholding the benefits was unreasonable or without proper cause has a bad faith tort claim. Id. Many jurisdictions have bad faith torts similar to California's bad faith law.

Others have a tort similar to Wisconsin, which adds a subjective element: To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying policy benefits and the insurer's knowledge or reckless disregard of a reasonable basis for the denial. Anderson v. Continental Ins. Co., 271 N.W. 2d 368, 374, 377 (Wis. 1978).
Alabama has an unusual bad faith tort, with “normal” bad faith judged by a standard similar to the Wisconsin definition, but also allowing “abnormal” bad faith claims for an insurer’s alleged failure to investigate where the insured can show that an insurer “recklessly or intentionally failed to properly investigate a claim or to subject the results of its investigation to a cognitive evaluation.” *Employees’ Benefit Ass’n v. Grissett*, 732 So. 2d 968, 976 (Ala. 1998). Moreover, such recklessness “may be inferred and imputed to an insurer when it has shown a reckless indifference to facts or proof submitted by the insured.” *Id.* In *State Farm Fire & Cas. Co. v. Brechbill*, 144 So. 3d 248, 260 (Ala. 2013), however, the Court made clear that “[a] bad-faith-failure-to-investigate claim cannot survive where the trial court has expressly found as a matter of law that the insurer had a reasonably legitimate or arguable reason for refusing to pay the claim at the time the claim was denied.”

**C. Bad Faith Tort Variations**

Accordingly, the bad faith tort varies significantly from one state to the next. Various 50 state surveys are available; for example the “50 State Survey of Bad Faith Laws and Remedies,” dated October 23, 2014, by United Policyholders is available at http://www.uphelp.org/pubs/50-state-bad-faith-survey. As a starting point for a specific state, one might refer to the treatise, New Appelman on Insurance Law §55.03 (describing the definitions of the bad faith tort in various jurisdictions). Describing and analyzing the many bad faith tort variations is a task beyond the scope of this paper.

Generally, insureds can assert first party bad faith claims or third party bad faith claims:

- **First Party Bad Faith** – the plaintiff alleges that his/her/its insurer refused to pay a claim without a reasonable basis or failed to investigate the claim properly.

- **Third Party Bad Faith** – the plaintiff can also allege that his/her/its insurer failed to defend or to settle a claim within policy limits.

Against life, health and disability insurers, as well as against property and casualty insurers, a plaintiff may have first party bad faith claims. Against life, health and disability insurers, a plaintiff does not have third party bad faith claims, because those claims generally are based on a liability carrier’s duties to defend a lawsuit or to settle a lawsuit reasonably. So, these additional third party bad faith claim issues are not addressed in this paper. Instead, the discussion here is about first party bad faith.

One might question whether using litigation under varying state bad faith laws as a means of regulating insurers’ claims practices is effective or efficient public policy. Regardless of whether it is good policy, in most states in the United States, life, health and disability insurers and property and casualty insurers must defend first party bad faith litigation. For that reason, insurers should consider how to avoid or minimize the risks of extra-contractual compensatory and punitive damages.

**III. Steps Insurers Should Consider Before a Policy is Sold**

Before a policy is even sold, an insurer can take steps that reduce its bad faith claims risks. Several of these steps are discussed briefly below.

- **Goals and Incentives** – To minimize bad faith risks, an insurer should make sure that a plaintiff’s lawyer cannot characterize its internal goals, incentives, performance evaluations, or anything else applicable to the individuals making claims decisions as showing the individual handling a claim had a personal motive to deny the claim even if it should have been paid. For example, an insurer’s having internal goals of processing a certain number of claims should not be a problem, especially if denying a claim takes more time than determining it should be paid, but having an internal goal of denying a minimum number or a minimum percentage of claims might be problematic. A plaintiff’s lawyer would welcome the opportunity to tell the jury that
the jury must return a large enough punitive damages amount to make the insurer change its internal goals, incentives or whatever.

Sales Practices – To minimize bad faith risks, an insurer should make sure it has good sales practices. As an initial consideration, good sales practices can reduce the risk of lawsuits based on alleged misrepresentations, which also usually seek extra-contractual and punitive damages. Furthermore, some lawsuits with a bad faith claim begin with an insured’s misunderstanding of what the policy covers based on how the policy was sold, with many lawsuits asserting a bad faith claim also including fraud claims. Moreover, having both fraud and bad faith claims in the same lawsuit can magnify the risk that a jury wants to compensate the insured and punish a “bad” insurer.

Policy Language – To minimize bad faith risks, an insurer should make policy language as clear as possible, defining the events that trigger benefits and the amount of benefits with criteria that are as objective as practically achievable. As to clear language, many bad faith claims arise actually out of unclear policy language. One might think that to have a bad faith claim, a plaintiff would have to be entitled to judgment as a matter of law on the contract claim, but that is not required in many jurisdictions. Many courts submit the contract claim and the bad faith claim to the jury together. Other bad faith claims can arise from judgment calls that the policy language leaves to those handling the claims. As examples, decisions about whether a condition was pre-existing, a death was accidental, or an individual is totally disabled all can have subjective aspects. When feasible, an insurer should consider having only objective criteria or, for claims decisions that require judgment calls, including objective criteria. By having objective criteria and by limiting the subjective judgment calls, an insurer can limit the bad faith risks.

Arbitration – To minimize bad faith risks, an insurer may consider, for certain jurisdictions and for policies not funding an employee benefit plan governed by ERISA, having all claims related to the policy resolved by arbitration. Some state insurance codes expressly allow arbitration, some expressly prohibit it, and many do not mention it. Primarily, arbitration is commonly seen as posing less risk of runaway awards based on emotion. But there are no guarantees in arbitration, as with any other litigation. And if an arbitration results in a runaway award, there are almost never any appeal rights. Arbitration is supposed to be cheaper and quicker, but it usually does not provide for early dismissal or for dispositive motions. In some jurisdictions, arbitration can be the best option, but it is not a panacea.

IV. Steps Insurers Should Consider When Handling a Claim

When considering a claim and before a lawsuit is filed, an insurer should consider what steps it might take to prevent or minimize bad faith claims. Comprehensive details of what are good claims handling practices would vary by types of insurance and thus a complete discussion is beyond the scope of this paper. On the other hand, some general guidelines and suggestions are appropriate here.

Good Claims Denials – While the standard varies by jurisdiction, the bad faith tort is supposed to be for claims where the denial was not only wrong but the reason given also was not reasonable or was not debatable or some other similar standard. An insurer would not (or at least should not) deny claims for no reason or for a bad reason; in other words, an insurer should have a good reason based on the policy language for denying a claim. Most likely, an insurer will have to defend a bad faith claim based on only the reasons for the denial given in the denial letter or other communication to the insured. An insurer should write and send denial letters with all possible good reasons for denying a claim and explain those reasons in language so that a typical juror can understand the reasons for the denial. If a juror cannot understand the reasons for a denial, he or she probably is more likely to find the claim denied in bad faith.
Good Claims Processing – Common sense makes apparent that an insurer can minimize bad faith risks with good claims processing practices. An insurer not only needs good claims handling practices, but also needs to be able to convince a jury that it has good claims handling practices.

Putting aside whether a claim should or should not be paid, when handling a claim, an insurer should recognize that every written word from the insurer to the insured probably can be read to the jury. Moreover, the insurer’s internal communications, notes and other writings not sent to the insured also can usually be read to the jury. Even delay in communicating, lack of communications, and lack of notes or other writings indicating that the claim was being handled promptly can usually be brought to the jury’s attention.

Some may believe this sounds trite, but another way to express the same idea would be that, when handling a claim, an insurer should follow the Golden Rule – treat others as one would wish to be treated. Matt. 7:12 (“So whatever you wish that others would do to you, do also to them.” ESV). Always be polite, cooperative and professional with insureds, handle the claims in a prompt, thorough and honest manner, and make sure these good claim handling practices are documented. Then, an insurer can demonstrate to the jury how well the claim was handled.

Documenting Good Claims Handling – An insurer not only needs good claims handling practices, but also needs to document those practices so those practices can be proven in court. Possible claims handling documentation practices to consider:

- Date stamp materials and number pages when received
- Keep good telephone notes or memos, including of no answers
- Keep good notes or memos of all activity
- Consult experts when appropriate
- Provide experts with all facts and with no opinions
- Send or summarize any new information to the insured for response
- Inform the insured in writing of what information insurer reviewed
- Invite the insured to submit any additional information
- Follow up even when it is another’s turn to respond
- Add related emails to the claim file
- Maintain records to avoid spoliation motions or arguments
- Follow all written claim procedures or guidelines carefully
- Do not write down speculation, opinion, gratuitous comments
  - “Gee, maybe Bob should have . . . “
  - “This lady cannot be telling the truth”
  - “I am so tired of her calling every day”
- Assume a jury will read all written notes, memos or other materials

Bottom line: Do not handle a claim in a way a jury would not like, do not allow documents to be created that would allow a jury to be given the impression that the claim was not handled well, and create documents showing that the claim was handled well.

The ACA and Health Claims – Health claims are required to comply with the Affordable Care Act’s Internal Claims and Appeals and External Processes Review. Here is a link to an April 15, 2016 slide pre-

As a practical matter, the ACA’s claim requirements have almost eliminated bad faith claims for ACA covered health benefits. The ACA requires external reviews to be independent. If an external review finds a claim payable, the insurer pays it. If the independent external review finds a claim not payable, alleging bad faith would seem to be frivolous. Unless an insurer uses a biased external reviewer, does not provide the appropriate information to the external reviewer, or otherwise games the external review, the risk of bad faith claims for ACA covered health benefits should be remote.

For non-ACA claims, an insurer might consider adopting concepts from the ACA’s requirements. For example, as reflected on the ninth slide at the link above, CMS has summarized the notice requirements for ACA-covered adverse health benefit determinations as follows:

1. Describe reason(s) including specific plan provisions, scientific judgment used
2. Describe any additional information needed to improve or complete the claim
3. Provide sufficient information to identify claim
4. Notification of internal appeals & external review rights
5. Notification about health insurance consumer assistance or ombudsman office availability
6. Provide notification that Culturally & Linguistically Appropriate Services (CLAS) are available

DOL Claim Regulation – For non-ERISA claims, an insurer might consider adopting concepts from the DOL claim regulation, 29 C.F.R. §2560.503-1. While no reported cases commenting on this practice were found, plaintiffs’ lawyers have used the DOL Claim Regulation at deposition to question witnesses as to why a non-ERISA claim was not handled in the same manner as an ERISA claim would have been handled. While arguably not a proper opinion, one might see a plaintiff’s claims handling expert testify that the DOL Claim Regulation provided the minimum standard of care and an insurer in bad faith did not meet that standard.

V. Steps Insurers Should Consider When a Lawsuit is Filed

After a plaintiff files a lawsuit asserting a bad faith claim, an insurer should consider litigation strategies to prevail and to minimize the damages that might be recovered. Appropriate steps include evaluating the forum, initial or other early venue and dispositive motions, limiting discovery, affirmative discovery, witness interviews, witness preparation, experts, limiting punitive damages, and settling.

The Forum – At times, a change in the forum can be outcome determinative: The judge might be the difference; the jury pool might be the difference. Forum arguments normally must be made almost immediately (remove to federal court within 30 days of service) (raise improper venue or service of process with initial pleading):

- Remove to federal court based on ERISA preemption
- Remove to federal court based on diversity
- Move to transfer venue based on improper venue
- Move to transfer venue based on forum non conveniens
- Move to compel arbitration
Opportunities for diversity removals to federal court at times arise as more information develops. As to diversity removals, an insurer might consider arguing fraudulent joinder, moving to dismiss a non-diverse defendant, or conducting discovery to establish that a plaintiff seeks damages above the amount in controversy.

**Initial or early motions** – Initial Rule 12(b) motions or early but not initial Rule 12(c) motions (judgment on the pleadings) or an early summary judgment motion might result in having the bad faith claim dismissed before discovery. A strategy to dismiss the bad faith claim early might be particularly helpful, because it can limit the scope of discovery, thereby avoiding the risk that a plaintiff through discovery develops evidence that allows avoiding a summary judgment dismissal after discovery. In some forums, even if the insurer cannot have the bad faith claim itself dismissed, one might move to strike or to dismiss a plaintiff’s bad faith pattern and practice allegations. In some forums, however, the chances of having any early dispositive motions granted is remote and the most likely consequence of filing such a motion might be educating the plaintiff’s lawyers on the facts, law, and the insurer’s theory of the case.

**Limiting Plaintiff’s Discovery** – Plaintiffs often seek discovery that some judges may allow and others may not: Written claims procedures, training materials, arguably similar claim denials or approvals, complaints by other insureds, goals for claims handling, payments, or denials, incentive programs, performance evaluations, personnel files, statistics on claim denials and approvals, reports or presentations for management, or communications with insurance rating companies. On the other hand, do not resist providing discovery of evidence that the insurer probably wants to use affirmatively, such as favorable claims statistics. Actually limiting a plaintiff’s discovery often turns on the predisposition and discretion of the judge. Try to make the judge want to help the insurer. That may take affidavit evidence about the burdensomeness of responding, legal arguments about the irrelevance of requested discovery, or hiring local counsel the judge whose arguments might be more likely to get the judge’s attention. Consider being proactive during a scheduling or status conference or with a motion for protective order, not just waiting to respond to a plaintiff’s motion to compel.

**Discovery from Plaintiff** – An insurer should almost always take affirmative discovery from a plaintiff. Many topics of discovery might be related to the policy and to a plaintiff’s understanding of the policy coverage. Formal and informal discovery might seek information about a plaintiff’s other litigation or about other credibility issues (for example, criminal convictions). If a plaintiff asserts he or she seeks mental distress damages, that may open the door to all types of discovery about medical treatment, activities, and social media. While an insurer may need to be careful, making an insured look less sympathetic to a jury might have an impact on liability as well as on damages.

**Witness Interviews** – An insurer should interview key internal and any third party witnesses early. First, a lawyer representing an insurer should consider making clear to an internal witness being interviewed that the lawyer represents the company and not the witness (an Upjohn warning). If the internal witness has done something questionable, the lawyer will want to tell the client, the insurer. An insurer should define what it wants to prove, its litigation objectives, and let witnesses know the objectives. Memory is fallible, so an insurer should first and early interview and document the memories of its employees, its other agents, and third parties. Witnesses should be interviewed and prepared on who, what, when, where, why and how. The interviewer should know the file well enough to ask tough questions, if appropriate, and not to accept answers on face value.

**Witness Preparation** – An insurer should make sure its lawyers prepare each witness to be deposed or to testify at trial as it would for any other high stakes lawsuit. For example, having witnesses practice answering direct and cross questions, even videotaping witnesses, should be considered. Usually, a plaintiff’s best bad faith evidence will come from cross-examination of the insurer’s witnesses. Through the insurer’s witnesses,
plaintiffs’ lawyers may attempt to portray the insurer as greedy, uncaring, or a threat to the safety and security of society (the plaintiffs’ “reptile theory”). A plaintiff’s lawyer’s questions may attempt to have witnesses admit to “rules” that protect insureds. For example, a series of questions may intend to establish that the primary rule for an individual handling a claim is to protect the insured from all the bad consequences flowing from not having the insured’s claim paid. Often, these questions may seem to be relatively innocuous questions seeking yes or no answers. When preparing witnesses, have each witness (1) know the insurer’s story or talking points (e.g., insurer considers claims fairly and pays almost all claims, but insurer should not pay claims not covered, because doing so would undermine insurer’s ability to pay covered claims), (2) do not agree with or adopt a plaintiff’s terms like “rules” or “duty” or adopt a plaintiff’s vague or overbroad statements, (3) answer questions with sentences (subject and verb) not one word (“yes”), which can be misunderstood, (4) practice answering safety and security questions, and (5) be likeable and caring about the plaintiff and other insureds.

**Expert Witnesses** – Expert witness use varies by jurisdiction. Expert discovery varies by jurisdiction and may vary depending whether the expert witness is a retained expert or an insurer employee. If a retained expert is appropriate, a former insurance regulator might be a good choice. Unless a plaintiff has a retained expert to whom an insurer needs a responding retained expert (i.e., cannot respond with an in-house expert), an insurer rarely would want to use a retained expert. Usually, an insurer wants a jury to perceive the insurer as having the expertise in-house to explain whatever needs to be explained. An insurer should attempt to exclude a plaintiff’s expert under the applicable Frye or Daubert standard, particularly focusing on all or parts of opinions that are actually legal conclusions, define legal terms, determine witness credibility, or opine on individuals’ motivations or state of mind. An insurer should consider having an in-house person as a witness to establish helpful facts, such as the total number of claims paid compared to the small number denied, the many steps taken to review a claim, how heavily regulated an insurer is, how many fraudulent claims are submitted, or other helpful facts. Often, an insurer has an employee who can serve both as a quasi-expert or non-retained expert and as a 30(b)(6) deposition representative. Whether such testimony is expert testimony depends on the testimony and on the jurisdiction.

**Punitive damages** – An insurer needs to develop a case specific strategy to minimize punitive damages. Before planning what evidence to present at trial, the bad faith punitive damages available under state law and constitutionally permissible under State Farm Mutual Ins. Co. v. Campbell, 538 U.S. 408 (2003), warrants considerable research for each jurisdiction and fact situation. Generally, punitive damages have been held to be constitutionally limited to a single digit (one to nine, depending on the circumstances) multiplier. Mental distress damages are at times discussed as increasing what can be multiplied, but some cases discuss whether mental distress damages have already been awarded as limiting the multiplier. A tough call is whether to ask to have the court bifurcate the case into contract and bad faith phases. Many courts will not do so. If the court does bifurcate, the bad evidence may be kept out of the initial contract phase, but the risks of high punitive damages would seem greater if the jury had already decided the insurer was wrong before considering evidence directed at punitive damages.

**Settlement** – As a practical matter, perhaps even more so than other high stakes litigation, bad faith cases seem to settle before trial. Settling a case reasonably requires being ready to try the case if the other side is not being reasonable. Settlement considerations include (1) how dangerous the forum is for large jury verdicts, especially against insurers, (2) the “heat” in the case from unfortunate evidence, (3) the plaintiff as a sympathetic witness, (4) an insurer’s witnesses’ ability to be likeable, to be credible, and to withstand cross examination, (5) other witnesses, if any, (6) the legal arguments and the facts related to mental distress and punitive damages, and (7) the dispositive legal arguments that might be made at summary judgment, after trial, and on appeal.
VI. Steps an Insurer May Take Involving ERISA Preemption

A. Why Insurer’s Want ERISA to Apply

The most effective step an insurer can take to manage bad faith risk is having the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§1001-1461, apply to the policy benefits. Insurers issue many life, health and disability insurance policies to employers to fund the employer’s employee benefit plan. For such a policy, if a court rules that ERISA preempts a plaintiff’s state law bad faith claims, an insurer should have no extra-contractual and punitive damages bad faith risks, other than possibly discretionary attorneys’ fees for the plaintiffs’ lawyers.

When adopting ERISA in 1974, Congress announced that ERISA was intended “to encourage the maintenance and growth of [employee benefit plans]; [and] . . . to maintain the premium costs of such system at a reasonable level [. . .]” 29 U.S.C. §1001b(c)(2, 5). The Supreme Court has instructed courts “to take account of competing congressional purposes, such as Congress’ desire to offer employees enhanced protection for their benefits, on the one hand, and, on the other, its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.” Varity Corp. v. Howe, 516 U.S. 489, 497 (1996).

To further these purposes, ERISA expressly preempts state laws that relate to an ERISA plan and impliedly preempts state laws that conflict with ERISA. To have ERISA preemption, there must be an ERISA plan, which requires a type of benefit covered by ERISA; life, health and disability benefits are ERISA benefits. ERISA §3(1), 29 U.S.C. §1002(1). ERISA preemption also requires that the plan be “established or maintained” by an ERISA covered employer or employee organization. ERISA §4(a), 29 U.S.C. §1003(a). Except for churches that have not affirmatively opted into ERISA coverage and for governmental entities, employers are ERISA covered employers. ERISA §4(b), 29 U.S.C. §1003(b). Cf. Nielsen v. UNUM Life Ins. Co. of Am., 58 F. Supp. 3d (W.D. Wis. 2014) (holding that the church plan at issue properly elected to be governed by ERISA).

ERISA has two types of preemption. Express preemption preempts a state law that “relates to” an ERISA plan. ERISA §514(a), 29 U.S.C. §1144(a). Implied preemption (often referred to as “complete preemption”) requires a state law claim that conflicts with the limited claims that Congress made available under ERISA§502(a), 29 U.S.C. §1132(a). As a practical matter, complete preemption is the most important concept as to limiting bad faith risk.

Whether a bad faith claim is completely preempted turns on the two-part test from Aetna Health Inc. v. Davila, 542 U.S. 200 (2004): “(1) whether the plaintiff could have brought its claim under [ERISA] §502(a); and (2) whether no other legal duty supports the plaintiff’s claim.” Gables Ins. Recovery, Inc. v. Blue Cross & Blue Shield of Fla., Inc., 813 F.3d 1333, 1337 (11th Cir. 2015) (quoting Conn. State Dental Ass’n v. Anthem Health Plans, Inc., 591 F.3d 1337, 1345 (11th Cir. 2009)). If a plaintiff seeks insurance benefits from a policy funding an employee benefits plan governed by ERISA, ERISA preempts any bad faith claim. Pilot Life Ins. Co. v. Dedeadux, 481 U.S. 41, 48-51 (1987) (ERISA expressly preempted the plaintiff’s Mississippi bad faith claims); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58, 65 (1987) (holding that ERISA completely preempted Michigan bad faith tort cause of action); Ibson v. United Healthcare Services, Inc., 776 F.3d 941, 945-46 (8th Cir. 2014) (holding that insured’s contract and bad faith claims were completely preempted); Bast v. Prudential Ins. Co., 150 F.3d 1355, 1358 (9th Cir. 1998) (holding that ERISA completely and expressly preempts bad faith claims brought under the Washington Insurance Code and under the Washington Consumer Protection Act); Smith v. Blue Cross & Blue Shield United of Wis., 959 F.2d 655, 657-59 (7th Cir. 1992) (“[U]nder Pilot Life the Smiths’ [bad faith] claims are clearly preempted by ERISA.”); Belasco v. W.K.P. Wilson & Sons, Inc., 833 F.2d 277 (11th Cir. 1987) (bad faith and fraud claims against insurer preempted).
If a plaintiff’s state law claims are completely preempted, an insurer can remove the claims to federal court and have the state law claims dismissed. While state courts have concurrent subject matter jurisdiction under ERISA over claims for benefits, in most circumstances courts expect a case to be removed if ERISA governs. Based on complete preemption, a plaintiff can then only bring claims under ERISA §502(a), 29 U.S.C. §1132(a).

The Supreme Court has held that ERISA provides only traditional forms of equitable relief such as reformation and restitution. See Sereboff v. Mid-Atlantic Medical Services, Inc., 547 U.S. 356 (2006), Aetna v. Davila, 542 U.S. 200 (2004), Great-West Life & Annuity Ins. Co., v. Knudson, 534 U.S. 204 (2002). In Cigna v. Amara, 131 S. Ct. 1866, 1878 (2011), the Supreme Court in dicta indicated that the ERISA equitable remedies might include surcharge as well as reformation and restitution. See Rochow v. Life Ins. Co. of N. America, 780 F.3d 364, 372 (6th Cir. 2015) (holding that ERISA equitable remedies limited to benefits, discretionary attorneys’ fees, and prejudgment interest, and warning that any interest award cannot be “at a rate so high that the award amounts to punitive damages”).

In other words, under ERISA, a plaintiff cannot recover extra-contractual damages or punitive damages and is also not entitled to a jury. Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (§1132(a)(2) does not provide for extra-contractual or punitive damages); Bishop v. Osborn Transportation, Inc., 838 F.2d 1173 (11th Cir. 1988) (holding that §1132(a)(1) and 1132(a)(3) do not provide for extra-contractual damages or punitive damages); Chilton v. Savannah Foods & Indus., 814 F.2d 620 (11th Cir. 1987) (no jury trial for ERISA claims).

B. How an Insurer Can Help Have ERISA Apply

To have ERISA apply to all of the life, health or disability policies it issues, an insurer would have to limit its policy sales to employers that are not governmental entities and are not churches that have not opted into having ERISA govern its plan. This step eliminates not only governmental employers and almost all churches, but also individual policy sales that are not part of an ERISA plan, which would be almost all individual policies.

To make a court more likely to find that an employer’s plan is governed by ERISA, an insurer might help the employer comply with ERISA’s disclosure requirements. As a practical matter, unless a governmental or church plan, a court would find that ERISA governs an employee benefit program funded by an insurance policy when the summary plan description (which can be the individual insured’s certificate for a group plan) and other plan documents say ERISA in the numerous places they should say ERISA.

The primary exception to a court’s finding ERISA applies to what looks like an employee benefit plan as described above, from an insurer’s perspective, is the ERISA payroll deduction safe harbor. For employers that wanted to avoid complying with ERISA’s disclosure requirements, the Department of Labor created a payroll deduction “safe harbor” exclusion from ERISA for qualifying insurance benefits paid for through payroll deduction. 29 C.F.R. §2510.3-1(j). “To qualify for the safe harbor, an insurance program may not, in part, be endorsed by the employer, whose sole function must only be ‘to permit the insurer to publicize the program to employees of members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer.’” 29 C.F.R. §2510.3-1(j)(3). The rationale for this regulation depends on a “requirement of employer neutrality . . ., namely the absence of employer involvement.” 40 Fed. Reg. 34,526 (Aug. 15, 1975) (preamble to final regulation). “The regulation explicitly obliges the employer who seeks its safe harbor to refrain from any functions other than permitting the insurer to publicize the program and collecting premiums.” Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1213 (11th Cir. 1999).
If an insurer requires the employer to do any one of the following, then the employer’s insurance program would fall outside of the payroll deduction safe harbor and thus ERISA would preempt any bad faith claims: (1) employer pays any portion of the premiums, (2) employer requires all employees to participate, (3) employer endorses the program, (4) employer takes any other action, such as choosing benefits, handling claim forms, or anything else, or (5) insurer pays or provides other consideration to the employer for offering the program. 29 C.F.R. §2510.3-1(j).

Surprisingly, many courts have interpreted the payroll deduction payroll safe harbor more expansively (i.e., found ERISA did not apply more often) than reading the regulation and Department of Labor guidance suggests was intended. Without analyzing the many cases wrestling with specific fact issues, the insurer’s safest requirements are to have the employer pay part of the premium or have the employer endorse the program. As an evidentiary matter, the payment or the endorsement needs to be done in such a way as the insurer can prove in court that it happened. For example, the individual insured could be required to sign an insurance application that says the employer endorses this insurance program.

C. ERISA Preemption When the Employer Did Not Intend for ERISA to Apply

A final consideration is that having taken steps to make sure ERISA applies helps, but is not determinative as to whether ERISA might apply. In some circumstances, ERISA can apply even if the employer has taken no steps to comply with ERISA and does not know it might apply or does not even want it to apply.

If insurance is issued to an employer or the employer otherwise is involved, asserting ERISA preemption should be considered even if the employer never thought about ERISA or even if the employer intended to avoid ERISA. An employer’s not having prepared or filed formal documents recognizing that the alleged benefits are part of an ERISA plan is inadequate to show that an ERISA plan has not been established. ‘ERISA does not . . . require a formal, written plan . . . . There is no requirement of a formal, written plan in either ERISA’s coverage section, ERISA §4(a), 29 U.S.C. §1003(a), or its definitions section, ERISA §3(1), 29 U.S.C. §1002(1).’ Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982) (en banc); see Williams v. Wright, 927 F.2d 1540 (11th Cir. 1991) (holding that an informal arrangement described in a letter was a plan governed by ERISA); accord Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 18 n.10 (1987) (“The fact that the employer had not complied with the requirements of ERISA . . . does not . . . mean that no such program was in existence.”) (dicta). An employer may have intended to fall within the payroll deduction safe harbor, but done too much under the regulation. Cf. Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1213-14 (11th Cir. 1999) (analyzing the payroll deduction safe harbor regulation from the employees’ perspective); Johnson v. Watts Regulator Co., 63 F. 3d 1129, 1134, 1137-38 (1st Cir. 1995 (analyzing the payroll deduction safe harbor regulation from the employees’ perspective); Blaylock v. Mutual of New York Life Ins. Co., 228 F. Supp. 2d 778 (S.D. Miss. 2002) (denying motions to remand for 42 plaintiffs participating in ten nongovernmental plans and holding that the plans did not fall within the payroll deduction safe harbor exclusion from ERISA).

VII. Conclusion

To avoid and to defend bad faith claims, life, health and disability insurers and lawyers representing these insurers need to consider a comprehensive approach, using strategies for any other high stakes litigation and some steps especially to address bad faith risks. An insurer’s strategies should include steps to take before selling the policy, when considering a claim under the policy, and when defending a lawsuit brought based on the policy. With planning, an insurer should be able to minimize the risks of an adverse bad faith verdict or to minimize the amount of damages beyond the policy benefits.