Expert Bias in Insurance Claim Denials

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About This Work

An insurer that denies a claim on the report of a physician, engineer, or contractor it selected and paid can usually point to a complete file and a qualified professional's opinion. Nothing in that file shows whether the opinion was independently formed. The evidence of bias lies in the expert's relationship with the insurer and in the expert's work on other claims.

This work contends that an insurer's reliance on a biased expert cannot make a claim denial fairly debatable, and that where the insurer withholds benefits due, its reliance on a biased expert establishes that the withholding was unreasonable. The contention does not propose a change in the law. It rests on doctrine the courts have already settled. This is the first work to treat insurers' use of biased experts as a field of law of its own.

Volume One develops the contention in eleven chapters. Chapters 2 through 5 cover the covenant of good faith and fair dealing, the special relationship between insurer and insured, the insurer's duties, and the fairly debatable defense. Chapters 6 through 9 state the standards for judging an expert's neutrality and the four categories of evidence from which courts infer bias, and they trace the vendors and administrators through which insurers retain experts. Chapter 10 describes the evidence of bias that courts have ordered produced, and Chapter 11 takes up the objections insurers raise to that discovery.

This sample contains the Table of Contents for both volumes, the overview of each chapter, and the complete Table of Authorities. The table lists 643 authorities, 522 of them decisions, and beside each, every section that cites it. A reader can look up a decision and see where the complete volume addresses it. Of those decisions, 219 are cited in Chapters 10 and 11.

The work is written primarily for practitioners in California and in federal courts within the Ninth Circuit, by an attorney who practices on the policyholder side of insurance disputes.

The complete Volume One is available to paid subscribers of *Expert Bias Report: Insurance Claims* at expertbiasreport.substack.com. Revised chapters replace the earlier ones there as they are released.

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The characterizations in this work of what a decision holds, what a regulatory examination found, or what a settlement required are the author's own reading of the cited sources. They are opinions, not findings, and nothing in this work should be taken as a statement of fact about the present practices of any insurer, vendor, or expert named in it. The author practices law on the policyholder side of insurance disputes, and the analysis is advanced in that light. The sources are public and are cited so that they can be checked independently. Readers who identify an error are invited to bring it to the author's attention.

Table of Contents

The work is issued in two volumes. Volume One states the foundational principles and the evidence: the covenant, the relationship from which the insurer's heightened duties derive, the duties themselves, the defense the insurer asserts against them, the standards and factors by which the neutrality of a retained evaluator is assessed, and the discovery through which the evidence bearing on neutrality is obtained. Volume Two takes the question into court and beyond it: how the issue is presented and decided on motion, what the litigated records disclose about the resistance to proving it, what the regulatory framework supplies and withholds, and what follows as evaluation is increasingly performed by automated systems.

Sections marked *[Reserved]* carry numbers that are held so cross-references remain stable. They are not omissions of material the work possesses.

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Chapter 1: Overview

An insurer that denies a claim on the report of a physician, engineer, or contractor it selected and paid can usually point to a complete file and a qualified professional's opinion (§ 1.1). Nothing in that file shows whether the opinion was independently formed; the evidence of bias lies in the expert's relationship with the insurer and in the expert's work on other claims. Existing doctrine supports the contention stated in § 1.2: an insurer's reliance on a biased expert cannot make a denial fairly debatable, and where the insurer withholds benefits due, its reliance on a biased expert establishes that the withholding was unreasonable.

Each later chapter develops one step of that contention, from the covenant of good faith in Chapter 2 to the discovery of the evidence, and the insurer's objections to it, in Chapters 10 and 11. Bias enters an evaluation that is otherwise complete at the points where the expert's judgment rests on experience, and the report gives a reader nothing to replicate or test (§ 1.3). The professional of concern is the one the insurer retains to evaluate the claim before any lawsuit, whom no one cross-examines (§ 1.4). The chapters are set out in sequence in § 1.5, and §§ 1.6 through 1.8 describe how the work was prepared, the terms it uses, and the limits a reader should weigh in relying on it.

Chapter 2: Good Faith and Fair Dealing

The implied covenant of good faith and fair dealing is the source of an insurer's obligations in handling a claim. The covenant is recognized in virtually every American jurisdiction, although jurisdictions differ on whether its breach in insurance gives rise to tort or only contract liability (§ 2.3). The Uniform Commercial Code and the Restatement (Second) of Contracts both codified it and left its specific content to development in context (§ 2.4).

The covenant protects each party's reasonable expectations of the benefits of the bargain. That principle belongs to the general law of contracts and not to the law of any one jurisdiction. Courts determine the expectations objectively, as of the time the contract was formed, by reference to the contract's purposes, the parties' circumstances, and community standards of fair dealing. In insurance, the insured's reasonable expectations include the expectation that claims will be evaluated through competent, unbiased investigation directed toward determining the truth of the claim (§ 2.6).

The covenant's limits do not protect an insurer that withholds benefits in reliance on a biased expert. The covenant cannot prohibit conduct the contract expressly authorizes, but no policy authorizes biased investigation. It cannot generate obligations independent of the contractual relationship, but the duty of fair investigation derives directly from the contract's protective purpose. Its breach gives rise to tort remedies only within a special relationship, and the insurer-insured relationship is the leading example of one (§ 2.7).

The covenant developed along two lines of authority. As a general contract doctrine, it emerged from cases decided before codification, with an insurance antecedent in *Brassil v. Maryland Casualty Co.* (1914) and its canonical formulation in *Kirke La Shelle Co. v. Paul Armstrong Co.* (1933), and California adopted it between 1942 and 1949 (§ 2.1). The insurer's own duty of good faith was stated by a California court in 1934 and described by the California Supreme Court as settled in the 1940s, although no remedy enforced it until *Comunale v. Traders & General Ins. Co.* in 1958 (§ 2.2). The two lines reflect the history of the remedy. There is one implied covenant, and nothing in the argument depends on treating insurance as governed by a covenant of its own.

Two scholarly accounts inform the courts' application of the covenant (§ 2.5). Summers's excluder analysis identifies forms of bad faith, among them evasion of the spirit of the bargain, lack of diligence, abuse of power, and failure to cooperate. Burton's foregone-opportunities theory identifies the exercise of discretion as the way bad faith most frequently occurs, and it treats that conduct as wrongful when a party exercises its discretion to recapture opportunities forgone at formation. California courts, as *Carma Developers* illustrates, use both accounts without recognizing any tension between them.

Chapter 3: The Special Relationship

Courts treat insurance differently from other contracts. Insurance pools risk and supplies a safety net on which policyholders, their dependents, injured third parties, and society rely, and courts have responded by applying tort principles to what had been the exclusive domain of contract law. They describe the insurer-insured relationship as "special," "quasi-fiduciary," or, in some settings, "fiduciary" (§ 3.1). Every court whose decision on the question was located treats insurance as different from an ordinary arm's-length contract, including the courts that decline the special-relationship label or confine the remedy to contract.

Under the covenant alone, an insurer that exercises a discretionary power unreasonably, so as to deprive the insured of the benefits of the policy, is in breach. The covenant does not explain why insurers alone owe specific claims-handling duties, or why insurance, and not other contracts, is governed by tort principles of breach and damages. The special relationship explains the second and is the likeliest explanation of the first. California decisions identified the relationship and its grounds in *Egan* and *Foley* (§ 3.2).

Ten attributes of the relationship recur in the opinions (§ 3.3). Four bear most directly on an insurer's reliance on a biased expert: the insured's trust and reliance, the parties' unequal bargaining power, the insurer's control and discretion over the claim, and the insurer's incentive to breach (§ 3.4). Selecting the professional who will evaluate the claim is an exercise of that discretion, and both the covenant and the special relationship require the insurer to exercise it fairly.

Most of the jurisdictions charted characterize the relationship as special but not fiduciary; some approach or cross the fiduciary threshold; and ERISA confers fiduciary status by statute (§§ 3.5.1–3.5.2). Other jurisdictions reach the same results without the special-relationship label (§ 3.5.4). The doctrine spread from California through Arizona to national adoption, and Wisconsin reached the same result by a separate route (§ 3.6).

Chapter 4: Insurer Duties

Courts applying the implied covenant to insurance have recognized six duties that bear on the handling of a first-party claim, some drawn directly from the covenant and others developed from it in the insurance cases: the duty to exercise claims-handling discretion so as not to deprive the insured of the benefits of the policy (§ 4.1), the duty not to unreasonably deny or delay (§ 4.2), the duty to give the insured's interests at least as much consideration as its own (§ 4.3), the duty to fully and fairly investigate (§ 4.4), the duty of honesty (§ 4.5), and the duty to disclose (§ 4.6). The list is not exhaustive. It covers the duties that bear most directly on an insurer's use of experts.

In the insurance field, the covenant is breached by the unreasonable withholding of benefits due, whether by denial, underpayment, or delay, and the validity of the claim is a condition precedent to a breach (§ 4.0.1). The enumerated duties are derivative and evidentiary: they are the grounds on which a withholding is shown to have been unreasonable, and none of them is a freestanding cause of action. In California, the culpability standard is objective, which allows bias built into a claims process to be proved. An insurer whose grounds for withholding were not reasonable under all the circumstances has breached the covenant, whatever it believed (§ 4.0.2).

The central biased-expert claim is accordingly a claim about a withholding: where an insurer withholds benefits due, its reliance on a biased expert establishes that the withholding was unreasonable and forecloses the genuine-dispute defense that would otherwise excuse it (§ 4.4.3). Stated as the proposition that the use of a biased expert, standing alone, breaches the covenant, the claim is open to the defense that no action lies where no benefits were due.

The policy states the insured's obligations in detail and leaves the handling of the claim to the insurer, so nearly everything the insurer does with a claim is an exercise of discretion, and the choice of the person who evaluates the claim is the clearest example (§ 4.1). Every party who holds discretion under a contract owes that general duty, while the specific duties bind only insurers. The duty not to unreasonably deny or delay began in *Comunale*'s strict rule for settlement and became a reasonableness standard that reaches delay as well as denial and makes a fair investigation a prerequisite to denial (§ 4.2). Under the duty of equal consideration, a claims-handling structure built to disadvantage the insured is evidence that a withholding was unreasonable (§ 4.3). The investigation duty is affirmative, comprehensive, fair, continuing, and nondelegable. An insurer that retains an expert remains responsible for the adequacy of the expert's process, and an investigation directed toward a predetermined result fails the duty as completely as if no investigation were conducted (§ 4.4.1). An insurer can fail in two ways: by relying on an expert opinion that is unreasonable or poorly reached, or by choosing an expert to produce a favorable result instead of a fair evaluation (§ 4.4.3.1). Courts have found bias shown by an expert's record of finding for the insurer regardless of the contrary evidence, by the insurer's advance knowledge of the expert's views combined with other evidence, and by the insurer's choice of an expert who lacked the specialty or experience the claim required (§ 4.4.3.4).

Affirmative misrepresentation, misrepresentation through omission, and misrepresentation about the investigation each establish that a withholding was unreasonable (§ 4.5), and the insurer must tell an insured who disputes a denial of the remedies the policy provides (§ 4.6). The insured's own duty of good faith is narrower: it rests mainly on the policy's express conditions, it carries only contract remedies, and it does not offset the insurer's breach (§ 4.7).

Chapter 5: The Fairly Debatable Standard

An insurer's good-faith disagreement about coverage or claim value does not, standing alone, constitute bad faith. The principle is known variously as the "fairly debatable" standard, the "genuine dispute" rule, and the "genuine issue" defense. From its earliest articulations, the doctrine has recognized that genuine disagreement between insurer and insured is both possible and legitimate, and that punishing every erroneous denial would distort the insurance relationship as surely as permitting every pretextual one (§ 5.1).

The defense is generally what puts an expert's bias at issue in a bad faith case. An insurer sued for withholding benefits does not have to show that the claim was invalid. It can argue instead that the claim was open to reasonable dispute, and when the dispute is over facts, it relies on an expert's opinion to prove it. Whether the insurer may do so is then a question about the expert's bias.

Courts allow the defense only when two conditions are met. The first is a good-faith investigation: an insurer that has not adequately investigated a claim cannot invoke a genuine dispute about it (§ 5.4). The second applies when the insurer relies on an expert, who must be independent and honestly selected and must give a reasonable opinion (§ 5.5). *Guebara* gave five circumstances in which a jury may find that an insurer's investigation was biased despite its expert support, among them dishonest selection of experts and unreasonable expert opinions, and said the list was not exhaustive. *Chateau Chamberay* adopted the list, repeated that it was not exhaustive, and added that an insurer may not escape bad faith liability by hiring an expert to manufacture a genuine dispute. Where an insurer withholds benefits due, its reliance on a biased expert therefore establishes that the withholding was unreasonable and forecloses the genuine dispute defense. *Hangarter*, *Sarchett*, and *Demer* confirm that conclusion most fully (§ 5.8).

Fletcher marked the outer boundary of the insurer's privilege to dispute at the manufactured dispute (§ 5.1.3). California reformulated the standard through successive decisions, from the early version in *Neff*, through the "genuine dispute" terminology consolidated in *Chateau Chamberay*, to its adoption as Supreme Court authority in *Wilson* (§ 5.2). The extension of the doctrine from legal disputes to factual disputes over claim value made the insurer's position depend on expert opinions, and the object of judicial scrutiny shifted from legal authorities to the independence and reasonableness of experts (§ 5.3).

At summary judgment, the defense can insulate potentially biased expert opinions from scrutiny, as *Cardiner* shows (§ 5.6). When courts grant summary judgment on the defense without asking whether the insurer's expert opinions were independently generated, the defense becomes a means of retreating from the bad faith doctrine of *Gruenberg*, *Egan*, and *Sarchett* (§ 5.6.5). Before granting summary judgment on the defense, courts should hold the insurer to the conditions *Chateau Chamberay* and *Wilson* attached to it: an independent expert, honestly selected, giving a reasonable opinion. Condition-precedent and limitations defenses can bypass the fairly debatable inquiry altogether, although even these remain constrained by the good faith obligation (§ 5.7).

Chapter 6: Neutrality Principles and Standards in Adjudicatory and Quasi-Adjudicatory Settings

Where the alleged bias arises from a financial interest, no adjudicatory or quasi-adjudicatory setting requires proof that the decision-maker was actually biased. Each evaluates bias objectively, from the circumstances, under its own test. The Due Process Clause disqualifies a judge where the arrangement would offer a "possible temptation" to the average judge (§ 6.1). An arbitrator must disclose "any dealings that might create an impression of possible bias," and a court vacates the award for nondisclosure without proof of actual bias (§ 6.2).[1] California courts treat an appraiser's financial dependence on the party that selected it as disqualifying (§ 6.4). Hearing officers and professional review bodies are held to the same principle in different words. The courts have not said whether the words state different thresholds, but the circumstances they examine are the same (§ 6.5).

The cases identify three circumstances from which bias may be found without proof of actual bias. The first is the decision-maker's financial dependence on one party, whether through fees, revenue, or the prospect of future work (§ 6.3). The second is one party's control over who decides. The third is nondisclosure of the relationship, which in arbitration is an independent ground for vacating the award. The same circumstances bear on the insurer's expert.

The insurer's expert decides in a quasi-adjudicatory setting. The Arizona Supreme Court has said that the insurance contract and relationship give the insurer "an almost adjudicatory responsibility" for the claim. An insurer that retains an expert to evaluate the claim hands part of that responsibility to the expert, who is selected and paid by the party with an adverse financial interest in the outcome, and who works without the disclosure, challenge, and review that constrain judges, arbitrators, and appraisers (§ 6.6.1).

Insurers argue that their experts are retained experts like any others, whose bias goes only to the weight of an opinion. A testifying expert is not disqualified for working for one side, but the insurer, unlike a party at trial, owes the insured a fair investigation and at least as much consideration as it gives its own interests, and no rule of evidence or procedure imposes either duty on a party's trial expert (§ 6.6.2). The circumstances that would disqualify a judge or impeach a trial expert therefore support an inference about the insurer's own conduct: whether, in relying on the expert, it investigated the claim fairly and gave the insured's interests equal consideration. The insurer-retained expert relationship meets all five conditions under which financial dependence goes unchecked, and six standards transfer from the adjudicative cases to the assessment of expert bias (§§ 6.6.4–6.6.5).

[1] Section 13.5 examines the Kaiser Permanente arbitration system and its Office of Independent Administration, an institutional-scale example of structural bias.

Chapter 7: Principles of Bias in Insurers' Experts

Bias in an insurer's expert is a tendency, arising from the expert's relationship with the insurer, to reach conclusions that favor the insurer. It differs from error, which is a mistake in a particular opinion (§ 7.1.1). Courts infer bias from the circumstances and do not require proof that the expert was actually biased (§ 7.1.3). The cases on judicial and arbitral bias, which have declined at each step to require proof of actual bias, support the same standard for an insurer's expert, although no court has drawn that connection expressly (§ 7.6.1). Where an insurer withholds benefits on the strength of a biased expert's opinion, the reliance establishes that the withholding was unreasonable and forecloses the genuine-dispute defense (§ 7.1.4).

The decided cases follow a three-tier structure (§ 7.6.6). At the first tier, the claimant produces evidence of a structural condition, such as the volume and value of the expert's work for the insurer, that creates a cognizable risk of bias. At the second, the claimant produces evidence from the expert's work, such as a pattern of outcomes or procedural irregularities, that strengthens the inference of bias without proving that the expert was actually biased. At the third, reasonable measures come in from either side. The insured may use the insurer's failure to take reasonable measures to secure the expert's neutrality as evidence against it, and the insurer may use the measures it did take as a defense. Where a court requires stronger evidence of bias on the facts before it, the absence of reasonable measures may tip the balance.

Insurers retain experts as employees, directly, through vendors (some of them affiliated with the insurer), through outside counsel, and through firms whose staff experts may jointly sign a report. Whether the insurer selects, pays, and reuses the expert directly or does so through an intermediary it chooses and continues to use, the expert's future work depends on the insurer's satisfaction (§ 7.2). The same principles govern every line of insurance, including property, auto, health, disability, life, and ERISA-governed claims, although the weight of each kind of evidence may vary by claim type (§ 7.3). An opinion resting on the expert's experience, which nothing in the file can check, does not prove bias without more, but where other evidence raises an inference of bias it is inherently suspect and lowers the showing needed (§ 7.1.5).

The courts state the threshold in different words in different settings, and the words may describe a range of thresholds, although no court has said whether they do. The weight each kind of evidence carries, and whether one is enough without another, vary from case to case (§ 7.4). *Demer v. IBM Corp. LTD Plan* illustrates the whole analysis in one decision (§ 7.5). The court inferred a financial conflict from the reviewers' volume and pay, shifted a burden of production to the insurer, noted the absence of outcome evidence and of records that could have shown the reviewers' neutrality, and identified procedural irregularities in the reviews. With no evidence of the reviewers' pattern of outcomes, the relational evidence and the irregularities were enough, although the court called the conflict "modest but extant." Once the claimant makes that showing, the burden of production shifts to the insurer, which holds the evidence (§ 7.7).

The principles apply to the insurer's experts and not to the insured's. The parties owe each other different duties. An expert the insurer uses to evaluate the claim performs part of the insurer's duty to investigate the claim fairly and to give the insured's interests at least as much consideration as its own. The insured owes the insurer good faith and cooperation in the investigation, but no duty to investigate the claim for the insurer, and an expert the insured retains is an advocate's expert, whose bias, like that of any party's trial witness, goes to the weight of the expert's opinion.

Chapter 8: Factors for Evaluating Expert Impartiality

The evidence from which courts infer the bias of an insurer's expert falls into four categories: relational metrics, reputational metrics, flawed methodologies and procedural irregularities , and reasonable measures. The four factors are the categories of evidence that courts have found probative in the leading decisions. They are not statutory elements, and no court has stated them collectively as a test.

Relational metrics (§ 8.1) measure the size and value of the business relationships from which an expert's financial dependence may arise: with the insurer, with a vendor, attorney, or affiliate through whom the insurer retains the expert, and with the insurance industry as a whole. Reputational metrics (§ 8.2) measure the expert's pattern of outcomes and the expert's record before other courts. Flawed methodologies and procedural irregularities (§ 8.3) are departures from sound method in the expert's work, in the claim at issue and across the expert's other engagements, including flawed or unsupported principles, theories, and methodologies. Irregularities are commonly shown by measuring the expert's work against the standards and practices of the expert's own field, the method most often used for property and other claims outside ERISA, or against a list of recurring irregularities that courts have built up in reviewing medical and disability claims, most of them under ERISA. Reasonable measures (§ 8.4) are the steps the insurer, and any vendor between the insurer and the expert, took to ensure that the expert was neutral and reliable.

No single factor is required, and the weight each carries varies from case to case. In *Demer*, volume and compensation figures alone raised a fair inference of a financial conflict, and the reviewers' failure to examine the claimant or explain their rejection of the claimant's corroborated complaints supported the finding of an abuse of discretion. Without outcome evidence, the court gave the conflict "some, but not substantial, weight."[1] In *Hangarter*, nineteen retentions, thirteen adverse findings in thirteen total-disability claims, and a retention letter that stated the insurer's view of the claim supported a jury's finding of a biased investigation. *Cardiner*, *Sekera*, *Bernstein*, and *Diaz* held that a history of insurer-side work, without more, did not suffice. None of them held that the same history would fail if it were joined to evidence of another factor. A pattern of outcomes is a rough showing, since an expert who routinely supports denial may be right. Procedural irregularities show bias more directly, and where the relational figures are large, relational metrics and irregularities together may be enough.

Relational metrics and reasonable measures apply to vendors and other intermediaries as well as to the expert. Reputational metrics and procedural irregularities are generally assessed at the level of the individual expert, although reputational metrics may also be assessed for a vendor whose experts work for many insurers. Statistics are the form in which much relational and reputational

[1] *Demer v. IBM Corp. LTD Plan*, 835 F.3d 893, 902–03 (9th Cir. 2016).

evidence is presented, and they belong with those two factors. The reasonable-measures factor also bears on the regulatory proposals of Chapter 14.

Chapter 9: Layered Retention and the Location of Bias

Insurers obtain much of their claims-stage expertise through others: vendors that supply physicians, engineers, and other professionals; administrators that handle claims for the insurer; companies the insurer owns; attorneys who retain experts on the insurer's behalf; and the firms through which experts practice, which range from one expert's own company to large consulting firms (§ 9.1). Any of those parties may hold the records that prove a factor.

A chief effect of the chain is to hide the expert's financial dependence. The dependence may arise at any link: between the expert and a vendor, between the vendor and the insurer, or between the expert and the insurance industry as a whole. A claimant who asks the insurer how often it retained the reviewer may receive a small and accurate number, since the insurer retained the vendor, and the vendor retained the reviewer, often thousands of times, for this insurer or many others. Flat fees, selection attributed to the vendor, and insurer work recast as work for the insured conceal the dependence further (§ 9.2).

Relational metrics and reasonable measures apply to every party in the chain, while reputational metrics and procedural irregularities are generally assessed at the individual expert, but the records for any of them may reside anywhere in the chain. The role each party played is often unknown until the parties produce the agreements among them. The service agreement, the payment records, the vendor's records, and the records of reasonable measures are the principal sources, and the insurer's possession or control of them determines from whom the claimant must seek them (§ 9.3).

Most decisions on those records turn on what the claimant asked for. Courts have ordered relational data at each link when it was requested, and many of the losses trace to requests that reached only one part of the chain (§ 9.4). Claimants have also accepted figures that the insurer, the vendor, or the expert compiled, which cannot be tested without the records behind them (§ 9.5). In ERISA plans, the plan and its administrator add parties, and the administrative record limits the evidence a court will consider (§ 9.6).

Chapter 10: Discovery of Evidence of Expert Bias

Every factor from which courts infer an expert's bias depends on records that the insurer, its vendors, or the expert hold. Those records show how often the expert was retained and for how much, how the expert's opinions came out, how the evaluation was conducted, and what the insurer did to keep the expert reliable and neutral. An insurer that defeats the discovery defeats the bias showing, whatever the merits of the claim. Federal Rule of Civil Procedure 26(b)(1) lists "the parties' relative access to relevant information" among the considerations that determine whether discovery is proportional, and where one party holds all of the evidence, that consideration favors production (§ 10.1).

Courts have ordered evidence of each factor produced, and their orders show what a claimant should request and from whom. A request that names the evidence, the party that holds it, and the form in which it is kept is harder to resist than a request for everything bearing on bias. For each factor, §§ 10.2 through 10.5 set out the kinds of evidence courts have ordered produced, the issues peculiar to that evidence, and the framing of the request.

Relational metrics show how often the insurer, its vendor, or its counsel retained the expert, how much they paid, for how long, and what share of the expert's income the work represents. That evidence shows whether the expert depends on the insurer, or on the insurance industry as a whole, for a steady stream of work. It involves no third party and comes in small volume, and courts order it produced more readily than any other bias discovery (§ 10.2). Reputational metrics measure the expert's record across many engagements: how often the expert's opinions support a denial or termination, how often they support paying less than the claim was worth, and what courts have found about the expert's work. The record resides in the expert's reports, whether held in other insureds' claim files, by the vendor, or by the expert (§ 10.3).

Most procedural irregularities appear on the face of the expert's report and need no discovery beyond it. Others appear only in the records of the evaluation, and the most telling appear only when the evaluation is compared with the expert's and the insurer's handling of other claims (§ 10.4). Evidence of reasonable measures shows how the insurer selects, rotates, pays, monitors, and audits its experts, and what it does when it learns that an expert's work is unreliable. That evidence belongs entirely to the insurer and its vendors. An insurer with working measures wants them in the record, and an insurer without them wants the subject closed (§ 10.5). Courts have also ordered other insureds' claim files produced for purposes beyond the expert, among them the insurer's pattern of claim handling, its interpretation of the policy, the genuine dispute doctrine, punitive damages, and class certification (§ 10.6).

Chapter 11: Overcoming Insurer Objections to Discovery of Bias Evidence

Insurers raise the same objections to bias discovery across cases and jurisdictions. Courts usually grant the discovery, and they usually grant it on narrowed terms. Every objection must be specific and supported by evidence (§ 11.1). Requests that anticipate the objections are confined to the expert or adjuster at issue, the type of claim, the state, and a defined period, and they come with an offer of a protective order and a form of production the insurer can supply from its own records.

The same objection fares differently depending on the evidence sought. An objection of undue burden to a ledger of the expert's fees has little force, while the same objection to ten thousand claim files may prevail. A privacy objection to other insureds' medical records protects real third-party interests, while a privacy objection to the insurer's own payment records protects none. Relational metrics and records of reasonable measures are held by parties that took part in handling the claim, involve no unrelated third party, and exist in small volume. Two kinds of discovery therefore do the most to overcome the objections: the records of what the insurer paid the expert and how often it retained the expert, and the records of the measures the insurer took to ensure that its experts are neutral and reliable.

The objections an insurer most often raises are relevance, overbreadth, burden, disproportion, fishing expedition, mini-trials, privacy, privilege and confidentiality, and lack of possession or control (§§ 11.2–11.10). Burden is a fact the insurer must prove, while proportionality is the court's judgment whether the discovery is worth its cost in the case at hand (§§ 11.4–11.5). In California, the fishing-expedition objection fails as a matter of law (§ 11.6). Pattern evidence does not require retrying the claims from which it comes (§ 11.7). Privacy is the most complex objection, although a protective order resolves it in most cases (§ 11.8). Where a vendor or administrator holds the records, the objection that the insurer lacks possession or control turns on its legal right to obtain them (§ 11.10).

The remaining objections, among them untimeliness, the ERISA administrative-record limit, and boilerplate, which combines many of the others, seldom succeed alone (§ 11.11). Taken together, the objections are also conduct. A record of objections made without evidence, representations offered in place of records, and orders restricted after they issue is evidence of the insurer's practices, of what the withheld material is likely to show, and of the good faith with which the insurer handled the claim (§ 11.12).

Table of Authorities

Authorities cited in Chapters 1 through 11, alphabetical within each division, with the sections in which each is cited, in a note or in the text. Pincites appear in the notes.

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