E-Treatise: Biased Insurance Experts, Principles and Practice

The Insurance industry's use of biased experts to minimize claim payments is a pervasive and deeply troubling practice that undermines the covenant of good faith and fair dealing. This evolving E-Treatise examines the legal principles and caselaw and provides practical advice to address this critical issue.

At its core, this E-Treatise equips practitioners with the knowledge and tools to effectively navigate and challenge insurers' systemic reliance on biased experts. A framework derived from the landmark case *Demer v. IBM Corp. LTD Plan* (9th Cir. 2016) 835 F.3d 893 lays the foundation for much of the practical considerations, as detailed in the article *Demer's Paradigm for Exposing and Eliminating Biased Experts*. Supplemented by sample discovery requests, jury instructions, and a disclosure statement for experts in the appendices, this comprehensive resource is a powerful aid for attorneys.

While the principles explored have broad applicability nationwide, this E-Treatise substantially emphasizes California law mainly due to California's pivotal role in developing the implied covenant and the duty of good faith and fair dealing, as well as California's extensive body of relevant case law over the past 50 years. The E-Treatise is especially valuable for California practitioners handling catastrophic claims, where biased experts can severely impact community rebuilding efforts.

A draft of each section of the E-Treatise has been completed. The Table of Contents for the draft follows below, and short summaries from the draft have been added as a roadmap. Changes may be made as the E-Treatise is rolled out over 6 – 12 months. This E-Treatise systematically analyzes the key issues, cases, and authorities related to biased insurance experts through periodic installments. It promotes fairness, accountability, and insureds' reasonable expectations in the claims process.

Questions and comments regarding this E-Treatise, including suggestions for cases and other authorities to consider and recommended changes and corrections, are welcome! Suggestions for topics to address in a post are also welcome. Please submit any questions, comments, and suggestions to cdion@exposingexpertbias.com.

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E-Treatise: Biased Insurance Experts
Principles and Practice

Chapter 1
Overview

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise, including this Chapter.]

Every contract contains an implied covenant of good faith and fair dealing, meaning that neither party will do anything to injure or destroy the other's right to receive the agreement's benefits. An insurance policy is subject to the same implied covenant as any other contract. Generally referred to derivatively in the insurance context as the duty of good faith and fair dealing, the implied covenant is typically used to impose more specific obligations on the insurer in the investigation, evaluation, and resolution of claims. Courts have used the implied covenant to impose duties upon the insurer to not unreasonably delay or withhold payment for a covered claim and to investigate the claim thoroughly, fairly, and objectively. As applicable to first- and third-party claims, the insurer's overarching duties include acting reasonably, with fairness, decency, and honesty towards their insured and treating the insured's interests as equal to their own.

One insurance claims practice that has largely gone unassailed over the past few decades is the industry's systemic use of biased experts in the claims process. This business practice is a form of institutionalized bad faith and is likely at the heart of most insurance disputes. It may be the most pervasive, pernicious, and nefarious form of predatory business conduct, bordering on mass fraud. By any measure, the practice contravenes the insured's reasonable expectations and injures their right to receive their benefits under their policy. It's unequivocally a breach of the insurance policy and a violation of an insurer's duties of fairness and honesty to the insured.

Yet, the practice has continued unabated for decades, enabled and supported by structural deficiencies in the law and lax governmental oversight. The judiciary effectively created a safe harbor for insurers to exploit the practice opportunistically. The courts have shied away from issuing guidance on assessing and eliminating bias in a quasi-adjudicatory, non-tribunal setting, where the insurer maintains unfettered discretion and the insured lacks due process protections. Regulators, charged with protecting the consumer's rights and ensuring fairness in the system, have, with full knowledge, ignored the issue altogether and glossed over the problems when a scandal erupts. Insurers

aggressively preserve the practice, maintaining the utmost secrecy and ensuring the underlying workings remain relatively hidden from public view and discourse.

This E-Treatise examines the implied covenant of good faith and fair dealing in the insurance context and its application to the institutionalized practice of using biased experts to deny or underpay claims pretextually.

Chapter 2 considers insurance's features and the unique bond that forms when individuals and companies purchase policies. It delves into the nine crucial factors that courts consider when recognizing the special or quasi-fiduciary nature of the insurance relationship. This unique relationship is the foundation for applying robust principles of tort law in the insurance realm, permitting policyholders to pursue total compensation for all damages inflicted by insurers who unjustly deny or unreasonably delay legitimate claims.

Chapter 3 examines the implied covenant and duty of good faith and fair dealing, including its origins, development, and adoption in every state. It also discusses the key parameters and and limitations applicable to expert bias issues.

Chapter 4 analyses the application of the implied covenant and duty of good faith and fair dealing in the insurance arena, imparting certain conditions and responsibilities on insurers that are conspicuously absent from the policy's express provisions. These include a duty to perform a full, fair, and objective (e.g., unbiased) claim investigation, a duty to take reasonable measures to fulfill its promises, and a duty not to misrepresent or conceal material matters from the insured.

Chapter 5 considers the development of the “fairly debatable” rule—a safe harbor created by the judiciary for insurers to avoid liability if they conduct a full and fair investigation and determine in good faith that the claim is fairly debatable. In conjunction with biased experts, the industry now exploits with near-universal success, preying on insureds without incurring any bad faith liability.

Chapter 6 examines the standards, factors, and presumptions for identifying and evaluating expert bias, including the “inference of bias” standard and four factors generally used to assess expert bias: the expert’s compensation and amount (frequency) of assignments; the expert’s pattern and practice of offering opinions that support coverage or denial; the expert’s use of reliable principles and methodologies; and the reasonable measures taken by the insurer to safeguard expert impartiality and reliability. This section also considers the permissive, rebuttable, and conclusive presumptions associated with varying degrees of inferential bias and the practical effect of burden shifting.

Chapter 7 delves into the practical side, focusing on discovering and exposing expert bias. This chapter explores the insured’s primary duty to establish relevance and nexus between the requests and the expert bias issues in the case. It provides eight principal relevancy grounds for obtaining discovery, correlating the discovery requests with each of four primary pleadings categories—breach of contract, breach of the duty of good faith and fair dealing, unfair business practices, and punitive damages. This chapter then examines each of the 13 common objections to discovery interposed by insurers, all of which are, for the

most part, specious and raised solely to cover up predatory practices and deny relevant and necessary discovery.

Chapter 8 addresses motion practice concerning the unique expert bias issues and how to address them from the initial pleadings through appeal. It emphasizes that the issues uniquely suit a claimant's dispositive motions.

Chapter 9 provides examples of several notable scandals involving the institutional bad-faith use of biased experts over the past two decades, involving myriad policy and claim types.

Chapter 10 considers the measures insurers use to shroud the expert bias practice and avoid implementing the necessary measures to restore fairness. This chapter provides numerous selection and compensation bias examples among four principal insurer-related parties: insurers and benefit plans, third-party administrators, vendors and intermediaries, and experts. Examples of other courts addressing specific insurer-related parties in the expert bias issues can be critical to discovery and case-dispositive motions, given that many experts are well-known in the courts and patterns and practices are identifiable.

Chapter 11 contrasts the federal and state regulatory regimes, their differing approach to biased expert issues, and the states' enablement of the practice. This chapter concludes with reform measures to significantly enhance expert transparency, impartiality, and reliability, drawing upon some measures already implemented in other contexts for neutral adjudicators. These statutory schemes include expert disclosures and due consideration of the insurer's responsibility to take reasonable measures to vet and scrutinize experts and their expertise, including considering policyholder complaints and whether independent means exist to replicate, test, and verify the expert's findings.

Finally, the Appendices provide sample templates for exposing and eliminating expert bias, including discovery requests, expert disclosures, jury instructions, and deposition prompts and scripts.

Chapter 2
Unique Nature of Insurance and the Parties' Special Relationship

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise. For now, as a placeholder for this Chapter, two blog posts (The "Special Relationship" and Insurer's Duty to Act Fairly and Honestly, and the Case Study: Insurer's Unfettered Discretion in the Homeowner's Claims) and Appendix C-1 (Insurer-Insured Relationship: Characterization and Attributes) have been added outlining much of what's to follow.]

Insurance policies are unique among widely used financial contracts. Insurance is rooted in risk pooling. Insurers collect premiums from policyholders and use these funds to pay claims to those who suffer losses. This allows the financial burden to be spread efficiently across many participants. The fortunate ones who avoid losses subsidize those who suffer, creating a sense of shared responsibility.

Insurance serves a social need by providing financial protection, stability, and resilience in the face of unexpected events or risks. It offers a safety net that helps society cope with unforeseen and often catastrophic events, such as accidents, illnesses, death, and property damage, preventing financial distress and ensuring people can maintain their quality of life even in challenging circumstances. It supports economic growth by allowing individuals and businesses to transfer the financial burden of potential dangers to a collective fund, enabling people to pursue activities and investments that might otherwise be considered too risky without protection.

Insurance offers peace of mind to individuals and families by reducing anxiety about potential future losses and reducing stress. It often requires policyholders to follow safety guidelines and take precautions to mitigate risks, which promotes responsible behavior and reduces the likelihood of accidents or losses. Insurance is part of a broad, interconnected, complex system of protection on which policyholders, dependents, tort victims, and society depend to provide security in the event of unforeseen harm.

The insurer's and insured's relationship is typically characterized as "special" or "quasi-fiduciary" based on various factors. This characterization and its unique underlying factors provide grounds for extraordinary legal treatment. They permit the integration of tort principles to evaluate an insurer's performance under the policy—in what had historically been the exclusive domain of contract law. Four principal distinctions emerge from the hybrid contract-tort approach to insurance law:

- **Duty of Care**. Unlike ordinary contracting parties, insurers are held to a high duty of care standard. Insurers must consider the insured's interests at least as much as they consider their own.[1] An even higher true-fiduciary standard applies for policies issued under ERISA,

which designates certain parties as true fiduciaries with a duty of loyalty to the plan and its participants and beneficiaries.[2]

- **Additional Implied Duties**. While every contract contains an implied covenant of good faith and fair dealing that neither party will do anything to injure the right of the other to receive the benefits of the agreement,[3] the implied covenant is treated differently in insurance and has far greater application.[4] It gives rise to additional implied duties for insurers not recognized in other contracts. They include a duty to settle a third-party liability claim within policy limits when there is a great risk of recovery beyond the policy limits[5] and a duty to conduct a thorough, fair, and objective investigation.[6] Above all, there is an overarching duty to act honestly and fairly towards the insured.[7]
- **Comprehensive Damages**. While recovery for breach of contract is typically limited to those damages reasonably foreseeable when the parties entered into the agreement, an insured generally may recover all damages from an insurer's breach of its duties, foreseeable or not.[8] Often described as extracontractual or tort-like damages, insureds may recover lost income, non-economic losses such as emotional distress, attorney's fees and costs, and sometimes punitive damages.
- **Tortious Breach Standard**. An insurer's breach of its duties is evaluated using a tort-like standard. While a contract breach typically occurs when a party fails to perform its obligations, an insured must show that the insurer *unreasonably* breached its duty.[9] Many states use an even higher standard for breach, requiring a showing of an insurer's wrongful intent.[10]

The California Supreme Court initially relied on the implied covenant of good faith and fair dealing—and the insured's reasonable expectations under the covenant—to treat insurance differently than other contracts in a way that supported the application of tort principles. The Court originally applied the covenant to third-party liability claims.[11] The Court later extended the tort principles to first-party loss claims, relying on the implied covenant.[12] Yet, given that the implied covenant is found in every contract, and the covenant is designed to effectuate the reasonable expectations of the parties, this approach failed to meaningfully distinguish between insurance and other contracts in a way that would justify the application of tort principles in one and not the other. While identifying additional insurer-specific duties is easy to explain simply from the implied covenant and the party's reasonable expectations, applying tort principles to breach and damage calculation is not nearly as defensible.

Attributes of the Special Relationship

In *Egan v. Mutual of Omaha Ins. Co.,*[13] the California Supreme Court finally offered a few grounds for treating insurance differently and applying tort principles. The Court began by addressing the insurance standard of care and comparing the first-party claims to third-party claims, stating that "[i]n both contexts the obligations of the insurer "are merely two different aspects of the same duty." ... For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it again must give at least as much consideration to the latter's interests as it does to its own."[14]

The *Egan* court highlighted several key differences between insurance and other contracts, noting that the insured seeks protection and peace of mind when entering the policy, not profit. The court analogized the insurance relationship to that of a fiduciary, noting the characteristics of a "special relationship" that merit the imposition of extracontractual damages for a breach of the duty of good faith and fair dealing, including that "[t]he insurers' obligations are ... rooted in their status as purveyors of a vital service labeled quasi-public in nature," "[t]he obligations of good faith and fair dealing encompass qualities of decency and humanity" and "the adhesive nature of insurance contracts places the insurer in a superior bargaining position."[15] In all, *Egan* introduced the "special relationship" and three factors supporting this characterization: the purpose of insurance (peace of mind), the overriding function as a public service, and the disparate bargaining power of the parties.

A decade later, the California Supreme Court revisited the underlying grounds for characterizing the insurance relationship as special. In *Foley v. Interactive Data Corp.*,[16] the Court declined to apply tort principles to a wrongful employment termination, reasoning that the insurer-insured relationship differs significantly from an employer-employee's.[17] While noting the *Egan* factors, the Court offered a few additional grounds for the unique tort treatment afforded insurance, each of which the court determined was missing from the employer-employee context.

First, the insurer's and insured's interests are not aligned but financially at odds. A benefit to one is a cost to the other, resulting in the potential for adversarial treatment by the insurer.[18] Second, the insured, having made their payments in advance, places their trust in the insurer and relies on it to perform in the event of calamity.[19] And finally, ordinary contract damages are inadequate to compensate the insured for their loss. While an employee must mitigate their damages by seeking alternative employment, an insured cannot purchase a replacement policy to cover a loss that has already occurred. Insurance covers fortuity, not a pre-existing loss.[20]

Egan has been widely cited for the unique features of insurance that characterize the insurer-insured relationship as "special," "quasi-fiduciary," or "fiduciary" to justify the application of tort principles.[21] Like *Foley*, courts nationwide have expanded on the original *Egan* grounds for treating insurance differently, collectively offering the following reasons:[22]

(1) **Public service.** Insurers are purveyors of a vital service affected by the public interest, whose obligations encompass qualities of decency and humanity. Unlike ordinary commercial transactions, insurance plays a critical role in societal stability and economic security. Policies offer a crucial safety net for personal and financial well-being. Given their role in mitigating financial risks, insurers are called upon to uphold qualities of decency and humanity.[23]

(2) **Purpose of Insurance**. Unlike other commercial transactions, the insured is motivated not by pursuing commercial gain when purchasing an insurance policy but by the desire for peace of mind and security. The insured pays premiums to ensure they have a safety net in times of need.[24]

(3) **Trust & Reliance.** The performance dynamics of an insurance policy are unique. As a contract that transfers risk, the insured fulfills their obligation by paying premiums

regularly, while the insurer's performance obligation may never arise unless a claim is made. This sequential nature means the insured demonstrates continuous good faith by fulfilling their part of the contract, trusting that the insurer will honor its obligations when needed. Most policyholders are not experts in the intricacies of insurance contracts and thus depend on the insurer to fulfill its obligations faithfully. This trust places the insurer in a position of power, which must be exercised responsibly.[25]

(4) Unequal Bargaining Power (Contract of Adhesion). Insurance policies are built on inequality and dependence. They are often described as contracts of adhesion, meaning the insurer drafts them with little to no input from the insured. The insurer enters into many such policies, but insureds enter into only a few. The insured typically has limited bargaining power and must accept the terms as they are presented.[26]

(5) Control & Discretion. Insurers wield significant, if not unfettered control and discretion over the investigation, evaluation, and resolution of claims. This level of control places the insurer in a position of authority.[27]

(6) Vulnerable Insured. The insured is often vulnerable after a calamity. They face the dual challenges of emotional distress and potential economic devastation. This vulnerability increases the possibility of opportunistic behavior by insurers, who may exploit the insured's desperate circumstances to avoid paying claims.[28]

(7) Misaligned Interests. The financial interests of the insurer and insured are directly at odds. In other contracts, the party's interests may align. Parties enter into employment agreements to work together to build a sustainable, profitable business. Insurance, though, is a zero-sum game. If the insurer pays a claim, it diminishes its resources. This competition for resources incentivizes the insurer to treat the insured as an adversary rather than a partner responding to a calamity—the opposite of the dynamic insureds sought and for which they pay premiums.[29]

(8) Breach Incentive. Without the threat of having to pay the plaintiff's attorneys' fees or tort damages, insurers face no financial risk from wrongfully denying claims. The only financial penalty is paying the amount that would otherwise be due. They are incented to deny, delay, and defend against claims if only to force favorable settlement terms upon the insured.[30]

(9) Inadequate Damages. In typical commercial contracts, ordinary damages aim to compensate for financial losses resulting from a breach. However, ordinary contract damages are inadequate for insurance claims because they do not require the party in the superior position to account for its action, and they do not make the inferior party whole or compensate the insured for their reason to purchase a policy—peace of mind.[31]

(10) Defeated Purpose. Insurance's principal purpose is to provide policyholders with financial protection and peace of mind. If insurers can refuse to pay valid claims without reasonable justification, the fundamental purpose of insurance is undermined, rendering the contract meaningless.[32]

(*) Reasonable Expectations. The insured's reasonable expectations have been suggested as grounds for characterizing the relationship as special. However, the implied covenant of good faith and fair dealing is found in every contract, and its very purpose is to effectuate the parties' reasonable expectations. While the insured's reasonable expectations may be critical to interpreting the policy and defining the precise contours of the insurer's duties, no meaningful distinction has been offered for treating the insured's reasonable expectations differently from other contracting parties to support the extraordinary treatment, except perhaps as incorporated in the above factors (e.g., the purpose of insurance, or trust and reliance).[33]

These attributes highlight the unique and special relationship between insurers and insureds.[34] Recognition by the courts of this special relationship underscores the importance of fairness, transparency, and good faith in the insurance industry. The special relationship is critical to evaluating the insurer's duties, particularly those invoking fairness and honesty. This relationship ensures that policyholders receive the protection and peace of mind they seek, reinforcing the fundamental purpose of insurance in our society. While each factor is critical to evaluating an insurer's use of biased experts, two are particularly so: the parties' unequal bargaining power and the insurer's unfettered discretion and control over evaluating and resolving the claim.

Footnotes:

[1] *See, e.g., Wilson v. 21st Century Ins. Co.,* 42 Cal.4th 713, 720 [171 P.3d 1082] (2007) (Wilson); *Egan v. Mutual of Omaha Ins. Co.,* 24 Cal.3d 809, 818 [620 P.2d 141] (1979) (Egan); *Crisci v. Security Ins. Co.*, 66 Cal.2d 425, 429 [426 P.2d 173] (1967) (Crisci); *Comunale v. Traders & General Ins., Co.* 50 Cal.2d 654, 659 [328 P.2d 198] (1958) (Comunale).

[2] *See* 29 U.S. Code §§ 1102 and 1104.

[3] *See, e.g., Wilson, supra,* 42 Cal.4th at 720; *Comunale, supra,* 50 Cal.2d at 658.

[4] *Gruenberg v. Aetna Ins. Co.,* 9 Cal.3d 566, 577-578 [510 P.2d 1032] (1973) (describing the duty of good faith and fair dealing as implied in law and independent of the performance of the insured's contractual obligations).

[5] *See, e.g., Crisci, supra,* 66 Cal.2d at 429; *Comunale, supra,* 50 Cal.2d at 659.

[6] *See, e.g., Wilson, supra,* 42 Cal.4th at 720-723, 726; *Egan, supra,* 24 Cal.3d at 819.

[7] *Major v. Western Home Ins. Co.,* 169 Cal.App.4th 1197, 1209 [87 Cal.Rptr.3d 556] (2009) (An insurer must act fairly, honestly, decently, and humanely towards its policyholder). *See also, Best Place, Inc. v. Penn Am. Ins. Co.,* 82 Hawai'i 120, 126 [920 P.2d 334] (1996) ("business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception and practice honesty and equity in all insurance matters" [citations omitted]); *Rawlings v. Apodaca*, 151 Ariz. 149, 163 [726 P.2d 565] (1986) (insured may maintain an action to recover tort damages if the insurer, by an intentional act, also breaches the implied covenant by failing to deal fairly and honestly with its insured's claim); *White v. Unigard,* 112 Idaho 94, 99 [730 P.2d 1014] (1986) ("insurance contract … requires that the parties deal with each other fairly, honestly, and in good faith.").

[8] *See, e.g., Neal v. Farmers Ins. Exchange,* 21 Cal.3d 910 [582 P.2d 980] (1978) (awarding punitive damages); *Gruenberg v. Aetna Ins. Co., supra,* 9 Cal.3d 566 (permitting recovery for emotional distress in first-party claim); *Crisci, supra,* 66 Cal.2d 425 (permitting recovery for emotional distress in third-party claim).

[9] *See, e.g., Wilson, supra,* 42 Cal.4th at 720 ("When the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." (citing *Frommoethelydo v. Fire Ins. Exchange*, 42 Cal.3d 208, 214–215 [721 P.2d 41] (1986).)

[10] *See, e.g., Missler v. State Farm Ins. Co.*, 41 N.E.3d 297, 302 (Ind. Ct. App. 2015) (citations omitted); *Habetz v. Condon*, 224 Conn. 231, 238 [618 A.2d 501] (1992).

[11] *See, e.g., Crisci, supra,* 66 Cal.2d 425; *Comunale, supra,* 50 Cal.2d 654.

[12] *See, e.g., Silberg v. California Life Ins. Co.,* 11 Cal.3d 452 [521 P.2d 1103] (1974); *Gruenberg, supra,* 9 Cal.3d 566.

[13] *Egan, supra,* 24 Cal.3d 809.

[14] *Id.*, at 819.

[15] *Id.,* at 820.

[16] *Foley v. Interactive Data Corp.*, 47 Cal.3d 654 [765 P.2d 373] (1988) (Foley). Following *Egan*, numerous cases attempted to extend the application of tort-like principles to breach of the implied covenant of good faith and fair dealing in other contracts. The initial focus was on banking and employment cases, as these actions were imbued to a degree with the same social welfare and unequal bargaining power found in insurance. The California Supreme Court initially gave some life to the movement in *Seaman's Direct Buying Service, Inc. v. Standard Oil Co.,* 36 Cal.3d 752, 769 [686 P.2d 1158] (1984), suggesting in dicta that a tort cause of action might lie "when, in addition to breaching the contract, [defendant] seeks to shield itself from liability by denying, in bad faith and without probable cause, that the contract exists." However, the Court quickly retreated. The Court cast doubt on the *Seamen's* dicta In *Foley*. The Court finally halted the expansion in *Freeman & Mills, Inc. v. Belcher Oil Co.,* 11 Cal.4th 85 [900 P.2d 669] (1995), declining to extend tort-like duties and damages to contracts (other than insurance) absent a violation of "an independent duty arising from principles of tort law." *Id.,* at 102.

[17] *Id.,* at 692-693.

[18] *Id.,* at 693.

[19] *Id.,* at 690.

[20] *Id.,* at 693.

[21] Many jurisdictions have elected not to recognize a special relationship. Nevertheless, many have adopted tort principles for insurance, while others provide either statutory remedies or an expansive view of contract damages that include as foreseeable many damages that would generally be characterized as tort based. *See, e.g., Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73 (2001) (rejecting a tort duty for insurers and cataloging jurisdictions with an expansive view of damages for an insurer's breach of contract); *Spencer v. Aetna Life & Cas. Ins. Co.*, 227 Kan. 914, 917-918 [611 P.2d 149] (1980) (discussing the Kansas statutory scheme for insurer breach).

[22] Four cases provide more complete analyses of the factors and are often cited by other courts: **CA:** *Egan, supra,* 24 Cal.3d 809 at 819–820; **AK:** *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152, 1155–1157 (Alaska 1989) (Nicholson); **HI:** *Best Place, Inc. v. Penn Am. Ins. Co.*, 82 Hawai'i 120, 128–132 [920 P.2d 334] (1996) (Best Place); and **ID:** *White v. Unigard*, 112 Idaho 94, 99 [730

P.2d 1014] (1986) (White). Collectively, they identified nine of the ten factors for insurance's extraordinary tort treatment, with *Nicholson*, *Best Place*, and *White* citing eight factors each. Each of the five cases cited the parties' unequal bargaining power, the public service nature and the purpose of insurance, which are the most widely cited reasons in other jurisdictions. Exhibit C-1 to this E-Treatise includes a chart summarizing the recognition of the relationship and supporting factors for many jurisdictions, including the cases cited in the footnotes below and others.

For further insight on the factors supporting the special relationship, see Anderson & Fournier, *Why Courts Enforce Policyholders' Objectively Reasonable Expectations of Coverage*, 5 Conn. Ins. L.J. 335, 385–391 (1998-1999).

[23] *See e.g.,* **CA:** *Egan, supra,* 24 Cal.3d 809 at 819–820; **AK:** *Nicholson*, supra, 777 P.2d at 1155–1157; **HI:** *Best Place, supra,* 82 Hawai'i at 128–132; **ID:** *White v. Unigard*, 112 Idaho at 99.

[24] *See* ns. 22, 23. *See also,* **NV:** *Ainsworth v. Combined Ins. Co.*, 104 Nev. 587, 592, 763 P.2d 673, 676 (1988), cert. denied, 493 U.S. 958, 110 S.Ct. 376, 107 L.Ed.2d 361 (1989).

[25] *See, e.g.,* **AL:** *Alabama Mun. Ins. v. Munich Reinsurance Am., Inc.,* 526 F. Supp. 3d 1133, 1136–1137 (M.D. Ala. 2021); **CA:** *Egan, supra,* 24 Cal.3d 809 at 819–820; **ID:** *White, supra,* 112 Idaho at 99.

[26] *See* ns. 22, 23. *See also,* **NM:** *Young v. Hartford Cas. Ins. Co.,* 503 F. Supp. 3d 1125, 1182-83 (D. N.M. 2020) (citing *Bourgeous v. Horizon Healthcare Corp.,* 117 N.M. 434 [872 P.2d 852] (1994)); **SD:** *Trouten v. Heritage Mut. Ins. Co.*, 2001 S.D. 106, ¶ 30 [632 N.W.2d 856, 863–864] (2001); **WY:** *Long v. Great W Life & Annuity Ins. Co.*, 957 P.2d 823, 829 (Wyo. 1998) (citing *McCullough v. Golden Rule Ins. Co.,* 789 P.2d 855 (Wyo. 1990)). For more on insurance policies as adhesion contracts, see *Case Study: Insurer's Unfettered Discretion in Homeowner's Claims*.

[27] *See* ns. 22, 23. *See also,* **IL:** *Roberts v. Western-Southern Life Ins. Co*., 568 F. Supp. 536, 554–555 (N.D. Ill. 1983); **TX:** *Universe Life Ins. Co. v. Giles,* 950 S.W.2d 48, 52-53 (Tex. 1997) (citing *Arnold v. National County Mut. Fire Ins. Co.,* 725 S.W.2d 165 (Tex. 1987)); **WI:** *Danner v. Auto-Owners Insurance, supra,* 245 Wis.2d 49, 67–72.

[28] *See* ns. 22, 23. *See also,* **AZ:** *Noble v. National American Life Insurance Co.,* 128 Ariz. 188, 189–190 [624 P.2d 866] (1981); *Rawlings v. Apodaca*, 151 Ariz. 149, 155 [726 P.2d 565] (1986); **CT:** *Grand Sheet Metal Products Co. v. Protection Mutual Ins. Co.,* 34 Conn. Supp. 46, 51 [375 A.2d 428] (Conn. 1977); **MS:** *Andrew Jackson Life Ins. Co. v. Williams,* 566 So.2d 1172, 1189 (Miss. 1990) (favorably citing *Egan, Rawlings,* and *Arnold* to support punitive damage award); **MT:** *Puryer v. HSBC Bank USA,* 2018 MT 124, 391 Mont. 361, 370–371 [419 P.3d 105] (Mont. 2018) (citing *Story v. City of Bozeman,* 242 Mont. 436 [791 P.2d 767] (Mont. 1990)); **OH:** *Hoskins v. Aetna Life Ins. Co.*, 6 Ohio St.3d 272, 275–277, 6 OBR 337, 339 [452 N.E.2d 1315, 1319] (1983); **OK:** *Wathor v. Mutual Assurance Administrators, Inc.,* 2004 OK 2 [87 P.3d 559, 561–562] (2004) (citing *Christian v. American Home Assur. Co.*,1977 OK 141 [577 P.2d 899] (1977)); **TX:** *Universe Life Ins. Co. v. Giles, supra,* 950 S.W.2d at 52-53.

[29] See *Foley, supra,* 47 Cal.3d at 692–693.

[30] *See* ns. 22, 23. *See also,* **AK:** *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152, 1155–1157 (Alaska 1989); **OK:** *Wathor v. Mutual Assurance Administrators, Inc., supra,* 87 P.3d at 561–562; **TX:** *Universe Life Ins. Co. v. Giles, supra,* 950 S.W.2d at 52-53. Several courts have considered and dismissed the insurer's arguments that statutory schemes are exclusive remedies or provide sufficient disincentives to breach. *See, e.g.,* **HI:** *Best Place, Inc. v. Penn Am. Ins. Co., supra,* at 126–127; **AK:** *State Farm Fire & Cas. Co. v. Nicholson, supra,* 777 P.2d at 1158; **ID:** *White v. Unigard, supra,* 730 P.2d at 1019 n. 3; **IL:** *Roberts v. Western-Southern Life Ins. Co.*, 568 F. Supp. 536, 555

(N.D. Ill. 1983). The lack of a statutory disincentive may be particularly so when it fails to provide a private cause of action, and the caselaw likewise fails to show enforcement action by regulators. However, there remains disagreement among the courts about the statutory frameworks. In *Spencer v. Aetna Life & Cas. Ins. Co.*, 227 Kan. 914, 917-918 [611 P.2d 149] (1980), the court provided a survey of the critical factors used in other states to support tort treatment but held that the statutory scheme adequately protects the insured.

[31] *See* ns. 22, 23. *See also,* **MT:** *Puryer v. HSBC Bank USA, supra,* 391 Mont. 361, 370–371.

[32] *See* ns. 22, 23. *See also,* **MS:** *Andrew Jackson Life Ins. Co. v. Williams, supra,* 566 So.2d at 1189; **AZ:** *Noble v. National American Life Insurance Co.,* 128 Ariz. 188, 189–190 [624 P.2d 866] (1981); **WI:** *Danner v. Auto-Owners Insurance, supra,* 245 Wis.2d 49, 67–72.

[33] *See, e.g.,* 8 New Appleman on Insurance Law Library Edition § 90.01 (2024) (identifying 8 cases).

[34] The special relationship and factors applicable to insurers appear derivative of the "special relationship" doctrine and test in tort law applicable to professionals and others. *See, e.g., Brown v. U.S.A. Taekwondo,* 11 Cal.5th 204, 215–216 [483 P.3d 159] (2021) (adopting a two-part test for recognizing a duty to protect others, including first ascertaining whether a special relationship exists). The two share many similarities, particularly concerning the creation of a duty that is based on dependency. The "existence of such a special relationship puts the defendant in a unique position to protect the plaintiff from injury." *Id.*, at 216. *See also* Robert F. Schopp and Michael R. Quattrocchi, *Tarasoff, The Doctrine of Special Relationships, and the Psychotherapist's Duty to Warn*, 95 J. Psychiatry & Law 13 (1984) (discussing the reach and application of the doctrine and the duty to warn or otherwise protect third parties under California law).

Case Study:
Insurer's Unfettered Discretion in Homeowner's Claims

The relationship between an insurance company and a policyholder is one of dependence and inequality. Insurance policies generally represent contracts of adhesion, a term which refers to a standardized contract drafted by the dominant party (the insurer)—to meet its own needs—for acceptance by the subordinate party (the insured), and which, due to the disparity in bargaining power between the parties, must be accepted or rejected by the insured on a 'take it or leave it' basis, without opportunity for bargaining and under such conditions that the insured cannot obtain the desired protection except by acquiescing in the form agreement."[35]

The insurer enters many such transactions, and the insured enters only a few. The entire policy is never presented when the insured first purchases it. The document typically is not read by the insured and, even if read, is likely unintelligible to a layperson. The terms are not subject to negotiation; the insured may be offered varying policy limits, endorsements, and amendments, but those alternatives do not alter the dependence and inequality that permeates the relationship.

A quintessential example of the adhesive nature of insurance policies is the ISO standard form homeowner's policy (the HO-3 form).[36] The HO-3 form is an all-risk policy (aka open perils) that covers any direct damage to the house or other structures on the property unless specifically excluded. Coverage for personal property under the HO-3 form is limited to the named perils only. While reviewed and approved by state regulators, a cursory review of the policy reveals that the form is drafted entirely for the benefit of insurers.

The insurance policy specifies a premium the insured pays to obtain coverage on the declarations page. That premium reflects the insured's principal promise under the policy and the sole benefit of the bargain that the insurer seeks in issuing into the policy. The insured has additional duties under the policy, reflecting various subordinate promises to protect the insurer during the claims process, including the following eight enumerated duties after loss:

- Give prompt notice to the insurer of a loss
- Protect the property from further damage
- Cooperate with the insurer in the investigation of the claim
- Prepare an inventory of damaged personal property (with specific details on quantity, cash value, and amount of loss)
- Show the property upon request
- Provide upon request all records and documents relating to the damaged property
- Submit to an examination under oath

- Submit detailed proof of loss upon request (including time, cause of loss, and detailed repair estimates).

The insured's specific obligations following a claim are expressly and precisely captured in the policy's terms and conditions.[37]

The ISO HO-3 standard policy further provides that the insurer's performance is conditioned on the insured's compliance with their duties under the policy. An insured may not institute suit against an insurer to recover under the policy unless they have complied with each of the preceding duties.[38] A violation of these duties without good cause often gives rise to forfeiture of benefits and the right to sue, particularly where the insurer has suffered substantial prejudice in its investigation of the claim.[39]

In exchange, the insurer promises to pay a covered loss if one occurs.[40] That is the entirety of the insurer's express obligations on the benefit of the bargain to the insured. The policy does not explicitly require the insurer to:

- Conduct thorough, fair, or objective claim investigations
- Honestly assess coverage
- Communicate truthfully with the policyholder
- Provide accurate or complete information
- Pay covered claims promptly

Not surprisingly, the policy has no provisions requiring the insurer to perform to the insured's reasonable expectations or to treat the insured genuinely or fairly. This disparity in contractual obligations highlights the adhesive nature of insurance policies. The insurer's performance is conditioned on the policyholder's compliance, yet the policy lacks provisions requiring the insurer to meet the policyholder's reasonable expectations or to treat them fairly and honestly.

The current state of homeowner's insurance policies reveals a systemic imbalance that has existed for 70 years—one that favors insurers at the expense of policyholders. This inequity undermines the fundamental purpose of insurance: to serve the public's interest and provide protection and peace of mind in times of loss.

Footnotes:

[35] *Steven v. Fidelity & Casualty Co.*, 58 Cal.2d 862, 882 [377 P.2d 284] (1962); *see also, Gray v. Zurich Insurance Co.,* 65 Cal.2d 263, 168 [419 P.2d 168] (1966). *See also, generally,* Friedrich Kessler, *The Contracts of Adhesion — Some Thoughts about Freedom of Contract Role of Compulsion in Economic Transactions Contract Role of Compulsion in Economic Transactions*, 43 Columbia L. Rev. 629 (1943). Courts typically address the adhesion issues in the context of onerous or unconscionable terms, evaluating the presence of both procedural and substantive

elements, with the former focusing on "oppression" or "surprise" due to unequal bargaining power and the latter focusing on the "one-sided" or "overly harsh" results. In recent years, the adhesion issue has often arisen in the context of an attempt to vitiate an arbitration provision as unconscionable. *See, e.g.*, *Higgins v Superior Court*, 140 Cal.App.4th 1238 [45 Cal.Rptr.3d 293] (2006) (mandatory arbitration provision in television appearance agreement held procedurally and substantively unconscionable and unenforceable); *Elite Logistics Corp. v. Hanjin Shipping Co.*, 589 Fed. Appx. 817 (9th Cir. 2014) (mandatory arbitration provision held procedurally and substantively unconscionable and unenforceable).

[36] The Insurance Services Office (ISO)—a national insurance industry trade group formed in 1971—drafts and promulgates standard form insurance policies for use by the industry. These forms are submitted for approval to state regulators and generally become the basis for issued policies. Some insurers use unaltered ISO forms, while others use modified versions or draft their versions. ISO currently offers nine standard homeowner policies: HO-1 through HO-8 and HO-14. Five of the policies (HO-1, HO-2, HO-3, HO-5, and HO-8) are for homeowners; HO-4 and HO-14 are for renters; HO-6 is for condominium unit owners; and HO-7 is for mobile homeowners. The HO-3 homeowners' policy is the most purchased. The current version (HO 00 03 03 22), released in March 2022, reflects the same terms, conditions, and eight duties for insureds on claims adjustment that were present in the 2011 version (HO 00 03 05 11), the 2000 version (HO 00 03 10 00), and the 1991 version (HO 00 03 04 91), with the exception that the insured's catch-all duty to "[c]ooperate with [the insurer] in the investigation of a claim" was added to the 2000 and later versions. Insurers' terms, conditions, and duties on claims adjustment are conspicuously absent from the current and predecessor ISO forms.

[37] California Insurance Code § 2071, first enacted in 1950, sets forth the standard form of fire insurance policy for use in California. The form applies to all homeowner policies covering residential structures of not more than four dwelling units, such that the policy terms must be no less favorable to the insured than those found in the statute. See Cal. Ins. Code §§ 10082.3 and 10087. The form includes the insured's duties after loss and an appraisal process, and they reflect the same duties for the insured as the ISO HO-3 standard form policy, except that the California terms and conditions have not yet been updated to incorporate the insured's catch-all duty to cooperate that was added to the ISO HO-3 form in 2000. California law also requires that the insurer notify the insured that the insured may obtain certain claim-related documents upon request. Like the ISO HO-3 policy, the insurer's duties for evaluating and processing claims are not reflected in the form. California law also requires that neither party misrepresent nor conceal information from the other, yet the HO-3 policy only captures the insured's duty.

[38] *See* ISO HO-3 form, which provides that "[n]o action can be brought against [the insurer] unless there has been full compliance with all of the [insured's duties under] the policy ..." *See also* Cal. Ins. Code § 2071, requiring the insured's full compliance with the policy terms as a condition precedent to filing suit.

[39] A clause in an insurance policy authorized by statute is valid, enforceable, and deemed consistent with public policy established by the Legislature. *Prudential-LMI Commercial Ins. v. Superior Court*, 51 Cal.3d 674, 684 [798 P. 2d 1230] (1990). Courts have uniformly upheld the limitations and compliance provision of Insurance Code 2071 for suits on claims, albeit often with due consideration of other legal principles and caselaw, such as the delayed discovery rule, estoppel, and equitable tolling. *See, e.g., Marselis v. Allstate Ins. Co.*, 121 Cal.App.4th 122, 125 [16 Cal.Rptr.3d 668] (2004); *Kapsimallis v. Allstate Ins. Co.*, 104 Cal.App.4th 667, 672-673 [128 Cal.Rptr.2d 358] (2002); *Vu v. Prudential Property & Casualty Ins. Co.,* 26 Cal.4th 1142, 1147-1149 [113 Cal.Rptr.2d 70] (2001); *Aliberti v. Allstate Ins. Co.*, 74 Cal.App.4th 138 [87 Cal.Rptr.2d 645] (1999), 142-148; *Prieto v. State Farm Fire & Casualty Co.*, 225 Cal.App.3d 1188, 1192-1997 [275

Cal. Rptr. 362] (1990). Similarly, courts have upheld the insured's forfeiture of rights for failing to comply with the duties after loss provision in the policy. *See e.g., Abdelhamid v. Fire Ins. Exchange*, 182 Cal.App.4th 990, 999-1001 [106 Cal.Rptr.3d 26] (2010) (failure to submit proof of loss); *Brizuela v. CalFarm Ins. Co.,* 116 Cal.App.4th 578, 587 [10 Cal.Rptr.3d 661] (2004) (failure to submit to examination under oath) (Brizuela); *Robinson v. National Auto. Etc. Ins. Co.,* 132 Cal.App.2d 709, 714-716 (1955) (failure to answer questions at an examination under oath). However, the court upheld forfeiture in each instance because the insurance company was prejudiced in performing its investigation. Courts have held an insured's lack of compliance, absent prejudice, or, if reasonable, not fatal to a claim. *See, e.g., Campbell v. Allstate Ins. Co.*, 60 Cal.2d 303, 305-307 [384 P.2d 155] (1963) (failure to provide notice must substantially prejudice insurer); *Brizuela, supra,* at 587.

[40] The insurer's obligations are so amorphous that the standard homeowner's policy never states that the insurer will pay for the losses arising from a covered claim, let alone timely pay. The policy merely states the insurer "will provide the insurance described in this policy in return for the premium and compliance with all applicable provisions of this policy," and the insurer will "insure against direct physical loss to property described in Coverages A and B." *See, e.g.*, ISO form HO-3, AGREEMENT, and SECTION I – PERILS INSURANCE AGAINST, respectively.

Chapter 3
Implied Covenant and Duty of Good Faith and Fair Dealing

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

Every contract contains an implied covenant of good faith and fair dealing, meaning that neither party will do anything to injure or destroy the right of the other to receive the benefits of the agreement. Hailed as one of the great advancements of modern contract law, the implied covenant is generally considered an overriding concept or principle of contract law intended to capture a maxim or fundamental governing rule of contracts. Since its recognition nearly 100 years ago, the covenant has become widely ingrained in the American judicial system. It's also likely the most controversial and widely debated commercial issue in legal scholarship and commentary over the past 50 years, especially its meaning, scope, and measure of the breach.

The covenant is often invoked to provide clarity when the contracting parties or the imprecise nature and vagaries of language otherwise fail, augmenting the express contract by supplying more precise terms, conditions, and duties to fulfill the spirit of the agreement and the reasonable expectations of the parties. Rather than an affirmative covenant or undertaking to perform or act in a particular manner, the covenant of good faith and fair dealing is also used contextually by the courts to exclude in the negative many categories of conduct that are deemed in bad faith, especially when: a contract contains a discretionary power granted to a party, which the party then exercises outside societal norms or reason to the detriment of the other party; a contract includes a provision making performance subject to the "satisfaction" of a party, which the party then uses opportunistically to avoid their contractual obligations; a party acts in a manner that materially attenuates the contractual rights of the other party; a party knowingly or intentionally withholds vital information from the other party, which detrimentally impacts the other parties' decision-making; or a party engages in deliberate unfairness, maliciousness, trickery or deceit, which deprives the other party of the benefits of the contractual bargain.

3. Implied Covenant and Duty of Good Faith and Fair Dealing
    - 3.1 Origins and Early Developments
    - 3.2 *Kirke La Shelle Co. v. Paul Armstrong Co.*
    - 3.3 Gradual Adoption by States

3.4 Codification in Restatement and UCC

3.5 Summers–Burton Debate

3.6 Parties' Reasonable Expectations

3.7 Scope, Parameters, and Limitations

Chapter 4
Express and Implied Duties of Insurers

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

An insurance policy is subject to the same implied covenant as any other contract. Generally referred to derivatively in the insurance context as the duty of good faith and fair dealing, the implied covenant is typically used to impose more specific duties on the insurer in the investigation, evaluation, and resolution of claims. In the context of third-party liability claims, the policy expressly obligates an insurer to defend and indemnify the insured for a covered claim, but only in the most general terms. Thus, courts have used the implied covenant to effectuate the insureds' reasonable expectations and impose further duties consistent with the dual express obligations upon insurers. Those duties include a duty to defend an insured if any of the allegations of a lawsuit is potentially within the scope of the policy and a duty to accept a settlement offer within policy limits if there is a substantial likelihood that a judgment could be obtained in excess of policy benefits.

Likewise, in the context of first-party loss claims, the insurer is expressly obligated under the policy to insure against losses arising from a covered claim, but only in the most amorphous and general terms. Courts have thus used the implied covenant to impose duties upon the insurer to not unreasonably delay or withhold payment for a covered claim and to investigate the claim fully, fairly, and objectively. As applicable to first- and third-party claims, the insurer's overarching duties include acting reasonably, with fairness, decency, and honesty towards their insured and treating the insured's interests as equal to their own. Consistent with the insurer's obligations to the insured and to society as a whole and to protect against some of the more unscrupulous insurer practices, every state has enacted statutes to impose additional duties upon the insurer consistent with the insurer's express obligations under the policy, and to characterize certain conduct as an unlawful practice.

4. Express and Implied Duties of Insurers
    4.1 Duty to Not Unreasonably Deny or Delay Coverage
    4.2 Duty to Investigate Claims Fully and Fairly
        4.2.1 Insured Duties
        4.2.2 Insurer Duties
        4.2.3 Biased Expert Distinctions

4.3 Duty to Act Honestly and Not Misrepresent, Conceal, or Withhold Material Information

4.4 Related Duties and Obligations

Chapter 5
The "Fairly Debatable" Rule

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

Following the *Egan* decision, the insurance industry implemented a strategy and framework for claims adjusting that would mitigate or avoid altogether the more negative implications of the decision. In many pre-1940s Midwest railroad cases, allegations were made that the defendant railroads and their insurers retained biased experts using unreliable principles, theories, and methodologies to create false narratives and improperly persuade jurors. The allegations were uniformly met with skepticism and resistance from the courts, often placing high hurdles for the plaintiffs to overcome. The courts commonly required the plaintiffs to prove the expert's opinions were the result of actual bias, a standard nowhere else found in the law and, for all practical purposes, nearly impossible to overcome.

Beginning in the 1980s and borrowing a page from their predecessors, many insurers focused on the thoroughness of the investigation, not fairness. Insurers hired biased experts who were predisposed in their inquiry to favorable outcomes for the insurance company. These experts, colloquially referred to as "hired guns" or "professional experts," undeniably suffer from the same selection, compensation, and adversarial bias that litigants routinely face in other industries. The key difference was that the insurance experts were the final decision-makers in a non-tribunal, quasi-adjudicatory setting affecting almost all of society. Because of the unique status of insurance, the experts were duty-bound to be fair and impartial. Yet, while statutes and common law precedents ensure that final decision-makers, such as judges, mediators, arbitrators, and appraisers in an adjudicatory forum, remain unbiased, no such protections exist in the insurance context. The insurance companies were not seeking fair and objective investigations to satisfy the consumer protection laws; they were merely seeking thorough and complete investigations. Insurers only sought to overcome any bad faith or punitive damage liability through the appearance of a reasonably well-performed investigation. That strategy has worked to near perfection.

The insurance industry created panel lists of experts. No longer was an adjuster to ask a colleague or attorney for an expert referral haphazardly. The claims process was automated down to the very last detail. A menu of outcome-oriented experts had been specifically tailored for claims adjustment. The adjuster is now selected from a list of pre-selected experts that would provide accommodating and universally favorable opinions for insurers. Simultaneously, the industry engaged in a campaign of tort reform in the courts and the legislatures nationally to change the ground rules, specifically by targeting the use

of experts to provide plausible cover for deniability for claims. Throughout the mid-1990s and early 2000s, most states adopted a version of the "fairly debatable" rule, which essentially provides that an insurer acts reasonably towards their insured and cannot be held liable for acting in bad faith when an insurer relies upon an expert's opinion as grounds for denying a claim. The fairly debatable rule is nearly identical in almost every state. In most instances, an insurer can now easily argue, with the assistance of a well-paid expert, that they acted reasonably.

In applying the new rule, the insurance industry focused entirely on the thoroughness of the investigation. The issue of whether the expert could be biased was assiduously avoided and nearly impossible for plaintiffs to attack. The courts ignored that *fairness* was an equal pillar of the duty to fully and fairly investigate the claim. Similarly dismissed was whether the experts' principles, theories, and methodologies underlying their opinions were unsound, flawed, or improperly applied. The industry also adopted a strategy to suppress the production of analogous claim files in litigation to avoid exposure to the insurers' patterns and practice of using biased experts in their investigations.

5. The "Fairly Debatable" Rule

Chapter 6
Assessing Experts' Neutrality and Reliability

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise. The article Demer's Paradigm for Assessing and Eliminating Expert Bias has been added for now as a placeholder for this Chapter, outlining much of what's to follow.]

The terms "bias" and "expert" are central to one of the most critical issues in insurance today - the industry's institutional use of biased experts to deny or underpay claims. "Bias" means an inclination, bent, tendency, predisposition, partiality, or prejudice in favor of or against something, such as a particular person, issue, or matter, especially one that is preconceived or unreasoned. Bias denotes a lack of fairness and impartiality—an inability to remain objective. It has no physical attributes; bias exists exclusively as a state of mind. An "expert" is someone having, involving, or displaying special skills or knowledge derived from training or experience.

The practice often stems from the substantial business relationship between experts and insurers. Insurers repeatedly hire and compensate experts to provide opinions on loss causation and damages. This creates a financial incentive for experts to favor insurers by minimizing liability in hopes of receiving future assignments. While seemingly objective, their opinions may subtly align with insurers' interests.

In every adjudicatory context, and even some non-adjudicatory proceedings, courts apply a probability-based inferential bias standard to assess impermissible partiality. The due process right to a trial in a fair tribunal applies equally to administrative adjudicatory agencies, where the U.S. Supreme Court has adopted a similar contextual, circumstantial standard of inferable bias. Yet, despite the prevalence of experts in the judicial system and their outsized effect on courts and juries, a lack of cases exists regarding the means for assessing and eliminating bias, particularly in the insurance context.

Recently, a few courts—increasingly in the ERISA context—finally recognized the inference of bias as the proper standard for evaluating expert bias. One recent case is notable for identifying the appropriate standard for assessing bias and the more significant factors that should be examined to determine inferable bias. In *Demer v. IBM Corporation LTD Plan*, the Ninth Circuit Court of Appeals applied the inference of bias standard and identified four principal factors for assessing bias:

- **Relational Metrics**. This factor examines whether a substantial business relationship exists that financially motivates the expert to favor the insurer, as evidenced generally by the amount of compensation and the number of assignments the expert receives from the insurance industry.

- **Pattern Metrics**. This factor analyzes whether the expert has a pattern and practice of offering opinions that favor insurers, as evidenced by the percentage of reports that support denial or underpayment of claim payments.
- **Principles, Methodologies, and Facts**. This factor explores whether the expert utilizes reliable principles and methodologies and properly and consistently applies them to the specific claim (or across a range of claims).
- **Reasonable Measures Ensuring Impartiality and Reliability**. This factor considers whether the insurer has implemented reasonable measures to ensure a fair investigation, such as properly vetting the expert, obtaining meaningful expert disclosures, and periodically reviewing the expert's reports, disputed claims, and complaints.

The court further distinguished structural conflicts from disqualifying financial conflicts and outlined how insurers can rebut the presumption that arises when a weak inference is present. Substantial case law supports the *Demer* standards as a coherent framework for identifying and eliminating expert bias across insurance proceedings.

6. Assessing Experts' Neutrality and Reliability
    - 6.1 Nature of Bias
    - 6.2 Claim Types
    - 6.3 *Demer v. IBM Corp. LTD Plan*
    - 6.4 Standards for Evaluating Impartiality
    - 6.5 Factors for Inferring Bias
    - 6.6 Rubric for Assessing Reliability
    - 6.7 Flawed Methodologies and Procedural Irregularities
    - 6.8 Presumptions and Burden-Shifting
        - 6.8.1 Irrefutable Evidence Supporting Coverage Decision
        - 6.8.2 Reasonable Measures to Ensure Neutrality and Reliability
    - 6.9 Application to Myriad Parties
        - 6.9.1 Insurers and Benefit Plans
        - 6.9.2 Third-Party Administrators
        - 6.9.3 Vendors and Intermediaries
        - 6.9.4 Experts

Demer's Paradigm for Assessing Biased Insurance Experts

Insureds, when they submit a claim, have fundamental reasonable expectations. They expect the insurer will perform a thorough and objective investigation, a coverage decision will be based on an honest assessment of the facts, any expert the insurer retains will be qualified and impartial, and the claim will not be unfairly denied or underpaid. These expectations are not just reasonable; they are the cornerstone of every insurance policy. However, court cases and national media attention reflect insurers' widespread use of biased experts to minimize claim payments. This practice, which has evolved into a form of institutionalized bad faith, not only impairs the insured's right to benefits under the policy but also breaches the insurer's implied covenant and duty of good faith and fair dealing. In essence, using biased experts violates contract law's core principles and is illegal.

The practice is supported by structural deficiencies in the law and lax governmental oversight. In the early 1990s, the California judiciary joined a national insurance-reform movement. It recognized the "genuine dispute" doctrine for first-party claims. This safe harbor shields insurers from bad-faith liability if the law or facts supporting a claim are reasonably debatable. An insurer's retention of an expert to opine on coverage issues, such as the existence or interpretation of facts related to causation, scope, or amount of damages, is generally sufficient under the doctrine to create a genuine dispute and avoid bad-faith liability. While retaining a *biased* expert undermines the genuine-dispute defense and evinces bad-faith conduct, the courts have eschewed issuing guidance to assess expert bias, allowing the practice to expand unchecked. Similarly, despite significant catastrophes and insurance scandals revealing the predatory practice, regulators have ignored consumers' pleas for reform.

The Ninth Circuit is the lone exception. In a series of cases spanning nearly two decades, the court incrementally addressed the key issues, finally offering in *Demer v. IBM Corp. LTD Plan* (9th Cir. 2016) 835 F.3d 893, a well-reasoned paradigm of standards, factors, and presumptions for assessing and eliminating expert bias. Yet, except for a few federal cases, the Ninth Circuit's direction has largely gone unnoticed, likely because the last two cases involved ERISA-based policies issued under federal statutory authority, exempt from bad faith liability, and evaluated under trust principles rather than contract law.

Despite the differences, the underlying obligations, incentives, and foundational legal principles are the same in both groups of claims. The cases and statutory frameworks overwhelmingly suggest that the *Demer* paradigm applies to both ERISA and non-ERISA claims, and the recent case of *Bagramyan v. Gov't Employees Ins. Co.* (Cal. Ct. App., July 20, 2023, No. B315018) 2023 WL 4636118, without explicitly stating, firmly endorsed the *Demer* paradigm.

Demer's Paradigm

Beginning with *Guebara v. Allstate Ins. Co.* (9th Cir. 2001) 237 F.3d 987, 996, the Ninth Circuit first recognized the problems associated with insurers' use of biased experts in the claims process, identifying a handful of circumstances where an expert's opinion would

not immunize an insurer's conduct under the genuine dispute doctrine, such as where the experts were unreasonable or the insurer deceived the insured, dishonestly selected its experts, or failed to investigate the claim thoroughly. The circumstances were not a test, nor were they even factors evidencing bias, but rather examples of unreasonable conduct that violated the duty of good faith and fair dealing.

The Ninth Circuit next addressed several examples of evidence that reflect bias in coverage decisions. In *Hangarter v. Provident Life and Acc. Ins. Co.* (9th Cir. 2004) 373 F.3d 998, 1010-1011, the court firmly acknowledged the substantial nexus between the insurer's use of a biased expert and the genuine dispute rule, citing the *Gueberra* circumstances in holding that an insurer's biased investigation of a disability claim "may preclude a finding that the insurer was engaged in a genuine dispute, even if the insurer advances expert opinions concerning its conduct."

Applying the circumstances, the court provided an example of conduct from which the insurer's selection bias could be inferred, holding that the insurer exhibited bias in retaining an expert who rejected the insured's claims of total disability in thirteen of thirteen comparable cases. Similarly, in *Nolan v. Heald Coll.* (9th Cir. 2009) 551 F.3d 1148, 1152-1155, the court opined on the financial conflict of interest—compensation bias—that arises with experts in coverage matters and held in a disability case that an inference of bias is permitted where an independent medical review company and its physicians receive substantial work and monies from the insurer.

The Ninth Circuit's analysis of biased experts culminated in *Demer v. IBM Corp. LTD Plan, supra,* 835 F.3d at 901-903, where the court offered a comprehensive framework to assess both the insurer's *selection bias* and the expert's *compensation bias* in claims investigations. After first identifying *inference of bias* as the standard for evaluating expert bias, the court held that the insured initially bears the burden of offering evidence of possible bias, which the insured satisfied in *Demer* with two simple metrics: the amount of compensation received by the experts and the frequency of claims investigated. The experts received between $125,000 – $175,000 per year from MetLife and worked on between 250 – 300 claims per year over the prior two years. The magnitude of these numbers alone was sufficient to "raise a fair inference that there is a financial conflict which influenced [the experts'] assessments." However, the court noted the inference would have been even higher had the plaintiff also provided evidence showing the expert's "parsimonious pattern of assessments disfavorable to claimants" or direct financial outcome in the claim.

The court added that once the insured met its initial burden, a rebuttable presumption of bias arises, shifting the burden to the insurer to show the expert's impartiality. The court then distinguished between the structural conflict of interest arising from the dual role as both insurer and claim evaluator and the financial conflict that often occurs with experts, stressing the insurer's reasonable measures taken to avoid the former (*e.g.,* walling off the claims department from the profit center) differs from the measures taken to assure

accurate claims assessment (*e.g.*, providing an analysis of the experts' opinions in other insureds' claim files to show neutrality in practice).

The court further emphasized the experts' lack of thoroughness and failure to use sound principles and methodologies in evaluating the claim, noting the experts performed only "paper reviews" of the insured's medical condition, failed to explain why they rejected the credibility of the insured and offered erroneous opinions that conflicted with other medical reviewers. In holding that the insurer abused its discretion in denying the claim, the court looked at the "totality of the circumstances," including the insurer's use of biased experts and the expert's lack of reliability.

In all, the *Demer* paradigm introduced the "inference of bias" standard, a rebuttable presumption of bias, and four non-exclusive factors for evaluating inferential bias: the expert's past and expectant benefits for providing opinions; the expert's patterns and practices; the expert's failure to use reliable principles and methodologies; and the insurer's reasonable measures to safeguard expert impartiality and reliability.

Demer's Paradigm and Non-ERISA Policies

While significant differences exist between ERISA and non-ERISA insurance policies (*e.g.,* auto, homeowner, and commercial general liability policies), the *Demer* paradigm applies equally in both groups of claims. Both groups of policies involve the same discretionary power conferred upon an insurer to evaluate claims and determine benefits, the insurer's attendant obligation to perform a full and fair claim investigation, and the insurer's abuse of power by retaining a biased expert to offer opinions that support full or partial denial or underpayment of claims.

Similarly, identical structural and financial conflicts of interest exist in both claim groups, where the insurer performs the same role as the claim evaluator and benefits payer, and the expert has the same financial expectant interest based on prior business dealings. *Demer* addressed the power, duty, and abuse by applying trust law to the ERISA statutory scheme. The non-ERISA policies address identical issues applying contract law to the implied duty of good faith and fair dealing. (*See, e.g., Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720-723; *Carma Developers (Cal.), Inc. v. Marathon Development California, Inc.* (1992) 2 Cal.4th 342, 371-373; *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 818-819; Cal. Admin. Code, tit. 10, § 2695.7(d).)

The principal inquiry into the expert's leanings and flaws is identical in ERISA and non-ERISA claims. The analysis of expertise has evolved over the past two decades from evaluating an expert's qualifications to closely scrutinizing the reliability of the expert's testimony, with a critical examination of the expert's underlying principles, theories, and methodologies and the expert's interpretation and application of facts. (*See generally*, *Sargon Enterprises, Inc. v. University of Southern California* (2012) 55 Cal.4th 747, 769-772; *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, (1993) 509 U.S. 579.) A medical examiner's diagnosis and reliability in a health, disability, or personal injury claim is unaffected by whether the claim arose under an ERISA or non-ERISA policy.

Likewise, in both groups of claims, the insurer is held to a high standard of care in evaluating claims: in the former arising from its statutory designation as a fiduciary, and in the latter from the characterization of the insurer-insured's relationship as "special" or "quasi-fiduciary." The same nine non-exclusive factors cited in *Egan, supra,* or its progeny are present in both contexts and support the characterization and higher standard of care. While each factor is relevant to the benefit plan or insurer's misuse of biased experts, three hold greater significance in requiring a fair benefits determination: the adhesive nature of the plan or policy, the plan and insurer's unfettered discretion, and the participant and insured's vulnerability and blind trust.

California courts have only touched upon the core bias issues in other contexts, but they are remarkably consistent with *Demer*. For example, outside the ERISA context, courts typically evaluate bias using the probability-based "inference of bias" test—a standard adopted by the U.S. Supreme Court for judges and arbitrators. California followed the Supreme Court's guidance, using a myriad of terms to describe the inferable bias standard in various contexts, such as the appearance of bias, the impression of possible bias, and intolerable risk of bias (*see, e.g., Haworth v. Superior Court* (2010) 50 Cal.4th 372; *Natarajan v. Dignity Health* (2021) 11 Cal.5th 1095), often interchangeably in the same case. This differing terminology suggests that the standard may exist across a spectrum of relationships ranging from slight (appearance of bias) to more significant (intolerable risk of bias) and that a higher evidentiary standard may be required under certain circumstances.

California courts have also briefly addressed several factors identified in the *Demer* paradigm. In *Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1025, the Court reflected on the bias that infers when a relationship contains a financial element, opining, "[o]f all the types of bias that can affect adjudication, pecuniary interest has long received the most unequivocal condemnation and the least forgiving scrutiny." And in *Michael v. Aetna Life & Casualty Ins. Co.* (2001) 88 Cal.App.4th 925, 938-940, the court applied the inference-of-bias standard in concluding that an arbitrator need not disclose a relationship that is based on a social acquaintance, joint membership in a professional organization, or involving insubstantial business dealings but must disclose a substantial current, prior or continuing business relationship that involves financial consideration.

California law also suggests that the burden lies with the insurer in demonstrating expert neutrality. While the courts have again remained conspicuously silent on the issue, an insurer that interposes the genuine-dispute defense based on an expert's fair and thorough investigation should be required under the Code to show impartiality and reliability, at the very least where the insured raises a weak inference of bias. (*See, e.g.*, Cal. Evid. Code § 500). The most recent amendments to Rule 702 of the Federal Rules of Evidence similarly reflect the movement to place the burden on the party offering expert opinions to demonstrate by a preponderance of the evidence that the views are reliable.

Finally, as with *Demer* for ERISA claims, California courts apply a "reasonableness" measurement and a "totality of the circumstances" standard in evaluating an insurer's

abuse of discretion in unreasonably denying or delaying payment of a non-ERISA claim. (*See, e.g., Wilson, supra,* at 723.)

While critical differences exist between ERISA and non-ERISA policies, such as the deference on review, the measure of damages, and the degree of consideration the insurer must give to the insured's interests, these differences are irrelevant to the core bias issues and the standards, factors, and presumptions for evaluating expert reliability. One federal court has already cited *Demer* in a non-ERISA claim, granting discovery of relational metrics (*e.g.*, compensation and assignments) to show an inference of bias. (*See, e.g., Leung v. UNUM Life Ins. Co. of America* (S.D. Cal. June 15, 2023, case no. 22-cv-00767), 2023 WL 4056041 *6.)

Application to Bad Faith and Genuine Disputes

In non-ERISA claims, the biased-expert inquiry extends beyond benefits eligibility and coverage. An insurer's use of biased experts weighs in the calculus of whether the insurer breached the duty of good faith and fair dealing by unreasonably delaying or failing to pay a claim, which includes a duty to perform a thorough, fair, and objective investigation.

The systemic use of biased experts may also constitute unfair business practices under the Unfair Competition Law. The biased expert inquiry also factors into insurers' most potent defense in summary judgment proceedings to first-party bad faith claims—the genuine-dispute doctrine. In response to the defense, insureds invariably focus on the thoroughness of the investigation and the expert's conclusions without considering the expert's objectivity. And in the absence of evidence to the contrary, courts presume the expert is unbiased and the dispute is "genuine." Hence, mere reliance on an expert by an insurer is generally sufficient to raise a dispute and defeat a bad faith claim.

The recent case of *Bagramyan v. Gov't Employees Ins. Co., supra,* typifies the bias and genuine-dispute issues insureds face in summary judgment proceedings. It is a perfect example of an underdeveloped and likely erroneous decision resulting from the California judiciary's failure to recognize the *Demer* paradigm or provide guidance on the key issues. *Bagramyan* may be most notable as the first state appellate decision nationwide to identify "inference of bias" as the reference standard applicable to experts—albeit only indirectly in an unpublished decision. *Bagramyan* is also the first case to recognize several *Demer* factors as essential in the bias calculus.

After correctly identifying the standard and factors approach to evaluating bias, the remainder of the opinion lacked more thoughtful reasoning or legal analysis. The factors in *Bagramyan* created, at the very least, a weak inference of bias, far more than necessary to survive a summary judgment motion. The insurer's accident-reconstruction expert offered only experientially based conclusions, needing more independent verification for the principles and methodologies employed and precisely the type of opinions expected from a biased expert. The insured's expert easily disputed the views. On the issue of metrics, the record reflected that the insurer "does not track how many times it has hired [the expert]" and "does not know how often [the expert] makes findings to support a denial of coverage."

These statements stretched the limits of credulity, and while no mention was made of the expert's compensation in either party's papers, those two statements alone were tantamount to an admission that the insurer failed to take reasonable measures to ensure expert neutrality or reliability.

Sufficient evidence of selection and compensation bias was present in *Bagramyan* to shift the burden, which the insurer did not and could not meet. Yet, in granting the insurer’s motion based on the genuine-dispute doctrine, the court stressed the *insured's* failure to produce metrics and practices information—evidence exclusively in the insurer's possession and control, which it withheld from production.

Had the court carefully considered the *Demer* factors or rebuttable presumption, the outcome would likely have differed. While the case appears highly flawed, it at least finally recognizes the key bias issues and decisively supports the *Demer* paradigm for evaluating expert bias in non-ERISA disputes.

The California courts' full recognition of the *Demer* paradigm is long overdue. Each *Demer* factor is vital in genuine dispute and summary judgment analysis. Without guidance, insurers have every incentive to suppress the discovery of expert bias and shun reasonable measures to ensure expert impartiality and reliability, which is precisely what they’ve done for several decades.

Practical Considerations

An insurer's duty to fully and fairly investigate claims implicates two pillars of inquiry (thoroughness and fairness). Yet, practitioners and courts mistakenly focus solely on whether the investigation was complete, not whether the investigation was performed objectively. It is a fatal strategy for most insureds, as retention of a biased expert, despite lacking objectivity, generally satisfies the full investigation pillar.

Demer levels the playing field by offering a simple roadmap for expert objectivity and reliability, forcing insurers to take reasonable measures to ensure fairness. *Demer's* paradigm is simple to understand but challenging to implement since each factor used to evaluate inferential bias is subject to insurer manipulation.

The first of the four *Demer* factors examines the direct and indirect prior substantial business dealings between the expert and the insurer (including its representatives, such as attorneys, vendors, and outsourcers). The inquiry's general thrust is on the total amount of compensation and number (frequency) of assignments that create a sufficient temptation for the expert to tilt the principles or facts underlying opinions in exchange for future business, either with this specific insurer or, in some cases, the industry.

It is the most critical factor for evaluating the expert's bias and one for which courts generally grant discovery. In unique cases, particularly those involving professional trial experts, the inquiry may extend to the expert's dealings with other insurers and the insurance industry. This factor is susceptible to insurer manipulation using a proxy or intermediary, as insurers then suggest a lack of selection bias because they did not *directly* retain or pay the expert.

Experts likewise attempt to neutralize this factor by suggesting the insured retained or paid them merely because the insured signed an authorization to permit the expert's investigation and agreed to be liable for any amounts not covered by insurance. Both suggestions are misguided attempts to conceal the selection and compensation bias inherent in the practice: the insurer is still indirectly selecting a biased expert, and the expert's expectant benefits are still conditioned on providing favorable opinions to the insurer.

The second factor detects patterns and practices evidencing the expert's leanings in other insureds' claim files (OICFs). As *Bagramyan* accurately notes, the focus is on whether the expert supports coverage denial or underpayment. Since this factor is also metrics-based, segmentation of the claims into categories using any number of considerations (*e.g.*, the cause of damage, amount in dispute, retention pre- or post-denial, and retention for trial versus coverage) permits a deeper analysis and reveals superior insights into bias.

The insurer manipulates this factor by reframing the inquiry to focus on whether the insurer paid *some* amount on the claim, which is relevant only if the insurer paid the entire amount the insured sought under the claim. Although the information to determine full payment is often not included in the claim files, the information is likely present in cost-to-repair cases. It may be essential, as courts have universally held that "[w]here the parties rely on expert opinions, even a substantial disparity in estimates for the scope and cost of repairs does not, by itself, suggest the insurer acted in bad faith." (*See, e.g., Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 334, 348.)

While metrics and the lack of reasonable measures to ensure impartiality may be sufficient to show unfair bias in cost-to-repair cases, a pattern and practice of substantially underestimating scope and costs relative to other insureds' estimates may prove invaluable and is relatively simple to analyze.

The third factor scrutinizes the expert's reliability, including whether the underlying principles are sound, whether proper methodologies are followed, and whether all facts were considered and correctly applied to the principles to arrive at reliable opinions. Key determinants include whether the expert's views are disputed (or disputable), independently verifiable through objective testing, based on experiential or empirical analysis, or involve subjective interpretation of facts. The OICFs are again highly relevant to an expert's reliability, as bias may appear in the inconsistencies between how the expert applied the principles, methodologies, and facts in the present claim versus how they were used across a spectrum of OICFs. Variances may identify precisely how the expert's leanings are tailored to meet specific policy exclusions.

The fourth factor examines the reasonable measures taken by the insurer to ensure expert impartiality and reliability. While *Demer* focused on the insurer presenting metrics demonstrating the expert's impartiality, better evidence is likely found in the insurer's selection, approval, and performance monitoring practices, particularly where the expert is identified on a preferred or approved vendor list or performs substantial work for the insurer.

The insurer’s files should include disclosures made by the expert to obtain the assignment (or preferred vendor status) and periodic updates, including a description of any facts that may suggest bias, such as the percentage of work performed for insurers and the financial consideration received for performing such work. The insurer's files should also include a review of all complaints made against the expert by other insureds or their experts. Of most interest are the identification and reconciliation of any specific reliability issues and the authoritative resources the expert relied upon. If properly documented and maintained, the insurer’s records should contain in one place the necessary facts to fully evaluate bias, and the absence of such records may factor into the bias calculus and intent for bad faith and punitive damages and alone provide sufficient grounds for more invasive discovery.

Finally, while state courts outside California are often hostile to discovering OICFs and communications with regulators, which can be costly and time-consuming, California courts generally grant discovery, although sequential discovery may be necessary. Metrics under the first factors are most accessible to obtain and typically will provide sufficient evidence to proceed with further discovery.

While insurers may argue that tax information is privileged, accounting invoice and payee information is not, nor is the tax privilege absolute when the accounting information is unavailable. The metrics also help define the OICF universe, with the added benefit of addressing a common insurer ploy to inflate the universe, increase the estimated costs, and avoid discovery. Insurers delaying attempts or failure to provide sufficient compensation and assignment metrics, as in *Bagramyan*, may also provide grounds to obtain the OICFs immediately. However, courts may first require some minimal showing that the expert's conclusions are either disputable, experientially based, involve subjective determinations, suffer procedural irregularities, or reflect other indicia of flawed principles, methodologies, or application of facts.

Finally, contact details for other insureds, while also generally discoverable over the insurer's privacy objections, subject to a protective order, are generally unnecessary to show bias, bad faith, and intent. The mere request often elicits judicial skepticism and creates unnecessary hurdles (*e.g.*, objections based on probative value and "mini-trials") that can defeat the entire discovery request. For contact details, focused sequential discovery (*e.g.*, specific OICFs) or sampling may be appropriate.

Conclusion

Elementary requirements of fairness and impartiality are vital to every proceeding affecting a party's rights. Comprehensive statutory frameworks and case law exist to ensure neutrality for a myriad of ultimate decision-makers, typically focusing on self-assessment, disclosure, and disqualification.

Though imperfect, the laws guard against egregious forms of inferential bias. Yet, no framework exists for experts providing opinions for coverage in a quasi-adjudicatory, non-tribunal setting, where the insurer maintains unfettered discretion and the insured needs due process protections. The U.S. Department of Labor is the only agency that has taken

meaningful steps to remediate the expert bias problem—over the objections of the insurance industry. Shortly after *Demer*, the DOL amended the ERISA regulations to require unbiased claim investigations and evaluations by plan fiduciaries. Yet these amendments failed to offer apposite guidance on the necessary expert disclosures or the factors for assessing experts, except for a relatively minor reference to reputational considerations (*e.g.,* pattern metrics).

Considering the ubiquitous presence of experts in the legal and dispute resolution realm and even more significant presence in the insurance claims arena, the conspicuous silence by regulators and courts to eliminate "hired guns" and "junk science" is disconcerting. While legislative action is likely necessary to end this systemic problem, and clarification work remains for the *Demer* paradigm, at the very least, *Demer* provides a well-developed roadmap for courts and practitioners to eliminate expert bias.

Chapter 7
Discovery Strategies and Obstacles

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months, and this chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise, including two that pertain to this Chapter.]

Insureds often face an uphill battle in the discovery process due to a critical misstep—failing to articulate their requests' nexus and relevance clearly. Many insureds make vague assertions about bad faith or a general need to show recidivist conduct for punitive damages, frequently directing their arguments toward obtaining other insureds' contact details or claim files. However, courts tend to view such unsupported arguments with skepticism, particularly given that contact details are generally unnecessary and perhaps best approached sequentially, if at all.

The following more straightforward and abundant grounds for establishing nexus and relevance exist:

- **Biased Subjective or Experiential Opinions**. To show biased opinions (and lack of credibility) to support a breach of contract claim.
- **Erroneous or Inconsistent Opinions**. To show the expert's erroneous or inconsistent interpretation or application of principles, methodologies, and facts to support a breach of contract claim.
- **Interpretation or Application of Policy Terms.** To show the expert's erroneous or inconsistent interpretation or application of policy terms to support a breach of contract claim.
- **Biased Claim Investigations**. To show selection or compensation bias to support a bad faith claim.
- **Bad Faith Claims Adjusting.** To show specific bad faith patterns and practices to support a bad faith claim.
- **Genuine Dispute Doctrine**. To oppose an insurer's "genuine dispute" defense to a bad faith claim by showing the investigation, while perhaps thorough, was biased and unfair, thus undermining the "genuine" or "fair" pillar of the defense.
- **Insurer's Intent**. To show an insurer's intent (*e.g.*, conscious disregard) to support a bad faith claim.
- **Excusable Error**. To oppose an insurer's defense of mistake, inadvertence, or negligence to a bad faith claim.

- **Punitive Damages**. To show conscious disregard and recidivist conduct to support punitive damages.
- **Unfair Competition Law**. To show a pattern of unfair business practices.

When tailored to the case's specific facts and correlated with each of four primary pleadings categories—breach of contract, breach of the duty of good faith and fair dealing, unfair business practices, and punitive damages—, these grounds can effectively overcome an insurer's objections, the most common of which are generally specious.

7. Discovery Strategies and Obstacles
    - 7.1 Relationship Metrics
        - 7.1.1 Compensation
        - 7.1.2 Assignments
    - 7.2 Other Insureds' Claim Files and Contact Details
        - 7.2.1 Patterns and Practices
        - 7.2.2 Principles, Theories, and Methodologies
        - 7.2.3 Third-Party Privacy Rights
        - 7.2.4 Opt-outs versus Opt-ins
        - 7.2.5 Sampling
        - 7.2.6 Geographic, Temporal, and Other Restrictions
    - 7.3 Insurer's Reasonable Measures to Ensure Neutrality and Reliability
        - 7.3.1 Statistical Significance
    - 7.4 Insured's Duty to Establish Relevance and Nexus
    - 7.5 Common Insurer Objections
        - 7.5.1 Lacks Relevance
        - 7.5.2 Overbroad
        - 7.5.3 Undue Burden or Oppression
        - 7.5.4 Disproportionate to the Needs of the Case
        - 7.5.5 "Fishing Expeditions"
        - 7.5.6 Differing Facts and "Mini-Trials"
        - 7.5.7 Third Party Privacy Rights
        - 7.5.8 Privilege
        - 7.5.9 Lack of Possession or Control

7.5.10 Other

7.5.10.1 Prejudicial Harm

7.5.10.2 Untimely

7.5.10.3 Available from Other Sources

7.5.10.4 Insured’s Lack of Undue Hardship

7.5.10.5 Permissive, Rebuttable, and Conclusive Presumptions

Chapter 8
Motion Practice

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

The biased expert issues are uniquely suited to the claimant's dispositive motions. Key considerations are presented here for the principal pleadings and motions directed at discovery, exposing, and eliminating expert bias.

8. Pleadings and Motion Practice
    - 8.1 Pleadings
    - 8.2 Motion to Compel Discovery or Further Discovery Responses
    - 8.3 Motion for Summary Judgment and the Fairly Debatable Rule
    - 8.4 Motion for Summary Adjudication of Expert Bias
    - 8.5 Motion to Supplement the ERISA Administrative Record
    - 8.6 Motion in Limine to Exclude Expert Testimony
    - 8.7 Motion for Hearing to Assess Expert Qualifications and Reliability
    - 8.8 Jury Instructions

Chapter 9
Case-Studies

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

Insurers have a good faith right to be wrong. They can and do make mistakes. What insurers cannot do is manipulate the claims process, unlawfully stack the deck, and then assert they merely made a mistake. Using biased experts to deny or underpay claims pretextually is likely at the heart of every insurance scandal—and likely most insurance disputes—since the mid-1980s. Yet, in every instance, the scandals only exposed the superficial, describing the insurer's bad faith conduct in the most general terms. Upon closer inspection, the common denominator in each scandal is insurers' use of biased experts, which regulators have only superficially addressed or ignored.

9. Case-Studies
    - 9.1 Auto Claims and Panel Experts
    - 9.2 Disability Claims and Medical Examiners
    - 9.3 Catastrophic Claims and Forensic Engineers
    - 9.4 Health Claims and Physicians
    - 9.5 Property Claims and Plumbers
    - 9.6 Other Claim Types and Experts

Chapter 10
Selection and Compensation Bias in Practice

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

A case or collection of cases addressing a specific insurer-related party can be critical to discovery and case-dispositive motions, given that many experts are well-known in the courts and patterns and practices are identifiable. Examples of selection and compensation bias cases abound among four principal insurer-related parties: insurers and benefit plans, third-party administrators, vendors and intermediaries, and experts. This collection of cases supports motions to discover, expose, and eliminate expert bias.

10. Selection and Compensation Bias in Practice
    - 10.1 Insurers and Benefit Plans
    - 10.2 Third-Party Administrators
    - 10.3 Vendors and Intermediaries
    - 10.4 Experts

Chapter 11
Regulatory Oversight and Reforms

[Note: The following is an initial summary of this Chapter. The entire E-Treatise will be uploaded in installments over 6 – 12 months. This Chapter will be uploaded in a future post. See the most recent "Next Up" blog entry describing the next few installments of the E-Treatise.]

In *United States v. South-Eastern Underwriters Association* (1944) 322 U.S. 533, the U.S. Supreme Court addressed the industry's anti-competitive behavior under the Sherman Anti-Trust Act. It held that the Commerce Clause undeniably granted Congress the right to regulate the industry's interstate activities. The Court effectively gave Congress the unparalleled power to regulate insurers that had been missing for 75 years. The insurance industry responded to the potential regulatory threat and lobbied Congress in 1945 to pass the McCarron–Ferguson Act. The Act delegated plenary power over the industry to the states and eliminated potential federal oversight. The exclusive power granted to the states under the Act is conditioned on the states creating, maintaining, and enforcing laws that regulate insurance.

The National Association of Insurance Commissioners (NAIC) worked with the states to develop legislation governing insurance claims. They promulgated several model acts and regulations. Every state has adopted the Model Deceptive Practices Act, the Model Trade Practices Act, or a related insurance-specific trade practices act. Nearly every state has adopted the Model Claims Practices Act or a related claims-specific act. Most states have adopted the Model Property Claims Settlement Regulations or related claims-specific regulations. However, as lax regulatory oversight and structural deficiencies suggest, the states have ignored claims and the biased expert issue for decades. Likewise, the state courts—long considered the last bastion of defense against these predatory schemes—have taken a more conservative and myopic view of insurance bad faith practices in the past several decades.

Conversely, the federal government has responded more actively to expert bias issues. Shortly after Demer, the DOL amended the ERISA regulations—over the insurance industry's objections—to require unbiased claim investigations and evaluations by plan fiduciaries. Yet these amendments failed to offer apposite guidance on the necessary expert disclosures or the factors for assessing experts, except for a relatively minor reference to reputational considerations (*e.g.*, pattern metrics).

11. Regulatory Oversight and Reforms
    11.1 Early Developments and the McCarran-Ferguson Act of 1945

11.2 NAIC Model Laws and Regulations

11.3 State Insurance Laws and Regulations

11.4 Federal ERISA Regulations

11.5 Affordable Care Act Requirements

11.6 State Regulatory Settlement Agreements and Conservatorships

11.7 Legislative Proposals and Reforms

- 11.7.1 Frameworks
- 11.7.2 Expert Disclosures
- 11.7.3 Sunshine Laws

Appendices

[Note: The Expert Bias Toolkit is complete, except for the Deposition Prompts and Scripts, which will be uploaded in 6 – 12 months. See the blog for future installments of the E-Treatise and the most recent "Next Up" post describing the next few installments.]

- A Table of Authorities
- B Expert Bias Tools
  - B-1 Special Interrogatories
  - B-2 Request for Production of Documents
  - B-3 Request for Admissions
  - B-4 Subpoena Attachments
  - B-5 Sample Expert Deposition Script and Prompts (coming soon)
  - B-6 Sample Expert Disclosure Statement
  - B-7 Sample Jury Instructions
- C 50-State Surveys
  - C-1 Insurer-Insured Relationship: Characterization and Attributes
- D Case Studies

Appendix B-1

SAMPLE SPECIAL INTERROGATORIES

1. State the total compensation paid by YOU or on YOUR behalf to [*insert name of expert*] RELATING TO PLAINTIFF'S CLAIM. (For the purposes of these requests, the terms "YOU" or "YOUR" means and refers to [*insert name of insurer/benefit plan in dispute*], and its agents, attorneys, employees, representatives, accountants, and all other PERSONS representing or acting, or purporting to represent or act, on its behalf, including any third-party administrator, vendor, procuring agent, group, and other intermediary. For purposes of these requests, the terms "PERSON" or "PERSONS" means and refers to and includes any natural person, and any third-party administrator, vendor, procuring agent, group, or other intermediary, and any business entity, including but not limited to corporations, partnerships, limited partnerships, other types of limited liability entities, trusts, associations, unincorporated associations, firms, joint ventures, governmental bodies or entities, and their directors, officers, employees, agents, representatives, and attorneys acting on their behalf. For the purposes of these requests, the terms "RELATED TO" or "RELATING TO" or any grammatical variation of such words, refer to, with respect to a given subject, memorializing, identifying, describing, discussing, assessing, stating, referring, constituting, containing, embodying, and/or referring directly or indirectly, in any way, to the particular subject matter defined. For the purposes of these requests, the term "CLAIM" or "CLAIMS" means and refers to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits. For the purposes of these requests, the term "PLAINTIFF'S CLAIM" means and refers to that certain claim reported to YOU and assigned claim number [*insert claim number*].)

2. State the total compensation paid by YOU or on YOUR behalf to [*insert name of expert*] each year from [*insert year, e.g.,* 2019] to the present for services RELATING TO CLAIMS.

3. State the total compensation paid by YOU or on YOUR behalf to any PERSON (*e.g.*, a third-party administrator, vendor, procuring agent, group, or other intermediary) each year from [*insert year, e.g.,* 2019] to procure the services of [*insert name of expert*] RELATING TO CLAIMS.

4. Identify each CLAIM (by policy number, claim number, and date of claim) in which [*insert name of expert*] provided an opinion RELATING TO such CLAIM.[1]

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[1] *In unique cases, add geographic and/or temporal constraint to the requests as necessary, such as:* "The term "RELEVANT TERRITORY" means and refers to the State of California", and "The term "RELEVANT TIME PERIOD" means and refers to January 1, 2019 through and including the date upon which this subpoena is answered."

5. Identify each CLAIM (by policy number, claim number, and date of claim) in which [*insert name of expert*] provided an opinion that supported full payment of all benefits sought by the claimant under such CLAIM.

6. Identify each CLAIM (by policy number, claim number and date of claim) in which [*insert name of expert*] provided an opinion that supported full denial of such CLAIM.

7. Identify each CLAIM (by policy number, claim number and date of claim) in which [*insert name of expert*] provided an opinion that supported partial denial of such CLAIM.

8. Identify YOUR process for approving [*insert name of expert*] to perform services for YOU.

9. Identify YOUR process for monitoring the performance of [*insert name of expert*] RELATING TO CLAIMS.

10. Identify all measures YOU have taken to ensure the reliability of [*insert name of expert*]'s opinions RELATING TO CLAIMS.

11. Identify all measures YOU have taken to ensure the neutrality of [*insert name of expert*]'s opinions RELATING TO CLAIMS.

12. Identify YOUR process for retaining [*insert name of expert*] to perform services RELATING TO PLAINTIFF'S CLAIM.

13. Identify all PERSONS involved in retaining [*insert name of expert*] to provide an opinion RELATING TO PLAINTIFF'S CLAIM.

14. For each opinion of [*insert name of expert*] RELATING TO PLAINTIFF'S CLAIM that relies upon experiential knowledge of any matter and for which there is a range of opinions in the professional community concerning the matters subject to such experiential knowledge, please provide a summary of such range of views.

15. For each opinion of [*insert name of expert*] RELATING TO PLAINTIFF'S CLAIM that relies upon subjective interpretation of any matter, and for which there is a range of opinions in the professional community concerning the matters subject to such subjective interpretation, please provide a summary of such range of views.

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appropriate course of action based on the laws in your jurisdiction. The samples may not be fully up-to-date or account for all possible legal scenarios. Laws and procedures can change over time and may be interpreted differently by courts and regulatory bodies. By accessing and using these samples, you agree that Exposing Expert Bias, LLC, and Chris Dion are not responsible for errors, omissions, or outdated information. We make no warranties or guarantees about the sample documents' accuracy, completeness, or adequacy. The samples are provided "as is" without any representations or warranties, express or implied. All warranties and conditions of any kind about the samples are hereby disclaimed. In no event shall Exposing Expert Bias, LLC, and Chris Dion or its attorneys be liable for any special, direct, indirect, consequential, or incidental damages or any damages resulting from the use of or reliance on the sample documents. The use of these samples does not create an attorney-client relationship. Please seek legal counsel for your specific situation. For additional information, please see *the Disclaimers and Privacy Policy on* ExposingExpertBias.com. Copyright © 2024. All rights reserved.

Appendix B-2

SAMPLE REQUESTS FOR PRODUCTION OF DOCUMENTS

DEFINITIONS

For these requests, the following terms shall have the following meanings:

A. The terms "CLAIM" and "CLAIMS" refer to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits.

B. The terms "COMMUNICATION" and "COMMUNICATIONS" mean and refer to all forms of information exchange, whether written, oral, in person, by telephone, facsimile, computer, electronic mail, or other mode of transmission, and shall, concerning oral communications, include all DOCUMENTS which memorialize, in whole or in part, the contents of said oral communications, including correspondence, memoranda, agreements, handwritten notes, transcriptions, or e-mails.

C. The term "DOCUMENT(S)" includes any writing, including, but not limited to, handwriting, typewriting, printing, photostating, photographing, photocopying, transmitting by electronic mail or facsimile, and every other means of recording upon any tangible thing, any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of how the record has been stored.

D. The term "ELECTRONIC" includes having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

E. The terms "PERSON" and "PERSONS" refer to any natural persons and legal entities, including corporations, companies, firms, associations, organizations, partnerships, joint ventures, proprietorships, businesses, trusts, limited liability companies, and public entities. Unless noted otherwise, references to any PERSON include their agents, attorneys, employees, employers, officers, directors, or others acting on or purporting to act on behalf of said PERSON.

F. The term "PLAINTIFF" means and refers to [*insert name of Plaintiff*] and their representatives and agents (*e.g.*, attorney).

G. The term "POLICY" refers to that policy of insurance or benefit plan provided by YOU, with reference number [*insert identification number of Policy*].

H. The terms "RELATED TO" and "RELATING TO" or any grammatical variation of such words, mean and refer to, concerning a given subject, memorializing, identifying, describing, discussing, assessing, stating, referring, constituting, containing, embodying, and referring directly or indirectly, in any way, to the particular subject matter defined.

I. The term "RELEVANT TIME PERIOD" refers to [*insert relevant time period, such as* January 1, 2019, through and including the date upon which this request is answered].

J. The terms "YOU" and "YOUR" mean and refer to [*insert name of insurer/benefit*

plan in dispute] and its agents, attorneys, employees, representatives, accountants, and all other persons or entities representing or acting, or purporting to represent or act, on its behalf, including any third-party administrator, vendor, procuring agent, group, and other intermediary.

K. The terms "and" and "or" shall be construed conjunctively and disjunctively to acquire the broadest meaning possible, and each shall include the other whenever such construction serves to bring within the scope of these requests any information that would not otherwise be brought within their scope. The term "any" includes and encompasses "all." The singular shall always include the plural, and the present tense shall include the past tense.

INSTRUCTIONS

a) Any representation of YOUR inability to comply with any demand shall state, under oath, that a diligent search and reasonable inquiry has been made. In addition, YOU shall specify whether the inability to comply is because the particular DOCUMENTS never existed, have been destroyed, have been lost, misplaced, or stolen, or are no longer in the possession, custody, or control of YOU. This statement shall set forth the name and address of any natural person or organization known or believed by YOU to have possession, custody, or control of that item or category of items.

b) Concerning the production of emails or other electronic documents, each email or electronic document, or grouping of emails or electronic documents, shall be produced in such a fashion so that the identity of the PERSON from whose computer or email account the electronic document or email was taken can be identified or ascertained.

c) If YOU object to the production of any electronically stored information on the grounds that it is from a source that is not reasonably accessible because of undue burden or expense, identify in YOUR response: (a) the types or categories of sources of electronically stored information that YOU assert are not reasonably accessible; (b) the quantity or approximate quantity of electronically stored documents (including, if available, the number of emails) which are not being produced, on a type-by-type, or category-by-category basis; (c) the reasons, stated with particularity, as to why the electronically stored information is not reasonably accessible, stated on a type-by-type, or category-by-category basis; (d) the estimated number of hours of work, on a type-by-type, or category-by-category basis, that would be required to gain access to and produce the electronically stored information; and (e) the dollar cost, on a type-by-type, or category-by-category basis, that would be required to gain access to and produce the electronically stored information, including copies of any cost estimates or vendor estimates which YOU have obtained pertaining to, or corroborating, the cost of this work.

d) Where DOCUMENTS are produced that were in the possession of third parties who are agents of YOU (such as YOUR attorneys or accountants), the DOCUMENTS shall be produced in such a fashion so that it is ascertainable from which specific third party's

files the DOCUMENT(S) was located.

e) These requests include all relevant DOCUMENTS within the possession, custody, or control of YOU, to the maximum extent permitted under applicable law.

f) DOCUMENTS from any single file should be produced in the same order found in such file. If copies of DOCUMENTS are produced instead of the originals, such copies should be legible and bound or stapled similarly. Labels or other file designations should be produced and copied.

g) To the extent that electronically stored information is responsive to any document requests, all such information shall be in their native file formats.

h) To the extent any of these requests for production calls for a DOCUMENT subject to privilege, produce all those DOCUMENTS called for in that request not subject to a claim of privilege and so much of each DOCUMENT subject to a claim of privilege that does not contain privileged information, with redactions if necessary to conceal the privileged information. With respect to any DOCUMENT or portion of any DOCUMENT withheld because of privilege, state in writing the basis for YOUR privilege claim as follows: (a) the date appearing on the DOCUMENT, or if no date appears, the date on which the DOCUMENT was prepared; (b) the title of the DOCUMENT; (c) the name and job title of the person(s) who signed the DOCUMENT, or if not signed, the name and job title of the person(s) who prepared it; (d) the name and job title of each person making any contribution to the authorship of the DOCUMENT; (e) the name and job title of the person(s) to whom the DOCUMENT was addressed; (f) the name and job title of each person, other than the addressee(s) identified in (e) above, to whom the DOCUMENT, or a copy thereof, was sent or with whom the DOCUMENT was discussed; (g) the name, job title, and address of each person who has custody of the DOCUMENT (or any copy thereof); (h) the general nature or description of the DOCUMENT and the number of pages; and (i) the specific ground(s) on which YOUR claim of privilege rests.

DOCUMENTS REQUESTED FOR IDENTIFICATION AND PRODUCTION

1. All DOCUMENTS that describe your selection, approval, retention, and performance monitoring of [*insert name of expert*],

2. All DOCUMENTS between YOU and any vendor, procuring agent, group, and other intermediary that is involved in the procurement and provision of [*insert name of expert*]'s services RELATING TO CLAIMS, including without limitation contracts and agreements, memoranda of understanding, service agreements, and vendor agreements.[1]

3. All DOCUMENTS relating to the measures YOU have taken to ensure the reliability, accuracy, and impartiality of [*insert name of expert*]'s opinions, including the procedures YOU employ to oversee and monitor the performance of experts used for investigating claims and including all documents relating to YOUR performance monitoring of [*insert name of expert*].

4. All DOCUMENTS that identify any potential inaccuracy in [*insert name of

expert]'s opinions, including all complaints (formal and informal) received from insureds and plan participants, their representatives, and regulatory authorities (*e.g.*, California Department of Insurance and U.S. Department of Labor).

5. All DOCUMENTS that identify the amounts paid to [*insert name of expert*] for services related to claims for benefits made to YOU.[2] Please note that YOU may withhold tax forms (*e.g.*, IRS Form 1099) if YOU produce documents that identify the total payments made to [*insert name of expert*] for each year by YOU, and YOU identify such withheld tax forms on a detailed privilege log (including the identification of payee and payor).

6. All DOCUMENTS identifying the number of claims in which [*insert name of expert*] provided any opinions relating to claims made on policies issued by YOU.

7. All DOCUMENTS prepared by [*insert name of expert*] containing opinions relating to claims made on policies issued by YOU.

8. All COMMUNICATIONS between YOU and YOUR insureds that incorporate or reference an opinion provided by [*insert name of expert*].[3]

9. All COMMUNICATIONS between YOU and [*insert name of expert*]. Please note that all emails and a copy of YOUR claim management system's diary, log, notes, or other document reflecting the claim adjuster's notes on the CLAIMS in which [*insert name of expert*] communicated with YOU, if available, is sufficient for this request.

10. All DOCUMENTS that identity the persons, groups, or entities YOU have retained in the last five years to perform services RELATED TO a CLAIM [*in the State of California*][1] involving [*optional: limit by inserting policy type, nature of Plaintiff's claim, applicable exclusion, or expert's area of expertise*], together with all documents that identify the number of CLAIMS that such person, group or entity has evaluated for YOU.

11. All DOCUMENTS that identity persons, groups, or entities that claim adjusters may retain to investigate CLAIMS RELATING TO [*optional: limit by inserting policy type, nature of Plaintiff's claim, applicable exclusion, or expert's area of expertise*]. Please note that, if available, a list of the experts, vendors, procuring agents, groups, and other intermediaries (e.g., a preferred or approved vendor list) is sufficient for this request.

12. All DOCUMENTS that identify the fields in the database(s) YOU use for adjusting claims, and the tools or methods available to perform a search on such database.

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[2] *In unique cases, add geographic and/or temporal constraint to the requests as necessary, such as:* "The term "RELEVANT TERRITORY" means and refers to the State of California", and "The term "RELEVANT TIME PERIOD" means and refers to January 1, 2019 through and including the date upon which this subpoena is answered."

[3] Optional: If expert was retained for more than 50 claims, consider sampling and/or limiting to interim and final coverage decisions and emails.

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Appendix B-3

SAMPLE REQUEST FOR ADMISSIONS

1. Admit that in or about the month of [*insert month and year of Plaintiff's Claim*], PLAINTIFF reported PLAINTIFF'S CLAIM to YOU. (For these requests, the terms "YOU" or "YOUR" means and refers to [*insert name of insurer/benefit plan in dispute*] and its agents, attorneys, employees, representatives, accountants, and all other persons or entities representing or acting, or purporting to represent or act, on its behalf, including any third-party administrator, vendor, procuring agent, group, and other intermediary. For these requests, the term "PLAINTIFF" means and refers to [*insert Plaintiff's name*]. For these requests, "PLAINTIFF'S CLAIM" refers to a particular claim reported to YOU and the assigned claim number [*insert claim number*]. For these requests, the term "PLAINTIFF'S POLICY" means and refers to that policy of insurance or benefit plan provided by YOU, with reference number [*insert account number of policy/plan*].)

2. Admit that the damage PLAINTIFF suffered relating to PLAINTIFF'S CLAIM was caused by a covered peril under PLAINTIFF'S POLICY.

3. Admit that the damages PLAINTIFF suffered relating to PLAINTIFF'S CLAIM are not excluded from coverage under PLAINTIFF'S POLICY.

4. Admit that PLAINTIFF has reported PLAINTIFF'S CLAIM to YOU in a timely manner under PLAINTIFF'S POLICY.

5. Admit that PLAINTIFF has substantially complied with all relevant terms and conditions of PLAINTIFF'S POLICY pertaining to PLAINTIFF'S CLAIM.

6. Admit that YOU did not pay to PLAINTIFF all benefits due under PLAINTIFF'S POLICY pertaining to PLAINTIFF'S CLAIM.

7. Admit that YOU did not thoroughly investigate PLAINTIFF'S CLAIM.

8. Admit that YOU did not investigate PLAINTIFF'S CLAIM fairly.

9. Admit that YOU have a pattern and practice of minimizing CLAIM payments to insureds under policies issued by YOU based on [*insert applicable exclusion or specific reason*]. (For these requests, the term "CLAIM" or "CLAIMS" means and refers to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits.)

10. Admit that YOU frequently rely on opinions from [*name of expert*] in YOUR coverage decisions on CLAIMS.

11. Admit that [*name of expert*] received substantial compensation for providing YOU opinions about CLAIMS.

12. Admit that the principles and methodologies used by [insert name of expert] in rendering their opinions on PLAINTIFF'S CLAIM are unreliable.

13. Admit that the test results utilized by [*insert name of expert*] in rendering their opinions on PLAINTIFF'S CLAIM are not independently verifiable.

14. Admit that [*insert name of expert*] did not reliably apply generally accepted principles and methodologies in rendering their opinions for PLAINTIFF'S CLAIM.

15. Admit that [*name of expert*] did not reliably apply the facts to the principles and methodologies they relied upon in reaching their opinions for PLAINTIFF'S CLAIM.

16. Admit that YOU did not take reasonable measures to ensure that [*insert name of expert*]'s opinions were impartial.

17. Admit that YOU did not take reasonable measures to ensure that [*insert name of expert*]'s opinions were reliable.

18. Admit that YOU did not take reasonable measures to ensure that [*insert name of expert*]'s opinions were accurate.

19. Admit that substantial evidence exists that [*insert name of expert*] performed a biased investigation of PLAINTIFF'S CLAIM.

20. Admit that [*name of expert*] has a pattern and practice of offering opinions disfavorable to YOUR insureds.

21. Admit that [*insert name of expert*] has a pattern and practice of performing biased investigations of CLAIMS for YOU.

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Appendix B-4

SUBPOENA FOR THIRD-PARTY EXPERT ATTACHMENTS "3" AND "4"

DEFINITIONS

A. The terms "CLAIM" and "CLAIMS" refer to a claim made for benefits under a policy of insurance or benefit plan provided by YOU, including without limitation any appeal of a denial of a claim for benefits.

B. The term "DOCUMENT(S)" includes any writing, including, but not limited to, handwriting, typewriting, printing, photostating, photographing, photocopying, transmitting by electronic mail or facsimile, and every other means of recording upon any tangible thing, any form of communication or representation, including letters, words, pictures, sounds, or symbols, or combinations thereof, and any record thereby created, regardless of how the record has been stored.

C. The terms "and" and "or" shall be construed conjunctively and disjunctively to acquire the broadest meaning possible, and each shall include the other whenever such construction serves to bring within the scope of these requests any information that would not otherwise be brought within their scope. The term "any" includes and encompasses "all." The singular shall always include the plural, and the present tense shall include the past tense.

REQUEST FOR PRODUCTION OF DOCUMENTS

1. All DOCUMENTS reflecting any income you received for your services performed for or on behalf of [*insert name of insurer/benefit plan in dispute*]. Please identify the amounts by year, and please identify separately the amounts you received for services related to: (1) employee benefit plans, (2) worker's compensation benefits, and (3) social security benefits.[4]

2. All DOCUMENTS reflecting any income you received for services you performed for or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan in dispute*].

3. All DOCUMENTS reflecting any income you received for your services from claimants and their representatives relating to their insurance and benefit plan CLAIMS.

4. All DOCUMENTS reflecting the number of CLAIMS you were retained by or on behalf of [*insert name of insurer/benefit plan in dispute*].

5. All DOCUMENTS reflecting the number of CLAIMS in which you were retained

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[4] *In unique cases, add geographic and/or temporal constraint to the requests as necessary, such as:* "The term "RELEVANT TERRITORY" means and refers to the State of California", and "The term "RELEVANT TIME PERIOD" means and refers to January 1, 2019 through and including the date upon which this subpoena is answered."

by or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan in dispute*].

6. All DOCUMENTS reflecting the number of CLAIMS claimants retained you.

7. All DOCUMENTS reflecting opinions you offered to or on behalf of [*insert name of insurer/benefit plan in dispute*].

8. All communications between you and [*insert name of insurer/benefit plan in dispute*]. Please note that copies of all emails between you and [insert name of insurer/benefit plan in dispute] in electronic format are sufficient for this request.

DEPOSITION TOPICS

1. Principles and theories that you relied upon in evaluating [*insert name of Plaintiff*]'s claim.

2. Methodologies used in evaluating [*insert name of Plaintiff*]'s claim.

3. Nature and type of services you perform for or on behalf of [*insert name of insurer/benefit plan in dispute*].

4. Measures you have taken to ensure the reliability and accuracy of your opinions for insurers and benefit plans.

5. Measures you have taken to ensure the impartiality of your opinions for insurers and benefit plans.

6. Communications between you and [*insert name of insurer/benefit plan in dispute*].

7. Compensation you receive for services you perform for or on behalf of [*insert name of insurer/benefit plan at issue in the dispute*], including the total amount broken down annually.

8. Compensation you receive for services you perform for or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan at issue in the dispute*], including the total amount broken down annually.

9. Compensation from claimants and their representatives for services you perform on CLAIMS, including the total amount broken down annually. If you performed any work for claimants, please separately identify the amounts you received for services relating to: (1) employee benefit plans, (2) worker's compensation benefits, and (3) social security benefits.

10. Number of CLAIMS in which you performed services for or on behalf of [*insert name of insurer/benefit plan at issue in the dispute*], including the number of CLAIMS broken down annually.

11. Number of CLAIMS in which you performed services for or on behalf of insurers and benefit plans other than [*insert name of insurer/benefit plan at issue in the dispute*], including the number of CLAIMS broken down annually.

12. Number of CLAIMS in which claimants retained you, including the number of CLAIMS broken down annually.

13. The percentage of CLAIMS in which you perform services for or on behalf of insurers and benefit plans versus the percentage of CLAIMS in which you perform services for claimants is broken down annually.

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2. Qualifications

1. Provide a copy of your most recent curriculum vitae, including:
   (a) a description of your professional employment and experience (including the name of the employer, firm, or other group, and start and end date).
   (b) list of professional licenses (including license number, issuing entity, and date of issuance).
   (c) list of published works (including publisher, title, and date publication).

3. Insurance Related Work

1. For each of the past seven years, identify each insurance company, benefit plan, and third-party administrator for which you performed services on claims.[5] State for each year the total number of claims for which you performed services for each such entity.
2. For each of the past seven years, state the total compensation you received for performing work relating to claims. Of this total compensation, state:
   (a) the amount you received (directly or indirectly) from or on behalf of insurance companies, benefits plans, third-party administrators, and their representatives (*e.g.*, attorneys, vendors, procuring agents, groups, and other intermediaries).
   (b) the amount you received from claimants and their representatives (*e.g.*, their attorneys).
3. For each of the past seven years, state the percentage of your total income derived from performing work relating to claims under insurance policies and benefit plans. Of this percentage, state:
   (a) the percentage attributable to services performed by or on behalf of an insurance company, benefits plan, third-party administrator, and their representatives.
   (b) the percentage attributable to services for which the claimant and their representatives retained you.
4. For the past seven years, identify each vendor, procuring agent, group, or other intermediary involved in retaining you to perform claims-related services. State the

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[5] As used herein, the term "claims" means a claim made for benefits under an insurance policy and/or a benefit plan, including without limitation any appeal of a denial of a claim for benefits.

number of claims you performed services for each vendor, procuring agent, group, or other intermediary for each year.

5. For each of the past seven years, identify the number of claims for benefits under insurance policies and benefit plans for which you provided an opinion. Of these claims, state:
   (a) the percentage in which you provided an opinion that supported full payment of all benefits sought by the claimant of such claim.
   (b) the percentage in which you provided an opinion that supported complete denial of such a claim.
   (c) the percentage in which you provided an opinion that supported partial denial of such a claim.
6. Identify all matters you provided (*e.g.*, live testimony, deposition, declaration, or affidavit), including the jurisdiction, case title, case no., and the party retaining you.

4. Knowledge/Expertise

1. Please provide a general description of your area(s) of expertise. For each area of knowledge, provide the following:
   (a) Describe the fundamental principles and theories you apply to evaluate claims.
   (b) Provide a list of source materials (including any peer-reviewed articles and studies) you rely upon to reach your opinions.
   (c) Describe the methodologies you use to evaluate claims.
   (d) Describe the tests you use to evaluate claims.
      a. Are the tests generally accepted in the expert community?
      b. Are the test results independently verifiable?
      c. Do the test results involve subjective interpretation?
2. Please provide three samples of your reports where you have been requested to provide your professional opinions (*e.g.*, a claim investigation report or an independent medical examination). For each report, identify:
   (a) each of your opinions relies upon experiential knowledge.
   (b) each of your opinions is based on a subjective interpretation of principles, theories, tests, or facts.
   (c) for each of your opinions, where there is a range of views in the scientific and professional community concerning matters subject to experiential knowledge or subjective interpretation of principles, theories, tests, or facts, summarize the range of opinions.

3. Have you ever been subject to adverse action relating to your professional experience (*e.g.*, your license was suspended or revoked)? If so, please describe the matter in detail (including the governing body that took such action and the date of such action).
4. Identify all matters in which you were a defendant and the subject matter of the case related to your professional experience.

5. Other

1. Describe all matters that could cause a person aware of the facts to reasonably entertain a doubt that you would be able to be impartial, including without limitation if you have a current arrangement concerning prospective employment or other compensated service to evaluate claims for benefits under insurance policies and benefit plans.

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Appendix B-7

The following instructions are complements to CACI Nos. 2300, 2303, 2304, 2306, 2330, 2331, 2332, and 2337. These instructions were drafted for use in most claim types. Instruction No. 1 is intended solely for homeowner policy claims.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 1
[*insert name of insurer*]'s Homeowners Insurance Policy is an All-Risk Policy with Specified Exclusions

[*insert name of insurer*]'s homeowners insurance policy is an "all-risk" policy. Under an "all-risk" homeowners insurance policy, all risks are covered except loss caused by those specifically excluded by the policy.

Authority: See [*insert name of insurer*]'s Homeowner's Insurance Policy, [*p. 3 (Section I – PROPERTY), and pp. 4-7 (exclusions)*]; *Freedman v. State Farm Ins. Co.* (2009) 173 Cal. App. 4th 957, 965 fn. 1; *State Farm Fire & Casualty Co. v. Von Der Lieth* (1991) 54 Cal.3d 1123, 1131; *Garvey v. State Farm Fire & Casualty Co.* (1989) 48 Cal.3d 395, 406-407; *Strubble v. United States Auto. Assn.* (1973) 35 Cal.App.3d 498, 504.

Notes: This instruction is a prefatory instruction to CACI Nos. 2300 and 2306 and entirely explanatory in nature. It is a simple, informative statement of the law generally endorsed by both parties.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 2
Purpose of Insurance

The nature of an insurance contract is unique. An insured does not enter into an insurance contract seeking profit but seeks security and peace of mind through protection against misfortune and accidental loss. Insureds pay premiums in advance for this protection. Thus, insurance companies have a "special relationship" with their insureds. Insurers are held to a higher standard in contract performance than other contracting parties, and the law imposes duties on insurers not found in other contracts. Above all, an insurer has a duty to treat the insured with fairness, decency, and honesty.

Authority: *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720-721; *Love v. Fire Ins. Exch.* (1990) 221 Cal.App.3d 1136, 1151; *Egan v. Mutual of Omaha* (1979) 24 Cal.3d 809, 819; *Mariscal v. Old Republic Life Insurance* (1996) 42 Cal.App.4th 1617, 1623; *Major v. Western Home Ins. Co.* (2009) 169 Cal.App.4th 1197, 1209.

Notes: This instruction is a prefatory instruction to CACI Nos. 2330, 2331, and 2332, and is fundamental to understanding insurance policies and the reason for the insurer's duty of good faith and fair dealing, as well as setting up the insured's general duty of good faith and fair dealing and the more specific duties in the instructions that follow.

"An insured does not enter into an insurance contract seeking profit, but instead seeks security and peace of mind through protection against calamity." (*Love, supra,* at 1151; see also *Egan, supra,* at p. 819; *Mariscal, supra,* at p. 1623.) Insureds pay premiums in advance for an intangible right: protection against misfortune. Even those insured who never suffer a loss receive the benefit of having peace of mind and security in the event misfortune occurs. The duty of good faith and fair dealing is predicated on this intangible, along with the perceived disparate bargaining power and the nature of insurance policies (which potentially allow predatory or unscrupulous insurers to exploit their insureds' misfortune when resolving claims). This instruction succinctly captures the unique nature of the insurance policy. The following is a similar instruction adopted in the Nevada Civil Jury Instructions that captures the foregoing:

> "The relationship of an insured to an insurer is one of special confidence and akin to that of a fiduciary. A fiduciary relationship exists when one has the right to expect trust and confidence in the integrity and fidelity of another. This special relationship exists in part because consumers contract for insurance to gain protection, peace of mind, and security against calamity. To fulfill its implied obligation of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests."

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 3
Insurance Company's Duties Once a Claim is Made

[*insert name of insurer*] has a duty under the law to promptly commence and diligently conduct a thorough, fair, objective, and unbiased investigation of a claim. When investigating [*insert name of Plaintiff*]' claim, it was essential for [*insert name of insurer*] to fully and fairly inquire into possible bases that might support [*insert name of Plaintiff*]'s claim, not just those facts, claims, or coverage theories advanced by [*insert name of Plaintiff*]. In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to fully and fairly inquire into possible bases that might support [*insert name of Plaintiff*]'s claim.

Authority: *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720; *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 215-220; *Egan v. Mutual of Omaha* (1979) 24 Cal.3d 809, 817-19; *Mariscal v. Old Republic Life Insurance* (1996) 42 Cal.App.4th 1617, 1623; *Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1072; Cal. Admin. Code tit. 10, § 2695.7, subs. (d); Cal. Ins. Code § 790.03(h)(3).

Notes: As an example of the disparate treatment in the enumerated duties of the insurer and policyholder, the industry-standard homeowner's insurance policy (*e.g.*, the ISO HO-3 form) describes the insured's duties after loss in detail. These duties are also found in the statutory form of California Insurance Code § 2071, and every California homeowner policy must incorporate terms that are no less favorable than those found in § 2071. The insured's duties include:

(1) giving notice to [*insert name of insurer*] without unreasonable delay;

(2) protecting the property covered by the policy from further damage;

(3) not destroying the property covered by the policy;

(3) maintaining accurate records of repair costs;

(4) making a list of all damaged personal property (with specific details on quantity, cash value, replacement cost and amount of loss);

(5) showing the property upon request;

(6) providing upon request all records and documents relating to the damaged property;

(7) providing testimony at an examination under oath; and

(8) submitting a proof of loss upon request.

(*see e.g.*, ISO HO-3 form, Section entitled "Conditions", subsection "2. Duties After Loss", pp. 8-9 of the policy form; *see also* Cal. Ins. Code § 2071)

A violation of these duties gives rise to forfeiture of benefits and the right to sue under the policy. On the other hand, the policy is silent as to the insurer's duties, and thus statutes, regulations, and judicial decisions have filled in the missing duties. The duty to conduct a

thorough, fair, objective, and unbiased investigation of a claim is one of the preeminent duties of an insurer and the most critical to evaluating expert bias.

While breach of this duty has generally been found to constitute unreasonable conduct and bad faith as a matter of law (*see e.g.*, *Wilson, supra,* at p. 729); *Frommoethelydo, supra,* at pp. 215-220; *Egan, supra,* at pp. 817-19; *Mariscal, supra,* at p. 1623; and *Jordan, supra,* at p. 1072), the last sentence of this instruction is modeled after CACI No. 2337, acknowledging that the breach is a factor for the factfinder to consider in evaluating unreasonable conduct.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 4
Insurance Company's Duty to Interview Percipient Witnesses

[*insert name of insurer*] has a duty under the law to diligently search for evidence that favors coverage under the insurance policy and evidence that disfavors coverage under the insurance policy. Once [*insert name of insurer*] was advised of the existence of witnesses who had knowledge of disputed facts that were material to [*insert name of Plaintiff*]'s claim, [*insert name of insurer*] had a duty to investigate those witnesses.

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to investigate witnesses who had knowledge of disputed facts material to [*insert name of Plaintiff*]'s claim.

Authority: *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 219-220; *Mariscal v. Old Republic Life Insurance* (1996) 42 Cal.App.4th 1617, 1624; *Hughes v. Blue Cross of Northern California* (1989) 215 Cal.App.3d 832, 846

Notes: Please refer to instruction No. 3 for support for this instruction.

While a breach of the duty to interview the percipient witnesses has generally been found to constitute unreasonable conduct and bad faith as a matter of law (*see e.g.*, *Frommoethelydo, supra,* at pp. 219-220; *Mariscal, supra,* at p. 1624; and *Hughes, supra,* at p. 846), the last sentence of this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 5
Insurer's Duty Not to Mislead or Conceal Material Information

[*insert name of insurer*] has a duty under the law not to mislead or conceal material information from [*insert name of Plaintiff*].

Authority: Cal. Ins. Code § 790.03(h)(1). *See also generally*, Cal. Ins. Code §§ 330, 332 (West's 2023); Cal. Admin. Code, Tit. 10, § 2695.7(b)(1) ; CACI No. 2308.

Notes: Please refer to instruction No. 3 for support for this instruction. The failure to communicate that which a party knows and ought to communicate is concealment. Insurers often successfully invoke this duty against insureds to rescind a policy — often after a claim is made — based on a material misrepresentation in the application process. *See e.g., Nieto v. Blue Shield of California Life & Health Ins. Co.* (2010) 181 Cal.App.4th 60, 75; *TIG Ins. Co. of Michigan v. Homestore, Inc.* (2006) 137 Cal.App.4th 749, 755-756. While the statute is reciprocal, and insurers have routinely used the statute to rescind policies, very few insureds have successfully used the statute against insurers, and never against an insurer based on the material misrepresentation or concealment concerning its claim handling practices (*e.g.*, the systemic use of biased experts).

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 6
Insurer's Duty to Give Equal Consideration to the Interests of the Insured

To fulfill its implied obligation of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests. When evaluating valid claims that are potentially covered by the insurance policy, an insurer may not consider the interests of its other policyholders or shareholders, its profitability, or the impact of the claim on its financial condition. When evaluating invalid claims not covered by the insurance policy, an insurer is not required to disregard the interests of its shareholders and other policyholders.

Authority: *Love v. Fire Ins. Exchange* (1990) 221 Cal.App.3d 1136, 1148-1149

Notes: Please refer to instruction No. 3 for support for this instruction. This instruction should be offered only if an insurer puts forth a jury instruction that it may consider the interests of its own shareholders. It's generally unnecessary and already covered in CACI No. 2330, which recites:

> "To fulfill its implied obligation of good faith and fair dealing, an insurance company must give at least as much consideration to the interests of the insured as it gives to its own interests."

The CACI instruction captures the import of the California Supreme Court in *Wilson v. 21st Century Ins. Co.* (2007) 42 Cal.4th 713, 720–723, which recites in relevant part:

> "The law implies in every contract, including insurance policies, a covenant of good faith and fair dealing. "The implied promise requires each contracting party to refrain from doing anything to injure the right of the other to receive the agreement's benefits. To fulfill its implied obligation, ***an insurer must give at least as much consideration to the interests of the insured as it gives to its own interests***. When the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." " (*Id.,* at p. 720, citing *Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 214–215, [emphasis added].)

Yet, insurers attempt to mislead the courts over this instruction by mis-citing *Love v. Fire Ins. Exchange,* which opined as follows:

> "Unique obligations are imposed upon true fiduciaries which are not found in the insurance relationship. For example, a true fiduciary must first consider and always act in the best interests of its trust and not allow self-interest to overpower its duty to act in the trust's best interests. An insurer, however, may give its own interests consideration equal to that it gives the interests of its insured; it is not required to disregard the interests of its shareholders and other policyholders when evaluating claims; and ***it is not required to pay noncovered claims, even though payment would be in the best interests of its insured***." (*Love, supra,* at p. 1148–1149 [citations omitted, emphasis added.].)

An insurer's shareholders have no interest in a claim, except as it relates to the company's profitability.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 7
Insurance Company's Duty to Provide the Claim-Related Documents to a Policyholder Upon Request

[*insert name of insurer*] has a duty under the law to notify [*insert name of Plaintiff*] that they may obtain, upon request, copies of all claim-related documents. [*insert name of insurer*] has a further duty to provide all claim-related documents to [*insert name of Plaintiff*] within 15 calendar days after receiving a request. The "claim-related documents" are all documents that relate to the evaluation of damages. They include [*insert name of insurer*]'s [*insert specific documents withheld from production upon request*].

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to timely provide the claim-related documents to [*insert name of Plaintiff*] upon request.

Authority: California Insurance Code § 2071

Notes: Please refer to instruction No. 3 for support for this instruction.

This instruction reflects the lone statutory duty imposed on insurers. The duty is found in Cal. Ins. Code § 2071, section entitled "Requirements in case loss occurs," which also describes the policyholder's duties. Yet, while all of the policyholder's duties identified in this provision were incorporated into the standard homeowner's policy, the insurer's only duty was omitted.

The last sentence of this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 8
Insurance Company's Duty to Respond Completely to a Policyholder's Request for Information

After receiving a request for information from a policyholder about a claim, [*insert name of insurer*] has a duty under the law to furnish the policyholder a complete response based on the facts as then known by [*insert name of insurer*]. [*insert name of insurer*] must furnish the response no later than 15 days after receiving the request.

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] failed to furnish [*insert name of Plaintiff*] with complete responses to their requests based on the facts as then known by [*insert name of insurer*].

Authority: Cal. Admin. Code tit. 10, § 2695.5, subs. (b); [*insert name of insurer*]'s Claims Manual (which incorporates and recites Cal. Admin. Code tit. 10, § 2695.5, subs. (b) verbatim)

Notes: Please refer to instruction No. 3 for support for this instruction.

This instruction is used when Plaintiffs make inquiries from their insurer for information and the insurer withholds that information. An insurer's failure to respond within 15 days fully and completely based on the facts then known is a violation of Cal. Admin. Code tit. 10, § 2695.5, subs. (b).

The last sentence of this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 9
Insurance Company's Duty to Use Impartial Experts

In determining whether [*insert name of insurer*] acted unreasonably by failing to perform a full and fair investigation, you may also consider whether [*insert name of insurer*]'s use of experts was unreasonable. You may conclude [*insert name of insurer*] acted unreasonably from any of the following:

(a) [*insert name of insurer*] failed to conduct a thorough and unbiased investigation;

(b) [*insert name of insurer*] dishonestly selected its experts;

(c) [*insert name of insurer*]'s experts were unreasonable;

(d) [*insert name of insurer*] was guilty of misrepresenting the purpose and nature of its investigation; and

(e) [*insert name of insurer*] misrepresented to or concealed material information about its investigation from [insert name of Plaintiff].

This list is not intended to be an exhaustive or exclusive list of unreasonable conduct, and you may conclude [*name of insurer*] acted unreasonably based on other conduct.

Authority: *Fadeeff v. State Farm Gen. Ins. Co.* (2020) 50 Cal.App.5th 94, 101-104; *Brehm v. 21st Century Ins. Co.* (2008) 166 Cal.App.4th 1225, 1237-1240; *Chateau Chamberay Homeowners Assn. v. Associated Internat. Ins. Co.* (2001) 90 Cal.App.4th 335, 348-349, n. 8; *Hangarter v. Provident Life and Acc. Ins. Co.* (9th Cir. 2004) 373 F.3d 998, 1010-1011.

Notes: Please refer to instruction No. 3 for support for this instruction.

The cornerstone of a "fair" investigation is the *lack of bias*. (See *Fadeeff, supra,* at pp. 101-104; *Brehm, supra,* at pp. 1237-1240; *Chateau Chamberay, supra,* at pp. 348-349; *Hangarter, supra,* at pp. 1010-1011.) Guidance is generally lacking on what constitutes bias in the claims-handling arena. The above instruction is the only direct guidance the courts have issued to date. Hence, the instruction is critical to the juror's evaluation of [*insert name of insurer*]'s bad faith conduct.

While it could be argued that the use of biased experts constitutes bad faith as a matter of law, this instruction is modeled after CACI No. 2337, thus eliminating any suggestion that the breach is bad faith as a matter of law. Rather, it is a factor for the factfinder to consider in evaluating unreasonable conduct.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 10
Definition of Bias and Factors to Consider

"Bias" means a strong feeling in favor of or against one side in an argument, often not based on fair judgment. You may conclude that [*insert name of expert*] has a substantial likelihood of bias in favor of [*insert name of insurer*] based on any circumstance concerning the [*insert name of expert*]'s relationship with [*insert name of insurer*] or otherwise, including one or more of the following:

(a) whether [*insert name of expert*] receives substantial compensation for their work on [*insert name of insurer*]'s claims, and whether [insert name of expert] works on a substantial number of [*insert name of insurer*]'s claims;

(b) whether [*insert name of expert*] has a pattern and practice of offering favorable opinions that support [*insert name of insurer*] denying some or all of a claim;

(c) whether [*insert name of expert*] failed to use reliable principles, theories, and methodologies in reaching their opinions, or whether [*insert name of expert*] failed to properly apply the facts of this case to those principles and theories; or

(d) whether [*insert name of insurer*] failed to take reasonable measures to ensure [*insert name of expert*]'s impartiality and the accuracy of the [*insert name of expert*]'s opinions.

You may not consider facts that show only a social acquaintance, such as common membership in the same social club, without any substantial business relationship.

Authority: *Demer v. IBM Corp. LTD Plan* (9th Cir. 2016) 835 F.3d 893 *Haworth v. Superior Court* (2010) 50 Cal.4th 372; *Natarajan v. Dignity Health* (2021) 11 Cal.5th 1095); *Haas Haas v. County of San Bernardino* (2002) 27 Cal.4th 1017, 1025; *Michael v. Aetna Life & Casualty Ins. Co.* (2001) 88 Cal.App.4th 925, 938-940;
https://www.oxfordlearnersdictionaries.com/us/definition/english/bias_1?q=bias

Notes: The duty of good faith and fair dealing requires the insurance company to conduct a full, fair, and thorough investigation of a claim. The cornerstone of a "fair" investigation is the *lack of bias*. This instruction is critical to introducing the *Demer* factors and the conduct that may give rise to a rebuttable presumption of bias.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 11
Obligation to Prove – Inference of Expert Bias

In the context of an insurer's use of biased experts, [*name of Plaintiff*] has the initial burden to show a weak inference of bias, which may be implied from facts indicating a likelihood of bias. Once [*name of Plaintiff*] shows a weak inference of bias on the part of [*insert name of expert*], the burden then shifts to [*name of insurer*] to show by a preponderance of evidence that [*name of expert*] is unbiased.

Authority: *Demer v. IBM Corp. LTD Plan* (9th Cir. 2016) 835 F.3d 893, 902-903; Evidence Code § 500; *see also* CACI Nos. 200, 2304.

Notes: A defendant bears the burden of proving affirmative defenses.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 12
Insurance Company's Continuing Duty of Good Faith and Fair Dealing

An insurance company's duty of good faith and fair dealing to the insured is a contractual duty that does not cease when litigation begins. The duty is a continuing obligation that persists throughout litigation until the claim is fully and finally resolved. Thus, any investigation of the claim performed by [*insert name of insurer*] during the litigation must be full, fair, thorough, and unbiased.

In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*]'s investigation of the claim after the litigation commenced was full, fair, thorough, and unbiased.

Authority: *White v. Western Title Ins. Co.* (1985) 40 Cal.3d 870; see also Insurance Code § 790.03(h)(6); *Jordan v. Allstate Ins. Co.* (2007) 148 Cal.App.4th 1062, 1072, n.7; *Tomaselli v. Transamerica Ins. Co.* (1994) 25 Cal.App.4th 1269; Insurance Code § 790.03(h)(6); Croskey et al., *Cal. Practice Guide: Insurance Litigation* (TRG 2022) ¶¶ 12:985-12:987

Notes: It's axiomatic that an insurance company's duty of good faith and fair dealing to the policyholder is a contractual duty that does not cease when litigation begins. The duty is a continuing obligation that persists throughout. (See *White, supra*; *Jordan, supra,* at p. 1072, n.7; *Tomaselli v. Transamerica Ins. Co.*, *supra*, at p. 1281 (insurer may violate the duty of good faith and fair dealing by employees lying during deposition); see also Insurance Code § 790.03(h)(6) (insurance company prohibited from forcing insureds to institute litigation to recover benefits due). In literature, the insurance company's duty is frequently referred to as the "doctrine of continuing duty of good faith and fair dealing" or "continuing bad faith." (See *e.g.*, Croskey et al., *Cal. Practice Guide: Insurance Litigation* (TRG 2022) ¶¶ 12:985-12:987.)

Thus, while an insurer arguably may not be held liable for much of its litigation conduct, it may not act in contravention of its pre-litigation duties, including the duty to investigate with unbiased experts fairly. Hence, any expert the insurer uses post-claim denial may be evaluated using the same standards as pre-claim denial experts.

POLICYHOLDER'S SPECIAL JURY INSTRUCTION NO. 13
Policyholder's Duties End Once a Claim is Denied

Under the [*insert name of insurer*] homeowners insurance policy, after the appearance of observable physical damage to property covered by the policy, an insured is required to perform certain duties, including giving notice without unreasonable delay, not destroying the property, and protecting it from further damage, and showing the property. A policyholder's unreasonable failure to comply with their duties after loss is grounds for denying a claim, and the policyholder may lose their right to sue the insurer for their benefits.

After [*insert name of insurer*] denied the claim, [*insert name of Plaintiff*] was not required to comply any further with their duties and they were not required to show the property to [*insert name of insurer*] or its experts. In determining whether [*insert name of insurer*] acted unreasonably, you may consider whether [*insert name of insurer*] required [*insert name of Plaintiff*] to show the property after the claim was denied, or whether [*insert name of insurer*] informed [*insert name of Plaintiff*] that they were not in compliance with the policy because they failed to show the property.

Authority: [*insert name of insurer*]'s Homeowners Insurance Policy, Section entitled "Conditions", subsections "2. Duties After Loss" and "13. Suit Against Us" (pp. 8-10 of the policy); Insurance Code § 2071; *Prudential-LMI Commercial Ins. v. Superior Court* (1990) 51 Cal.3d 674, 684; *Kapsimallis v. Allstate Ins. Co.* (2002) 104 Cal.App.4th 667, 672-673; *Vu v. Prudential Property & Casualty Ins. Co.* (2001) 26 Cal.4th 1142, 1147-1149; *Marselis v. Allstate Ins. Co.* (2004) 121 Cal.App.4th 122, 125; *Aliberti v. Allstate Ins. Co.* (1999) 74 Cal.App.4th 138, 142-148; *Prieto v. State Farm Fire & Casualty Co.* (1990) 225 Cal.App.3d 1188, 1192-1997; *Campbell v. Allstate Ins. Co.* (1963) 60 Cal.2d 303, 305-307; *Brizuela v. CalFarm Ins. Co.* (2004) 116 Cal.App.4th 578, 587-91; see also *Henderson v. Farmers Group, Inc.* (2012) 210 Cal.App.4th 459, 471-474; *Abdelhamid v. Fire Ins. Exchange* (2010) 182 Cal.App.4th 990, 999-1001; *Robinson v. National Auto. Etc. Ins. Co.* (1955) 132 Cal.App.2d 709, 714-716; *Hickman v. London Assurance Corp.* (1920) 184 Cal. 524, 532-535; *Shell Oil Co. v. Winterthur Swiss Ins. Co.* (1993) 12 Cal.App.4th 715, 759-764; *Xebec Development Partners, Ltd. v. National Union Fire Ins. Co.* (1993) 12 Cal.App.4th 501, 532-534; *Downey Savings & Loan Assn. v. Ohio Casualty Ins. Co.* (1987) 189 Cal.App.3d 1072, 1089; *Martinez v. Infinity Ins. Co.* (C.D.Cal. 2010) 714 F.Supp.2d 1057, 1063.

Notes: This instruction is essential when an insurer attempts to force the insured to permit a reinspection post-denial. Unlike the insurer, the insured's duties cease after the claim is denied. This instruction is derived from the ISO HO-3 form, Section entitled "Conditions", subsections "2. Duties After Loss" and "13. Suit Against Us" (pp. 8-10 of the policy.

These policy provisions – required by statute – are valid as a matter of law. "When a clause in an insurance policy is authorized by statute, it is deemed consistent with public policy established by the Legislature ... In addition, the statute must be construed to implement the intent of the Legislature and should not be construed strictly against the insurance company (unlike ambiguous or uncertain policy language)." (*Prudential-LMI, supra,* at p.

699; see also *Home Ins. Co., supra,* at p. 1392; *Doheny Park, supra,* at p. 1089 fn. 10; *Blue Shield, supra,* at pp. 735-736 (policy provisions more favorable to the insured are valid).)

The courts have also uniformly upheld the limitations and compliance provision of Insurance Code 2071 for suits on claims, albeit often with due consideration of other legal principles and caselaw, such as the delayed discovery rule, estoppel, and equitable tolling. (See *Kapsimallis, supra,* at pp. 672-673; *Vu, supra,* at pp. 1147-1149; *Marselis, supra,* at p. 125; *Aliberti, supra,* at pp. 142-148; *Prieto, supra*., at pp. 1192-1997)

Similarly, the courts have also upheld the forfeiture of the insured's rights for failing to comply with the duties after loss provision in the policy. (See *Abdelhamid, supra,* at pp. 999-1001; *Brizuela, supra*; *Robinson, supra,* at pp. 587-91; and *Hickman, supra,* at pp. 532-535.) But in each instance, the Court upheld the forfeiture because the insurance company was prejudiced *pre-denial* in their "full, fair and thorough" investigation.

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Appendix C-1

Insurer-Insured Relationship: Characterization and Attributes

ST	Relationship*	(1) Public Service	(2) Purpose of Insurance	(3) Trust & Reliance	(4) Unequal Power	(5) Discretion & Control	(6) Vulnerable Insured	(7) Misaligned Interests	(8) Breach Incentive	(9) Inadequate Damages	(10) Defeated Purpose
AL	S	-	Yes	Yes	Yes	-	Yes	-	-	-	-
AK	S	Yes	Yes	-	Yes	Yes	Yes	-	Yes	Yes	Yes
AZ	Q	-	Yes	-	Yes	-	Yes	-	-	-	Yes
CA	S, N	Yes	Yes	Yes	Yes	-	-	Yes	-	Yes	-
CO	Q [3rd party action]	-	Yes	-	Yes	-	-	-	-	-	-
CT	U	Yes	-	-	Yes	-	Yes	-	-	-	-
HI	S	Yes	Yes	-	Yes	Yes	Yes	-	Yes	Yes	Yes
ID	S	Yes	Yes	Yes	Yes	Yes	-	-	Yes	Yes	Yes
IL	S	Yes	-	-	Yes	Yes	-	-	-	-	-
IN	S, at times F	-	-	-	-	-	-	-	-	-	-
KS	Inapplicable; insurer's breach subject to statutory framework										
MS	S	-	-	-	Yes	Yes	-	-	Yes	-	Yes
MT	S	-	Yes	-	Yes	-	Yes	-	-	Yes	-
NV	S	Yes	Yes	-	Yes	-	-	-	-	-	-
NM	S	-	-	-	Yes	-	-	-	-	-	-
OH	U	Yes	-	-	Yes	-	Yes	-	-	-	-
OK	S	Yes	-	-	Yes	-	Yes	-	Yes	-	-
RI	F [3rd party action]	-	-	-	-	-	-	-	-	-	-
SD	S	Yes	-	-	Yes	-	-	-	-	-	-
TX	S	-	Yes	-	Yes	Yes	Yes	-	Yes	-	-
UT	F [3rd party action]	Yes	-	-	-	-	-	-	-	-	-
VT	F [3rd party action]	-	-	-	-	-	-	-	-	-	-
WA	Q	-	-	-	-	-	-	-	-	-	-
WI	Special-F	-	Yes	-	-	Yes	-	-	-	-	Yes
WY	S	-	-	-	Yes	-	-	-	-	-	-

* S=Special, Q=Quasi-Fiduciary, F=Fiduciary, N=Non-Fiduciary, U=Uncharacterized

Cases:

AL – *Alabama Mun. Ins. v. Munich Reinsurance Am., Inc.,* 526 F. Supp. 3d 1133, 1136–1137 (M.D. Ala. 2021).

AK – *State Farm Fire & Cas. Co. v. Nicholson*, 777 P.2d 1152, 1155–1157 (Alaska 1989).

AZ – *Noble v. National American Life Insurance Co.,* 128 Ariz. 188, 189–190 [624 P.2d 866] (1981); *Rawlings v. Apodaca*, 151 Ariz. 149, 155 [726 P.2d 565] (1986).

CA – *Egan v. Mutual of Omaha Ins. Co.,* 24 Cal.3d 809, 819–820 [620 P.2d 141] (1979); *Foley v. Interactive Data Corp.,* 47 Cal.3d 654, 683–693 [765 P.2d 373] (1988). *See also Vu v. Prudential Property & Casualty Ins. Co.,* 26 Cal.4th 1142, 1150–1151 [33 P.3d 487] (2001) (insurer not a true-fiduciary).

CO – *Goodson v. American Standard Ins. Co.,* 89 P.3d 409, 414 (Colo. 2004).

CT – *Grand Sheet Metal Products Co. v. Protection Mutual Ins. Co.,* 34 Conn. Supp. 46, 51 [375 A.2d 428] (Conn. 1977).

HI – *Best Place, Inc. v. Penn Am. Ins. Co.,* 82 Hawai'i 120, 128–132 [920 P.2d 334] (1996).

ID – *White v. Unigard,* 112 Idaho 94, 99 [730 P.2d 1014] (1986).

IL – *Roberts v. Western-Southern Life Ins. Co*., 568 F. Supp. 536, 554–555 (N.D. Ill. 1983).

IN – *Erie Ins. Co. v. Hickman by Smith,* 622 NE 2d 515, 518 (Ind. 1993).

MS – *Andrew Jackson Life Ins. Co. v. Williams,* 566 So.2d 1172, 1189 (Miss. 1990) (favorably citing *Egan, Rawlings,* and *Arnold* to support punitive damage award).

MT – *Puryer v. HSBC Bank USA,* 2018 MT 124, 391 Mont. 361, 370–371 [419 P.3d 105] (Mont. 2018) (citing *Story v. City of Bozeman,* 242 Mont. 436 [791 P.2d 767] (Mont. 1990)).

NV – *Ainsworth v. Combined Ins. Co.*, 104 Nev. 587, 592, 763 P.2d 673, 676 (1988), cert. denied, 493 U.S. 958, 110 S.Ct. 376, 107 L.Ed.2d 361 (1989).

NM – *Young v. Hartford Cas. Ins. Co.,* 503 F. Supp. 3d 1125, 1182-83 (D. N.M. 2020) (citing *Bourgeous v. Horizon Healthcare Corp.,* 117 N.M. 434 [872 P.2d 852] (1994)).

OH – *Hoskins v. Aetna Life Ins. Co.*, 6 Ohio St.3d 272, 275–277, 6 OBR 337, 339 [452 N.E.2d 1315, 1319] (1983).

OK – *Wathor v. Mutual Assurance Administrators, Inc.,* 2004 OK 2 [87 P.3d 559, 561–562] (2004) (citing *Christian v. American Home Assur. Co.*,1977 OK 141 [577 P.2d 899] (1977)).

RI – *Asermely v. Allstate Ins. Co.,* 728 A.2d 461, 464 (R.I. 1999).

SD – *Trouten v. Heritage Mut. Ins. Co.*, 2001 S.D. 106, ¶ 30 [632 N.W.2d 856, 863–864] (2001).

TX – *Universe Life Ins. Co. v. Giles,* 950 S.W.2d 48, 52-53 (Tex. 1997) (citing *Arnold v. National County Mut. Fire Ins. Co.,* 725 S.W.2d 165 (Tex. 1987)).

UT – *Machan v. UNUM Life Ins. Co. of America,* 116 P.3d 342 (Utah 2005) (recovery of tort-like damages permissible as foreseeable from insurer breach); *Beck v. Farmers Ins. Exchange,* 701 P.2d 795, 799 (Utah 1985) (fiduciary recognition only in 3rd party claims, and 1st party claims not subject to tort treatment).

VT – *Lauzon v. State Farm Mut. Auto. Ins. Co.*, 674 A.2d 1246, 1248 (Vt. 1995); *Myers v. Ambassador Ins. Co., 146 Vt. 552* [508 A.2d 689] (1986).

WA – *Cedell v. Farmers Ins. Co., of Washington,* 176 Wn.2d 686 [295 P.3d 239, 245] (Wash. 2013).

WI – Danner v. Auto-Owners *Insurance,* 245 Wis.2d 49, 67–72 [629 NW 2d 159] (Wis. 2001) (citing *Anderson v. Continental Insurance Co.*, 85 Wis.2d 675 [271 N.W.2d 368] (Wis. 1978)).

WY – *Long v. Great W Life & Annuity Ins. Co.*, 957 P.2d 823, 829 (Wyo. 1998) (citing *McCullough v. Golden Rule Ins. Co.,* 789 P.2d 855 (Wyo. 1990)).