Claims Against the Claims Handlers Under Large Deductible Workers' Compensation Insurance Policies

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Large deductible workers' compensation insurance policies arose in the late 1980s and early 1990s following a market crisis in which employers were unable to obtain required workers' compensation coverage from private insurers. The concept is simple. Employers can greatly reduce the amount of workers' compensation premiums they pay for employees if they agree to assume a large portion of the risk themselves—through a "high deductible" (commonly between $250,000 and $500,000)—after which insurance assumes exposure for amounts above that deductible.[1]

Under this notion, incentives exist for both employers and insurance companies to control costs incurred in managing workers' compensation claims. Because the employer is assuming risk on a dollar-for-dollar basis up to the limit of a high deductible, the employer has an incentive to ensure that workers' compensation claims are handled reasonably. Moreover, the employer has an incentive to keep the claim from exceeding the deductible, because the employer's subsequent risk ratings will normally increase when a claim exceeds the deductible, which will translate into higher premiums in subsequent policy periods. At the same time, once a claim exceeds the deductible, the insurance company has an incentive to handle the claim reasonably, because it is absorbing costs above the deductible.

But the critical feature of large deductible insurance policies is claims handling done for a fee charged to the employer. Because most employers lack personnel or expertise to adjust workers' compensation claims, they are eager to accept the offers of insurance companies to adjust those claims on their behalf. Under the typical arrangement, the insurance company (or its delegatee, a "third party administrator") undertakes the full scope of claims management—investigating the claim, challenging coverage if appropriate, managing medical treatment, reviewing medical bills, negotiating liens, seeking apportionment from third-parties, adjusting reserves, and settling claims.

The insurer advances expenses for such services under security (typically, a letter of credit) that the employer posts in case of default on amounts due. The insurer then bills the employer for services provided, and a tally is kept until the expenses reach the deductible. After the deductible is met, the insurer absorbs all remaining expenses itself (unless the policy arranges for the employer to share some percentage of ongoing expenses). Underwriters at the insurer determine the premiums to be paid, so this arrangement is suitably profitable for the insurer.

But trouble arises when the employer suspects the insurer is not adjusting the claims reasonably. What confidence does the employer have that the insurance company, with its interlocking bureaucracy of contractors and subcontractors and its own scale of profit for claims handling, is adjusting claims reasonably? As far as the employer is thinking, "*It's easy to spend money when it isn't yours*."

Surprisingly little case law exists regarding employers' claims against insurance companies under large deductible insurance policies. The reasons for that are many: the difficulty in proving mismanagement of claims, the ebb and flow of market forces that allow employers and insurance companies to renegotiate policy premiums in subsequent years, an employer's tendency to view losses as "sunk costs," an insurance company's reluctance to pursue collection efforts against an employer beyond a draw of a letter of credit, the existence of mandatory arbitration provisions, and, most importantly, whether the amount at issue is worth the costs of litigation in trying to recover it.

But sometimes the losses at stake compel a judicial resolution. Losses come in at least two ways. First, workers' compensation claims can be expensive to both administer and settle. Multiple claims mean multiple claims management expenses, and if mismanagement has occurred on multiple claims, the employer ends up paying considerable out-of-pocket expenses that it should never have had to pay. For example, claims mismanagement on just twenty claims files that each have a $250,000 deductible can mean losses of up to $5 million. Second, the more claims management expenses an employer incurs, the more its premiums will increase in subsequent policy periods. Workers' compensation premiums are typically set in reference to experience modification rates (called "Ex Mod" rates) assigned to classes of employees. The higher the amount of claim expenses, the higher the Ex Mod rate in subsequent years. Claims mismanagement results in higher premiums because of higher Ex Mod rates. Even a small bump in an Ex Mod rate can result in a significant premium differential, given a sizeable workforce.

In addition, because big workers' compensation claims take years to resolve, amounts wrongly paid over time can result in large interest losses. Finally, the employer can sustain various tangible and consequential losses if the insurer wrongly draws on the letter of credit or other security. When losses like these occur, and the insurance company refuses to acknowledge them, an employer may find it has no choice but to seek recourse through litigation to recover its losses.

A Contract is a Contract

As even the scant case law in this area confirms, general principles of insurance law govern the relationship between the employer and the insurance company accused of claims mismanagement.[2] The relationship is one of contract, and policy terms generally control. What makes claims against an insurance company under a large deductible policy unique is that such policies are a hybrid between first-party and third-party liability insurance.

The policy is a third-party policy to the extent it requires the insurer to defend and indemnify the employer against workers' compensation claims. Workers' compensation policies often contain a clause that provides, "We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance." In cases involving a policy with such a clause, the duty to defend is widely recognized under law, and the insurance company is obligated to (a) investigate claims reasonably and promptly; (b) provide a defense if a potential for liability exists; and (c) attempt to effect timely, reasonable settlements of third-party claims within policy limits.[3]

But the policy is also a first-party policy to the extent it promises to pay benefits due, and such benefits run the gamut of claims administration expenses (such as intake, treatment, billing review, and lien negotiation). Although the insurer advances expenses on behalf of the employer, the employer is ultimately responsible for those expenses. In such a case, the employer expects to receive benefits due under the policy and presumes the insurance company will: (a) have made a thorough and prompt investigation of whether the expenses for the insured's benefits are justified; (b) if the expenses are justified, pay the expenses of those benefits without unreasonable delay; and (c) perform services reasonably.[4]

The insurer's duties are express under the terms of the policy or are implied as a matter of law. The insurer must: (1) complete timely and appropriate investigations of claims; (2) manage medical treatment properly; (3) object to claimants seeking treatment for additional unrelated injuries; (4) pursue apportionment from third parties responsible for claimant injuries; (5) charge reasonable rates for reviewing and adjusting medical bills; (6) reasonably set or adjust loss reserves; and (7) settle claims reasonably. If the insurance company breaches one or more of these duties, the employer has a claim for

breach of express or implied contract. In such a case, the employer also has a claim for breach of the covenant of good faith and fair dealing, because an implied covenant exists in every contract such that "neither party will do anything which will injure the right of the other to receive the benefits of the agreement."[5]

> [T]he essence of the implied covenant of good faith and fair dealing is that the insurer must refrain from doing anything that will injure the right of the insured to receive the benefits of the insurance agreement, the terms and conditions of which define the duties and performance to which the insured is entitled.[6]

What makes an employer's claim against its insurer for breach of contract unique is that the claim is proved by way of negligence—the insurer owes a duty to manage claims reasonably. The insurer breaches that duty when it fails to adjust claims according to the standard in the insurance industry. However, the claim is not for negligence, because "negligence is not among the theories of recovery generally available against insurers."[7] Such claims are tantamount to claims for professional negligence proven through a claim for breach of contract.[8]

Remedies available to an employer against its insurer for breach of contract and breach of the covenant of good faith and fair dealing include all economic losses sustained, such as (1) losses for overpayment of claims (i.e., the difference between the amount the employer actually paid due to claims mismanagement and the amount the employer would have paid if there were no mismanagement); (2) losses for overpayment of premiums (i.e., the difference between the amount of actual Ex Mod rate and the putative amount of Ex Mod rate); (3) loss of interest for claims expenses wrongfully paid; and (4) losses due to any wrongful draw on a letter of credit or other security, including consequential damages resulting from that draw (such as lost business contracts, bank fees, and other interest).[9] In addition, to the extent the employer can show the insurer's conduct was "unreasonable" in any of the above respects, the employer can recover attorneys' fees.[10] In extreme cases, an employer can claim punitive damages.

Another potential claim an employer may assert is for "unfair business practices" under section 17203 of the California Business and Professions Code. Section 17203 provides, "Any person who engages, has engaged, or proposes to engage in unfair competition may be enjoined in any court of competent jurisdiction." Section 17200 of that Code defines "unfair competition" to include "any unlawful, unfair or fraudulent business act or practice." Arguably, an insurance company that wrongfully and unreasonably mismanages workers' compensation claims engages in "unfair competition" under section 17203. Remedies for violations of section 17203 include restitution and injunctive relief.[11] Moreover, section 1021.5 of the California Code of Civil Procedure authorizes an award of attorneys' fees when a party seeks to enforce important rights affecting the public interest. Arguably, a party is acting in the public interest when the party forces a large insurance company to (a) cease charging excessive and unwarranted claims-related expenses to itself and its favored contractors; and (b) cease imposing higher premiums because of unwarranted increases in an employer's Ex Mod rate.[12]

Not surprisingly, proving that an insurance company's claims management agent mishandled claims involves competing experts who will opine on whether and how the agent mishandled claims and the extent to which such mishandling damaged the employer. An employer that suspects that claims mismanagement has occurred should contact an outside specialist and have that suspicion confirmed before launching into costly litigation.

Limits of Statutes of Limitations

Large deductible insurance policies present a host of untested and thorny issues related to the statute of limitations. Generally, an employer has four years in which to bring an action for breach of contract under California law.[13] Less clear is the statute applicable to actions for breach of the covenant of good faith and fair dealing, because that action is based on a tort, not a contract. Courts have indicated that a two-year statute applies to a claim for a breach of the covenant of good faith and fair dealing.[14] The primary difference between the two types of claim is in the type of damages available to the employer, because, unlike a claim for breach of contract, a claim for breach of the covenant of good faith and fair dealing can entitle the plaintiff to damages for emotional distress, attorneys' fees, and punitive damages.

Under either claim, issues abound. When does the statute of limitations begin to run? A breach of contract accrues when the contract is breached.[15] Thus, in the case of a first-party coverage contract, the claim accrues upon the insurer's unconditional denial of the insured's claim.[16] But this event is unlikely to occur in the context of back-and-forth billing activity and communications between the employer and the insurer regarding a claim. A claim for claims mismanagement is much larger than a claim for improper billing entries. Such a claim addresses the entire handling of the claim, again, akin to a claim for negligence by a professional. Further, such a claim may involve not only a breach of the duty to defend, but incursion of expenses not otherwise owed, or of services rendered improperly.

In claims for professional negligence, an action typically accrues when appreciable harm occurs and, in contract actions, that means when the contract is breached.[17] However, under the "discovery rule," the accrual of a cause of action is postponed "until the plaintiff discovers, or has reason to discover, the cause of action."[18] An employer that suspects claims mismanagement should investigate promptly and determine the facts or risk having the statute run from when the employer first started raising objections to the insurer's conduct.[19] In legal malpractice cases, the statute will be delayed until after the attorney ceases to represent the client in the same case.[20] The "discovery rule" seems plausibly applicable here, because the insurer has effectively undertaken continuous representation of the employer and the employer cannot reasonably be expected to sue its insurance company while that representation remains pending.

Unfortunately, the "discovery rule" fails to provide guidance on whether the statute of limitation runs as to each claim the insurer manages or whether it is tolled until the last act under any claim under the policy—which may well be many years after other individual claims are resolved. Courts might apply the rule applicable to "divisible" contracts: Where a contract is divisible, breaches of its severable parts will give rise to separate causes of action, and the statute begins to run at the time of each breach.[21] In that case, the insurer's negligent claims handling of one claims file may have its own separate (four-year or two-year) statute of limitations that would not toll while the insurer continues to manage other claims files for the employer.

On the other hand, if the insurance company is making the same kinds of errors across multiple claims files, the employer may avail itself of the "continuing violation doctrine," which would allow the employer to recover not only for the actions that took place during the statute of limitations period, but also for the insurer's misconduct that occurred outside the period and across multiple claims files, provided such misconduct is "sufficiently linked" to the insurer's conduct during the limitations period. Because "[e]ach new breach of an obligation provides all the elements of a claim—wrongdoing, harm, and causation," multiple acts of mismanagement on a claims file (or on other claims files) may revive otherwise dead claims.[23]

Finally, these issues are complicated by the different types of claims an employer might assert against the insurer. The statute applicable to an employer's claim that the insurer failed to settle a claim reasonably may be different than the employer's claim that the insurer overcharged the employer for claim expenses. The former is akin to a breach of the duty to defend, while the latter is akin to a breach of the duty to pay benefits due on a policy.

Defenses to Anticipate

Not surprisingly, an insurance company may raise several defenses in response to charges of claims mismanagement. The "account stated" defense argues that the employer is barred from contesting amounts owed because the employer already agreed to the charges on "accounts" established between them. Related defenses include defenses of "voluntary payment" (on grounds the employer already paid the charges) and "waiver" (on grounds the employer waived its right to challenge the charges). Nevertheless, all of these defenses are predicated on the notion that the employer knew of claims mismanagement and failed to act on it—a notion that can be disputed if the employer lacked knowledge of facts that would have enabled it to know that claims mishandling was occurring.

Other defenses include "unclean hands" and "equitable estoppel," in which cases the insurer attacks the employer and accuses the employer of "bad conduct," such as in not reporting workers' compensation claims timely, settling employee claims under the insurer's radar,

and withholding information about workplace safety. Such are the usual counter-attacks that occur when one party accuses another party of negligence. They are fact-based issues to be resolved at trial and before a jury that is unlikely to sympathize with the insurer.

Conclusion

An employer may be justified in thinking that an insurance company has found it easier to spend the employer's money when managing workers' compensation claims under a large deductible insurance company. Still, the employer must act on that thinking quickly and cautiously. Further, if the employer's losses are substantial, it must quantify them and pursue them quickly.

Endnotes

1 *See* Workers' Compensation Large Deductible Study, Nat'l Ass'n of Ins. Comm'rs/ Int'l Ass'n of Indus. Accident Bds. and Comm'ns Joint Working Grp. (Mar. 2006), http://www.naic.org/store/free/WCD-OP.pdf.

2 Reported cases on an insurer's liability for claims mismanagement in California are few and old and do not concern large deductible insurance policies. *See, e.g.,* MacGregor Yacht Corp. v. State Compensation Ins. Fund, 63 Cal. App. 4th 448 (1998) (workers' compensation insurer breached duties in failing to conduct follow-up investigations of claims and in denying claims with the statutory sixty-day period); Notrica v. State Compensation Ins. Fund, 70 Cal. App. 4th 911 (1999) (insurer was properly liable for an "unfair business practice" in over-reserving for workers' compensation claims which allowed it to charge higher premiums to the employer); Lance Camper Mfg. Corp. v. Republic Indem. Co. of Am., 90 Cal. App. 4th 1151 (2001) (affirming jury award of $6.3 million in compensatory and punitive damages claim of employer against workers' compensation insurer for improper claims reserves).

3 Comunale v. Traders & Gen. Ins. Co., 50 Cal. 2d 654, 658 (1958). *See also* Merritt v. Reserve Ins. Co., 34 Cal. App. 3d 858, 882 (1973) (In undertaking its duty to defend, an insurance company assumes the duty "to employ competent counsel to represent the assured and to provide counsel with adequate funds to conduct the defense of the suit"); Amato v. Mercury Cas. Co., 53 Cal. App. 4th 828, 831 (1997) ("Breach of an insurer's duty to defend violates a contractual obligation and, where unreasonable, also violates the covenant of good faith and fair dealing, for which tort remedies are appropriate.").

4 Silberg v. Cal. Life Ins. Co., 11 Cal. 3d 452, 461-62 (1974); Cal. Shoppers, Inc. v. Royal Globe Ins. Co., 175 Cal. App. 3d 1, 54-55 (1985).

5 *Comunale*, 50 Cal. 2d at 658-59, 663. *See also MacGregor Yacht Corp.*, 63 Cal. App. 4th at 477-78 (citing Tricor Cal., Inc. v. State Compensation Ins. Fund, 30 Cal. App. 4th 230, 240 (1994)) ("Because the powers so confided in SCIF's discretion will impact the degree of plaintiff's primary burden under the policy, it appears logical that the covenant of good faith and fair dealing indeed requires SCIF to conduct its claims resolution and reserve allocation processes with good faith regard for plaintiff's interests.").

6 Brandwein v. Butler, 218 Cal. App. 4th 1485, 1514-15 (2013) (brackets, emphasis, and internal quotes omitted).

7 Tento Intern., Inc. v. State Farm Fire & Cas. Co., 222 F.3d 660, 664 (9th Cir. 2000) (quoting Sanchez v. Lindsey Morden Claims Svs., Inc., 72 Cal. App. 4th 249, 254 (1999)). *See also* Benavides v. State Farm General Ins. Co., 136 Cal. App. 4th 1241, 1250 (2006) ("[A]bsent coverage, there is no tort liability for improperly investigating a first-party insurance claim whether the insurer's conduct is characterized as an implied covenant breach or negligence.").

8 *See* Everett Assoc., Inc. v. Transcontinental Ins. Co., 159 F. Supp. 2d 1196, 1203-04 (N.D. Cal. 2001) (while "California courts have not treated [an insurer's] negligent investigation as a separate cause of action in negligence," the better approach "is to treat negligent investigation as a predicate for breach of the duty to defend and, if wrongful, a breach of the implied covenant.").

9 *Silberg*, 11 Cal. 3d at 462; Archdale v. Am. Int'l Specialty Lines Ins. Co., 154 Cal. App. 4th, 449, 467 (2007).

10 Brandt v. Sup. Ct., 37 Cal. 3d 813 (1985).

11 Zhang v. Sup. Ct., 57 Cal. 4th 364 (2013).

12 Whether a claim for unjust enrichment may exist is doubtful. While traditional notions would indicate that an insurance company has been "unjustly enriched" by keeping and spending the employer's money unreasonably, courts recently have indicated that the proper remedy is a "quasi-contract claim" seeking restitution, not a stand-alone cause of action for unjust enrichment. Astiana v. Hain Celestial Grp., Inc., 783 F.3d 753 (9th Cir. 2015).

13 CAL. CIV. PROC. CODE § 337.

14 § 339(1); Richardson v. Allstate Ins. Co., 117 Cal. App. 3d 8, 13 (1981); Smyth v. USAA Prop. & Cas. Ins. Co., 5 Cal. App. 4th 1470, 1477 (1992).

15 Romano v. Rockwell Int'l, Inc.,14 Cal. 4th 479, 488 (1996).

16 State Farm Fire & Cas. Co. v. Sup. Ct., 210 Cal. App. 3d 604, 609 (1989).

17 *Romano*, 14 Cal. 4th at 488.

18 Fox v. Ethicon Endo-Surgery, Inc., 35 Cal. 4th 797, 807 (2005). *See also* CAL. CIV. PROC. CODE § 340.6, which provides that an action for legal malpractice must be commenced "after the plaintiff discovers, or through the use of reasonable diligence should have discovered, the facts constituting the wrongful act or omission."

19 Jolly v. Eli Lilly & Co., 44 Cal. 3d 1103, 1110-11 (1988).

20 *See* CAL. CIV. PROC. CODE § 340.6(a)(2) (Generally, time for commencement of legal action against attorney for malpractice shall not exceed four years, except that period shall be tolled during the time "the attorney continues to represent the plaintiff regarding the specific subject matter in which the alleged wrongful act or omission occurred"); *see also* Beal Bank, SSB v. Arter & Hadden, LLP, 42 Cal. 4th 503, 511 (2007) (applying section 340.6(a)(2) to toll claims as to the attorney *and the attorney's former law firm and its attorneys* when the attorney continues to represent the client in the same specific subject matter).

21 Armstrong Petroleum Corp. v. Tri-Valley Oil & Gas Co., 116 Cal. App. 4th 1375, 1388-89 (2004).

22 Richards v. CH2M Hill, Inc., 26 Cal. 4th 798, 812 (2001); Aryeh v. Canon Bus. Sols., Inc., 55 Cal. 4th 1185, 1198 (2013).

23 *Aryeh,* 55 Cal. 4th at 1199.