

## Confessions of A Former Insurance Defense Lawyer

I began work as an attorney for insurance companies and self-insured employers in the 1980s. Being a lawyer for insurance companies and employers brought me a feeling of accomplishment, offering me a role where I contributed to the prevention of insurance fraud. The career of the claims adjuster seemed to be a solid one then also. Adjusters and managers worked the same companies for years until retirement. The claims sent out to attorneys had legitimate legal or factual disputes. I felt that my clients and I had mutual respect for each other. When I gave legal advice, applying current law to the facts of their cases, they accepted it, even if they had lost objectivity on a particular case. They understood that a pyrrhic victory was something that adversely affected their company and public policy. Most importantly, we worked as a team and I greatly enjoyed that aspect of the work.

### Disturbing Trends Start in The Early Nineties

Sometime around the early 1990s, the industry began to subtly, but radically change. First, there was a constant turnover in claims adjusters. There were fewer "career" adjusters and more clerks, generally young women, promoted within companies who were apparently set upon a path of training of which the emphasis was the denial of claims. Then another pattern sprung up. I found that if a claims examiner did not agree with defense counsel's legal advice, he or she would either try to get the lawyer to agree with them or pull the case, sending it to a lawyer who would agree to do what they wanted. Often, in attempting to formulate agreement, they would quote law as though the legal principles occurred in vacuum, rather than within the context of the facts of an individual case. Other times, they would purport to having obtained a "second opinion" from another lawyer so that they could argue about the case. We ceased to become a team, and instead became quasi-adversaries. Frequently, defense attorneys would find themselves unprofessionally maligned when a case was pulled and given to another attorney. It became common for claims adjusters to allege that they hadn't received reports and documents, and I began to routinely fax documents so that my office had proof of receipt.

This was also the era when I began to hear phrases like "Let's starve them out!" or "This should drive them crazy!" A colleague of mine who follows bad faith in insurance has labeled this practice "gaslighting". This approach clearly incorporates the belief that the party with deep pockets, namely the insurance company or employer, can hold out longer than the injured claimant or plaintiff.

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These new adjusters too the cases deeply personally. When a claimant would retain an attorney to represent them, many of these adjusters were personally insulted. I also started to hear statements from adjusters that implied blatant contempt of our laws. For example, I repeatedly heard workers' compensation claims adjusters saying, "If I don't pay, so what? It's only a ten percent penalty. Big Deal!" State-imposed penalties for delaying payments of claims meant nothing to the insurers or these new claims adjusters. (A parallel in another area insurance is the summary denial of claims, which fall under federal ERISA guidelines and therefore are not subject to the safeguards of insurance bad faith.)

### The Cost to the Public of Ignoring Legitimate Claims

The approach of denying claims, trying the case in court and appealing when the insurer lost, even though they knew they would both lose the case and the appeal, developed purportedly to "send a message" to workers. The cost? The worker's benefits could be held up many months on appeal. The claimant's attorney, whose income was limited by statute, also had to wait to be paid upon ultimate resolution of the case. This way, adjusters stated, other workers would think twice before they filed a claim!

As a tax payer myself, I became increasingly disturbed with the way claims were handled by public employers, who were often self-insured and handled their own claims within their companies or had third party administrators who adjusted their claims

for them. In the early 1990s, I represented a self-insured employer whose claims were handled by a third party administrator (TPA). I had worked for this particular TPA for years. Their new manager, who was unnecessarily hard-nosed, was training her adjusters to be likewise. One day, I was sent to a case, which involved several claims filed by a law enforcement officer who worked for a school district in an impoverished and dangerous urban area. After reviewing the facts and taking the claimant officer's deposition, I recommended my client accept and settle the main claim, but dispute several of the appended questionable claims. My recommendation was backed by strong reasoning. The claimant's testimony was solid and impressive. There were no witnesses to rebut his testimony. On the contrary, the chief of law enforcement for the district agreed with the claimant's perception of the facts. The claimant's attorney offered to settle the main claim for under \$30,000. The demand was fair. The claims manager, however, was livid when I presented them the settlement demand with a recommendation that they take it. Her response? "Fight it all the way. That's why we hired you."

Further expensive discovery merely confirmed what I already knew: we simply had no witnesses to support our unreasonable position. This would have the effect of increasing any future

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settlement amount. Nonetheless, instead of trying to settle, my client seized on the fact that the claimant was a recovering alcoholic in an attempt to impugn the claimant's character. This approach, I knew, was certain to backfire with a judge. The morning of the trial, the injured officer's lawyer demanded \$32,000 — still an extremely reasonable demand for settlement. The judge advised me that he had reviewed the file and asked me why we weren't settling. At the judge's avid behest, I called the claims manager. Angry at my call, she stated that if the judge has recommended that we settle, and then he should excuse himself from the case for "bias" against us. Sighing inwardly, I carefully explained that part of the judge's job is to try to get the parties to settle when appropriate. The concept, however, was lost on her.

Two years and four claims adjusters later, my client was still fighting every single issue tooth and nail. The claimant's attorney was quite patient because he and I had a long-standing mutually respectful working relationship. Not unpredictably, though, the final hearing in the case regarded a penalty against

my client's continuing delay of legitimately due benefits. In preparation for this hearing, I instructed the claims adjuster to bring evidence of timely payment. She assured me she would. On the day of the hearing, the adjuster arrived with a piece of paper with handwritten "dates paid". She stated that her supervisor, the angry manager, had told her that she didn't need to bring anything; she could just "testify" to the dates paid. Since the claimant was there with actual evidence, namely the dated check stubs, I tersely advise that we settle — immediately. We settled that day, but from that day forward, my office was no longer on this company's approved list and they eventually pulled all of their files from my office.

**The clincher?** Ultimately, this case cost the public over \$250,000, excluding my legal fees — almost ten times more than if we had settled it at the outset.

I had a similar experience with another public entity, in which I negotiated a fair settlement on a case with massive exposure, both financially and politically. The claimant in this case was a credible witness with impressive credentials and a legitimate claim. She would be able to give irrefutable testimony because the claimant's own boss, the principal of a public high school, stated that the claimant's perception of the facts and events were indeed correct. Having completed my discovery and recognizing the huge financial exposure to my client because the claimant was completely disabled, I continued to recommend settlement. The day before the settlement conference, the human resources manager for the school district pulled the file and sent it to another law office, striking our office from their list of approved attorneys. Approximately a year later, I happened to see the attorney to whom the file was transferred. I asked him what had finally happened to the case. Shaking his head he said, "What happened is just what you said would happen, and you'd already done the work. The judge gave the claimant a 100 percent disability rating. I don't know how the district thought they would get a different result."

## Attorneys and Ethics

As the business changed, my colleagues and I began to have closed door discussions about the ethical ramifications of following the directives of our clients. A serious dilemma was how to handle a client's outright rejection of legal advice, which would result in significant financial loss to the client. Any continuing education class on legal malpractice will teach an attorney to write a confirming letter to the client to document that the

client has chosen not to follow it. To the insurance defense attorney, this is a confounding Catch-22. If such a letter is written, the result can be loss of business. However, without this documentation, we found that claims adjusters would willingly point the finger at the defense attorney for disastrous results, denying that the advice was given to them.

Along with the increasing ignoring of legal advice, companies began to institute stringent fee guidelines and other “creative” arrangements to eliminate or reduce legal costs. In the mid-1990s, many of my long-standing clients began to demand flat fees for handling of cases or sought to impose arbitrary fee guidelines. The result of this policy was that a client could very well insist that the attorney take the case to trial, but would “allow” only two hours for trial preparation. Since legal ethics, as well as maintaining our malpractice coverage, mandated that we prepare properly and thoroughly, the potential windfall savings for the companies were obvious. We could be exposed to suit if we didn’t prepare properly. The other disquieting trend was the encouragement of bidding wars between attorneys, with the work going to the lowest bidder. This is a true conflict of interest to the detriment of the insured.

Basically, we were becoming dupes. Everyone knew it, but no one could talk about it. The rhetoric became especially heated about insurance fraud perpetuated by the filing of false claims. One company, which no longer exists, went so far as to take out full-page newspaper advertisements to show how they were “tough” on workers’ compensation fraud. It is of particular interest to note that one of the largest fraud cases in California was actually against an insurance company for the alteration and destruction of documents — it was the same company that took out the ad.

### Life Threatening Illness Brings Me Home to Reality

In 1995, I was diagnosed with cancer. After a year of treatment and recovery time, I returned to work part-time. My own experience with a potentially terminal illness brought me face to face with the torment that persons who are injured or ill and uncompensated are faced with when they cannot collect the benefits they paid for or are entitled to. After my own illness, I found it difficult to represent a client who would fight an injured worker for a disputed \$30.00 medical bill. I would point out that the cost of my legal fees to fight would be higher than the disputed amount. However, all too often the client insisted on going to court and after losing, appealing the matter perhaps, many times in an effort to discourage injured or ill parties from

Pursuing claims. If the case was lost, the attorney would be blamed. If the case was won, “anyone” could have won it.

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When I retired some years later due to more surgery and serious disability I found myself wanting to make amends for being a dupe. I found myself facing the same nightmare so many of the claimant I met must have lived. Fortunately for me, the company I was dealing with, after “investigating” my claim for over a year, which included a “defense IME”, agreed to provide the benefits I was legitimately due. I acknowledge, though, even though I was seriously ill, I still had a leg up on a “normal” claimant because of my unique experience.

### Changing Sides, Changing Views

After leaving the field, I made contact with other disabled people who have had similar experiences with insurers and attorney who, like me, worked for companies and third party administrators. There are many people with legitimate claims who are victimized by insurers in many areas of insurance coverage who enjoy collecting premiums and making great profit, but don’t want to pay the benefits. Many lawyers’ livelihood depend on doing what the insurance companies and administrators tell them to do. These lawyers, like me, have children and families who depend on them. Walking away from a paying client is not an easy decision. Many lawyers simply may not fully realize the consequences of what they are doing, but they do know that a lawyer in their business can be dropped for practicing ethically and fairly. As far as loss of health is concerned, most people just think it could never happen to them.

The more perplexing question is why adjusters working for public entities persist in unreasonable approaches to claims handling at the taxpayers’ expense. I believe that it reflects a growing tendency of private insurers not to want to pay legitimate claims, which spills over perforce into claims handling in the public arena. Some attorneys have recognized this and realize that it is a serious personal, philosophical and moral dilemma. They have left the field and or crossed over to the other side and now represent claimants. I believe that companies have a right to be represented, but they do not have a right to require the representatives collude in questionable claims practices.