

The Insurance Relationship as Relational Contract and the “Fairly Debatable” Rule for First-Party Bad Faith

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Major law schools are defined by the presence of major scholars, and from time to time, scholars in a field become concentrated, creating an intellectual movement identified with a particular place and time, such as legal realism at Yale and Columbia in the 1920s and 1930s and law and economics at Chicago from the 1970s on. Although not at a single institution, in the 1980s and 1990s, the two ends of a stretch along Interstate 90 marked such a time and place. At Northwestern University School of Law, Ian Macneil built the magnificent intellectual edifice of relational contract theory, and Richard Speidel, who once described himself as a Midwesterner who naturally had “a mainstream orientation,”¹

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1. Richard E. Speidel, *Edward J. Murphy: The Man and the Casebook*, 71 NOTRE DAME L. REV. 571, 572 (1996).

glided easily between grand relational theory and practical application.² Macneil and Speidel produced a series of works on relational contract in theory and practice and collaborated with Thomas Stipanowich on what may be the most underappreciated treatise in the history of American legal scholarship.³ At the University of Wisconsin Law School at Madison, Stewart Macaulay, John Kidwell, and William Whitford produced pathbreaking works of empirical contracts scholarship that added further grounding to the relational approach and a coursebook—*casebook* is not the right name—that uniquely focused, as its title stated, on *Contracts: Law in Action*.⁴

Just as legal realism fell out of vogue and ultimately became inculcated in legal culture as a set of insights so watered down from their original strength as to seem banal, so too is relational contract theory no longer the talk of the town among contracts scholars. I use the occasion of this symposium dedicated to the memory of Dick Speidel to bring renewed attention to relational contract theory, to suggest a dimension of it that has been understated in the literature, and to illustrate its application to a particular doctrinal problem in insurance law. That problem is the standard to be applied to evaluate the behavior of insurance companies in first-party bad faith cases—cases in which a policyholder alleges that the insurance company, its contracting partner, has violated the duty of good faith and fair dealing that is present in every contract and intensified in insurance contracts.

I. RELATIONAL CONTRACT THEORY

A. A Summary of Relational Contract Theory

Relational contract theory contains an anthropological account of human interaction. It begins with the “primal roots of contract” and yields a theory that is remarkably broad in scope.⁵ The core is exchange, which includes any social interaction in which reciprocity is a major element. Contract is narrower but not much narrower, including any

2. The addition in 1987 of a young Ian Ayres added further luster to Northwestern’s contract faculty.

3. 1–5 IAN R. MACNEIL, RICHARD E. SPEIDEL & THOMAS J. STIPANOWICH, *FEDERAL ARBITRATION LAW: AGREEMENTS, AWARDS, AND REMEDIES UNDER THE FEDERAL ARBITRATION ACT* (1999).

4. 1 STEWART MACAULAY, JOHN KIDWELL & WILLIAM WHITFORD, *CONTRACTS: LAW IN ACTION*, at iii (2d ed. LexisNexis 2003) (1995).

5. Macneil identifies the primal roots of contract as society, specialization of labor and exchange, choice, and awareness of future. IAN R. MACNEIL, *THE NEW SOCIAL CONTRACT: AN INQUIRY INTO MODERN CONTRACTUAL RELATIONS* 1–4 (1980). See also Jay M. Feinman, *Relational Contract Theory in Context*, 94 NW. U. L. REV. 737, 741 (2000).

interaction “in which economic exchange is a significant factor.”⁶ The anthropology reveals that contract occurs along a spectrum. At one end is the discrete exchange, the isolated, narrowly focused, wealth-maximizing exchange that is the paradigm of neoclassical economics and of classical contract law. At the other end is the relational contract, extending over time, involving a range of performance elements and personal relationships, and ill-suited to complete planning at the moment of its formation. In between are transactions having discrete and relational characteristics and taking an infinite variety of forms. Although the discrete transaction was long the model for understanding the social institution known as the market and the body of contract law that enabled and regulated it, in fact, exchange relations are far more common than discrete exchanges. Indeed, the discrete exchange is little more than an intellectual construct because even the most discrete exchange is situated within a framework of relations that help define, support, and bound it.⁷

This descriptive component of relational contract theory leads directly into its normative component. Exchange as a social process gives rise to norms, “[A] case of an ‘is’ creating an ‘ought.’”⁸ Macneil identified ten common contract norms that are immanent in the institution of exchange itself; these include such norms as role integrity, reciprocity, the implementation of planning, and propriety of means.⁹ Some of these norms are intensified by discrete and relational exchanges, respectively. For example, the narrowly focused and well-defined nature of discrete exchanges causes the norms of implementation of planning and effectuation of consent to be given greater emphasis.¹⁰ The breadth and openness of relational exchanges, on the other hand, give greater importance to maintaining the integrity of one’s role within the relation and to harmonizing the relation with the surrounding social matrix.¹¹

6. IAN R. MACNEIL & PAUL J. GUEDEL, *CONTRACTS: EXCHANGE TRANSACTIONS AND RELATIONS*, at v (3d ed. 2001).

7. See David Campbell, *The Relational Constitution of the Discrete Contract*, in *CONTRACT AND ECONOMIC ORGANISATION* 40 (David Campbell & Peter Vincent-Jones eds., 1996).

8. Ian R. Macneil, *Relational Contract Theory as Sociology: A Reply to Professors Lindenberg and de Vos*, 143 J. INSTITUTIONAL & THEORETICAL ECON. 272, 274 (1987).

9. MACNEIL, *supra* note 5, at 36–59.

10. *Id.* at 59–64.

11. *Id.* at 64–70; Ian R. Macneil, *Values in Contract: Internal and External*, 78 NW. U. L. REV. 340, 364–66 (1983).

The contract norms are not expressed in the parties' agreement but are a source of obligation nonetheless. Indeed, for Macneil, these immanent norms yield "more precise, intellectually coherent principles which are nevertheless sufficiently open-textured for effective use in the law of modern contractual relations."¹²

Although the norms are abstract and general, their use in the law is not. A necessary step in the translation of relational principles into legal principles is to contextualize them. This contextualization both places particular contracts or kinds of contracts along the relational-discrete continuum and focuses on functional categories, such as long-term relationships involving sophisticated commercial parties and insurance contracts involving consumers, the subject matter of this Article. The contract norms are also supplemented by norms that are external to the relation, including norms derived from the setting in which the relation is situated, such as "reasonable commercial standards of fair dealing"¹³ in the trade and general social values, such as controls on the abuse of power.

One source of relational contract theory's power is that it is both general and contextual. It treats exchange at the most general level and it contextualizes to examine specific types of relations. Within that contextualization, one might identify emphasis on two strains of contracts at the relational end of the continuum. One strain focuses on the long-term contract between sophisticated commercial parties of relative equality. This strain emphasizes the limited nature of the initial planning of the relation and the need for ongoing cooperation and accommodation as the relation extends through time. The other strain focuses on relations that are more often characterized by dependence and inequality, of which employment and family relations are prominent examples.

B. The Insurance Relation as Relational Contract

The relationship between an insurance company and its consumer policyholder is perhaps the best example of a relational contract of dependence and inequality.¹⁴ The insurance contract is a relational contract par excellence. The relation created by the contract extends over time; although a typical policy term is a year, the rate of renewal is very high, often in the order of ninety percent, so a typical relation

12. Ian R. Macneil, *Reflections on Relational Contract*, 141 J. INSTITUTIONAL & THEORETICAL ECON. 541, 545 (1985).

13. U.C.C. § 2-103(1)(j) (2008).

14. Insurance policies issued to sophisticated commercial entities bear some but not all of the same characteristics as policies issued to consumers. The discussion in this Article addresses only the latter type of policy.

extends over years or even decades. The insurance contract is distinctive because, as a contract that transfers risk, performance may never be required if the risk insured against never comes to pass. If the risk does occur, however, cooperation and performance in ways not specified in the contract are required, particularly on the part of the company; the company's duty of prompt payment and performance in good faith are seldom defined in the policy and are only fully realized in the surrounding norms of practice and law. The relation is also situated in a context of social relationships; the single insurance contract is an instance of a system of insurance on which policyholders, dependents, tort victims, and society at large depend to provide security in the event of harm.

Therefore, the insurance contract is clearly a relational contract. As with any other class of relational contracts encompassing a large number of specific examples, it can be described in a number of ways. As relevant to the issue of the first-party bad faith standard, a few different elements of the insurance relationship bear emphasis. The first is about the insurance policy, the formal legal contract that creates the relationship. The second is about the nature of performances under the policy. The third is about the representation of the relationship by the company and the understanding by the policyholder created by that representation.

The insurance policy is a classic contract of adhesion. It is a standard form contract drafted by the dominant party, the insurance company, and adhered to by the subordinate party, the policyholder;¹⁵ the dominant party enters into many such transactions and the insured enters into few. The document typically is not read by the insured and, in significant part, is not likely to be understood if it is read; the insurance policy is an extreme example of the "agreement now, terms later" form contract because the entire policy is never presented at the time the insured first purchases it. The terms are not subject to negotiation; the insured may be offered varying policy limits, riders, and amendments, but those are also adhesion alternatives that do not dramatically expand the range of choices available.

The insurance policy is a complex document. Even though personal lines insurance policies are now typically drafted in plain language, plain does not equate with short or simple. The policy most commonly

15. Insurance policies are often promulgated by the Insurance Services Office (ISO)—a national insurance industry trade group—and approved by state regulators. But for all practical purposes, the ISO is the voice of the insurance companies and state regulation of policy terms is seldom meaningful.

purchased by homeowners, the HO-3 policy produced by the ISO, contains: three pages of declarations; two pages of general definitions, not counting definitions stated elsewhere in the policy; six pages describing what property is covered; three pages stating what risks are covered; two pages describing what risks are excluded from coverage, not counting exclusions stated elsewhere in the policy; three pages of conditions on the property coverage; and seven pages describing the liability coverage, including more statements of risk, exclusions, and conditions. And that is only the basic policy; attachments might include limited earthquake coverage, workers compensation for residence employees, oil tank coverage, and other special provisions.¹⁶

From the company's perspective, the policy plans in detail the terms of the relationship, specifying the risks covered and excluded and the duties of the company and the insured in the event of loss. The policy, in the jargon of relational contract theory, "presentiates" the relationship at the moment of formation by projecting all elements of performance and risk from the future into the present and at that moment defining the performance and risk terms that govern the relationship.¹⁷ From the insured's perspective, the policy is at best a modest exercise in planning, specifying a few important items such as policy limits. This conflict of perceptions suggests that the company views the policy as having more discrete elements because the norms of implementation of planning and effectuation of consent are intensified. The insured is likely to have a different perspective. The details of the insurance policy become important to the insured only at the point of loss. At that point, because of the limitations and exclusions from coverage of which the insured was not previously aware, the policy becomes a device by which the company is able to avoid responsibility.

This conflict is exacerbated because, unlike many relational contracts, in which both parties perform over an extended period of time, performance under an insurance policy is always sequential. The insured's essential performance is to pay the premium, which it does at the time of formation. The company's essential performance is to relieve the insured of the burden of a loss, a performance that is only required later, if at all. This creates for the company the ability to act opportunistically. When a loss occurs, it is in the company's interest not to pay a claim or to pay as little as possible; there is a zero-sum game in play by which every dollar the

16. A copy of the policy is available on the Insurance Information Institute website. Ins. Servs. Office, Inc., Homeowners 3—Special Form, http://server.iii.org/yy_obj_data/binary/748905_1_0/HO3_sample.pdf (last visited Aug. 9, 2009).

17. Ian R. Macneil, Commentary, *Restatement (Second) of Contracts and Presentiation*, 60 VA. L. REV. 589, 589 (1974).

company does not pay the insured becomes a dollar of profit for the company. At the time of loss, the insured has few means of compelling the company's performance. Unlike many other contracts, because the performances are sequential, the insured cannot withhold its own performance to give the company an incentive to pay because that performance, the payment of the premium, has already occurred. Also, unlike many other contracts, once the loss has occurred, the insured cannot procure a substitute performance through another contract; a buyer whose seller breaches the duty to deliver contracted goods can measure its damages by the difference between the contract price and the market price or the cover price, but the insured cannot purchase alternative insurance against a risk that has already come to pass. The policy terms and the surrounding law that measure the company's performance, including the law of bad faith, are vague and therefore difficult to enforce, especially compared to the terms measuring the insured's performance—the insured either does or does not pay the premium on time, but whether the company has failed to pay in good faith is much harder to determine.

The conflict between the company and the policyholder arises in large part because of the representation of the relationship by the company and the understanding by the policyholder created by that representation. The typical insured understands the insurance relationship to be one in which the company promises security and protection, rather than a detailed and obscure set of specifications and exclusions of coverage. This understanding is fostered by the presentation of the relationship by insurance companies themselves through extensive advertising. Many of the iconic slogans of American marketing portray insurance as a place of security and refuge from the dangers of the world: "Like a good neighbor, State Farm is there" and "You're in good hands with Allstate." More recently, Liberty Mutual's slogan: "Responsibility. What's your policy?"

II. FIRST-PARTY BAD FAITH AND THE FAIRLY DEBATABLE RULE

Speidel commented about the prospect that relational contract theory has to inform doctrinal questions:

The combination of a broader, more complex descriptive theory with the potential for the relationship itself to generate internal norms that become part of the obligations of the parties both distinguishes relational theory from modern contract law and

provides a challenge to courts which are petitioned to resolve relational contract disputes.¹⁸

This description of essential elements of the insurance contract as relational contract provides a basis for examining the doctrinal focus of this Article, the standard applied in first-party bad faith cases.¹⁹

Bad faith can arise in two contexts in insurance cases. In third-party cases involving liability insurance, the company acts in bad faith when it breaches its duty to defend or settle litigation against its policyholder. In a typical case, the company rejects an offer to settle the case against its insured within policy limits, exposing the insured to a judgment in excess of those limits. In first-party cases, the company acts in bad faith when it fails to properly pay a claim for coverage by the policyholder.

The law of bad faith aims to fully compensate the policyholder for its losses when the insurance company in bad faith fails to keep its promise to indemnify and, in third-party cases, to defend. Simply awarding the policyholder the amount it was due under the policy would not compensate for the delay and expense of obtaining the payment, such as attorneys' fees and other costs and, in appropriate cases, emotional distress. In third-party cases, the compensation includes the amount of the excess judgment for which the policyholder is liable, an excess amount that resulted from the company's bad faith failure to settle. Bad faith law also aims to check the insurance company's temptation to behave opportunistically; by delaying or denying payment to the policyholder, the company increases its own profits at the expense of its policyholder.

In third-party cases involving liability insurance, nearly every jurisdiction allows an action either in tort or contract or under a fair claims practices statute by a policyholder against its insurer for breach of the duty of good faith and fair dealing inherent in every contract. In a typical case, the insurer breaches its obligation to give adequate consideration to the insured's interest by failing to exercise good faith in settling a case by a tort victim against the policyholder, exposing the policyholder to the possibility of an excess judgment.

A much smaller number—about half of the jurisdictions—permit an action by the policyholder against a first-party insurer for breach of the covenant of good faith and fair dealing.²⁰ Among these jurisdictions,

18. Richard E. Speidel, *The Characteristics and Challenges of Relational Contracts*, 94 Nw. U. L. REV. 823, 827 (2000).

19. The discussion here is about the standard to be applied to evaluate the insurer's good faith, assuming that the jurisdiction allows the action at all. Although the relational analysis that leads to a rejection of the fairly debatable standard also suggests something about whether there should be a cause of action at all, I do not address that directly.

20. ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, *UNDERSTANDING INSURANCE LAW* 183–84 (4th ed. 2007).

courts describe the content of the good faith duty in a variety of ways, but most require something more than a negligent failure to investigate or pay a claim, adopting instead the fairly debatable standard.²¹ Perhaps the most widely cited formulation of the standard comes from the Wisconsin Supreme Court's decision in *Anderson v. Continental Insurance Co.*:

To show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one. "Bad faith" by definition cannot be unintentional.²²

The court further explained:

The tort of bad faith can be alleged only if the facts pleaded would, on the basis of an objective standard, show the absence of a reasonable basis for denying the claim, *i.e.*, would a reasonable insurer under the circumstances have denied or delayed payment of the claim under the facts and circumstances.

....

Under these tests of the tort of bad faith, an insurance company, however, may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to process or pay) a claim without a reasonable basis.²³

Note that calling this the fairly debatable test is something of a misnomer because it is not strictly speaking one that measures good faith solely by whether the underlying claim was fairly debatable. Because the court characterizes bad faith as an intentional tort, it requires the insured to show both that the underlying claim was not fairly debatable and also that the company knew that it was not fairly debatable or acted recklessly with respect to that issue.

Later courts created a procedural elaboration on the fairly debatable test. "Under the 'fairly debatable' standard, a claimant who could not have established as a matter of law a right to summary judgment on the substantive claim would not be entitled to assert a claim for an insurer's bad-faith refusal to pay the claim."²⁴ The summary judgment elaboration was both the logical consequence of the requirement that an action for bad faith would lie "only if the facts pleaded would, on the basis of an objective standard, show the absence of a reasonable basis for denying

21. *Id.* at 186.

22. 271 N.W.2d 368, 376 (Wis. 1978).

23. *Id.* at 377.

24. *Pickett v. Lloyd's*, 621 A.2d 445, 454 (N.J. 1993).

the claim,”²⁵ and it was grounded in policy:

“[W]hen a claim is ‘fairly debatable,’ the insurer is entitled to debate it, whether the debate concerns a matter of fact or law.” The rationale for this legal principle is based upon the potential *in terrorem* effect of “bad faith” litigation upon the insurer. “‘An insurer should have the right to litigate a claim when it feels there is a question of law or fact which needs to be decided before it in good faith is required to pay the claimant.’”²⁶

III. THE FAIRLY DEBATABLE RULE AND THE RELATIONAL APPROACH

The fairly debatable rule and the summary judgment elaboration of the rule is the strong majority rule among jurisdictions that permit a cause of action for bad faith in first-party cases. From the perspective of relational contract theory, however, it is deeply flawed.

Begin with the contrast between the account of the insurance relationship implicit in the fairly debatable rule and the description of that relation derived from the application of relational theory. The rule is based on a perception that the policy terms are the predominant feature defining the relationship.

The policy defines the scope of the insurer’s liability; as companies often say, their duty is to pay what is owed according to the policy, no less but no more. In a coverage dispute, therefore, the insurer is permitted to dispute any issue as long as that issue is fairly debatable. The summary judgment elaboration of the rule follows from this posture; if there are material facts or legal issues in dispute—if the insured cannot obtain summary judgment in the coverage action—then it is not bad faith for the company to contest the action. Indeed, the company is practically required to do so. If the company were to pay a claim when there was a reasonable basis for disputing it, the cost of the claim would be unfairly imposed on other insureds through an increase in premium costs. Only when the company not only lacks a reasonable basis for disputing the claim under the policy terms, but when it also knows or recklessly disregards the unreasonableness of that basis, is it acting in bad faith.

The policy seldom contains explicit terms about the claim administration. Instead, the company is bound only by a general provision requiring it to adjust the claim and by an implicit policy term, the obligation of good faith. In these cases, too, the standard imposed by the fairly debatable rule is absence of a reasonable basis for the action and knowledge or reckless disregard of that absence. To act in bad faith is not merely to breach or to breach through negligence, but to act with an element of

25. *Anderson*, 271 N.W.2d at 377.

26. *Polizzi Meats, Inc. v. Aetna Life & Cas. Co.*, 931 F. Supp. 328, 334–35 (D.N.J. 1996) (citation omitted) (quoting *Anderson*, 271 N.W.2d at 376, 377).

willfulness, or at least recklessness, to subvert the ends of the deal. If the company unreasonably delays payment of a claim, fails to investigate, or denies payment, it has simply exercised its rights under the policy as long as it does not act with knowing or reckless disregard of its obligations.

In short, implicit in the fairly debatable rule is an assumption that the insurance company and the policyholder are adverse; the insured has only the rights clearly defined in the contract, and the company is entitled to vigorously protect its own interests in investigation and application of the contract provisions. From the relational perspective, this focus on the terms of the policy, express or implied, incorrectly characterizes the insurance relationship.

As a descriptive matter, this focus situates the insurance contract too far at the discrete end of the discrete-relational spectrum. It assumes that the policy represents a considered exercise in planning by the parties that deserves to be implemented throughout the relation. In fact, because the insurance relation is a relation of dependence and inequality rather than one of bargaining between parties of equal sophistication and leverage, it is incorrect to focus on the terms of the policy as fully constituting the relationship. Looking through a relational lens at the way insurance policies are drafted through industry collaboration, framed to limit the rights of policyholders, redrafted as necessary to account for negative court decisions, and imposed on policyholders who will not read or understand them suggests that the policy terms are an uncertain guide to the content of the relation. In areas other than bad faith, insurance law recognizes this reality, interpreting ambiguities against the company, reading grants of coverage broadly and exclusions narrowly, and honoring reasonable expectations, among other things.

The focus on policy terms misconceives the relation in another way. The perception that the core of what the insurance company is selling and the policyholder is buying is the detailed terms specified in the policy is at odds with the representation and understanding of the relation as providing protection against risk through a promise of security by a trustworthy partner. Such a partner—a good neighbor, a responsible company, someone who keeps you in good hands—does not niggle about terms, looking for any reasonable basis to deny coverage, being negligent or inattentive to its dependent partner's needs.

This point is reinforced by the normative analysis of relational contract theory. Relational contract theory moves from description to prescription through its identification of the norms immanent in exchange relations

and in the larger society. Here, I will illustrate by using only one part of Macneil's elaborate structure of the common contract norms, role integrity, which takes on enhanced importance in relations.

In relational contracts such as insurance, roles have not only "an element of individual utility enhancement" but also have "intricate interlinkings of habits, custom, internal rules, social exchange, expectations respecting the future, and the like."²⁷ The insurance company's role illustrates this complexity. Although the company's role includes writing policies, investing premiums, and paying claims in order to make a profit, its role also includes securing the future of the policyholder in the event of loss. This is true not only of the company but also of its employees; adjusters, for example, are trained to be empathetic and supportive, and industry standards and law demand that they be responsive, careful, and protective of the policyholder's interest. As such, it is a violation of the company's and the adjuster's role integrity to act in its own interest at the expense of the policyholder unless it has a clear basis for doing so.

Macneil recognizes that roles are conflictual in this way and suggests that this conflict can be "a perfectly good basis for normative behavior."²⁸ One must balance the short-term interest in maximizing profits against the long-term interest in the company's and the insurance industry's well-being. The history of insurance is replete with examples in which opportunism is maximizing in the short-term for a single company but so destructive of public trust in the long-term that it is detrimental to the interest of all companies—an example of Nobel Prize-winning economist George Akerlof's proposition that lemons drive out peaches.²⁹ Policyholders expect every company "to approximate the product of similar tensions" among all companies;³⁰ the insurance industry's portrayal of itself is of security and fairness in the claims process, a portrayal that would be violated by denying claims simply because they are fairly debatable.

This conflict is reflected in the differences between neoclassical and relational approaches to contract law and, in turn, by the different approaches of the fairly debatable rule and the relational approach.

27. MACNEIL, *supra* note 5, at 65.

28. *Id.* at 43.

29. See George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 495 (1970). For example, policy provisions and statutes making life insurance policies incontestable after a period of coverage had passed arose because insurance companies frequently used innocent errors by policyholders in their applications for life insurance as an after-the-fact basis for avoiding payment on policies. This practice threatened the saleability of life insurance. See Richard E. Stewart & Barbara D. Stewart, *The Loss of the Certainty Effect*, 4 RISK MGMT. & INS. REV. 29, 41 (2001); Eric K. Fosaaen, Note, *AIDS and the Incontestability Clause*, 66 N.D. L. REV. 267, 268–69 (1990).

30. MACNEIL, *supra* note 5, at 43.

Neoclassical law assumes a core of self-interest affected at the periphery by custom and regulation. From that view, the insurance company is free to act in its interest and so to maximize its profits except to the extent that it is limited by terms of the policy or regulatory restrictions. Relational contract law assumes a baseline of obligation in which self-interest and other-regardingness are intertwined. Insurance law already has adopted at least some relational insights, with some courts regarding insurance contracts as sufficiently different from ordinary commercial contracts in that they demand an enhanced obligation of good faith.³¹

A test for this view of the role is to ask how the participants in the contract would regard the fairly debatable rule.³² The rule states that the company may resolve doubts in its own favor rather than that of the insured and may act carelessly in investigating a claim, determining coverage, and deciding whether and when to pay. Would the insurance company be willing to advertise its policies on that basis, and would a prospective policyholder buy a policy from such a company? Would a company include a policy provision that rendered it immune from liability for bad faith, and therefore not subject to consequential damages in the event of a negligent coverage decision or an improper claims practice unless it acted with the intent to harm the policyholder's interests or acted in reckless disregard of them, and would a knowledgeable policyholder accept such a provision? None of these are likely because the relation of insurance is about security, and the hypothetical advertisement and provision are inconsistent with the perceptions of the relation.

The relational approach also highlights another aspect of the insurance relation that the fairly debatable rule ignores or understates: the nature of the insurance contract as one of sequential performance that creates the potential for opportunism by the insurer. If one assumption underlying the fairly debatable rule is that the policy terms are the touchstone of obligation, a second assumption underlying the rule is that the typical insurance company ordinarily fulfills the terms of the policy voluntarily and in good faith. Because the company routinely acts properly, it needs

31. A classic example of the limitation of the enhanced duty of good faith to insurance contracts is the rise and fall of bad faith in California law. *See Freeman & Mills, Inc. v. Belcher Oil Co.*, 900 P.2d 669, 671–80 (Cal. 1995); *Foley v. Interactive Data Corp.*, 765 P.2d 373, 389–402 (Cal. 1988) (en banc).

32. Indeed, this is a more expansive version of the hypothetical contract approach propounded by law-and-economics scholars and judges that attempts to construct the maximally efficient terms to which parties would have agreed.

to be sanctioned only in the unusual case in which it departs significantly from normal behavior by acting with malice or with reckless disregard for the policyholder's rights under the policy. The relational approach focuses attention on the problem of opportunism in general and on its specific manifestations in the claim process. That different focus demonstrates further deficiencies with the fairly debatable rule.

Most of the focus on opportunism in the insurance literature is about policyholder opportunism, manifested in moral hazard or adverse selection.³³ But there has long been a significant problem with insurer opportunism. Historically, this was often manifested through the behavior that became known as "post-claim underwriting."³⁴ When a claim was presented, a company would seize on errors by the insured in the application to deny coverage.³⁵ The courts and legislatures recognized this and responded in various ways, such as through doctrines of waiver, estoppel, incontestability, and materiality of misrepresentation.³⁶ Today, the greater problem is opportunism in the claims process.

As a matter of theory, the attraction to the insurance company in behaving opportunistically is obvious. The company that denies payment of a claim in whole or part increases its profits. The company that only delays payment of a claim increases its investment income and thereby increases its profit. Bad faith law aims to deter this behavior. As a federal court in New Jersey said, "Recognition of an action permitting an insured to recover damages in excess of the actual amount owed under the contract would provide an effective means of countering the existing incentives for an insurance company to wrongfully delay or deny payment."³⁷

Behaving opportunistically by delaying or denying payment of rightful claims is attractive in part because, outside of bad faith litigation, there are insufficient controls on or deterrents to opportunism. Market discipline is largely absent because prospective policyholders have no access to useful and reliable information about claims practices, and insurance companies rarely advertise their claim-paying attributes in meaningful ways. Regulators have been largely absent in this area as well. Although some state regulators have begun to collect claim practices information and report it through the National Association of Insurance Commissioners, the information is not available to the public. Aside from the occasional, exceptionally searching market conduct examination, regulators have not systematically addressed claim practices abuses. The few high visibility

33. See TOM BAKER, *INSURANCE LAW AND POLICY* 4–5 (2d ed. 2008).

34. See Thomas C. Cady & Georgia Lee Gates, *Post Claim Underwriting*, 102 W. VA. L. REV. 809, 810 (2000).

35. *Id.* at 812–13.

36. *Id.* at 838–54.

37. *DiSalvatore v. Aetna Cas. & Sur. Co.*, 624 F. Supp. 541, 543 (D.N.J. 1986).

exceptions—the response to insurance practices after Hurricane Katrina is the most notable—are the exceptions that prove the rule.

Beyond theory, although the insurance industry obviously disputes the charge, there is substantial evidence that since the early 1990s, insurance companies have increasingly viewed the claims process not as the site for keeping their promise of security but as a profit center.³⁸ Through systematic reorganization of the claims process, incentives to employees and managers, and more aggressive approaches to litigation, the companies have embarked on a strategy that increases profits at the expense of claimants. This development has taken place across property, casualty, and disability insurances as a whole. The relational approach reminds us to focus on context at increasingly finer levels, and that focus reveals several particular areas in which opportunism has become a major feature of the claims landscape.

One class of cases involves auto accidents with low-speed impact in which the victim suffers injuries that manifest as sprains and strains rather than fractures or injuries easily visible on X-rays or other diagnostic tests. These are known as Minor Impact Soft Tissue (MIST) claims and are sometimes derided by the insurance industry as whiplash claims.³⁹ Insurance companies have focused on these as an area in which an aggressive posture tends to discourage claimants and therefore reduce claims payouts.⁴⁰ Because relatively smaller amounts of damages are at stake, an aggressive defense posture makes it less profitable for an attorney to represent a victim on a contingency fee basis, so victims may not be able to press their claims.⁴¹

Because MIST claims are often the subject of systematic insurer opportunism, they present an area in which courts should be particularly watchful in policing behavior. But the fairly debatable test goes in just the opposite direction. Insurance companies have amassed an army of experts in biomechanics, accident reconstruction, and neck and back injuries to refute claims in MIST cases, typically by finding that the

38. This development is the topic of my forthcoming book, JAY M. FEINMAN, *DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT* (forthcoming 2010). See also Jay M. Feinman, *Incentives for Litigation or Settlement in Large Tort Cases: Responding to Insurance Company Intransigence*, 13 ROGER WILLIAMS U. L. REV. 189, 193–97 (2008).

39. See 1 KAREN K. KOEHLER & MICHAEL D. FREEMAN, *LITIGATING MINOR IMPACT SOFT TISSUE CASES* §§ 1:1, 3:1 (2008), available at 1 LMISTC s 1:1, 3:1 (Westlaw).

40. *Id.* §§ 1:3, 5:1, available at 1 LMISTC s 1:3, 5:1 (Westlaw).

41. 1A *id.* § 38:3, available at 1A LMISTC s 38:3 (Westlaw).

injuries suffered could not have been incurred in an accident of this type or that the victims' injuries are transitory or the product of malingering or outright fakery.⁴² If the insurance company can produce some of this evidence, it raises an issue of fact that prevents summary judgment and thus the bad faith claim fails the fairly debatable test. Therefore, for example, when an insurance company can obtain a report of a so-called independent medical examination of the policyholder by a doctor retained by the insurance company—perhaps routinely retained by the insurance company—that is enough to make the claim fairly debatable.⁴³

A second class of cases involving opportunism includes those cases in which the company raises the specter of insurance fraud. Companies have integrated fraud allegations into the claim process, routinely using referrals to their Special Investigation Units (SIUs) and suspicions of fraud to delay or deny payment. These suspicions carry weight because the insurance industry has been dramatically successful in its campaign to raise fears of an epidemic of insurance fraud. In the minds of the public, enforcement agencies, claimants, and judges, the public campaign makes more credible the suspicions in individual claims cases. Allegations of fraud, perhaps supported by inferences rather than actual evidence, even when met by an overwhelming amount of evidence to the contrary, are enough to make the insurance company's decision to deny a claim seem reasonable and thus fairly debatable. Where, for example, the company's allegations of arson by the policyholder are supported by a few pieces of evidence even though the bulk of the evidence exonerates the insured, the claim is fairly debatable.⁴⁴

The difficulties with the fairly debatable rule from the relational perspective are made worse when it is framed in terms that allow the insured to establish bad faith only if it would have won a motion for summary judgment on the coverage claim. The summary judgment standard states that an insured is entitled to summary judgment "if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law."⁴⁵ The key to summary judgment is whether a factual dispute exists. As long as there is a triable issue of fact, summary judgment must be denied. The court denies summary judgment unless a reasonable fact finder viewing the

42. 1 *id.* §§ 7:1, 21:1, available at 1 LMISTC s 7:1, 21:1 (Westlaw).

43. See, e.g., *Prince v. Bear River Mut. Ins. Co.*, 2002 UT 68, ¶ 35, 56 P.3d 524.

44. See *Polizzi Meats, Inc. v. Aetna Life & Cas. Co.*, 931 F. Supp. 328, 331–32, 335 (D.N.J. 1996).

45. FED. R. CIV. P. 56(c).

evidence in the light most favorable to the party opposing the motion would be compelled to find for the moving party.

As is well known, this is a difficult standard to meet. As a California court emphasized:

Because a summary judgment denies the adversary party a trial, it should be granted with caution. Declarations of the moving party are strictly construed, those of the opposing party are liberally construed, and doubts as to whether a summary judgment should be granted must be resolved in favor of the opposing party. The court focuses on issue finding; it does not resolve issues of fact. The court seeks to find contradictions in the evidence, or inferences reasonably deducible from the evidence, which raise a triable issue of material fact.⁴⁶

In a bad faith case using a summary judgment standard under the fairly debatable rule, all the insurer must do is present evidence that raises a factual dispute or persuade the court that the evidence in favor of the insured is not unquestionable or does not conclusively establish coverage. In a MIST case, that burden can be met by the presentation of expert testimony challenging causation or the extent of injuries, evidence that is standardized and routinely available. In a fraud case, that burden can be met by having an SIU investigator raise some doubts about benefit or opportunity or identify some suspicious facts about the cause of the risk. In both cases, the relational understanding of security and the need to prevent opportunism is undermined by application of the standard.

IV. A NEGLIGENCE STANDARD FOR FIRST-PARTY BAD FAITH CASES

The fairly debatable rule and particularly the summary judgment elaboration on the rule misunderstand the nature of the insurance relationship and the contexts in which insurance claims are presented. The rule permits the insurance company to act unreasonably during the claim process. It even permits the company to intentionally injure the insured's interest or to act with reckless disregard for the insured's interest as long as there is some evidence that it has acted at the worst negligently, that is, that it can avoid summary judgment on the issue of intent.

The perspective that relational contract theory provides on the insurance relation suggests a different rule. A few jurisdictions use such an alternative rule that is more attuned to the relationship and its contexts as seen

46. *Jordan v. Allstate Ins. Co.*, 56 Cal. Rptr. 3d 312, 318 (Ct. App. 2007) (citation omitted).

through the lens of relational contract theory.⁴⁷ That rule renders a company liable for bad faith if it is negligent in failing to pay a claim without also requiring that the company have acted with intent or recklessness.

From the relational perspective, negligence is a better rule because it recognizes that the terms of the policy are the starting point for analysis of the insurance relationship but, because of the relational character, the policy insufficiently defines the terms of that relationship. That relationship, as represented by the company, is one of security, in which the company has adopted a role of acting not as an adverse party to its insured but in a responsible manner to give the insured the benefits it reasonably expects. The rule also recognizes the possibility of insurer opportunism in the area of claim practices, and the heightened possibility in particular classes of cases, such as MIST claims and fraud allegations. Such a rule serves the broader social role of the insurance relation in providing indemnity and security for large numbers of people at the time it is most needed—when substantial risks come to pass.

The negligence rule is consistent with widely accepted standards in the insurance industry and the law for the company's reasonable behavior in the claim process. For example, the National Association of Insurance Commissioners' Model Unfair Claims Settlement Practices Act states that the company must "effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear."⁴⁸ To do this, the company also is required by the statute to "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies."⁴⁹ In its investigation, the company must be objective, discovering and evaluating facts that support the claim and not just facts that give it a basis for turning down the claim. The company may not "[c]ompel[] insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them."⁵⁰

The question raised in first-party bad faith is how closely a company must hew to these standards before it violates the norms of the insurance relation and acts in bad faith. The fairly debatable rule and the summary judgment elaboration state that as long as a company does not intentionally or recklessly violate the standards, it has not acted in bad faith. Moreover,

47. STEPHEN S. ASHLEY, *BAD FAITH ACTIONS: LIABILITY AND DAMAGES* § 5:02 (1997), identifies eight jurisdictions that adopt this rule, following the California Supreme Court's landmark decision in *Gruenberg v. Aetna Insurance Co.*, 108 Cal. Rptr. 480 (1973). Reading the cases that he cites suggest this may overstate the number.

48. MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4(D) (1997).

49. *Id.* § 4(C).

50. *Id.* § 4(E).

the determination of intent or recklessness will be made through a process that favors the company and disfavors the insured because, unless the insured can demonstrate indisputably that the claim was not fairly debatable, bad faith is not present.

From the relational perspective, this fails to embody the norms of the insurance relation. The norms require more. Providing security and avoiding opportunism are not well-served by a company that is careless even if it does not intentionally injure its insured or act with disregard for its interests. It is too much to expect an insurance company to get every claim right, to investigate correctly, or to give all of the benefit of the doubt to the insured. What is expected, however, is that the company act reasonably.

