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SCOPE OF INVESTIGATION REQUIRED BY HEALTH INSURERS IN MISSISSIPPI PRIOR TO DENIAL OF FIRST-PARTY CLAIMS

Michael K. Graves

I. INTRODUCTION

One of the greatest dilemmas currently facing individuals and society is the availability of affordable health care. As medical research continues to reveal new, technologically advanced treatments, and the cost of medical malpractice insurance continues to skyrocket, the cost of necessary health care may naturally be expected to increase concomitantly. Consequently, "[h]ospital and medical insurance is absolutely essential in this era of astronomical medical costs"[1] to insure that an individual may promptly receive vitally necessary medical treatment. Without dependable health insurance, the individual may be confronted with either potential economic disaster, should prolonged health care be required, or the harrowing prospect of foregoing life-saving medical treatment.

Most individuals procure health insurance coverage, the "modern America[n] security blanket,"[2] to alleviate these concerns. Indeed, "one of the driving forces behind a buyer seeking insurance protection is the peace of mind and freedom from worry its acquisition will bring."[3] This "peace of mind"[4] sought by individuals is well-known to insurers and used to great advantage by insurers in peddling their wares:

> That insurers sell their products as being not only an agreement to indemnify the insured for certain kinds of loss but also to relieve the purchaser from anxiety concerning all aspects of claims is readily apparent in our society. One cannot watch televised entertainment for very long without being exposed to commercials for the sale of insurance which, for example, indicate that the purchaser will be in "good hands," that he will have the assistance of a troop of mounted cavalry, that he [will have] "a piece of the rock," or that "like a good neighbor" the insurer will be there.[5]

In part a result of the "vulnerability" of individuals seeking this protection, many courts, including the Mississippi Supreme Court, have had little difficulty in recognizing a special relationship between the insurer and insured created by

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1. Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 811 (Miss. 1983).

2. Raphael Cotkin, *Litigating An Insurer's Bad Faith*, 14 LITIG., 39 (1988).

3. William H. Gilardy, Jr., Note, *Good Faith and Fair Dealing in Insurance Contracts:* Gruenberg v. Aetna Insurance Co., 25 HASTINGS L.J. 699, 713-14 (1974) [hereinafter *Good Faith*].

4. *See, e.g.*, Ainsworth v. Combined Ins. Co. of Am., 763 P.2d 673, 676 (Nev. 1988) ("A consumer buys insurance for security, protection, and peace of mind.") (citation omitted).

5. Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172, 1175 n.5 (Miss. 1990) (quoting Farris v. United States Fidelity & Guar. Co., 587 P.2d 1015, 1028 n.4 (Or. 1978) (Lent, J., dissenting) (citations omitted)).

the contract of insurance.[6] Emanating from this "special relationship" is an implied covenant of good faith and fair dealing between the insurer and insured.[7]

Although this implied covenant of good faith and fair dealing applies to both the insured and insurer, the burdens (duties) concomitant with the covenant bear more heavily upon the insurer.[8] One rationale underlying imposition of a heavier burden of good faith and fair dealing on insurers is clearly exhibited in the transactional realities accompanying the procurement of insurance coverage:

> It is a matter almost of common knowledge that a very small percentage of policy holders are actually cognizant of the provisions of their policies and many of them are ignorant of the names of the companies issuing the said policies. The policies are prepared by the experts of the companies, they are highly technical in their phraseology, they are complicated and voluminous . . . and in their numerous conditions and stipulations furnishing what may be veritable traps for the unwary . . . . [C]ourts, while zealous to uphold legal contracts, should not sacrifice the spirit to the letter *nor should they be slow to aid the confiding and innocent.*[9]

There are additional justifications—beyond the adhesive nature of the contract—for imposition of a greater obligation of good faith and fair dealing on the insurer: (1) the insured purchases insurance for security and peace of mind, whereas the insurer's motivation for entering into the contract is purely one of

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6. *See, e.g., Andrew Jackson*, 566 So. 2d at 1189 (quoting Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987) (citations omitted)) (" '[W]e have recognized that a duty of good faith and fair dealing may arise as a result of a special relationship between the parties governed or created by a contract.' ").

But see T. H. Freeland, III & T. H. Freeland, IV, *Bad Faith Litigation: A Practical Analysis*, 53 MISS. L.J. 237, 243 (1983) ("Fiduciary relations are special ones that do not exist in ordinary contract or commercial settings, such as insurance contracts.") (footnote omitted).

7. [E]very contract contains [an implied] covenant of good faith and fair dealing. This covenant applies to both insured and insurer—albeit more so to the latter party. In short, the duty requires abstinence by *all* parties from commission of wrongful conduct which injures the right of [the another] [sic] to receive the benefits of the agreement.

Andrew Jackson, 566 So. 2d at 1188 (citations omitted).

8. *Andrew Jackson*, 566 So. 2d at 1188.

9. Raulet v. Northwestern Nat'l Ins. Co., 107 P. 292, 298 (1910), *cited in Andrew Jackson*, 566 So. 2d at 1189.

See Jeff Goldberg, *Standards of Liability for Bad Faith Refusal to Pay Benefits in First Party Insurance*, 54 DEF. COUNS. J. 169 (1987) [hereinafter Goldberg]:

> In addition to the insurance company's superior financial position, the insured is further disadvantaged by the adhesive nature of the insurance contract. The insured has no input into the terms of the contract which is usually written in boilerplate language and is not understandable by most laymen. Providing the insured with a tort remedy and the possibility of punitive damages is an attempt to restore balance in the contractual relationship.

Id. at 170-71 (footnotes omitted).

commercial advantage;[10] (2) the unequal bargaining position of the parties;[11] and, (3) insurance companies, because of the vital nature of the services they provide, are quasi-public entities rather than purely private entities which might properly be concerned only with self-interest.[12]

Only since 1973 has breach of the duties arising out of the implied covenant of good faith and fair dealing by the insurer been considered tortious.[13] Since that time, at least one-half of the states, including Mississippi,[14] have permitted recovery of extra-contractual damages for the breach of this covenant, now commonly recognized as an insurer's bad faith in handling claims.[15] This article considers the scope of investigation required by health insurers in Mississippi prior to denial of a claim for health benefits in order to satisfy this implied covenant of good faith and fair dealing in investigating the claim.

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10. *See* Goldberg, *supra* note 9, at 170. *See also* Rawlings v. Apodaca, 726 P.2d 565 (Ariz. 1986):

> [O]ne of the benefits that flow from the insurance contract is the insured's expectation that his insurance company will not wrongfully deprive him of the very security for which he bargained or expose him to the catastrophe from which he sought protection. Conduct by the insurer which does destroy the security or impair the protection purchased breaches the . . . covenant of good faith and fair dealing implied in the contract.

Rawlings, 726 P.2d at 571, *quoted in Andrew Jackson*, 566 So. 2d at 1189.

11. *See* Goldberg, *supra* note 9, at 170 ("Insurance companies are backed by substantial financial resources while the insured is often in an especially vulnerable economic position after the insured loss occurs.").

See also Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165 (Tex. 1987):

> In the insurance context a special relationship arises out of the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insureds' misfortunes in bargaining for settlement or resolution of claims. In addition, without such a cause of action insurers could arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed. An insurance company has exclusive control over evaluation, processing and denial of claims. For these reasons, a duty is imposed that "[a]n indemnity company is held to that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business."

Id. at 167 (citations omitted), *quoted in Andrew Jackson*, 566 So. 2d at 1189.

12. *See, e.g.*, Goldberg, *supra* note 9, at 171; *Good Faith*, *supra* note 3, at 711.

See also Charles James Vinicombe, Comment, *North Carolina's Cautious Approach Toward the Imposition of Extracontract Liability on Insurers for Bad Faith*, 21 WAKE FOREST L. REV. 957, 959 (1986) (recognizing the "quasi-public nature" of insurers); Ainsworth v. Combined Ins. Co. of Am., 763 P.2d 673, 676 (Nev. 1988) ("The insurance industry is heavily regulated by the state, because it is an important public trust."). In McLaughlin v. Connecticut Gen. Life Ins. Co., 565 F. Supp. 434 (N.D. Cal. 1983) the court stated:

> Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements . . . . [A]s a supplier of a public service rather than a manufactured product, the obligations of insurers go beyond meeting reasonable expectations of coverage. The obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary.

McLaughlin, 565 F. Supp. at 451 (quoting Egan v. Mutual of Omaha, 620 P.2d 141 (Cal. 1979) (quoting William M. Goodman & Thom G. Seaton, *Forward: Ripe For Decision, Internal Workings and Current Concerns of the California Supreme Court*, 62 CAL. L. REV. 309, 346-47 (1974))).

13. A cause of action in tort for an insurer's bad faith handling of a claim for first party benefits was initially recognized by the California Supreme Court in Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973).

14. In Standard Life Ins. Co. v. Veal, 354 So. 2d 239 (Miss. 1977), the Mississippi Supreme Court held that both compensatory and punitive damages may be awarded for an insurer's refusal to honor a legitimate claim when the insurer had no legitimate or arguable reason for refusal.

15. *See* JOHN C. MCCARTHY, PUNITIVE DAMAGES IN BAD FAITH CASES § 1.1 A (3d ed. 1983).

See also Goldberg, *supra* note 9, at 169 n.1 (listing the jurisdictions – which comprise the majority of jurisdictions – recognizing an independent cause of action in tort for an insurer's bad faith refusal to pay benefits).

II. BACKGROUND

A. The Bad Faith Claim in Mississippi

The benchmark case for bad faith claims in Mississippi is *Standard Life Insurance Co. v. Veal.*[16] In *Veal*, the insurer refused to pay benefits under a credit life policy which had been issued by the insurer[17] to the plaintiff when the plaintiff entered into a contract for a small loan.[18] Although the policy specifically provided coverage for all "insured obligors"—defining such as "the principal or first signatory on a contract of indebtedness *and his or her spouse by marriage*"[19]—the insurer refused to pay benefits under the policy upon the demise of the plaintiff's spouse.[20] The only reason for denial stated by the insurer was that the plaintiff's deceased spouse had not signed the note on which the policy was issued.[21]

Recognizing that there was no requirement that the plaintiff's spouse sign the note in order for the policy to provide coverage on the spouse,[22] the Mississippi Supreme Court found that the insurer "failed to honor the legitimate claim filed following the death of plaintiff's wife and there was no reason whatever to justify its action."[23] The *Veal* Court then noted that the insurer "only offered to pay the face amount of the policy *after plaintiff had filed his suit.*"[24] In light of these unjustifiable actions by the insurer—in blatant disregard of the insured's right to benefits under the policy—the *Veal* Court enunciated the rationale underlying and justifying imposition of punitive damages for an insurer's refusal to honor a legitimate claim:

> This case demonstrates the necessity of awarding punitive damages when an insurance company refuses to pay a legitimate claim, and bases its refusal to honor the claim on a reason clearly contrary to the express provisions of its own policy. If an insurance company could not be subjected to punitive damages it could intentionally and unreasonably refuse payment of a legitimate claim with veritable impunity. To permit an insurer to deny a legitimate claim, and thus force a claimant to litigate with no fear that claimant's maximum recovery could exceed the policy limits plus inter-

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16. 354 So. 2d 239 (Miss. 1977). Though *Veal* has become commonly referred to as "the seminal bad-faith case" in Mississippi, Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172, 1184 (Miss. 1990), the *Veal* Court made no explicit statement recognizing a "bad faith" cause of action. *But see* Blue Cross & Blue Shield of Miss. v. Campbell, 466 So. 2d 833 (Miss. 1984). "We have come to term an insurance carrier which refused to pay a claim when there is no reasonably arguable basis to deny it as acting in bad faith, and a lawsuit based upon such an arbitrary refusal as a bad faith cause of action." *Campbell*, 466 So. 2d at 842.

17. The plaintiff entered into a brokerage contract with Ades Finance Company, by which Ades would negotiate a small loan on behalf of the plaintiff. This contract was entered into when Ades, acting as an agent for Standard Life Insurance Company of Indiana, also issued a decreasing term life insurance policy to the plaintiff. The policy was to cover the amount of the indebtedness and decrease concurrent with payments made on the indebtedness. *Veal*, 354 So. 2d at 241.

18. *Id.*

19. *Id.* (emphasis added).

20. *Id.* at 242-43.

21. *Veal*, 354 So. 2d at 248.

22. *Id.*

23. *Id.*

24. *Id.* (emphasis added).

est, would enable the insurer to pressure an insured to a point of desperation enabling the insurer to force an inadequate settlement or avoid payment entirely.[25]

The *Veal* Court also recognized, however, that an insurer should not be subject to punitive damages merely because the insurer denies a claim. Even if denial of the claim is wrongful and amounts to a breach of the insurance contract by the insurer,[26] a punitive damages award is not warranted absent some conduct by the insurer "attended by intentional wrong, insult, abuse or such gross negligence as to consist of an independent tort."[27]

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25. *Veal*, 354 So. 2d at 248. *Cf.* Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254 (Miss. 1985) (recognizing that an insurer's deception, in the particular case *sub judice*, evidences that many other insureds may have previously been deceived by *this* insurer's "bad faith"):

> Common sense tells us there are many accidents which in and of themselves might cause no particular problems, but coupled with the physical condition of [this] victim can cause serious injury or disease. How many [of the defendant insurance company's] insureds have there been who sustained some minor injury, and because of some underlying physical condition suffered serious problems, yet who accepted at face value the clear language of the policy [which the Mississippi Supreme Court has already held to be inapplicable in this set of circumstances]? *It would not be at all beyond the bound of reason for such injured insured to have read the initial rejection, examined his policy, and concluded that he was not covered.* Such insured in all likelihood would not have known about our court decisions. [The defendant insurance company], on the other hand, did know about them. [The defendant] played the odds in this case and lost.

Crenshaw, 483 So. 2d at 271 (emphasis added).

26. "[I]f an insurance company has a legitimate reason or an arguable reason for failing to pay a claim, punitive damages will not lie . . . [,]" *Veal*, 354 So. 2d at 248, although the insurer may be found liable for the disputed claim under the contract.

This standard—"a legitimate reason or arguable reason for failing to pay a claim"—has not been uniformly described in subsequent decisions. *See* Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172 (Miss. 1990):

> Various phrases have been used by this Court to describe the basis upon which an insurer may deny a claim and avoid, in most cases, punitive-damages liability. *Compare* Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 809 (Miss. 1983) (using "reasonably arguable basis"), *with* Mutual Life Ins. Co. of N.Y. v. Estate of Wesson, 517 So. 2d 521, 528 (Miss. 1987) ("arguable reason or a legitimate reason or a justifiable reason (all three [phrases mean] . . . the same)"), *and* Reserve Life Ins. Co., 444 So. 2d at 815 (Robertson, J., specially concurring) (" '[L]egitimate' and 'arguable' and 'reasonable' are surely synonymous. There is I insist no such thing as a 'legitimate reason' which is not by definition a 'reasonable reason.' The same of 'arguable reason.' Clarity demands that we jettison two of these synonyms. I would salvage 'arguable.' ").

Andrew Jackson, 566 So. 2d at 1184.

See also Crenshaw, 483 So. 2d at 269 (citations omitted) ("Was there an 'intentional and unreasonable refusal' to pay a legitimate claim? Was there a *legitimate or an arguable reason* for failing to pay [the insured's] claim? Or, was there a 'reasonably arguable basis, either in fact or in law, to deny the claim?' "):

> Arguably-based denials are generally defined as those which were rendered upon dealing with the disputed claim fairly and in good faith. And whether the insurer rendered its denial fairly and in good faith is generally to be determined by the trial judge when he or she considers a motion for a directed verdict (or the like) on the underlying policy or contract claim. If the judge is unable to make the determination, then logic generally dictates that the insurer's rightful or wrongful denial of the claim was not reached in bad faith. In these cases, the punitive-damages issue *generally* should not be submitted to the jury.

Crenshaw, 483 So. 2d at 269.

But see State Farm & Casualty Co. v. Simpson, 477 So. 2d 242 (Miss. 1985):

> We are of the opinion the term "legitimate or arguable reason," although spawning much comment in our cases . . ., is nothing more than an expression indicating the act or acts of the alleged tortfeasor do not rise to the heightened level of an independent tort. Additionally, the very term expresses the holding of this Court establishing a distinction between ordinary torts, the product of forgetfulness, oversight, or the like; and heightened torts, which are the product of gross, callous or wanton conduct, or, if intentional, are accompanied by fraud or deceit.

Simpson, 477 So. 2d at 250 (citation omitted).

27. Progressive Casualty Ins. Co. v. Keys, 317 So. 2d 396, 398 (Miss. 1975) (citations omitted).

The basis of this independent tort is found in the implied covenant of good faith and fair dealing inhering in the contract of insurance,[28] and in the duties of the insurer established by this covenant and arising out of the special relationship between the insurer and insured.[29] This duty of good faith and fair dealing is "independent of the ordinary contractual duty"[30] and, thus, is not breached by mere failure of the insurer to honor the terms of the contract. In fact, "[Mississippi] law requires a finding of *'bad faith-plus'*—based upon a preponderance of the evidence—before punitive damages may be awarded."[31] "Bad faith-plus" is, of course, phraseology coined to describe conduct by the insurer having "some element of aggression or some coloring of insult, malice or gross negligence, evincing ruthless disregard for the rights of [the insured]."[32] Whether an insurer's conduct rises to the level of "bad faith-plus"—thus constituting a tort independent of the breach of the contract and warranting imposition of punitive damages—is a question of law for the determination of the court:[33]

> [T]he trial court should examine whether *as a matter of law* the insurer has a legitimate or arguable reason to deny the claim. Should the court find that there is a legitimate or arguable reason for the denial, a punitive damage instruction should not be given; if, however, reasonable minds could differ as to whether there is a legitimate or arguable reason, the court must next consider whether there is evidence of gross negligence or intentional misconduct in the denial of the claim. If there is sufficient evidence to indicate that the insurer had no legitimate or arguable reason to deny the claim *and* that the insurer acted intentionally or was grossly negligent, a punitive damage instruction should be granted.[34]

B. The Insurer's Duty to Investigate

In handling claims for health benefits under Mississippi law, there is a "clear duty upon an insurance company to promptly and adequately investigate an insured's claim before denying it."[35] To satisfy this duty of prompt and adequate investigation, the following is required:

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28. *See Andrew Jackson*, 566 So. 2d at 1188; *supra* notes 6-9 and accompanying text.

29. *See* Goldberg, *supra* note 9, at 169; *supra* note 8 and accompanying text.

30. Goldberg, *supra* note 9, at 169.

31. *Andrew Jackson*, 566 So. 2d at 1188. *See* Gulf Guar. Life Ins. Co. v. Kelley, 389 So. 2d 920, 922 (Miss. 1980).

32. Standard Life Ins. Co. v. Veal, 354 So. 2d 239, 247 (Miss. 1977) (quoting Fowler Butane Gas Co. v. Varner, 141 So. 2d 226, 233 (Miss. 1962)).

33. *See* O'Connor v. Equitable Life Assurance Soc'y, 592 F. Supp. 595, 597 (N.D. Miss. 1984) ("The general rule which appears to prevail [in Mississippi] is that if, *as a matter of law*, there is an 'arguable reason' for the insurance company to deny liability on the policy, punitive damages are improper regardless of whether the insurance company prevails or loses on the issue of liability.") (emphasis added) (citations omitted); Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 809 (Miss. 1983) (trial court's finding that a legitimate or arguable reason existed for the insurer to deny payment of the claim would mean "the trial court should refuse to grant a punitive damages instruction even though it submits to the jury the question of whether or not the insurer owed the compensatory claim for which proofs of loss were filed.").

34. Merchants Nat'l Bank v. Southeastern Fire Ins. Co., 751 F.2d 771, 775 (5th Cir. 1985) (citing Reserve Live Ins. Co. v. McGee, 444 So. 2d 803, 809-10 (Miss. 1983)) (citations omitted) (emphasis added).

35. Eichenseer v. Reserve Life Ins. Co., 682 F. Supp. 1355, 1366 (N.D. Miss. 1988) (footnote omitted).

> [A]n insurance company must, at a minimum, (1) check to see if the policy provision relied upon to deny the claim has been held invalid and unenforceable by a state or federal court, (2) interview its employees and agents to ascertain if they possess any relevant knowledge regarding the claim in question, and (3) *if the claim is related to the plaintiff's health,* then make reasonable efforts to obtain all available medical information relevant to the claim.[36]

A breach of this investigative duty "attended by intentional wrong, insult, abuse or . . . gross negligence"[37] constitutes actionable bad faith—as a breach of the implied covenant of good faith and fair dealing and, thus, an independent tort—by the insurer, and subjects the insurer to potential punitive damages. This award of punitive damages is in addition to a compensatory award on the breach of contract claim for the insurer's wrongfully withholding benefits as a result of the inadequate investigation.

The implied covenant of good faith and fair dealing not only requires that the insurer "make a reasonably prompt investigation of all relevant facts,"[38] but also that the *insured* provide the insurer with sufficient medical information to enable the insurer to initiate or complete an investigation and adequately evaluate the claim.[39] In fact, the insurer's investigative duty does not come into operation until the claimant has submitted "a completed proof of loss . . . claim as required under the terms of the policy and Mississippi law."[40] Once the insured provides the insurer with notice of the claim adequate to permit the insurer to initiate an investi-

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36. *Id.* (citations omitted) (emphasis added).

37. Standard Life Ins. Co. v. Veal, 354 So. 2d 239, 247 (Miss. 1977) (quoting Progressive Casualty Ins. Co. v. Keys, 317 So. 2d 396, 398 (Miss. 1975) (citations omitted)).

38. Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 276 (Miss. 1986).

The rationale behind imposition of a duty to conduct a reasonably prompt investigation of all facts relevant to the claim has been posited as follows:

> In the past, a favorite tactic of insurers in handling claims that might prove troublesome was simply to do nothing. Such insurers felt that by taking the initiative . . . they might stir up problems that the insured might not pursue on his own initiative. Files were allowed to lay dormant until the insured . . . was prompted into making requests for action. These requests were often met with the response that more time was needed to complete the investigation, after which the file would again be allowed to lay dormant until further prompting by the insured. Good faith and fair dealing requires that the insurer undertake investigation of the claim promptly on receipt of notice of loss by an adjuster or investigator capable of dealing with the particular problem presented, who promptly identifies and notifies the insured of any rights the insurer intends to reserve or defenses it will claim.

Richard C. Tinney, *Insurer's Breach of Covenant of Good Faith and Fair Dealing—First-Party Claims,* 31 AM. JUR. PROOF OF FACTS 2D 323, 387 (1982) [hereinafter *Insurer's Breach*] (footnote omitted).

See also Harrison v. Benefit Trust Life Ins. Co., 656 F. Supp. 304, 308 (N.D. Miss. 1987) ("An insurance company has a duty to promptly and adequately investigate an insured's claim."); Life & Casualty Ins. Co. of Tenn. v. Bristow, 529 So. 2d 620, 623 (Miss. 1988) ("Mississippi law does indeed impose a duty upon the insurance company to promptly and fully investigate any claim. In the case of medical or disability insurance, this involves 'the obtaining of all available medical information relevant to [the] claim.' ") (quoting *Crenshaw,* 483 So. 2d at 272).

39. *See* Tucker v. Aetna Casualty & Sur. Co., 609 F. Supp. 1574, 1578-80 (S.D. Miss. 1985) (insured's failure to "produce documentation such as narrative medical reports, disclose the identity of her other medical insurance coverage," and "failure to timely waive the medical privilege was unreasonable and prevented [the insurer] from attempting to learn what medical bills were actually related to the accident in question," and prevented imposition of punitive damages); *see also* New Hampshire Ins. Co. v. Smith, 357 So. 2d 119, 121 (Miss. 1978) (reversing award of punitive damages on grounds that insured did not furnish insurer a copy of insured's doctor's report or authorization for the insurer to consult with the insured's doctor).

40. Seay v. Southern Life & Health Ins. Co., 660 F. Supp. 1076, 1084 (S.D. Miss. 1986).

gation into the validity of the claim, the insurer has a non-delegable duty[41] to make a reasonably prompt and reasonable investigation of all facts relevant to the claim.[42]

III. ANALYSIS

An insurer in Mississippi has a duty to investigate promptly and adequately the validity of a claim for health benefits pre-denial.[43] The failure of the insurer to satisfy this duty – resulting in a wrongful denial of benefits – unquestionably provides the insured an ordinary breach of contract action to obtain compensation for any wrongfully denied benefits.[44] Moreover, the insurer also subjects itself to a potential punitive damages award if the failure to investigate promptly or adequately the claim evinces conduct by the insurer rising to the level of an independent tort.[45] Though a matter of law,[46] whether the breach of this duty to investigate by the insurer also amounts to a breach of the implied covenant of good faith and fair dealing,[47] and thus constitutes "bad faith-plus", has not been explicitly addressed by the Mississippi Supreme Court.[48]

Although the court has not enunciated a "standard" upon which an insurer might gauge its investigative activities in order to avoid a subsequent finding of "bad faith-plus" as a result of an "inadequate" investigation,[49] there are emerging patterns discernible in the court's decisions exhibiting the scope of an insurer's duty to investigate pre-denial in Mississippi.[50] Additionally, there are decisions illustrative of various methods of investigation previously utilized by insurers in Mississippi, at least implicitly suggesting the Mississippi Supreme Court's acceptance or rejection of these methods.[51] Analysis of these emerging patterns and methods of investigation considered by the court reveal a practical and workable

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41. The insurer cannot insulate itself from potential punitive damages by delegating the investigation of claims to an independent contractor. *See, e.g.*, Jessen v. National Excess Ins. Co., 776 P.2d 1244, 1248 (N.M. 1989) (rejecting the insurer's argument that punitive damages should not be awarded because the only reckless or grossly negligent acts of investigation of the claim were committed by the independent investigator retained by the insurer, and ruling that "[t]he duty of good faith dealing by parties to an insurance contract [is] a nondelegable duty, breach of which supports the award of punitive damages") (citation omitted).

42. *See supra* notes 35-36 and accompanying text.

43. *See supra* notes 35-42 and accompanying text.

44. *See* Goldberg, *supra* note 9, at 170.

45. *See supra* notes 28-33 and accompanying text.

46. *See supra* notes 33-34 and accompanying text.

47. See supra notes 6-9 and accompanying text.

48. The Mississippi Supreme Court has simply recognized that "[a]n insurance company has a duty to the insured to make a reasonably prompt investigation of all relevant facts." Bankers Life and Casualty Co. v. Crenshaw, 483 So. 2d 254, 276 (Miss. 1986). *See supra* note 38 and accompanying text.

49. The scope of this paper is limited to the "adequacy" of the scope of an insurer's investigation pre-denial, and the paper does not consider at length the insurer's duty to "promptly" investigate the claim. There is, however, consideration given to an insurer's failure to investigate until suit has been filed for breach of the policy, as such action by the insurer is facially "inadequate" investigation in regard to both the *extent* and the *promptness* of the investigation. *See infra* notes 69-100 and accompanying text.

50. *See infra* notes 56-100 and accompanying text.

51. *See infra* notes 98-133 and accompanying text.

standard[52] which may be utilized by insurers in Mississippi to ensure satisfaction of the implied covenant of good faith and fair dealing inherent in its duty to investigate promptly and adequately claims for benefits under the contract of insurance pre-denial.

A. "Honest and Realistic Evaluations" of Claims

As preface to a consideration of the investigative activities of insurers and the viability of a bad faith claim predicated upon these activities, one must first be cognizant that insurers have a "lawful responsibility of investigating any claim which is dubious."[53] An intensive investigation into the validity of the claim does not, therefore, necessarily imply bad faith on the part of the insurer, even if the investigation culminates in rejection of the claim. Furthermore, "if a justifiable reason or an arguable basis for denying a claim exists, the insurance company is under a duty to assert it."[54] To assist the insurer legitimately fulfilling this duty, the Mississippi Supreme Court has ruled that it will not "penalize honest and realistic evaluations of claims."[55] There are, however, at least two distinct situations in which the court has found an insurer's investigative activities to be neither "honest" nor "realistic" but, rather, indicative of the insurer's bad faith in handling the claim.

1. Investigation Conducted for Purpose of Denying Claim.

The Mississippi Supreme Court has recognized that an investigation undertaken for the sole purpose of gathering information upon which the claim may be denied is indicative of bad faith by the insurer and has further held that such conduct constitutes an independent tort which warrants the submission of punitive

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52. The insurer must not solely seek information germane to the claim which provides an "arguable" reason for *denial,* but must also pursue *any* information relevant to the validity of the claim. *See infra* notes 56-68 and accompanying text. The insurer must also initiate investigation of the claim "promptly" upon receipt of the claim, and certainly, at a minimum, before the insured is forced to file suit to enforce the claim. *See infra* notes 69-100 and accompanying text. Finally, the investigation must minimally consist of interviewing the insured and the insured's physician and obtaining a complete medical file on the insured. *See Crenshaw,* 483 So. 2d at 270; *infra* notes 102-34 and accompanying text.

53. Blue Cross & Blue Shield of Miss. v. Campbell, 466 So. 2d 833, 841 (Miss. 1984).

54. *Crenshaw,* 483 So. 2d at 271. *Cf.* Duir v. John Alden Life Ins. Co., 754 F.2d 245 (7th Cir. 1985):

> [W]hen an insurer exercises its duty of ordinary care and reasonable diligence in investigating and evaluating claims and determines that a claim is "fairly debatable," the insurer is entitled to debate and/or litigate the claim if it feels that there is a question of law or fact which must be decided before the insurer, in good faith, is required to pay.

Duir, 754 F.2d at 249 (citations omitted).

Though the Mississippi Supreme Court has not made clear to whom the duty to investigate is owed, one must presume it is to the other insureds of the insurer, as payment of dubious claims by the insurer would result in higher premiums to all insureds. *See Crenshaw,* 483 So. 2d at 271; *Campbell,* 466 So. 2d at 841.

55. *Campbell,* 466 So. 2d at 841.

damages to the jury.[56] Therefore, when an insurer "gambles" on a risk by not adequately investigating the insured's medical history *prior* to receiving premiums – and subsequently "loses", when the claim is filed, the insurer may properly be considered as acting in bad faith when it then undertakes an intensive investigation of the insured's medical history in an effort to deny the claim.[57] The Mississippi Supreme Court has explicitly recognized the manifest injustice of these post-claim, "uh-oh" investigations:

> To allow [the insurer] to "sandbag" and gloss over its investigation of [the insured's] medical history at the time of evaluating the underwriting risk then comb intensively for five months his prior records after a claim is made "looking for a defense" (even based on a condition unrelated to his benefit claim) and then deny coverage "in good faith" is to invite manifest abuse of the public in such relationships. Under such circumstances punitive damage awards provide the public with its best protection from such abuse of this relationship between insured and insurer.[58]

The insurer, of course, has a vested interest in denying a claim and may be logically expected to seek more fervently information favorable to its interest – denying the claim – than information substantiating the claim.[59] The special relationship between the insurer and insured,[60] however, militates against such actions by the insurer as intentionally ignoring evidence substantiating the claim[61]

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56. *See* Southern United Life Ins. Co. v. Caves, 481 So. 2d 764, 768-69 (Miss. 1985).

But cf. McLaughlin v. Connecticut Gen. Life Ins. Co., 565 F. Supp. 434, 452 (N.D. Cal. 1983) ("Clearly the duty to investigate possible bases for an insured's claim includes the duty to investigate grounds for denying the claim."); *Campbell*, 466 So. 2d at 838 ("bad faith" not found where insurer denied claim based on determination of "in-house" Medical Review Department "consisting of five registered nurses and a medical doctor [which] reviewed claims to determine, among other things, *if they were for pre-existing conditions*") (emphasis added).

57. *See Caves*, 481 So. 2d at 768.

58. Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 811 (Miss. 1983).

59. *See* Bankers Life and Casualty Co. v. Crenshaw, 483 So. 2d 254 (Miss. 1986):

> [The physician retained by the insurer to review the claim for health benefits] should have recognized that under any standard of prudent medical practice it is foolhardy to attempt to make a diagnosis on incomplete medical records. [The physician's] in-house memos clearly indicate that he knew review of [the insured's] emergency room record was essential to a trustworthy diagnosis; however, he never required [the insurer] to obtain a copy of it before rendering his opinion. The inter-office memos indicate the executive personnel engaged in a distinct, yet subtle nudging of [the physician] in the direction of an opinion favorable to it. They "used" their doctor and he quite willingly accommodated them in the affair. [The physician] ignored the gaps in the information needed in order to make an accurate evaluation, picked the facts favorable to [the insurer], and gave a medical opinion.

Id. at 272-73.

60. *See supra* note 6 and accompanying text.

61. *See* GUY O. KORNBLUM ET AL., CALIFORNIA PRACTICE GUIDE: BAD FAITH (1986) [hereinafter KORNBLUM ET AL.], providing the following example:

> Insurer denied [insured's] claim for disability benefits. It *purposely ignored* a great deal of medical evidence showing [the insured] was unable to continue her regular occupation. Instead, it chose to rely on doctors it had selected to examine her; but these doctors had not seen her medical records and did not know what physical activity her work required. Insurer's conduct was held sufficiently "outrageous" to constitute the tort of intentional infliction of emotional distress, supporting an award of both compensatory and punitive damages.

Id. (citing Little v. Stuyvesant Life Ins. Co., 136 Cal. Rptr. 653 (1977)).

or purposely neglecting to seek information which might substantiate the claim.[62] One group of scholars in the arena of bad faith litigation has persuasively noted that "investigations must be even-handed, so as to verify both facts *supporting* the claim as well as those which would be ground for its denial."[63] Such even-handed investigations are, indeed, the only assurance that the insurer has, in good faith, satisfied both the duty to uncover and contest unsubstantiated claims[64] and the duty to promptly and adequately investigate all claims.[65]

Though an insurer is not duty-bound to conduct an intensive investigation of the insured prior to the filing of a claim,[66] the insurer must, at a minimum, conduct a cursory investigation of any facts which the application reveals, or are otherwise within the knowledge of the insurer,[67] which suggest the potential for subsequent denial of benefits. An insurer is certainly acting neither honestly nor realistically[68] when it denies a claim for benefits based on facts readily available *ab initio*, but only discovered later during an intensive investigation conducted for the purpose of uncovering information upon which to deny the claim. Indeed, such action is clearly indicative of "bad faith-plus" by the insurer.

2. Investigation Conducted Only After Suit Filed

A fact pattern closely related to – but distinctly dissimilar from – only investigating a claim for the purpose of denying benefits[69] is the instance where the insurer fails to investigate adequately the claim for benefits until the insured has filed

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62. *See* Continental Assurance Co. v. Kountz, 461 So. 2d 802 (Ala. 1984):

> [The claims manager] testified about [the insurer's] methods of obtaining information upon which to deny or allow a claim. The questioning sought an explanation of [the insurer's] failure to request information directly from [the insured's doctor] before denying the claim:
>
> Q. Oh, I see. You will [directly] request things that you think will help get you out of [paying the claim], but if it's something that might substantiate [the claim], you go through the group employer, right?
>
> A. To a degree, that's what we are told [to do] by the employers.

Id. at 808.

63. KORNBLUM ET AL., *supra* note 61, § 5.25, at 5-6.

64. *See supra* notes 53-55 and accompanying text.

65. *See supra* notes 35-42 and accompanying text.

66. *See supra* note 40 and accompanying text.

67. Knowledge of the insurer's issuing agent concerning the health of the insured is imputed to the insurer, and failure of the agent to provide this information to the insurer does not constitute an arguable or legitimate reason for the insurer to deny the claim based on the undisclosed information. *See, e.g.*, National Life and Accident Ins. Co. v. Miller, 484 So. 2d 329 (Miss. 1985):

> The failure of the application to contain all of the information relayed by [the insured] to [the issuing agents] does not constitute an arguable basis for denying the claim.
>
> [The insurer also] asserts that the knowledge gained by [the agents] while taking the application from [the insured] cannot be imputed to it because they were merely soliciting agents. That position is contrary to the law of this state as defined both by statute and case law.

Id. at 334 (citing MISS. CODE ANN. § 83-17-1 (1972)) (citations omitted).

Cf. McCann v. Gulf Nat'l Life Ins. Co., 574 So. 2d 654, 656 (Miss. 1990) ("Under the principles of agency, an insurer is bound by the acts of its agents. MISS. CODE ANN. § 83-17-1 (Supp. 1990), which defines an agent, was enacted 'to prevent insurers from operating through third persons and later denying responsibility for the acts of those persons.' ") (citations omitted).

68. *See supra* notes 53-55 and accompanying text.

69. *See supra* notes 56-68 and accompanying text.

suit to recover benefits due under the policy.[70] The necessity of an action for tortious bad faith in these cases – where the insurer only conducts an investigation into the validity of the claim after suit has been filed – is clearly demonstrated in *McLaughlin v. Connecticut General Life Insurance Co.*[71]

In *McLaughlin,* the insured was diagnosed as having terminal lung cancer and rejected her doctor's advice to undergo chemotherapy, opting instead for immuno-augmentative therapy, "an experimental cancer therapy not approved by the FDA for use in the United States."[72] The insurer subsequently denied a claim for coverage of these benefits on two separate occasions, stating as its only reason for denial that the therapy was not FDA approved.[73]

After the insured filed suit for breach of contract and breach of the implied covenant of good faith and fair dealing,[74] the insurer asserted numerous other grounds for denial of the claim, specifically: "that the . . . therapy was worthless and therefore not necessary to . . . treatment; that . . . the only licensed physician at the Immunology Researching Centre . . . did not prescribe the therapy; and that . . . use of the therapy was illegal in [the state]."[75] The *McLaughlin* Court noted, however, that the insurer's agents had clearly testified that the only reason for denial was that the therapy had not been approved by the FDA[76] and, more importantly, recognized that the agents had not conducted any investigation into bases potentially substantiating the claim pre-denial:

> Despite the fact that [the insured] had represented to [the insurer] that [the insured's personal physician] was impressed with her condition following the immuno-augmentative treatments, and later [another treating physician of the insured] wrote [the insurer] that the therapy may have benefitted [the insured], none of [the insurer's] agents contacted either of these doctors to ask their opinion about whether the therapy was effective for [the insured]. Nor did they contact the Immunology Researching Centre or any other doctor who believed that the therapy may be effective. They never requested [the insured's] medical records.[77]

In rejecting the additional defenses asserted by the insurer at trial, the *McLaughlin* Court stated that "an insurance company which relies on specified grounds for denying a claim thereby waives the right to rely in subsequent litigation on any other

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70. *See* Aetna Life Ins. Co. v. Lavoie, 505 So. 2d 1050, 1053 (Ala. 1987) ("Once the bad faith has occurred, once the duty to use good faith in considering insurance claims has been breached, the insurance company cannot later seek to justify its denial by gathering information which it should have had in the first place.").

71. 565 F. Supp. 434 (N.D. Cal. 1983).

72. *Id.* at 437. The insured received the therapy at the Immunology Researching Centre in the Bahamas. The fact that this treatment was received outside the United States posed no issue as "the policy [provided] for coverage of medical expenses incurred in foreign jurisdictions." *Id.*

73. *McLaughlin,* 565 F. Supp. at 438. The district court noted, however, that "[t]he policy makes no mention of the effect on coverage or exclusion of the Food and Drug Administration's ("FDA") approval of drugs or treatments." *Id.* at 437.

74. *Id.* at 437.

75. *Id.* at 451.

76. *Id.* at 438.

77. *Id.* at 439.

grounds which a reasonable investigation would have uncovered."[78] Expounding on this holding, the *McLaughlin* Court posited the rationale underlying a finding of bad faith in a case where an insurer fails to investigate the possible bases supporting the validity of a claim until suit is filed:[79] "If an insurance company could deny a claim without thoroughly investigating it and then defend a subsequent lawsuit on grounds which it develops during discovery for trial, the company's incentive to fulfill its duty to investigate would be significantly diminished."[80]

In *Veal*, the seminal case of bad faith litigation in Mississippi,[81] the Mississippi Supreme Court adopted the rationale of *McLaughlin*, though not explicitly, affirming an award of punitive damages after finding that "[f]ollowing its initial rejection of the claim [the insured] employed an attorney and [the insurer] again rejected the claim for the original reason stated. [The insurer] only offered to pay the face amount of the policy *after [the insured] had filed his suit.*"[82] Following *Veal*, the court in *Blue Cross & Blue Shield v. Maas*,[83] explicitly recognized that an insurer's failure to investigate the validity of a claim until suit had been filed was actionable bad faith and warranted imposition of punitive damages.[84]

In *Maas*, a clerk employed by the insurer—acting upon a note from the insured's employer that the insured had quit—canceled coverage on the insured under the group insurance policy carried by the employer.[85] This cancellation was erroneous, however, as the employer continued to pay premiums on the insured which kept coverage effective until after the initial claim for benefits.[86] Approximately one month after filing the claims, the insured, after telephoning the insurer about the claims, was told that the insurer would "check into it."[87]

Having received no further response from the insurer—other than the initial rejection of the claims—the insured filed suit on January 10 seeking actual and punitive damages.[88] The insurer began an investigation into the validity of the claim on

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78. *Id.* at 451.

79. Although the insurer in *McLaughlin* was found to have breached the implied covenant of good faith and fair dealing in failing to investigate the claim, *id.* at 454, punitive damages were not awarded:

> [The insured] offered no evidence which suggests that [the insurer] intended to injure them or that it consciously disregarded the fact that it had no basis for its denial and that its denial would injure [the insured]. Though the evidence demonstrates that [the insurer] acted cavalierly in handling [the insured's] claim, it had valid reasons for being disinclined to grant the claim.

Id. at 454-55.

The *McLaughlin* court's failure to award punitive damages is questionable. The insurer's absolute neglect in investigating the validity of the claim despite persuasive evidence in the possession of the insurer that the insured benefitted from the therapy, *see supra* note 77 and accompanying text, is gross negligence "evincing ruthless disregard for the rights of [the insured]." Fowler Butane Gas Co. v. Varner, 141 So. 2d 226, 233 (Miss. 1962).

80. *McLaughlin*, 565 F. Supp. at 451.

81. Standard Life Ins. Co. v. Veal, 354 So. 2d 239 (Miss. 1977). *See supra* notes 16-26 and accompanying text.

82. *Id.* at 248 (emphasis added).

83. 516 So. 2d 495 (Miss. 1987).

84. *Id.* at 496-98.

85. *Id.* at 496.

86. *Id.*

87. *Id.*

88. *Id.* This suit was filed approximately two months after the initial claim for benefits.

January 14[89] and admitted at trial that "[w]e made a mistake."[90] Affirming an award of $100,000 in punitive damages, the Mississippi Supreme Court agreed with the trial court's finding that "the actions complained of by the plaintiffs were committed by gross negligence indicative of a wanton and willful disregard of the rights of others."[91]

In *National Life and Accident Insurance Co. v. Miller*,[92] the soliciting agent of the insurer filled out the application for insurance while eliciting responses to specific health questions from the applicant.[93] Although the agent was given honest and complete responses by the applicant, the agent purposely failed to enter certain health information on the application which the agent later described as "insignificant" information.[94] The insurer issued the policy on the basis of the agent's representations on the application, but subsequently denied benefits under the policy as a result of the failure of the application to disclose a pre-existing condition.[95] The agent had been made cognizant by the applicant of this condition at the time of application and had purposely failed to enter it on the application.[96] Finding that the insurer did not even interview the soliciting agent's supervisor—whereby its erroneous denial of benefits would have become readily apparent—until eleven months after the initial rejection of the claim and only two weeks prior to trial, the *Miller* court concluded that this action was an "inexcusabl[y] inadequate investigation" and warranted submitting the issue of bad faith and punitive damages to the jury.[97]

Veal, *Maas*, and *Miller* evidence that the Mississippi Supreme Court recognizes that an insurer has not honestly or realistically evaluated a claim[98] when the insurer initiates an investigation into the validity of the claim only after suit has been filed to recover allegedly wrongfully withheld benefits. Moreover, the court has explicitly recognized that there are no grounds upon which to submit the issue of punitive damages to the jury where "[the insurer pays] the full amount due under its policy prior to and without necessity of a suit being filed to collect it."[99] In light of these decisions, should an insurer in Mississippi choose to lie dormant until forced into action by judicial process, the insurer may be found, as a matter of law, to have handled the claim in bad faith and to be subject to an award of punitive

89. *Id.*
90. *Id.*
91. *Id.* at 498 (quoting Instruction P-13).
92. 484 So. 2d 329 (Miss. 1985).
93. *Id.* at 330.
94. *Id.* at 331.
95. *Id.* at 330-31.
96. *Id.*
97. *Id.* at 337.
98. *See supra* notes 53-55 and accompanying text.
99. Blue Cross & Blue Shield of Miss. v. Campbell, 466 So. 2d 833, 839 (Miss. 1984).

damages. Indeed, "an insured purchases insurance and not an unjustified court battle when he enters into the insurance contract."[100]

B. "Adequacy" of Investigative Procedures

The immediately preceding section considers two distinct factual situations in which the insurer's investigative activities suggest "bad faith" in handling the claim for benefits.[101] The more troublesome inquiry arises, however, where the insurer has clearly made at least minimal effort in investigating the validity of the claim prior to suit being filed to recover benefits under the contract. In these cases, the relevant inquiry becomes whether the insurer has made "adequate" investigation of the claim pre-denial.[102] The only clear guidance provided by the Mississippi Supreme Court as to the adequacy of investigation is that the insurer "has a duty to the insured to make a reasonably prompt investigation *of all relevant facts.*"[103] This section analyzes decisions in which either the scope and/or method(s) of investigation utilized by the insurer has been considered by courts in an attempt to glean from these decisions a more definitive standard of adequate investigation to be applied in bad faith litigation arising out of allegedly wrongful investigation of the claim pre-denial.

Adequate investigation, though admittedly without precise scope, requires at least the following:

> [D]oing whatever is necessary to develop sufficient information to permit an intelligent evaluation of the merits of the claim . . . . Depending on the circumstances, it may require interviewing witnesses; examining documents or physical objects; visiting the scene of an accident; contacting the insured, physicians, or witnesses by letter or telephone, or personally; or acquiring an expert's opinion on technical matters beyond the competence of the investigator to evaluate.[104]

In the context of a claim for health insurance benefits, the duty of investigation on the insurer requires that the insurer obtain all facts relevant to the concerned injury or illness. This process may require an objective intensive investigation[105] into the claimant's medical history as well as a complete investigation of all facts surrounding the particular occurrence. Though an insurer will not be subject to

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100. Gulf Atl. Life Ins. Co. v. Barnes, 405 So. 2d 916, 925 (Ala. 1981), *quoted in* Aetna Life Ins. Co. v. Lavoie, 505 So. 2d 1050, 1053 (Ala. 1987).

101. *See supra* notes 55-96 and accompanying text.

102. The standard of "adequate" investigation is suggested in Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 276 (Miss. 1985) ("[The insurer] has a further duty, *after an adequate investigation* [of all relevant facts] and a realistic evaluation of the claim, to tell the insured . . . the plain truth.") (emphasis added).

103. *Id.* at 276 (emphasis added). *See supra* notes 35-42 and accompanying text.

104. *Insurer's Breach*, *supra* note 38, at 382-83. (footnotes omitted).

105. An intensive investigation conducted *for the purpose of* denying a claim is indicative of an insurer's bad faith. *See supra* notes 56-68 and accompanying text.

imposition of punitive damages for mere "negligent" investigation,[106] "when there is evidence . . . that the insurer negligently failed to conduct a proper investigation that would easily adduce evidence showing its defenses to be without merit, the insurer's adherence to the meritless position is not likely to be a 'legitimate or arguable' reason to deny payment."[107] Thus, in determining whether an insurer's investigation is "adequate," one must consider the investigative methods utilized by the insurer pre-denial and whether these methods would easily adduce evidence supporting the *validity* of the claim.

The Mississippi Supreme Court has suggested that evidence of the validity of a claim might be easily adduced by interviewing the insured and the insured's doctor and obtaining a complete medical file on the insured.[108] Although the court has not explicitly adopted these methods as constituting an adequate investigation of the claim, as a matter of law, other decisions certainly indicate that the Mississippi Supreme Court considers this to be both a reasonable and workable standard of investigation. Most recently, the court has even intimated that the insurer should communicate with the agent issuing the policy under which the benefits are claimed prior to denial of benefits.[109]

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106. *See, e.g.*, Western Fire Ins. Co. v. Copeland, 651 F. Supp. 1051, 1056 (S.D. Miss. 1987) ("Even assuming *arguendo* that an investigation is conducted negligently, an award of punitive damages is not automatically justified.") (applying Mississippi law) (citations omitted); *see also* Bellefonte Ins. Co. v. Griffin, 358 So. 2d 387, 391 (Miss. 1978) (negligent failure of insurer to investigate facts following initial investigation did not warrant award of punitive damages).

107. Merchants Nat'l Bank v. Southeastern Fire Ins. Co., Inc., 751 F.2d 771, 777 (5th Cir. 1985).

108. *See* Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 270 (Miss. 1985).

109. *See* McCann v. Gulf Nat'l Life Ins. Co., 574 So. 2d 654, 659 (Miss. 1990) (issue of punitive damages should be submitted to jury where denial of benefits was made without contacting personal physicians or agents issuing the policy); *see also supra* note 67. *But see Crenshaw*, 483 So. 2d at 270, where direct communication with the issuing agent was not required in an insurer's investigative procedures implicitly approved by the court. The court found that an insurer's denial of a claim for health benefits without even adhering to its own investigative procedures "is a striking example of how an insurance claim should not be handled." *Id.* The court set forth the insurer's "claim inquiry form" (below) and noted that *none* of these steps had been taken pre-denial:

> Investigation is not confined to points checked below. Cover fully, but in addition, use good judgment in following all leads.
>
> * * * *
>
> Interview attending physician PERSONALLY and:
>
> Use confirmation of interview, Form 1425.
>
> Obtain photocopy of his records (if not available, explain).
>
> Emphasize the following point(s) when personally interviewing physician:
>
> Question thoroughly regarding policy provisions checked above.
>
> Past health history . . .
>
> Determine if injury is sole cause, independent of all other causes.
>
> Exact cite of amputation [this handwritten in]
>
> Obtain hospital record.
>
> Photocopy entire record.
>
> Exclude: nurses notes-temp charts.
>
> EKG reports.
>
> Interview insured and obtain:
>
> Signed statement on confirmation of interview.
>
> Signed medical authorizations.
>
> Description of circumstances surrounding accident.
>
> Description of injuries.
>
> Name and address of doctors and hospitals where confined.

Id.

1. Interviewing the Insured

One could hardly argue that interviewing the insured pre-denial would not facilitate a more complete and fair evaluation of the claim. Though insurers often provide the insured an opportunity to submit any additional information which would support the validity of the claim *post*-denial,[110] this practice impermissibly places the burden of investigating the claim on the insured.[111] Only by interviewing the insured in the preliminary stages to ascertain the appropriate scope of the investigation can the insurer be certain of fulfilling its duty of adequate investigation.[112] Though an insurer might contend that seeking information from the insured *is* "investigation," this position is only tenable where the insurer interviews the insured *pre*-denial.

2. Interviewing the Insured's Physician

"It is well settled that an insurance company is entitled to rely upon information from the insured's doctor in making its decision about benefits."[113] In fact, the Mississippi Supreme Court has recently ruled that the issue of bad faith should be submitted to the jury where the denial of benefits was made *without* contacting the insured's personal physicians or agents issuing the policy.[114] Although the Fifth Circuit Court of Appeals has further held that an insurer's reliance in denying a claim on an opinion by a *non-treating* physician retained by the insurer to examine the insured constitutes "an arguable defense as a matter of law,"[115] this holding does not import that an insurer is entitled to rely upon the opinion of a non-treating physician *absent examination* of the insured by the non-treating physician.[116] Thus, an insurer which does not provide for examination of the insured prior to denial must, at least "with a simple phone call or letter,"[117] directly communicate

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110. *See, e.g., McCann*, 574 So. 2d 654, 656 (Miss. 1990) (insurer sent letter to insured denying claim based on insurer's determination that insured failed to disclose a pre-existing condition on the application, and "[t]he letter directed [the insured] to get in touch with [the insurer] if he knew of any circumstances which might change the outcome.").

111. *See* Hughes v. Blue Cross of N. Cal., 245 Cal. Rptr. 273, 280 (Cal. Ct. App. 1988) ("The covenant of good faith and fair dealing . . . places the burden on the insurer to seek information relevant to the claim.").

112. *See supra* note 109 where the Mississippi Supreme Court implicitly approved the insurer's investigative procedures for an example of the type of information which should be obtained from the insured in the initial stage of the insurer's investigation.

113. Life & Casualty Ins. Co. of Tenn. v. Bristow, 529 So. 2d 620, 623-24 (Miss. 1988) (citations omitted) (reversing an award of punitive damages where the insurer sought and received information from the insured's doctor and continually sought to interview the insured's doctor).

See also Ledingham v. Blue Cross Plan for Hosp. Care of Hosp. Serv. Corp., 330 N.E.2d 540, 549 (Ill. App. Ct. 1975) (punitive damages award reversed where "[t]he decision to deny benefits was made in good faith on the basis of the *insured's* doctor's statement.") (emphasis added).

114. *McCann*, 574 So. 2d at 659.

115. Peel v. American Fidelity Assurance Co., 680 F.2d 374 (5th Cir. 1982) (applying Mississippi law).

116. *Cf.* Life Ins. Co. of Miss. v. Allen, 518 So. 2d 1189, 1193 (Miss. 1987) ("Making [the insurer's] conduct more egregious, [the insurer's claims adjuster] didn't even bother to check with [the insured's physician] *or any other physician* before denying the claim.") (emphasis added).

117. *Id.*

with the insured's treating physician pre-denial in order to fulfill its duty of "adequate" investigation.[118]

3. Obtaining a Complete Medical File on the Insured

In order to "honestly" and "realistically" evaluate a claim pre-denial, the insurer must not only acquire *all* medical records of the insured pertinent to the *specific* claim,[119] but also acquire any other medical information which may be helpful in determining the validity of the claim.[120] In fact, an insurer's investigative procedure form, implicitly approved by the Mississippi Supreme Court in *Crenshaw*,[121] specifically provided that "[i]nvestigation is not confined to points checked below."[122] These "points" consisted of interviewing the insured, personally interviewing the insured's treating physician, and obtaining a complete file of the insured's medical records.[123] For example, it would be extremely difficult for an insurer to satisfy its duty of contesting dubious claims[124] if the insurer did not have available all of the insured's medical records which might, upon careful examination, reveal that a pre-existing condition is the cause of the specific malady for which benefits are presently being sought. Thus, the insurer not only fulfills its duty of adequate investigation by procuring complete medical records on the insured, but also serves to fulfill its duty to contest unwarranted claims.

Though no court has ruled that an insurer must obtain a "complete" medical history of the insured – encompassing birth to present claim for benefits – prior to denying benefits, it has been specifically held that merely requesting information from the hospital where the insured was treated is insufficient investigation[125] and, additionally, if hospital records are to be the basis of denial, these records must contain all "critical" information relevant to the claim.[126] The Mississippi Supreme Court has at least implicitly recognized this requirement – that the records contain all "critical" information relevant to the claim – intimating that an insurer could have avoided imposition of punitive damages if only the insurer would have ad-

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118. *See supra* note 109 where the Mississippi Supreme Court implicitly approved the insurer's investigative procedures for an example of the type of information which should be obtained from the insured's treating physician prior to denial of the claim.

119. *See* Hughes v. Blue Cross of N. Cal., 245 Cal. Rptr. 273, 279 (Cal. Ct. App. 1988) ("In reviewing the medical necessity of hospitalization, [the] duty of investigation surely entails an obligation to make reasonable efforts to obtain all medical records relevant to the hospitalization."); *See also supra* note 109 (exhibiting types of medical records to be procured by the insurer).

120. *See* Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 270 (Miss. 1985) (the insurer "has a duty to the insured to make a reasonably prompt investigation *of all relevant facts*.") (emphasis added).

121. *Id.* at 270; *see supra* note 109.

122. *Id.; see supra* note 109.

123. *See supra* note 109.

124. *See supra* notes 53-55 and accompanying text.

125. *See* Ainsworth v. Combined Ins. Co. of Am., 763 P.2d 673, 675 (Nev. 1988) ("The sum total of [the insurer's] investigative effort was to send a $5 check to each of two hospitals, accompanied by a records request form. This effort was clearly inadequate to support [the insurer's] assertion that it handled the claim properly.").

126. Aetna Life Ins. Co. v. Lavoie, 505 So. 2d 1050, 1053 (Ala. 1987) ("Considering the fact that the decision to deny was made without the benefit of 'critical' sections of the medical file [nurses' notes and patient's progress notes], the jury could find that the claim was not 'properly investigated,' and that there was a 'reckless indifference to facts or to proof.' ").

hered to its own investigative procedures[127] which included acquisition of the entire hospital record of the insured.[128] Interestingly, however, the Mississippi Supreme Court has opined that once an insurer denies a claim based on "records submitted" to the insurer from the treating hospital which itself is seeking payment for services rendered the insured, the burden then shifts to the hospital *creditor* to provide the insurer with additional information substantiating the claim.[129] One must suppose, however, that the court does not intend this burden to shift until the insurer has fulfilled its duty to the insured of adequate investigation of the claim, including ensuring that it has received all information relevant to the claim from the hospital pre-denial.

In sum, the extent of medical records to be acquired by the insurer pre-denial is dependent upon the particular claim. Following an initial interview with the insured[130] and the insured's physician,[131] the insurer's claims representative—possessing sufficient medical skills[132]—will be able to ascertain the extent of medical history needed on the insured in order to effectuate an honest and realistic evalua-

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127. *See* Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 270 (Miss. 1985).

128. *Id.; see supra* note 109.

129. *See* Blue Cross & Blue Shield of Miss. v. Campbell, 466 So. 2d 833 (Miss. 1984):

> If a hospital wants to be paid for a claim in which its own records cast a serious doubt, the hospital should take the appropriate steps to see that [the insurer] is furnished with records or reputable medical opinion that the hospitalization was not *for*, or *as a result of* any ailment or disease or physical condition existing at or before the inception of [the policy].

Id. at 840.

130. *See supra* notes 110-12 and accompanying text.

131. *See supra* notes 113-18 and accompanying text.

132. *See* Staff Builders, Inc. v. Armstrong, 525 N.E.2d 783, 789 (Ohio 1988), in which the court found that "[i]t is abundantly clear that information relevant to the claim was either reviewed by persons unskilled in this evaluation or disregarded by those who possessed such skill," and affirmed an award of punitive damages where

> [a]n employee of [the insurer] who admitted that she had no medical training recommended denial of the claim prior to any review by medical personnel as to the justification for the expenses incurred. Moreover, despite the determination by a senior claim examiner in the home office . . . that additional medical information was necessary in order to evaluate the recommendation, the medical specialist for [the insurer] conceded that he had not reviewed a letter sent by the attending physician of [the insured].

Id. at 788-89. *See also Insurer's Breach, supra* note 38:

> Good faith and fair dealing requires that the insurer undertake investigation of the claim promptly on receipt of notice of loss *by an adjuster or investigator capable of dealing with the particular problem presented*, who promptly identifies and notifies the insured of any rights the insurer intends to reserve or defenses it will claim.

Id. at 387 (emphasis added).

tion of the claim.[133] Thus, in order for the insurer to fulfill its duty of adequate investigation by obtaining a "complete" medical file on the insured, the insurer must, at a minimum, directly communicate with the insured and the insured's treating physician.

IV. CONCLUSION

A duty of adequate investigation of health insurance claims[134] is justifiably imposed on health insurers pre-denial. Considering the vast amount of resources available to insurers[135] and the special relationship created by the contract of insurance between the insurer and insured,[136] an insurer must appropriately expect to shoulder at least this minimal duty of pre-denial investigation. Although at least one court has suggested that the extent of investigation should vary with the "seriousness" of the claim,[137] such a rule would detract tremendously from providing predictability and should be avoided in favor of a standard of minimum investigation to be conducted by the health insurer regardless of the "severity" of the claim.

The Mississippi Supreme Court's implicit recognition of "adequate" investigative procedures in *Crenshaw*[138] provides such a minimum standard of investigation which health insurers in Mississippi may appropriately be held, as a matter of law, to be duty-bound. The *Crenshaw* "standard" of investigation is both objective[139] and reasonable, and provides adequate assurance that the insured's peace of mind[140] will not be shattered as a result of an insurer's bad faith investigation of the validity of the insured's claim. A health insurer in Mississippi should be required

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133. The insurer's representative should have sufficient medical skills to ascertain from an initial interview with the insured and treating physician whether the claim might be attributable to an excluded pre-existing condition or other cause not covered by the terms of the policy. *See supra* note 132. Following this initial assessment, the insurer's representative may then determine which medical records of the insured are needed. Thus, should the initial assessment suggest the existence of a pre-existing condition, the insurer should be required to obtain and evaluate all medical information on the insured, dating back to the inception of the suspected pre-existing condition, prior to denial. For example, if the initial interview with the insured claiming benefits for heart surgery reveals that the insured had experienced chest pains at intermittent periods prior to the effective date of the policy, the insurer must, at a minimum, obtain all medical information on the insured which might reveal prior heart problems, prior to denial of the claim based on a pre-existing condition.

See Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 264 (Miss. 1985) (punitive damages awarded where insurer denied claim on basis that amputation of foot of insured was due to disease (not covered) rather than to injury (covered), although the insurer was aware that it had not obtained an emergency room report which would reveal if the amputation was necessitated by injury or disease).

134. *See supra* notes 35-42 and accompanying text.

135. A recent survey of financial data available on the ten largest insurance companies operating in Mississippi reveals that net income for these companies in 1990 ranged from $8.0 million (Lamar Life) to a low of $.2 million (Gulf National Life). Bill Montague, *Finding Cracks in Insurance*, THE CLARION LEDGER, Oct. 6, 1991, at C1.

136. *See supra* notes 6-7 and accompanying text.

137. *See* Ainsworth v. Combined Ins. Co. of Am., 763 P.2d 673, 676 (Nev. 1988) (*"[I]n spite of the serious nature of its insured's accident,* [the insurer] conducted no independent investigation and utterly failed to evaluate fairly the medical evidence it possessed in its claim file.") (emphasis added).

138. 483 So. 2d 254 (Miss. 1985); *see supra* note 109 and accompanying text.

139. Although the extent of medical records of the claimant to be procured by the insurer is largely dependent upon the particular claim and, thus, arguably not objective, the court may make an objective assessment of the scope of the records acquired by the insurer following introduction of evidence concerning the insurer's interview with the insured and the insured's physician. *See supra* notes 110-33 and accompanying text.

140. *See supra* note 4 and accompanying text.

as a matter of law to interview the insured and the insured's physician and to procure a complete medical record on the insured prior to denial of the claim[141] in order to avoid a finding of "bad faith-plus" in investigation of the claim.[142] Failure to conduct these activities is indicative of "bad faith-plus" by the insurer, evidencing either the insurer's intentional refusal to seek information supporting the validity of the claim as well as its denial or, at a minimum, gross negligence in complete disregard of the rights of the insured. Should the insurer not satisfy this minimal standard of adequate investigation, the insured is justifiably entitled to compensation for damage to the insured's peace of mind by an award of punitive damages. Such damages should be commensurate with the egregious nature of the insurer's conduct and be substantial enough to prevent similar conduct by the insurer in the investigation of future claims.

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141. *See* Bankers Life & Casualty Co. v. Crenshaw, 483 So. 2d 254, 270 (Miss. 1985). *See also supra* notes 101-33 and accompanying text.

142. Insurers are also found to be acting in bad faith where the investigation is conducted solely for the purpose of obtaining information upon which the claim may be denied, *see supra* notes 56-68 and accompanying text, and where the insurer initiates an investigation into the validity of the claim only after the insured has filed suit in an attempt to recover benefits, *see supra* notes 69-100 and accompanying text.