OVERCOMING ALLSTATE'S TRADE SECRETS AND WORK-PRODUCT OBJECTIONS

William F. Merlin, Jr., Esquire
Gunn Merlin, P.A.
1100 N. Florida Avenue, #300
Tampa, FL 33602
TEL: (813) 229-1000
FAX: (813) 229-3692

INTRODUCTION

The Insurance Industry Problem

The special nature of insurance and the role it has played in society has been recognized by courts and legislatures for many years. An insurance policy is not obtained for commercial advantage. Instead, it is obtained by people and entities protecting against unknown calamities which may, or may not, ever occur. Often, the policyholder, after paying the premium and expecting protection against calamity, is in an especially vulnerable economic and personal position when the calamity loss occurs. The entire purpose of insurance is defeated if insurance companies and adjusters can refuse or delay the prompt and full payment of monies due under the contract.

Today, the insurance industry is in a much more favorable legal and financial position than the purchasers of their products. An insurance policy contains mutual obligations. Unlike other general commercial contracts, the insurance company promises that it will provide financial security in the event of a catastrophe. It further promises and warrants that the policyholder has "peace of mind" that in the event of a catastrophe, such as a hurricane, the policyholder will be fully and promptly indemnified. Unlike a typical commercial contract, a non-breaching party (the policyholder) cannot replace the performance of the breaching party (the insurance company) by paying the then prevailing market price for counter-performance. Instead, the policyholder is completely dependent on performance by the insurance company when the insured is at its most vulnerable position. If the insurance company fails to fulfill its obligations completely, the policyholder will likely suffer contractual and extra-contractual

damages. Unfortunately, many insurance companies and adjusters delay, refuse or fail to uphold their part of the bargain.

Lately, the press and cultural media have picked up this bad faith conduct during the claims handling process.[1] These reports indicate that insurance companies are notorious for refusing to provide insurance coverage or engaging in sloppy, slow or deliberate bad claims handling.[2] It does not take a financial genius to figure out than an insurance company can make more money by collecting premiums and not paying claims, than the insurance company can make by collecting premiums and paying claims. Even the pro-industry press has picked upon this.[3]

Clearly, "the bargaining power of an insurance carrier vis-à-vis the bargaining power of the policyholder is disparate in the extreme.[4] Moreover, unless an insurance company is confronted with the prospect of paying all damages caused by its wrongful conduct, it will have no incentive to honor its obligations under its existing insurance policies:

> Unlike most other commercial actors fighting for supremacy in a world where possession is nine-tenths of the law, insurers always have the nine-tenths advantage: They hold the money. Consequently, insurers always get to play "play the float" in any dispute. Even where the judicial system acts rapidly and efficiently to provide compensation to wronged policyholders, the carrier may find that it made money by delaying payment of the claim. If its investments have been good, it may even

[1] See generally, Lisa B. Royle, Insuring Good Faith, ABA Journal, Oct. 1995, at 86. J. Grisham, The Rainmaker (Doubleday 1995).

[2] See Joseph Segal, Sluggish Claim Process Can Cause Insured Business' Demise, Claims, Feb. 1995, at 86; Jim Urban, Take It Or Leave It, EXEC. REP., Aug. 1996, at 18; Leslie Scism, Disputed Claims, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, Wall Street Journal, Oct. 15, 1996, at A1.

[3] Leslie Scism, Disputed Claims, Tight-Fisted Insurers Fight Their Customers To Limit Big Awards, Wall Street Journal, Oct. 15, 1996, at A1; Robert H. Gettlin, Fighting The Client, Best's Review P/C, Feb. 1997, at 49, 50 (noting that insurance companies spend over $1 billion a year litigating against their policyholders). See Best's Review P/C, Feb. 1996, at 40 (discussing the industry-wide imperative to stay "sharply focused on the bottom-line results and capital justification").

[4] Hayseeds, Inc., v. State Farm Fire and Cas., 352 S.E. 2d 73, 77 (W. Va. 1986).

> have made money to cover any prejudgment interest, costs, or consequential damages award, or counsel fees collected by the policyholder.[5]

Yet while greater risk may deter some insurance companies, the *status quo* is still clear from the viewpoint of the policyholder: "The insurance company is in no hurry. It has the money. It has your premium. It has an army of lawyers."[6]

The insurance industry recognizes the breach of its duty of good faith and the scope of the remedies available for breach of that duty. For example, a mandatory text studied by prospective Chartered Property and Casualty Underwriters (CPCUs) discusses the current state of the law of bad-faith insurance company conduct:

> 1. All insurance contracts contain a covenant of good faith and fair dealing.
> 2. If bad faith is a tort in a third-party claim, it should be a tort in a first-party claim as well.
> 3. Insurance is a matter of public interest and deserves special consideration by the courts to protect the public.
> 4. Insurance contracts are not like other contracts because insurers have an advantage in bargaining power. Insurers should therefore be held to a higher standard of care.
> 5. Recovery for breach of an insurance contract should not be limited to payment of the original claim.
> 6. The public's expectations are elevated by the insurer's advertising, slogans, and promises, which give policyholders the impression that they will be taken care of no matter what happens.
> 7. Policyholders buy peace of mind and are not seeking commercial advantage when they buy a policy. In addition, they are vulnerable at the time of the loss.

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[5] Jeffrey W. Stempel, Interpretation of Insurance Contracts: Law and Strategy For Insurers and Policyholders § 19.3, at 466-67 (1994).

[6] Herb Denenberg, "How Insurance Companies Avoid Payment of Claims", Reading Eagle, May 26, 1995, at A12 (Mr. Denenberg is a former Commissioner of Insurance for Pennsylvania and Professor of Insurance at the Wharton School of the University of Pennsylvania).

8. Policy language is sometimes difficult to understand. The benefit of the interpretation should be given to the policyholder.[7]

I. THE ALLSTATE CLAIMS PROBLEM

From 1994 through 1997, Allstate Insurance Company underwent a significant change in the way it adjusted claims. Allstate conducted a thorough review and analysis of its claims practice procedures. As a result, in 1995 Core Claim Practice Redesign (CCPR) was established as an agenda for Allstate to change its claims focus.

Traditionally, insurance companies accepted the premise that the average amount paid in indemnity dollars (actual dollars paid to the claimant on average) could not be ethically changed. Allstate challenged this notion and accepted a new premise. It decided that severities could be managed and devised a claims practice to do so. Thus, CCPR and CCPR II were developed by Allstate to control claims severity and focus on small to mid-size claims which Allstate believed provided the greatest opportunity to save money.

As part of this claims focus shift, Allstate Insurance Company developed several programs. It attempted to influence claimants to remain unrepresented by attorneys because Allstate's own studies revealed that it was cheaper for the company to negotiate directly with the claimant than when an attorney became involved. It developed a specialized handling of relatively minor impact claims involving soft-tissue injuries.

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[7] A.E. Anderson, et al., Insurance Coverage Litigation, 11-7 (2nd ed. 1999), citing James J. Markham, et al., The Claims Environment 277-78 (1st ed. 1993).

Further, Allstate attempted to approve the objectivity and consistency in its evaluation process. The central theme of the change was that adjusters could begin to rely upon a software program known as “Colossus” which provided adjusters with a tool indicating what a particular case would be worth. Colossus, along with historical verdict information and a second review by an evaluation consultant, was the primary evaluation change made at Allstate in its claims process.

Eventually the changes were first implemented in various “Focus” areas and throughout the United States. The bottom line result was that the new evaluation process saved the company money, albeit at the cost of greater litigation and trials – especially of those cases involving relatively minor amounts in controversy. From the perspective of the consumer, Allstate would not pay fully for the value of a case and challenged the consumer to spend a significant percentage of any eventual recovery in litigation costs and otherwise unnecessary attorney’s fees. Attorneys representing policyholders and claimants of Allstate have widely criticized Allstate for this tough negotiation position rather than simply paying the full amount owed, quickly and without the need for litigation.

AN OVERVIEW OF COLOSSUS

Colossus is the trade name for a software program which is licensed for use by The Continuum Company, Inc. The principal place of business for The Continuum Company is in Austin, Texas. Continuum is now a subsidiary of Computer Sciences Corporation.

Continuum is marketed as a software program which provides insurance companies help in assessing damages for bodily injury claims. It is essentially a relational data base where adjusters in-put information regarding a bodily injury claim and provides information regarding

the evaluation of damages. Adjusters take information regarding a claim, including liability, medical information and other general damage information and in-put the same within parameters set by Colossus. The information is processed and a valuation range for the value of the case is returned to the adjuster.

The software requires the adjuster to enter general information regarding the adjuster's name, date of loss, regional/branch office, claimant's name, date of birth, gender, etc.   It can provide responses based upon various economic regions to account for changes purely the result of geographical differences. Next, the adjuster must enter injury codes appropriate for the type of injuries sustained. Information regarding the length of treatment and resolution of each injury, including the type of treatment received, the medical provider providing the treatment and the dollar amount of the treatments are all recorded.

It is important to note that actual medical records and medical evidence, such as a doctor's report, is utilized to determine the information in-putted. The claimant's attorney's allegations are not sufficient as evidence. Accordingly, permanent impairment and work/household duty impairment must be supported by medical evidence.

Other information may also be calculated. Whether or not an attorney is involved, medical liens, aggravating circumstances contributing to the accident, and whether the claimant used available safety equipment may all be considered by the Colossus program. Obviously, wage and medical specials are considered in detail.

As a result, the Colossus makes recommendations regarding general damages, gross settlement ranges and final settlement ranges.

III. WHAT IT MEANS TO THE CLAIMANT WHEN THE ADJUSTER IS USING COLOSSUS

Interestingly, discovery in bad faith Allstate files has shown that Allstate has tracked the performance of adjusters with respect to their ability to negotiate settlements under the Colossus reports. For example, in the Seattle claims service area an evaluation was made in October, 1996 regarding the percentage of amounts paid in relation to Colossus activity. Since the Colossus evaluation can be reviewed by claims management and field adjusters know their managers can easily determine whether they are adjusting within the Colossus recommendations for settlement, there is a great deal of pressure placed upon those adjusters if they deviate from the recommendations made by the computer regarding the value of another human's claim.

As a result, many attorneys representing claimants complain that human adjusters would otherwise settle claims and blame the Colossus analysis as an excuse for not doing so. Thus, the Colossus analysis and recommendation becomes paramount if a claimant is to receive fair treatment from Allstate.

Unfortunately, an old adage becomes very important – "**garbage in results in garbage out.**" The adjuster conveniently blames the computer software program as an alleged reason for not settling the case. The adjuster will not share the results of the information despite the fact a written report is generated, nor will the Allstate adjuster explain how the computer software program arrived at its conclusion(s). While many would certainly claim that Allstate should openly share the information with its own policyholders – and third-party claimants if one really believed it treated third-party claimants the same as policyholders - if it was really looking out for the policyholder's interests, Allstate simply refuses to share how the information is manipulated by the computer program to provide the result it renders.

Nevertheless, some very important lessons can be gleaned from the aforementioned and from the relatively few materials available regarding Colossus. First, the adjuster putting the information into the Colossus program may not be adequately or properly trained so that the misinformation placed into the program places a lower value on the claim than what the software program would otherwise make. While very few adjusters will ever share how they in-put this information, it is strongly suggested that the attorney go over in detail each fact regarding each injury, the initial treatment, the subsequent treatment, the future treatment, each prognosis with respect to each part of the body injured and the duration of injury and/or impairment for each part of the body injured. The Colossus program breaks down these injuries in a very detailed fashion and requires the adjuster to make numerous entries which the adjuster may have improperly in-putted by not correctly reading the information about the case. It does little good to argue in generalities regarding the injury and settlement value if the adjuster is prevented from offering a higher amount because of “garbage in” information.

Further, ask the adjuster what the settlement ranges and evaluation ranges are regarding the Colossus report. From the best information available, Colossus will provide the adjuster a “recommendation” regarding settlement. Detailed notes regarding these conversations should be kept by the claims attorney if it later turns out that the Allstate adjuster deceptively offered an amount less than these ranges.

A perfectly acceptable method to settle these cases would seem to have Allstate simply offer the amount it determines to be within the fair settlement range generated by Colossus. Instead of claimant’s attorneys being accused of asking for “too much” for a particular injury, a number of claimant’s attorneys have simply asked the insurance company to make the first offer which they believe is fair based upon the computerized opinion from Colossus. Sine Allstate has

invested so much money to license this equipment and make "fair" evaluations, it would seem Allstate should be willing to offer and share the results of evaluations with its shareholders. After all, it was the shareholders whose premiums paid for this software to begin with.

Finally, many catastrophic injuries and significant subjective scarring cases have not been traditionally within the use of Colossus. Certainly, the software program will have a greater difficulty providing an accurate range in the major catastrophic case than in cases where there is a greater historical data base upon which it can rely. Attorneys representing catastrophically injured claimants should not expect any Colossus type of adjustment from Allstate which is accurate.

IV. DISCOVERY FROM ALLSTATE: WHAT CAN BE OBTAINED

1. Complete paper and electronic claims file: home, office, regional and local.

a) Reports and correspondence.
b) Memos of any type, i.e., telephone slips, inter-office communications, handwritten notes, etc.
c) Tapes – Video and Audio.
d) Photographs – original negatives.
e) Instructions regarding investigation, coverage questions, etc.
f) Statistical documents and draft copies.
g) Copy file jacket (Note: examine original files for evidence of authenticity or alterations.
h) Loss Notice.
i) Claim Diary.

2. **<u>Testimony and statements of client and any witnesses.</u>**

a) Depositions – including past cases.
b) Original tapes.
c) Claims handler affidavits and testimony.

3. **<u>Claims Manuals</u>**

a) Property loss handling procedures.
b) Liability claim handling procedures.
c) Supervisor's and manager's manuals.
d) Date processing/ systems manuals.
e) Fraud/arson or S.I.U. manuals.
f) Personnel manuals.
g) Human Resource manuals.
h) Operational Guides.
i) Policy manuals.
j) Index of all Manuals, Guides and Company Operating Procedures.

4. **<u>Information on the handling adjusters and supervisors.</u>**

a) Job descriptions.
b) Original application for employment.
c) Annual performance evaluations.
d) History of salary and promotions/demotions.
e) Educational history (including company courses); curriculum (taped or written) used for these courses.
f) Letters of commendation or complaint.
g) Memberships in professional organizations.

5. **<u>Personnel or salary administration manuals.</u>**

a) Job descriptions.
b) Salary grade classifications.
c) Criteria for promotion/demotion.
d) Plans for adequate staff levels.
e) Performance evaluations and activity reviews.
f) Incentive programs and retirement funds.
g) Profit sharing and stock ownership.
h) Criteria for supervisor to follow during evaluations and objective setting.

6. **Documents which show the legal history of the claim.**

a) Legal opinions prior to the date of the denial.
b) Legal analysis of issues at any time (as when the defendant was devising the program or policy).
c) Correspondence to/from counsel.
d) Telephone conversations and non-written communication.
e) Counsel's billing records.

7. **Reports, correspondence and materials providing by "outside" investigators.**

a) Confidential reports.
b) Surveillance tapes (audio or video).
c) Activities checks.
d) Investigations to determine level of disability.
e) List of investigators used for similar claims.
f) PILR.
g) Computerized claims databases.

8. **Reports, correspondence, and materials provided by experts.**

a) Testing results.
b) Tapes (video or audio).
c) List of experts used for similar claims.
d) Surveys/research.
e) Complete file.
f) Billing records – interval and final bill.

9. **Loss reserve history.**

a) Documents showing original reserves and all changes.
b) Documents showing methods and criteria for setting reserves.
c) Procedures for setting reserves.

10. **Reinsurance information, facultative or treaty and Excess Insurance.**

a) Reinsurance policies.
b) Reinsurance treaties.
c) "Loss pooling" agreements.
d) Documents concerning the acquisition, negotiation, and drafting of the agreement including bills, payments, claims inspections or other

e) Job descriptions, personnel files and address of person with most knowledge about reinsurance.
f) List of reinsurers with whom the company had contracts.
g) Correspondence, notice and status conferences regarding claims.

11. Documents pertaining to programs designed to control claim costs (including both indemnity and allocated/unallocated claim costs).

a) Medical cost containment.
b) Medical management.
c) Peer review.
d) Bill review.
e) Severity control.
f) Financial claims budgets and forecasts.
g) Management objectives and goals regarding claims costs and severity:

  i) Branch.
  ii) Regional.
  iii) National.

12. Videotaped, recorded or written training materials on the subject of:

a) Property loss adjusting.
b) Fire or accident investigation.
c) Investigation, evaluation and handling of disputed claims.
d) Liability claims handling.
e) Fraud and arson detection, S.I.U. units.
f) Hired outside experts or investigators.
g) Policy and interpretation of coverage.
h) Medical training.
i) Resolving ambiguous policy language.
j) Dealing with attorneys.
k) Dealing with unrepresented claimants.

13. Employee Handbook.

a) Orientation manual or booklets.
b) Information regarding benefits and disability plans.
c) Information regarding profit-sharing, stock ownership and incentive plans.
d) Company philosophies and policies.
e) Personnel administration and manual.

14. Newsletters.

a) Company-wide.
b) Regional.
c) Local.
d) Claims.
e) "Sales."

15. Quality control audits or surveys for the officers handling the claim.

a) Home office or regional audits.
b) Manuals or guidelines for audits.
c) Claim handling quality criteria.

16. Records of public complaints.

a) Civil Remedy Notices.
b) Consumer complaints.
c) Market Conduct Studies.
d) Penalties or fines by Insurance Commissioners.

17. Records of other Bad Faith litigation or bad faith complaints.

18. Forms, publications and manuals available for use by the claims staff.

a) Index or inventory of available materials.
b) Copies of bulletins, memoranda, or other documents not part of the "official" manuals used to convey instructions from management to claim handlers.
c) Job descriptions, personnel files, and addresses of the authors of the materials.
d) Trade manuals used for estimating.
e) Verdict research data and publications.

19. Company guides for letter writing or correspondence.

a) Index of form letters.
b) Electronic index of form letters.

20. <u>Description of the data processing equipment in use in the insurer's claim department.</u>

a) Language of the system.
b) Programs available for specific loss situations:
   i) Bulletins and manuals explaining the capabilities and capacities of the programs.
   ii) Orientation bulletins or manuals used to train employees on the use of the equipment.
   iii) Location of date "centers."
   iv) Job descriptions, personnel files, and addresses of the most knowledgeable about the data processing systems.
   v) Artificial intelligence or computerized claims evaluation and software.

21. <u>Documents of any type which provide information on the organization and officers of the insurance company.</u>

a) Diagram or chart of the claim department "chain of command."
b) Management documents with show the company structure by line and level of authority.
c) Manuals or bulletins on the issuance of management reports and the preparation of operations, displays.
d) Job descriptions, personnel files, and addresses of those most knowledgeable on annual reports, management reports, and/or organizational charts.
e) Job descriptions, personnel files and addresses of those most knowledgeable of writing the manuals and bulletins.

22. <u>Annual reports.</u>

a) 10K reports to the Securities and Exchange Commission.
b) Reports to the shareholders.
c) Reports to regulators/insurance departments.

23. <u>Advertising or promotional materials used to sell the specific policy.</u>

a) Video ads displayed in area prior to loss.
b) Audio ads displayed in area prior to loss.
c) Print ads displayed in area prior to loss.

24. Archives or records storage:

a) Bulletins, manuals and video tapes on the subjects of records retention and destruction policies.
b) Index of retained materials, including instructions for retrieval.
c) Documents which explain the establishment, location and accessibility or archives or records storage centers.
d) Location of historical material.
e) Job descriptions, personnel files, and addresses of the people most knowledgeable about records storage and archives.

25. Documents which detail the services, procedures, and activities of loss control, engineering or risk inspection services.

a) "Inspections" of risk subject.
b) Manuals for loss control.
c) Correspondence and reports of Risk/Loss control.

26. Agency Manuals/Agent File.

a) Service instructions for premiums, claims handling, communications, access to medical information, handling of complaints and disputed claims and other related activity.
b) Advertising, representations, specifications and descriptions of any nature used to attract the policyholder.
c) Entire agency file.

27. Seating plan of claims department showing the physical proximity of the individuals handling the claim.

28. Documents pertaining to the establishment, existence, coexistency and activities of a "claim committee."

a) Names of the committee members.
b) Any reports or directives issued by the committee with regard to the case.
c) Documentation of any "committee" deliberations.
d) Manuals and procedures of a "claims committee."

29. List of organizations by name and address of which the company is a member or subscriber.

a) Dates such associations began.
b) Code of ethics of by-laws.

30. Underwriting files on the property and insured in question.

a) Inspection reports.
b) Any manuals used in any phase of the process of issuing the policy.

31. Corporate liability insurance policies for E&O, professional liability, bad faith or suits:

a) Copies of the policies.
b) Reports and correspondence to such insurers.
c) Names of the persons handling the investigation and adjustment.

32. Any separate file on the loss which details the "fieldwork," evaluation, expert investigation, consultant review, salvage, accounting, subrogation, cause and origin investigation, or any other subject.

33. "Binders," course materials, audio/video tapes of local, regional or home office conferences for adjusters, managers or others.

34. Documents of any type which set forth the insurer's philosophies on:

a) Claims handling policies.
b) Providing service to policyholders.
c) Good/bad faith claim handling.
d) Extra-contractual damages and suits.
e) Compliance with Unfair Claims Practices statutes.
f) Wrongful claims handling.
g) Code of Ethics.

35. Speech transcripts.

a) Executive officers.
b) Claims officers.
c) "House" counsel.

36. **Public Relations Releases.**

a) Bad faith verdicts.
b) Insurance Commissioner penalties or fines.
c) Claims practices.
d) Adjustment activities.
e) Proof of Loss.
f) Claim severity or loss control.

V. THE OBJECTIONS

The Work-Product Privilege.

The work product privilege generally protects investigative materials and other documents prepared "in anticipation of litigation" although the cases are not uniform in first party cases.

The work product privilege was established in a landmark case of Hickman v. Taylor, 329 U.S. 495 (1947), where the court held that written statements of witnesses obtained by an attorney and the attorney's notes prepared in the course of his legal duties in anticipation of litigation were non-discoverable. The court held the privilege necessary so that the attorney could assemble information and prepare legal theories and strategy without undue interference.

This privilege was later broadened to cover not only materials prepared by attorneys, but those prepared by any representative of a party. The privilege was restated in Federal Rule of Civil Procedure 26(b)(3) as follows:

> …a party may obtain discovery of documents and tangible things otherwise discoverable…and prepared in anticipation of litigation or for trial by or for another party or by for that other party's representative (including his attorney, consultant, surety, idemnator, insurer, or agent) only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of his case and that he is unable without undue hardship to obtain the substantial equivalent of the materials by

> other means. In ordering discovery of such materials when the required showing has been made, the court shall protect against disclosure of the mental impressions, conclusions, opinions, or legal theories of an attorney or the representative of a party concerning the litigation.

The various states have similar, but not always identical, work product doctrines. There are four key points to remember:

1) The privilege covers only documents "prepared in anticipation of litigation."

2) The privilege is a qualified one, which may be overcome by a showing of "substantial need" and "undue hardship".

3) Federal Rule of Civil Procedure 26(b)(3) appears, under a plain language approach, to provide absolute protection for "mental impressions, conclusions, opinions or legal theories of an attorney or other representative of a party", but the Supreme Court has not yet decided whether this protection is actually absolute.

4) The privilege applies not only to attorneys, but also to other representatives to the party, such as investigators. United States v. Nobles, 422 U.S. 225 (1975).

The threshold question is whether the materials were prepared "in anticipation of litigation." If you cannot make the "anticipation" cut, forget about the privilege.

In first party cases, courts often regard the initial phase of investigation as routine or in the ordinary course of the insurer's business and place on the insurer the burden of showing the time when litigation was first anticipated. There is no widely recognized bright line test for when the insurer shifts from an "ordinary" investigation to one "in anticipation of litigation."

> …Because a substantial part of an insurance company's business is to investigate claims made by an insured against the company or by some other party against an insured, it must be presumed that such investigations are part of the normal business activity of the company…This is not to say, however, that under appropriate circumstances an insurance company's investigation of a claim may not shift from an ordinary business activity to conduct "in anticipation of litigation" admittedly, there is no bright line which will mark the division between these two types of activities in all cases.

Hawkins v. District Court, 638 P.2d 1372,1379 (Colo.1982).

It has been suggested that the date of denial may function as the presumptive date when anticipation of litigation begins, with latitude to demonstrate litigation was anticipated earlier. "If the insurer argues it acted in anticipation of litigation before it formally denied the claim, it bears the burden of persuasion by specific evidentiary proof of objective facts demonstrating a resolve to litigate." Burr v. United Farm Bureau Mutual Ins. Co., 560 N.E. 2d 1256, 1255 (Ind.App. 1990).

Hiring a lawyer is only one factor to be considered in determining the onset of anticipation of litigation, but it is not conclusive. Burr, 560 N.E. 2d at 1254; Fine v. Bellefonte Underwriters Ins. Co., 1981 Fire & Ins. Cases 1319 (S.D.N.Y. 1981).

Some courts require proof of an objective ground to anticipate imminent litigation, such as a demand letter from the insured's attorney threatening suit. Stringer v. Eleventh Court of Appeals, 720 S.W. 2d 801 (Tex.1986); Phelps Dodge Refining Corp. v. Marsh, 733 S.W. 2d 359 (Tex. App. – El PaSo 1987 no writ).

Proving the "anticipation" date depends on the facts and circumstances of each case.

> **The insurer bears an affirmative burden of demonstrating that the documents or tangible items at issue were, in fact, prepared in anticipation of litigation by or for the parties represented.**

Compagnie Francaise D'Assurance Pour Le Commerce Exterieur v. Phillips Petroleum Company, 105 F.R.D., 16,41 (S.D. N.Y. 1984).

Rule 26 draws a distinction between ordinary work product prepared in anticipation of litigation and work product which represents the mental impressions, conclusions, opinions or legal theories of an attorney. This distinction is reflected and defined in numerous cases as well. See e.g., Kuiper v. District Court of Eight Judicial District, Mont., 632 P.2d 694, 701-02 (1981)

(state law is made relevant to the interpretation of the scope of privilege by Rule 501 of the Federal Rules of Evidence); Reavis v. Metro Property and Liability Insurance Company, 117 F.R.D. 160 (S.D. Cal. 1987); Baker v. CAN Insurance Company, 123 FRD 322 (D. Mont. 1988). The rule really defines three categories of work product, each with its own standard for production. Ordinary work product prepared not in anticipation of litigation is fully discoverable. Ordinary work product prepared in anticipation of litigation can be produced by demonstration of a substantial need and undue hardship. Opinion work product, at least when drawn from the files of prior terminated litigation, can usually be discovered where the discovering party proves not only a substantial need and hardship but also that the substance of the opinion work product is directly at issue in the litigation at bar.

In all cases, the party opposing discovery has the initial burden of proof on the issue of whether the documents sought are attorney work product. Fairbanks v. American Can Company, 110 FRD 685 (D.Mass.1986).

Further, the work product privilege does not extend to materials assembled during the ordinary course of business or for any other non-litigation purpose. Fairbanks v. American Can Company, 110 FRD 685 (D.Mass.1986).

Further, the work product privilege does not extend to materials assembled during the ordinary course of business or for any other purpose or for any other non-litigation purpose. Fairbanks v. American Can Company, 110 FRD 685 (D.Mass.1986).

> The Courts have repeatedly recognized that, while litigation often results from an insurance company's denial of a claim, it cannot be said that any document prepared by an insurance company after such a claim has arisen is prepared in anticipation of litigation within the meaning of Rule 26(b)(3)…the nature of the insurance business is such that an insurance company must investigate a claim prior to determining whether to pay its insured….We do not believe that Rule 26(b)(3) was designed to so insulate insurance companies merely because they always deal with

> potential claims. If this were true, they would be relieved of a substantial portion of the obligations of discovery imposed on parties generally that are designed to insure that the fact finding process does not become reduced to gamesmanship that rewards parties for hiding or documents prepared by an insurance company in investigating a claim are, by definition, complied in the ordinary course of business and, thus, automatically subject to discovery…In sum, a court must determine whether in light of the nature of the document and the factual situation in the particular case, the document can fairly be said to have been prepared or obtained because of the prospect of litigation…or whether it must be deemed to have been prepared in the company's ordinary course of business.

APL Corporation v. Aetna Casualty and Surety Company, 91 F.R.D. 10, 17-18 (D.M.D. 1980).

Further,

> Because an insurance company has a duty in the ordinary course Of business to evaluate claims made by its insureds, the claims file containing such documents usually cannot be entitled to work product protection. Normally, only after the insurance company makes a decision with respect to the claim will it be possible for there to arise a reasonable threat of litigation so that information gathered hereafter might be said to be acquired in anticipation of litigation….This is not to say that the threat of litigation may never arise at an earlier time. However, if the insurer argues that it acted in anticipation of litigation before it formally denied the claim, it bears the burden of persuasion by presenting specific evidentiary proof of objective facts demonstrating a resolve to litigate. Additionally, claims that litigation became a realistic possibility at a certain time will normally have to be supported by affidavits which give specific factual detail for that conclusion.

Pete Rinaldi's Fast Foods, 123 F.R.D. at 202-203. See also APL Corp., 91 F.R.D. at 14-15 (section of defendant's claim manual concerning defendant's interpretation of inventory exclusion in plaintiff's policy discoverable despite trade secret objection).

COMPELLING PRODUCTION OF ALLSTATE'S CLAIMS MANUALS

In Robertson v. Allstate Ins. Co., 1999 Lexis 291 (E.D. Pa., March 10, 1999), a federal court found the claims file relevant to discovery and significantly ordered the internal claims and

procedures manuals of Allstate to be disclosed over work-product objections. The court noted the following:

> The court has determined that information contained in the manuals is relevant because it contains instructions concerning procedures used by Allstate employees in handling UM claims such as plaintiff's claim. Although the fact that Allstate employees departed from established standards in handling plaintiff's UM claim would not along establish bad faith, such information "is probative evidence for plaintiff to demonstrate bad faith." See Kaufman v. Nationwide Mut. Ins. Co., 1007 U.S. Dist. LEXIS 18530, 1997 WL 703175 (in bad faith case, insurer ordered to produce information in claims manuals concerning procedures used by insurer's employees in handling UM claims). Given the liberal scope of federal discovery and the fact that such information may lead to the discovery of admissible evidence, Allstate is ordered to produce claims or procedure manuals setting forth company practices or policies regarding the handling of UM claims…
>
> …
>
> Clearly, information found in the first party claims file may have influenced the UM negotiator or may indicate a difference in opinion or analysis between the first party claims adjuster and agents or employees involved in processing plaintiff's UM claim. As such, the first party claim file may be a relevant factor in determining if plaintiff's UM claim was ultimately processed by Allstate in a reasonable manner. Accordingly, Allstate is ordered to produce plaintiff's first party claim file.

A party claiming such privilege bears the burden of identifying the type of document, general subject matter, date or such other information as is sufficient to identify the document, including where appropriate, the author, addressee, and any other recipient of the document. The purpose of this rule is to require the objecting party to seriously examine the factual and legal basis for any work product objections and to provide opposing counsel and the curt with sufficient information to analyze the alleged privilege.

PLAINTIFF HAS A SUBSTANTIAL NEED FOR THE REQUESTED DOCUMENTS.

Rule 26(b)(3) protects materials prepared in anticipation of litigation or for trial by or for another party or by or for that other party's representatives unless the party seeking discovery has a substantial need for the material and is unable, without undue hardship, to obtain the material through other means. The rule suggests two threshold tests: 1) The rule only protects work product which is developed in anticipation of litigation. 2) The rule does not extend to materials assembled in the ordinary course of business. Fed.R.Civ.P. 26, Advisory Committee's Notes to the Federal Rules of Civil Procedure, 48 FRD, 487, 497-508 (1969).

Cases have held specifically that material prepared to assist in day-to-day business is not protected even if there exists a likelihood of ultimate litigation. Baker v. CNA Ins. Co., supra, Soeder v. General Dynamics Corp., 91 FRD 253 (D.Nev. 1980); Fine v. Bellefonti Underwriters Ins. Co., 91 FRD 420 (S.D.N.Y. 1981).

In Baker the Court adopted the view that the privilege applies where preparation for litigation was a primary motivation leading to the development of the requested material, and that a generalized alertness to the possibility of litigation will not suffice to bring material within the purview of the work product doctrine. Baker. 123 FRD at 328, citing U.S. Davis, 636 F.2d 1028 (5th Cir. 1981); Atlantic Coca-Cola Bottling Co. v. TransAmerica Ins. Co., 61 FRD 115 N.D. Ga. 1972).

The United States District Court of Massachusetts adopting a case-by-case approach to determining whether documents were prepared in anticipation of litigation, stated, clearly, the fact that an allegedly injured person files a claim with an insured's insurer does not, of itself,

make litigation likely, reasonably probable, or a contingency. PaSteris v. Robillard, 121 FRD 18 (D.Mass. 1988).

The District Court in Pasteris was influenced by the position of a Federal District Court in Illinois which, permitting discovery of work product, explained:

> **It is a fact of common knowledge that an overwhelming majority Of claims asserted by parties generally are amicably resolved and That only a very small portion of them rise to the level of disputes, Let alone to the level of lawsuits. Thomas Organ Co. v. Jadranska Slobodna Plovidba, 54 FRD 367, 374 (N.D. Ill. 1972). See also, Sham v. Hvannis Heritage House Hotel Inc., 118 FRD 24 (D.Mass. 1987).**

The second threshold test in determining whether ordinary work product should be produced arises only when it has been determined that the work product was prepared in anticipation of litigation. **However, such material becomes discoverable when the party seeking discovery demonstrates substantial need of the materials in the preparation of the party's case and that the party is unable without undue hardship to obtain the substantial equivalent of the materials by other means.** The substantial need and undue hardship standards were specifically recognized by the Montana Supreme Court in Kuiper v. District Court of the Eighth Judicial District, *supra.*

> **Plaintiff has alleged bad faith against Defendant for Defendant's Refusal to make payment to Plaintiff, to which she was entitled, and failure to meet the standards required by California Insurance Code Sec. 790.03. Plaintiff needs the information in Defendant's insurance claims files to determine the motivating factors behind Defendant's decision to deny Plaintiff's claims for both medical payments and for damages against Metropolitan's insured. Plaintiff needs to make a realistic evaluation of her case 80 that litigation and settlement strategies will be based upon knowledge and not speculation. Plaintiff cannot obtain the equivalent information by other means. Reavis, 117 FRD at 163, citing Plaintiff's Memorandum of Points and Authorities in Support of Motion to Compel Production of Documents, page 11, LL3-13. Id. (emphasis added).**

The Court in Reavis adopted the Plaintiff's reasoning and ordered production of the requested material. In the process of ordering production, the court noted that depositions of insurance adjusters and other claims representatives may not produce the substantial equivalent of the documentation contained in the claims files.

The substantial need for production of the Defendant's claims file and other related information is demonstrated by the very nature of the bad faith action. It is equally clear that Plaintiff cannot access the same information through any other channels. In re Bergeson, 112 FRD 692,697 (D.Mont. 1986). In Bergeson the court cited with approval the position of the Arizona Supreme Court and articulated as follows:

> **Bad faith actions against an insurer, like actions by client against attorney, patient against doctor, can only be proved by showing exactly how the company processed the claim, how thoroughly it was considered and why the company took the action it did. The claims file is a unique, contemporaneously prepared history of the company's handling of the claim: in an action such as this, the need for the information in the file is not only substantial, but overwhelming.**
> **(emphasis added).**

The standard for production of opinion work product, while higher than the substantial need and undue hardship standards set for ordinary work product, is not absolute. Rule 26 provides a special protection for opinion work product, but does not explain the scope of this protection nor furnish a test would indicate in what situations discovery of opinion work product would be allowed. Courts and commentators have proposed a variety of tests to define the boundaries of protected opinion work product. One such proposal suggests a hierarchy of standards which must be met to discover opinion work product: First, the opinion work product must be relevant, a prerequisite to all discovery. Second, the opinion work product may only be obtained upon a showing of substantial need and undue hardship, the showing required for

ordinary work product. Third, the party seeking discovery must show that the material requested is at issue in the litigation. Comment, The Potential for Discovery of Opinion Work Product under Rule 26(b)(3), 64 Iowa L.Rev. 103 (1978).

The "at issue" test is reflected in case law. In Reavis, 117 FRD at 164, the Federal District Court of California recognized that, in a third-party bad faith case, the strategy, mental impressions and opinions of Metropolitan's agents concerning the handling of the claim were directly at issue. The Court then stated: "When mental impressions and opinions are directly at issue in a case, courts have permitted an exception to the strict protection of Rule 26(b)(3) and allowed discovery." Id., citing Truck Insurance Exchange v. St. Paul Fire and Marine Ins. Co., 66 FRD 129 (E.D. Pa. 1975); Bird v. Penn Central Co., 61 FRD 43 (E.D. Pa. 1973); Handgards, Inc. v. Johnson and Johnson, 413 F.Supp. 926 (N.D. Ca. 1976); Brown v. Superior Court, 137 Ariz. 327, 670 P.2d 725,734(1983).

In Handgards, another case from within the Ninth Circuit, the District Court considered production of opinion work product in a case where the good faith of the defendants in instituting and maintaining a prior patent litigation was at issue. The Court justified production not only because the substance of the work was directly at issue but because plaintiff required such information in order to cross-examine attorneys for defendants who were likely to testify in the bad faith case. Handgards, 413 F.Supp. at 931.

In a general statement which appears to encompass opinion work product, the court has issued strong language justifying production of the claim file in a bad faith case. In Silva v. Fire Insurance Exchange, 647 F.Supp.1397 (D.Mont. 1986), the Court declared:

> **The time-worn claims of work product and attorney-client privilege cannot be invoked to the insurance company's benefit where the only issue in the case is whether the company breached its duty of good faith in processing the insured's claim.**

TRADE SECRET ASSERTIONS

Under Federal law, "trade secrets and other confidential commercial information enjoy no privilege from disclosure, although a defendant may have a legitimate interest in protecting its trade secrets, that interest must yield to the rights of a plaintiff to discover the full truth of the facts involved in the issues of the case where issues cannot be fairly adjudicated unless the information is available." I: See Kleinerman v. United States Postal Service, 100 F.R.D. 66,69 (D. Mass. 1983); See National Utility Service v. Northwestern Steel and Wire Company, 426 F.2d 222 (7th Cir.1970) (trade secrets are not privileged against discovery).

Additionally, investigative documents which include manuals setting forth an insurer's investigative procedures with respect to a particular claim are relevant and subject to production despite a defendant's contention that such manuals constitute confidential or proprietary trade secret material. APL Corp., 91 F.R.D. at 14-15.

Accordingly, if the defendant satisfies the court that requested information meets the legal criteria for a trade secret, the court may not compel its disclosure unless the plaintiff shows that the need and importance of the information outweigh the threat of harm to the defendant likely to result from permitting discovery. Following this balancing of interests, the court may (1) require disclosure, (2) deny disclosure, or (3) require disclosure and issue a protective order limiting the use and dissemination of the material by the plaintiff. In the large majority of cases, courts adopt the third approach.[8]

In Robertson v. Allstate Ins. Co., 1999 Lexis 291 (E.D. Pa., March 10, 1999), the Court noted that the "trade secrets" objection merely required that the information be kept confidential:

[8] Full Disclosure, Combatting Stonewalling and Other Discovery Abuses, 1994, ATLA

> Allstate argues that plaintiff should be required to keep information obtained from the claims manual confidential because "the claims manuals…contain information in the nature of trade secrets that could be used by Allstate's competitors." See Def.'s Answer at 8, n.4. Despite the vagueness of Allstate's allegations regarding the existence "trade secrets," the court will order that plaintiff is required to keep all information provided in the claims manual confidential in order to provide adequate safeguards for Allstate's confidential materials.

CONCLUSION AND RECOMMENDATIONS

Attorneys representing consumers and victims of catastrophe should do the following:

1. Ask the insurance company to make an offer on a claim.
2. Demand that the insurance company explain the reasons for their offer, in writing, along with any computerized analysis supporting their decision similar to the way insurance companies typically provide a detailed estimate for car damage or other types of property damage.
3. When bringing bad faith cases or unfair trade practice cases against Allstate, make sure the pleadings reflect the secret and general business nature of Allstate's wrongful conduct and that the motive for such conduct is claims profit at the expense of broken promises of honest, good faith, prompt and fair treatment.
4. Request and try to obtain as many materials as possible to support the allegation that the culture of Allstate Insurance Company is to promote claims profit at the expense of its policyholders and catastrophe victims.
5. Retain an insurance claims consultant or bad faith expert who will prepare and file affidavits supporting the relevance of the documents requested and that those

documents are *substantially necessary* and otherwise not available for the proper presentation and proof of the allegations made.

6. Be prepared to file numerous motions to compel on numerous items requested. Explain to the judge in writing and orally that you are afraid that Allstate's nationwide tactic of discovery non-response will apply in your case and that the judge may get "tired" of the discovery battle and simply acquiesce to Allstate's tactics.

7. Take depositions not only to establish the facts of your particular claim, but of the Allstate supervisors and corporate representatives with knowledge regarding the local, regional and nationwide goals of claims severity and the programs which Allstate has instituted to achieve the goals.

8. Attempt to obtain the internal documents and the McKinsey & Company documents explaining the profit motive underlying Core Claim Practice Redesign.

9. Colossus discovery must be conducted to determine how Colossus was used in your case, how the Evaluation Consultant used the information regarding your client's loss to arrive at a settlement value, and how Colossus has been "tweaked" in the Allstate Market Claim Office to arrive at figures which are lower than a good faith offer.

10. Establish how adjusters and the management always look for ways to minimize the amount of a claim rather than offering the full amount based upon Allstate's own analysis.

11. Join the ATLA Bad Faith Litigation Group and obtain various internal Allstate manuals, including Colossus, so that you will be ahead of the litigation and know when Allstate is not conducting discovery in good faith.

Good faith claims handling and outstanding customer service are pledges often heard by the insurance company management. Unfortunately, the reality of the product provided in relation to the aforementioned goal is often sadly lacking. Today, Allstate competes against other in an oligopoly which creates an incentive for Allstate and other insurers to cheat on their claims handling.

To maintain profit margins and reach acceptable management goals/budgets, Allstate claims departments are under funded or under staffed to properly serve their insureds. Instead, that emphasis is often placed on controlling claims severities, rather than paying each individual claimant the full amount deserved, without concern for the bottom line. When Allstate is truly free from the unethical budget constraints and monetary incentives placed upon them, policyholders and victims will begin to receive the promise they paid for.