Doctored Claims

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> *"Of all the oxymorons in the world, an Independent Medical Examination occupies first place by thousands of leagues. There is nothing Independent about the process; it is hardly undertaken for Medical purposes and all too often resembles an inquisition rather than an Examination."*
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> –Judge Thomas P. Smith[1]

INTRODUCTION

Home health aide Shu-Ying Xu was injured on the job while trying to keep a patient from falling.[2] The injury caused such debilitating pain the Social Security Administration considered her "totally disabled."[3] Still, Ms. Xu's workers' compensation insurer had her undergo an independent medical examination ("IME") to review her injury, and sent her to Dr. Wayne Kerness.[4] Dr. Kerness did not ask her any questions, completing the exam in two minutes.[5] His report said Ms. Xu could resume working because her disability was only mild.[6] His report also claimed she spoke English (which she did not), and she took no medications (while she took nine).[7] When

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1. JAY M. FEINMAN, DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT 110–11 (2010) (quoting Judge Thomas P. Smith, *Alice in Discovery Land: A Practical Guide to Recurrent Discovery Problems*, MILLER & ZOIS, LLC, https://www.millerandzois.com/files/judge-smith-discovery-article.pdf [https://perma.cc/E4TZ-ANPE]).
2. N.R. Kleinfeld, *Exams of Injured Workers Fuel Mutual Mistrust*, N.Y. TIMES (Mar. 31, 2009), https://www.nytimes.com/2009/04/01/nyregion/01comp.html [https://perma.cc/JL3T-UEXK].
3. *Id.*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*

confronted by these discrepancies, Dr. Kerness admitted only that he erroneously reported Ms. Xu's English capabilities and affirmed the rest.[8]

Another workers' compensation claimant, Carol Houlder, injured her ankle working as a substance abuse counselor, but her insurer kept her waiting in pain for a year before approving surgery.[9] The insurance company required an IME first, which she video recorded, capturing orthopedic surgeon Dr. M. Pierre Rafiy grasping her ankle and saying it was swollen.[10] Yet his written report stated there was no swelling, no disability, and that Ms. Houlder could return to work.[11] When challenged on his inconsistency in a deposition, the insurer-selected doctor blamed the no disability statement on a secretary but made no other corrections.[12] In a later interview, he claimed that he had no way to determine whether Ms. Houlder was in "real pain," adding that people "lie a lot" because they "don't want to work."[13]

While both incidents were workers' compensation claims, similar IMEs also appear in other insurance contexts, including personal injury.[14] Often, insurance companies use biased medical examiners ("ME") to illegitimately deny meritorious claims through so-called independent medical examinations or records reviews. Though insurers may use biased IMEs to deny any injury claim, at particular risk are unrepresented claimants because they do not have legal counsel to detect and counter this stratagem.

This Comment advocates enacting a statute that prevents insurance companies from denying or reducing claims brought by an unrepresented claimant based in any part on a medical examination or medical records review, unless conducted by a commission-appointed medical professional. Part I introduces the problem, first comparing the way insurance should work with the way insurers actually conduct business, which includes using biased MEs to deny legitimate claims. Part I then investigates ways other states have sought to control biased IMEs. Next, Part II proposes that unrepresented claimants in Arizona are vulnerable to IME-based benefits denial and explores how insurers have been able to skirt or weaken most state attempts

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8. *Id.* Dr. Kerness's website proclaims that his "thoughtful, well-documented" IME reports result from "cogent analyses . . . derived through comprehensive research [and] intensive due diligence." *Services: Why QAM Is a Preferred IME Provider*, QUALITY ASSURED MED. EVALUATIONS, http://www.qamedevals.com/services.html [https://perma.cc/335F-UE3B].

9. Kleinfeld, *supra* note 2.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. *See, e.g.*, Michael E. Schatman & Janet L. Thoman, *Cherry-Picking Records in Independent Medical Examinations: Strategies for Intervention To Mitigate a Legal and Ethical Imbroglio*, 7 PSYCHOL. INJ. & L. 191, 191–92 (2014).

to control IMEs. Part II then suggests that the most effective solution would be to have independent MEs, which the state could achieve by enacting a new statute. Last, Part II posits that fraudulent claims detection does not require a *biased* examiner, merely an independent one. All things considered, the policyholder, a one-time claimant, needs more protection than an insurance company, a repeat player with systemic advantages.

I. THE ORIGIN OF THE BIASED IME, AND WHAT HAS BEEN DONE TO ADDRESS IT

An IME makes sense, in theory. Even plaintiffs' attorneys accept an insurance company's right to have a claimant examined by a qualified, impartial ME when liability or damages are at issue.[15] The insurers are at an initial disadvantage because they do not know the nature and scope of the claimant's asserted injuries.[16] Ideally, the IME's primary function is to give the insurance company a chance to discover the extent of the claimed injury.[17] The examiner's opinion should validate or refute all or part of the claim honestly and fairly.[18] Secondarily, either party could offer these opinions into evidence at trial or arbitration to assist the trier of fact with determining causation and damages.[19] Trial or arbitration would allow a claimant to test the ME's credibility and bias through cross-examination and opposing expert testimony.[20]

However, insurance companies abuse this theoretically neutral process, misusing the IME to deny or delay legitimate claims in defiance of fundamental rules.[21] Part I.A will detail the decline. Part I.B will explore state responses, as some have implemented solutions with limited effectiveness.

A. From "On Your Side" to Mayhem Like IMEs

Insurers' profit margins, unlike many other businesses, should not be mainly based on balancing price and costs. This is because insurers act more like a bank, holding customer funds like a fiduciary to benefit its

15. John C. McLaren, *Defense Medical Examinations: The Fallacy of Impartiality*, 4 HAWAII B.J. 1 (2000).
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.* at 11.
21. FEINMAN, *supra* note 1.

customers, while investing those held funds to make money.[22] Yet many insurance companies have taken billions of dollars away from customers to keep for themselves.[23] Insurers do this in several ways centered on an underlying strategy of underpaying, delaying, and denying legitimate claims. One method that unrepresented claimants are vulnerable to is the use of an IME conducted by a biased ME.

1. The Risk Business: Old-Time Good Faith and Fair Dealing

Insurance may be an ancient concept,[24] but insurance is not a normal business.[25] Its purpose is to mitigate the financial impact of a risk on an individual by transferring the risk to a group and sharing the costs of the risks that manifest among the group's members.[26] The individual sacrifices a small, certain loss (the monthly premium) to avoid the risk of an uncertain, but potentially much larger loss (such as medical care for injuries sustained in an automobile collision).[27] On the other side, the insurance company accepts the risk of large, uncertain losses because it pools many small payments.[28] This creates a special relationship because, unlike a typical contract, the policyholder does not intend to gain a commercial advantage or make a profit.[29] Rather, the insured desires "protection and security from economic catastrophe" caused by the uncertain loss.[30]

This special relationship is protected in part by the duty of good faith and fair dealing.[31] This duty prevents an insurance company from unfairly denying a policyholder honest payment on a legitimate claim.[32] That is, the insurer must give equal consideration to the insured's interests.[33] Equal consideration means the insurer cannot "lowball claims or delay claims,"

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22. DAVID J. BERARDINELLI, FROM GOOD HANDS TO BOXING GLOVES: THE DARK SIDE OF INSURANCE 23–24 (2008); FEINMAN, *supra* note 1, at 16.

23. *See infra* text accompanying notes 73–77.

24. RAY BOURHIS, INSULT TO INJURY: INSURANCE, FRAUD, AND THE BIG BUSINESS OF BAD FAITH 5 (2005) (having existed in some form in ancient China, Babylonia, Greece, Rome, and Byzantium).

25. Whitney R. Mauldin, *Good Business/Bad Faith: Why the Insurance Industry Should Adopt a Good Faith Model*, 43 TORT TRIAL & INS. PRAC. L.J. 151, 151 (2008).

26. FEINMAN, *supra* note 1, at 13.

27. *See id.* at 14.

28. *Id.*

29. Rawlings v. Apodaca, 726 P.2d 565, 570 (Ariz. 1986).

30. *Id.*

31. *Id.* at 569–70.

32. BOURHIS, *supra* note 24, at 13.

33. *Rawlings*, 726 P.2d at 571.

cannot "force an insured to go through needless adversarial hoops," and cannot do anything that might "jeopardize the insured's security under the policy."[34] This is "the very essence of the insurer-insured relationship."[35]

When a loss occurs, an insured is in a vulnerable position because he depends on the insurance company to pay the claim fairly and promptly.[36] The policyholder might be unable to work and earn an income because of physical injury and resulting medical care.[37] With an automobile crash, the collision might leave the policyholder's car inoperable, rendering him unable to fulfill occupational, familial, and medical treatment duties.[38] Contrast this with the insurer's advantageous position as both the policy maker and sole judge of the claim's merit and value.[39] Further, the insurance company already has the policyholder's premiums he has faithfully paid to obtain security in these exact circumstances. This imbalanced relationship gives the insurer tremendous leverage,[40] therefore the law imposes a duty on the insurer to not put its own interests (i.e., profits) ahead of the insured's.[41]

Even absent legally imposed obligations, fair payment of covered claims should be simple, under the traditional insurance business model. This is because insurance companies are designed to make most of their profit on investments, not on premiums.[42] In the time between receiving premiums and paying out claims, insurers invest their policyholders' money.[43] This money is called float.[44] By the time a claim is made the insurer has already rightfully earned its money, and all that is left to be done is to make the promised payment.[45] If an insurance company intentionally denies, undervalues, or

34. Zilisch v. State Farm Mut. Auto. Ins. Co., 995 P.2d 276, 280 (Ariz. 2000).

35. Campbell v. State Farm Mut. Auto. Ins. Co., 98 P.3d 409, 415 (Utah 2004) (quoting ERIC M. HOLMES, APPLEMAN ON INSURANCE § 8.7 (2d ed. 2004)).

36. BERARDINELLI, *supra* note 22, at 21.

37. *See* BOURHIS, *supra* note 24, at 6.

38. BERARDINELLI, *supra* note 22, at 21.

39. *Id.* at 22; *See also* Rawlings v. Apodaca, 726 P.2d 565, 570 (Ariz. 1986) (recognizing that the insurer plays an almost adjudicatory role in the claims process).

40. BERARDINELLI, *supra* note 22, at 22.

41. Lozier v. Auto Owners Ins. Co., 951 F.2d 251, 254 (9th Cir. 1991). This Comment will discuss how federal, state, and private means of enforcing this duty are ineffective in Part I.A.4.

42. FEINMAN, *supra* note 1, at 16 (quoting EMMETT J. VAUGHAN & THERESE M. VAUGHAN, ESSENTIALS OF RISK MANAGEMENT AND INSURANCE 120 (2d ed. 2002) (describing insurers as "investment companies that raise the money for their investments by selling insurance")).

43. BOURHIS, *supra* note 24, at 6; FEINMAN, *supra* note 1, at 16.

44. FEINMAN, *supra* note 1, at 16.

45. *Id.*

delays a claim without a reasonable basis, it breaches the duty of good faith and fair dealing.[46] This is a tort, commonly called bad faith.[47]

2. The Change: From Good Hands to Boxing Gloves[48]

In the 1990s, the insurance industry pivoted away from the established model. The Allstate Corporation ("Allstate") hired mega-consulting firm McKinsey & Company ("McKinsey"), which recast the claims department from a promise-fulfillment center into a profit-making center.[49] This reflected the perspective that claims were a zero-sum game: a player only wins what the other player loses.[50] Insurers could increase profits by taking away value that insureds rightfully made claim to under their policies.[51]

McKinsey's strategy for maximum take was for Allstate to either pay claims promptly *or* fairly—but never both.[52] Either way, this approach breached the duty of good faith and fair dealing.[53] This tactic leveraged the insurer's biggest advantages in the claims process: the claimant's financial susceptibility to delayed benefits payment, and Allstate's superior experience and resources litigating over claim values.[54]

Insurance companies exploited this imbalance in several ways, including discouraging claimants from obtaining lawyers.[55] Allstate focused on reducing attorney representation because, as McKinsey knew, claimants with a lawyer recover on average five times more than those without.[56] One technique was to avoid mentioning the advantages of hiring a lawyer, with the insurer promising to "handle the claim fairly and promptly" without additional help.[57] Alternatively, the claims adjuster might emphasize or even

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46. Zilisch v. State Farm Mut. Auto. Ins. Co., 995 P.2d 276, 280 (Ariz. 2000).

47. *Id.*

48. This delightful turn of phrase is from the title of the cited David J. Berardinelli book *From Good Hands to Boxing Gloves: The Dark Side of Insurance*, which in turn quotes directly from the slides McKinsey & Company used in its presentation to Allstate. BERARDINELLI, *supra* note 22, at 93–94.

49. FEINMAN, *supra* note 1, at 56.

50. *Id.* at 63.

51. Jay M. Feinman, *The Law of Insurance Claim Practices: Beyond Bad Faith*, 47 TORT TRIAL & INS. PRAC. L.J. 693, 717 (2012).

52. BERARDINELLI, *supra* note 22, at 93–98.

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.* at 95.

57. FEINMAN, *supra* note 1, at 88; *see also Claim Payments*, ALLSTATE INS. CO., https://www.allstate.com/claims/claim-payments.aspx [https://perma.cc/R3DJ-4HBD] (asserting its claims process is "fast, fair and hassle-free"); *Search Results for "Lawyer,"* ALLSTATE INS.

misstate the cost of hiring an attorney,[58] preventing lawyers from advising claimants on how the insurer is supposed to act.

Then, Allstate would delay making an offer for three to six months, letting its own insured bear the financial burden from the loss, before delivering a lowball offer of just sixty percent of the legitimate claim value.[59] Policyholders pressured into letting Allstate keep the other forty percent of their claim would then be paid promptly (if a six-month delay is prompt).[60] Those who refused the low offer would be met with the boxing gloves of litigation; the only possibility of a fair claims payment would be to sue Allstate and endure expensive litigation that might take years.[61] Court expenses alone could "virtually wipe[ ] out" the claim's value.[62]

Another aspect of the boxing gloves approach was an effort to "exploit the economics of the practice of law."[63] Plaintiffs' personal injury attorneys typically earn their fee on a contingency basis.[64] The lawyer would receive a percentage of what is recovered but would be paid nothing if unsuccessful, regardless of how much work she did on the case.[65] Also, the attorney often advances costs and fees, sometimes to the point where a significant amount of her own money is invested in a client's case.[66] And so insurers began to aggressively litigate small-value claims,[67] making them so expensive for plaintiffs' lawyers to resolve that the claims became financially detrimental to accept.[68] Insurance companies even took losses in litigation, spending

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CO., https://www.allstate.com/search.aspx?q=lawyer [https://perma.cc/M6JB-54Q2] (showing that Allstate never mentions lawyers on its website).

58. FEINMAN, *supra* note 1, at 89.

59. BERARDINELLI, *supra* note 22, at 96.

60. *Id.* at 96–97.

61. *Id.* at 97.

62. Campbell v. State Farm Mut. Ins. Co., 98 P.3d 409, 415 (Utah 2004) (quoting ERIC M. HOLMES, APPLEMAN ON INSURANCE, § 8.7 (2d ed. 2004)).

63. FEINMAN, *supra* note 1, at 90.

64. David A. Hyman, Bernard Black & Charles Silver, *The Economics of Plaintiff-Side Personal Injury Practice*, 2015 U. ILL. L. REV. 1563, 1563 (2015).

65. FEINMAN, *supra* note 1, at 90; STEPHEN GILLERS, REGULATION OF LAWYERS: PROBLEMS OF LAW AND ETHICS 113 (10th ed. 2015).

66. BOURHIS, *supra* note 24, at 76–77 (paying possibly hundreds of thousands of dollars up-front for holding depositions, gathering evidence, hiring expert witnesses, and incurring travel expenses).

67. For example, an insurer may offer nothing and dispute liability even when it is obvious which driver is at fault (such as a driver who ran a red light). Aaron DeShaw, *The Segmentation of Injury Claims*, *in* I ANATOMY OF A PERSONAL INJURY LAWSUIT 15, 19 (John F. Romano ed., 4th ed. 2015).

68. *Id.* at 18.

more in legal fees than the claim's value, just for the deterrent effect on claimant representation.[69]

A complementary way insurance companies changed claims centers into profit centers was by altering the role of the claims adjuster. Traditionally, insurers tasked adjusters with settling claims for what they were actually worth and had substantial autonomy and authority to achieve this goal.[70] To reduce payout amounts, McKinsey put computer programs in place to artificially cap claim valuations far below their true worth, lower than even the most conservative adjusters.[71] Along with incentives and new performance metrics, this fostered a culture of treating claimants as adversaries and reinforced the zero-sum strategy.[72]

Fighting their own policyholders at their most vulnerable proved wildly successful for Allstate's bottom line. About a decade before the changes, in 1987, the insurer paid out in claims about seventy percent of its premiums collected, in line with the industry average.[73] The total difference between premiums collected and claims paid was about $82 million per year between 1986 and 1995.[74] Allstate implemented McKinsey's system in 1996.[75] Ten years after the changes, in 2006, Allstate was paying out less than fifty percent of premiums as claims.[76] This resulted in a difference between premiums collected and claims paid out of about $2.49 *billion* per year (over thirty-three times the previous average).[77] The result of playing a zero-sum game was that Allstate took nearly $2.5 billion *every year* from insureds who suffered losses to keep for itself.[78]

Allstate was the first to implement these practices, and other companies soon followed.[79] McKinsey itself worked with State Farm, United Services Automobile Association (USAA), Farmers, Liberty Mutual, The Hartford, Nationwide, and others.[80]

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69. *Id.*
70. FEINMAN, *supra* note 1, at 57.
71. DeShaw, *supra* note 67 at 26–27. Replacing adjusters' fair valuations with computer programs has proven so effective that one insurer claims to make $200 million per year more just by using one. *Id.* at 27.
72. BERARDINELLI, *supra* note 22, at 108.
73. *Id.* at 31–32.
74. *Id.* at 32–33.
75. *Id.* at 33.
76. *Id.* at 31–32.
77. *Id.* at 33; FEINMAN, *supra* note 1.
78. BERARDINELLI, *supra* note 22, at 33.
79. *Id.*
80. *Id.* at 51–52.

3. The Biased IME: We Know a Trick or Two

Insurance companies use still another way to lowball or outright deny legitimate claims—employing a biased doctor to conduct a so-called independent medical examination.[81] IMEs, and paper-based records reviews, are never used to increase claim values, only to decrease, deny, or (in the best case) confirm them.[82] Even if there is no express collusion, insurance companies have a natural tendency to select an ME who will be more likely to opine that the claimant is malingering, is not injured as severely, has a different cause for the injury, or is simply not injured at all.[83] Examinations may be incomplete or flat-out designed to discredit the injury claims.[84] In one situation, the insurer explicitly instructed the ME to discuss whether the automobile collision caused the claimant's injury "[o]nly if in negative."[85]

Despite ethical[86] and professional considerations, a combination of incentives drives MEs to participate in IMEs and provide favorable results for insurers. First, MEs stand to make hundreds of thousands of dollars in annual income.[87] IME and trial prep fees "are usually far greater" a revenue source than in-office patient care and nearly all noninterventional treatments.[88]

Second, the possibility of regular and repeat business also financially motivates MEs to maintain a positive relationship with the hiring insurance company.[89] During an IME, an ME's primary legal and professional obligation is not to the examinee-claimant but to the insurance company that hired her.[90] And while honest MEs exist, insurance companies do not tolerate examiners who find for claimants, even if they are skilled and truthful.[91] MEs

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81. EVAN K. AIDMAN, WINNING YOUR PERSONAL INJURY CLAIM 146 (3d ed. 2005); Schatman & Thoman, *supra* note 14, at 191.

82. FEINMAN, *supra* note 1, at 110.

83. *Id.* at 111.

84. *Id.* at 112.

85. *Id.* (emphasis in quoted source, double-underlined in insurer's original request).

86. *Code of Medical Ethics Opinion 1.2.6: Work-Related and Independent Medical Examinations*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/work-related-independent-medical-examinations [https://perma.cc/W4VF-SUSA].

87. McLaren, *supra* note 15; *see, e.g.*, Metro. Prop. & Cas. Ins. Co. v. Overstreet, 103 S.W.3d 31, 42 (Ky. 2003) ("Dr. Primm earned as much as $832,500.00 annually from [IMEs].").

88. Jerome Schofferman, *Opinions and Testimony of Expert Witnesses and Independent Medical Evaluators*, 8 PAIN MED. 376, 377 (2007).

89. Schatman & Thoman, *supra* note 14, at 191.

90. *Id.* Some courts go further, holding that an ME's duty is *exclusively* to the party requesting the IME. Johnston v. Sibley, 558 S.W.2d 135, 138 (Tex. Civ. App. 1977).

91. DOROTHY CLAY SIMS, 1 EXPOSING DECEPTIVE DEFENSE DOCTORS § 1:02 (Lisa Dunne ed., rev. 6 2018).

are aware that insurers will no longer give them business if they reach a conclusion contrary to insurance interests more than two times.[92]

Beyond being a lucrative income source, IMEs are simpler and incur less liability than treating patients.[93] IMEs do not involve haggling with insurance companies or Medicare, fighting bill down-coding or reductions, treating unhappy or non-compliant patients, or dealing with patients' families or friends.[94] There are no night or weekend calls.[95] Perhaps most importantly, IMEs also have almost no potential for a malpractice suit because the doctor is not treating the examinee.[96] But when the threat of malpractice liability is removed, so is much of the deterrent that would otherwise protect a patient from unprofessional medical practices.

4. The Reality: No One There To Help Claims Go Right

Insurance companies today can regularly violate their good faith and fair dealing duties because the three potential sources of oversight are largely ineffective.[97] This subsection will consider federal, state, and private means of enforcement.

Federal regulatory enforcement is ineffective because it does not exist.[98] The 1945 McCarran-Ferguson Act[99] prevents the federal government from enacting any insurance consumer protections at all.[100] Congress justified its laissez-faire stance with the idea that states were better positioned to regulate the supposedly local industry of insurance.[101] A competing view is that insurers lobbied for the Act's passage, preferring local regulation to federal

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92. *Id.*; *see also* Kleinfeld, *supra* note 2 (providing one ME's viewpoint as, "'If you did a truly pure report . . . the insurers wouldn't pay for it. You have to give them what they want, or you're [out of a job]. That's the game, baby.'").

93. SIMS, *supra* note 91.

94. *Id.*

95. Schofferman, *supra* note 88, at 377.

96. SIMS, *supra* note 91.

97. BOURHIS, *supra* note 24, at 20 (stating the three potential oversight sources).

98. *Id.*

99. 15 U.S.C. §§ 1011–15 (2018).

100. BOURHIS, *supra* note 24, at 20; *see also* FEINMAN, *supra* note 1, at 204 (quoting Missouri Insurance Commissioner Jay Angoff in Scot J. Paltrow, *The Converted: How Insurance Firms Beat Back an Effort for Stricter Controls*, WALL ST. J. (Feb. 5, 1998), https://www.wsj.com/articles/SB88663001862022000 [https://perma.cc/3QX4-8DHY] ("[Insurance companies] [would] rather be regulated by [fifty] monkeys than one big gorilla.")).

101. Michael D. Rose, *State Regulation of Property and Casualty Insurance Rates*, 28 OHIO ST. L.J. 669, 694 (1967).

oversight because insurers believed they already had great influence over state regulators.[102]

On the state level, enforcement is ineffective and penalties are toothless, even though all states have unfair insurance practices legislation and insurance departments.[103] No state insurance department has the power to sue an insurance company on behalf of a cheated claimant—all they can do is investigate.[104] If there is an investigation, and if an insurer has violated an unfair practices act, in theory the state could fine the company.[105] But this rarely happens.[106] When a fine is assessed, it is nominal and does nothing to compensate the injured policyholder.[107]

Arizona has substantially adopted[108] the Model Unfair Claims Settlement Practices Act, created by the National Association of Insurance Commissioners ("NAIC").[109] This model act offers minimum standards for the industry, including the duty to act promptly, the duty to fully pay all legitimate claims, the duty to investigate claims objectively, and the duty to not put an insurer's own interests above the interests of its policyholder.[110] However, an insurance company only violates this statute if it breaches its duties "with such a frequency to indicate [the failure is] a general business

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102. Scot J. Paltrow, *The Converted: How Insurance Firms Beat Back an Effort for Stricter Controls*, WALL ST. J. (Feb. 5, 1998), https://www.wsj.com/articles/SB88663001862022000 [https://perma.cc/PHL6-RWUH]. One study of state insurance commissioners' careers found that over half go on to work in the insurance industry after leaving office, "suggestive of a revolving door." Martin F. Grace & Richard D. Phillips, *Regulator Performance, Regulatory Environment and Outcomes: An Examination of Insurance Regulator Career Incentives on State Insurance Markets*, 32 J. BANKING & FIN. 116, 122 (2008).

103. BOURHIS, *supra* note 24, at 21.

104. *Id.*

105. *Id.*

106. *Id.* at 21–22 (characterizing state commissioners as "pro-industry hacks" who obtained their position based on their "ability to do exactly the opposite of what a watchdog regulator is supposed to do").

107. *Id.* at 21.

108. *See* ARIZ. REV. STAT. ANN. § 20-461 (2015).

109. MODEL LAWS, REGULATIONS AND GUIDELINES (NAT'L ASS'N OF INS. COMM'RS 1997), https://www.naic.org/store/free/MDL-900.pdf [https://perma.cc/U2VD-TYAG]. The NAIC is governed by the chief insurance regulators from the states, the District of Columbia, and five U.S. territories. *About the NAIC*, NAT'L ASS'N OF INS. COMM'RS https://www.naic.org/index_about.htm [https://perma.cc/67SW-JN3C]. But the NAIC "acts more like a trade organization than a regulator." *Perspectives on Modernizing Insurance Regulation: Hearing Before the S. Comm. on Banking, Hous. and Urban Affairs*, 111th Cong. 5 (2009) (testimony of J. Robert Hunter, Director of Insurance Federation of America). In fact, right after leaving office, NAIC presidents have taken insurance industry jobs such as lobbyists and company presidents. *Id.* at 14.

110. § 20-461; *see also* Zilisch v. State Farm Mut. Auto. Ins. Co., 995 P.2d 276, 280 (Ariz. 2000).

practice."[111] Every single time a company violates a fair claims practices standard it injures its consumer, who deserves to be made whole.[112] Yet the statute does not create a private right of action.[113] Rather, only an administrative remedy is available.[114]

What is the administrative penalty if an insurer engages in unfair practices with such frequency as to be its general practice? A cease and desist order.[115] The Arizona Department of Insurance ("ADOI") Director *may* also impose up to a $1,000 fine for each violation (but never more than $10,000).[116] Even if the violation was *intentional*, the Director may only impose up to a $5,000 fine for each violation (but never more than $50,000 in any six-month period).[117] These fines do not even go toward compensating the cheated policyholders but instead are placed into the state's general fund.[118] Meanwhile, insurers are making billions of dollars per year from these violations.[119]

Compare this with the penalty for a claimant who, for the first and only time, knowingly makes a false statement or representation in a claim. Under section 23-1028 of the Arizona Revised Statutes, this is a class six felony (punishable by four months to two years in prison)[120] that carries a fine of up to $50,000, payment of restitution (to the insurer and the attorney general),[121] and forfeiture of all claim benefits.[122]

Other than governmental oversight, private enforcement is available through a lawsuit to recover damages for additional injuries suffered from the insurer's bad faith acts.[123] This can provide relief.[124] However, bad faith laws and their protections vary by state.[125] And while a bad faith claim can include

111. § 20-461. Jay M. Feinman characterizes this type of statutory language as like saying criminals are free to commit offenses and may be punished only if such crimes are organized or habitual. *See* FEINMAN, *supra* note 1, at 218.

112. FEINMAN, *supra* note 1, at 218.

113. § 20-461(D).

114. *Id.*

115. ARIZ. REV. STAT. ANN. § 20-456(A) (2015).

116. § 20-456(B).

117. *Id.*

118. § 20-461(E).

119. S*upra* text accompanying notes 75–80.

120. ARIZ. REV. STAT. ANN. § 13-702 (2020).

121. ARIZ. REV. STAT. ANN. § 20-466.02 (2015).

122. ARIZ. REV. STAT. ANN. § 23-1028(D) (2016).

123. BOURHIS, *supra* note 24, at 23.

124. FEINMAN, *supra* note 1, at 220 ("[S]tudies have shown that claims payments are higher in states with strong bad faith law, indicating that the law induces companies to observe fair claims practices.").

125. *Id.*

damages beyond coverage limits, these damages are generally only compensatory and remedial.[126] This would achieve the objective of making the claimant whole, but these added injuries should not have occurred but for the insurer's bad faith actions.[127] Even when the claimant obtains the full claim value through litigation, the delay may still benefit the insurance company. In part, this is because the insurer will be generating more float income throughout the delay from the illegally withheld claim payment.[128] A three-year payment delay from being forced through the judicial process could allow the company to earn fifty percent on the policyholder's withheld money, meaning the insurer only pays fifty cents of every dollar it originally owed.[129] Thus, compensatory damages are not much of a deterrent.

When a claimant alleges bad faith, the fairly debatable rule further narrows liability.[130] This rule requires the insurer to have formed the bad faith element of intent "without reasonable or fairly debatable grounds."[131] One way a claim's value or coverage can be considered fairly debatable is based on IME results, which can justify more investigation and result in further delay or complete denial of benefits.[132] Insurers may use a biased ME to avoid bad faith liability by providing these fair debatability grounds, even though the intentional use of a biased ME would itself be bad faith.[133]

Punitive damages would be more of a deterrent but are exceedingly difficult to obtain. In Arizona, plaintiffs must show bad faith plus "something more."[134] A claimant must prove that the insurer's "evil hand was guided by an evil mind."[135] And a plaintiff can only prove the evil mind by either showing the insurer consciously intended to injure the policyholder or the insurer consciously acted knowing it created a substantial risk of significant harm.[136] But even if a claimant proves the insurer acted intentionally, as long

126. *See* Feinman, *supra* note 51, at 693, 700–01.

127. *See* State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408, 416 (2003).

128. FEINMAN, *supra* note 1, at 221–22.

129. John Haberstroh & Kevin Mulhern, *Stories from the Front: IE (IME) Excesses and How to Counter Them*, 17 FORENSIC EXAMINER 1, 44, 47.

130. *Cf.* Zilisch v. State Farm Mut. Auto Ins. Co., 995 P.2d 276, 280 (Ariz. 2000) (recognizing that fair debatability is "not always" sufficient to avoid a bad faith claim, implying that there are circumstances where it is).

131. Rawlings v. Apodaca, 726 P.2d 565, 576 (Ariz. 1986).

132. Bronick v. State Farm Mut. Auto. Ins. Co., No. CV-11-01442-PHX-JAT, 2013 U.S. Dist. LEXIS 98319, at *5–7, *16–17 (D. Ariz. July 15, 2013).

133. *See* Nardelli v. Metro. Grp. Prop. & Cas. Ins. Co., 277 P.3d 789, 810–11 (Ariz. Ct. App. 2012) (Swann, J., concurring in part and dissenting in part) (quoting *Rawlings*, 726 P.2d at 576.).

134. *Rawlings*, 726 P.2d at 577.

135. *Id.* at 578.

136. *Id.*

as the insurer's motive was purely financial, it still would not meet the "something more" standard.[137] As a result, courts reserve punitive damages only for the most "rare and extreme bad faith case."[138] In the extraordinary situation that the plaintiff proves the evil mind and shows the insurer was motivated by something other than profits, the court may still cap any punitive damages award in proportion to compensatory damages.[139]

Overall, private regulatory actions are ineffective because punitive damages and bad faith claims are too infrequent and difficult to obtain to prevent good faith breaches, and purely contractual damages are not enough to either adequately compensate the policyholder or substantially discourage handling claims in bad faith.[140]

B. State Approaches

Some states have looked to address the biased IME problem through various statutory, regulatory, and judicial solutions. One approach is to prevent the insurer from hand-picking the ME conducting the IME. Hawaii requires ME selection by agreement of the parties, or if the parties cannot agree, then the court, commissioner, or adjudicator will make an appointment.[141] Pennsylvania allows only the court to select the ME.[142] In Vermont workers' compensation claims, the commissioner appoints an ME from a pool of names that appear on both management's and labor representatives' lists.[143] The selected ME's impairment opinion is binding, unless there is substantial error, omissions fraud, or "gross departure from generally accepted medical practices."[144]

Another way to control bias is to disqualify MEs based on conflicts of interest. In Maine workers' compensation claims, disqualification can occur

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137. *Nardelli*, 277 P.3d at 811.

138. *Id.* (finding it "difficult to imagine *any* case in which an insurer's bad faith is not motivated by its own economic self-interest" (emphasis in original)).

139. State Farm Mut. Auto. Ins. Co. v. Campbell, 538 U.S. 408, 424–25 (2003); BOURHIS, *supra* note 24, at 187 (pointing out that a punitive damages cap defeats its deterrent effect, which is its purpose).

140. *Rawlings*, 726 P.2d at 575.

141. HAW. REV. STAT. ANN. § 431:10C-308.5 (West 2008).

142. 75 PA. STAT. AND CONS. STAT. ANN. § 1796 (West 2018).

143. VT. STAT. ANN. tit. 21, § 667 (2018). Some solutions are more limited and apply only to workers' compensation claims, like this Vermont statute. But biased IMEs present similar issues in personal injury claims, so it is instructive to consider state approaches in both contexts.

144. *Id.*

based on the ME's industry connections that would cause partiality.[145] Disqualifying industry connections could include a history of working extensively with insurance companies or generating significant money from doing defense IMEs.[146] Additionally, failure to disclose potential conflicts may be grounds for disqualification.[147]

Yet another approach in the workers' compensation context has been to allow the insurer to select the ME but limit the compensation allowed.[148] Ostensibly, this is to reduce the financial incentive for the ME to favor the hiring insurance company.[149] A Florida regulation has instituted a cap of $300 per hour for eight hours maximum.[150] If the insurer pays an ME above this limit, the court may disallow the ME from testifying in any resulting trial.[151]

Aside from these codified checks on MEs, some jurisdictions follow the modern trend in finding that some level of doctor-patient relationship or duty exists because of the IME, but specifics vary by state.[152] Louisiana recognized a full doctor-patient relationship, declaring that doctors performing IMEs must test and diagnose with "the level of care consistent with the doctor's professional training and expertise."[153] Montana is similar, but the ME's duty is determined on a case-by-case basis and is not necessarily the same as a treating physician's duty.[154]

Other jurisdictions are more restrained. An IME in Virginia or Michigan only comes with a duty to "do no harm" in the "actual performance of the examination," but there is no duty in the diagnosis.[155] New Jersey recognized a duty to exercise reasonable care "both in conducting the examination" and in communicating any abnormalities found to the examinee.[156] While not

145. 90-351-004 ME. CODE R. § 2(6) (LexisNexis 2020); Laskey v. S.D. Warren Co., 774 A.2d 358, 365 (Me. 2001).

146. *Laskey*, 774 A.2d at 362–64.

147. § 2(6); *Laskey*, 774 A.2d at 364.

148. *See* City of Riviera Beach v. Napier, 791 So. 2d 1160, 1161 (Fla. 2001).

149. Samuel D. Hodge, Jr., Melissa Thomas & Connor Lacy, *A Guide to the Independent Medical Examination,* 25 ALB. L.J. SCI. & TECH. 339, 367 (2015).

150. Unless the overage is specifically approved in writing. FLA. ADMIN. CODE ANN. r. 69L-30.008 (2018).

151. *Napier*, 791 So. 2d at 1160.

152. Stanley v. McCarver, 92 P.3d 849, 852 (Ariz. 2004) (identifying that other states, federal circuit courts, and at least one Arizona case have imposed some duty on MEs). However, some states do not find any such duty or relationship exists, including Alaska, New York, Utah, Texas, and Minnesota. Hodge, Thomas & Lacy, *supra* note 149, at 348–50.

153. Green v. Walker, 910 F.2d 291, 296 (5th Cir. 1990).

154. Webb v. T.D., 951 P.2d 1008, 1014 (Mont. 1997).

155. Harris v. Kreutzer, 624 S.E.2d 24, 31–32 (Va. 2006); *see* Dyer v. Trachtman, 679 N.W.2d 311, 314–15 (Mich. 2004).

156. Reed v. Bojarski, 764 A.2d 433, 443 (N.J. 2001).

legally binding, the American Medical Association believes an IME creates a limited doctor-patient relationship.[157]

In Arizona, it is unsettled precisely what duty exists during a personal injury claim IME. In 1995, the Arizona Supreme Court held that the IME practitioner owes a duty only to the insurer (as the requesting party).[158] The court found that the ME owed no duty to the examinee because an ME does not "intend to treat, care for or otherwise benefit" the examinee.[159] The court reasoned that, if it recognized a doctor-patient relationship, no physician would ever perform an IME because of the liability risk.[160]

Yet in *Stanley v. McCarver*, the Arizona Supreme Court explained that a duty of reasonable care may exist even without a formal doctor-patient relationship.[161] This is because a claimant who is "in the hands of a medical professional," even if only at the request of his insurer, reasonably expects reasonable care.[162] The court conducted a factors-based analysis to determine whether the duty of reasonable care existed.[163] Considerations included whether the IME doctor was in a unique position to prevent harm, if the claimant relied on the doctor's diagnosis, how close the connection was between the IME doctor's conduct and the injury, the certainty that the claimant has suffered or will suffer harm, the skill or special reputation of the actors, the burden of preventing harm, and public policy.[164]

More recently, in *Ritchie v. Krasner*, the Arizona Court of Appeals applied this analysis in a workers' compensation context, and found that an IME doctor owed the *Stanley* duty to exercise the same standard of care as "one with his skill, training, and knowledge."[165] This duty existed, despite a limited liability agreement that disclaimed any doctor-patient relationship, because a formal relationship is not necessary for a duty of reasonable care to exist.[166] On the other hand, the court explicitly rejected the notion "that every IME physician has a duty of care in every situation."[167] Here, the IME doctor was

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157. *Code of Medical Ethics Opinion 1.2.6*, AM. MED. ASS'N, https://www.ama-assn.org/delivering-care/ethics/work-related-independent-medical-examinations [https://perma.cc/92CE-KKCZ].

158. Hafner v. Beck, 916 P.2d 1105, 1107–08 (Ariz. 1995).

159. *Id.* at 1108 (agreeing with the reasoning used by Texas court, which did not recognize any duty or doctor-patient relationship during an IME).

160. *Id.* at 1107–08.

161. Stanley v. McCarver, 92 P.3d 849, 852 (Ariz. 2004).

162. *Id.* at 853.

163. *Id.*

164. *Id.*

165. Ritchie v. Krasner, 211 P.3d 1272, 1280 (Ariz. Ct. App. 2009).

166. *Id.* at 1281.

167. *Id.*

hired to not only determine the injury's extent but also to make "treatment recommendations."[168]

II. HOW TO GET ARIZONA'S IME PROBLEM TO A BETTER STATE

As explained in Part I, the once mutually beneficial insurance relationship has deteriorated, with insurers exploiting customers' financial vulnerabilities, discouraging attorney assistance, incentivizing self-serving IME diagnoses, and weakening consumer protections. Because the relationship has been eroding for decades, it will take time and efforts from many directions to reconstruct. Despite this, Arizona can take a significant step by first protecting those most susceptible to partisan MEs through legislation that incorporates constraints successfully employed by other states that account for gaps insurance companies have slipped through.

Subsection A will establish that the current controls in place cannot adequately protect unrepresented claimants, who are more vulnerable than claimants with legal representation. Subsection B will show that simply adopting any state's solution wholesale will not work because no single jurisdiction's approach offers sufficient protection. Subsection C will propose that a statute ensuring genuinely *independent* medical examiners would be the best way to address the problem. Lastly, Subsection D will argue that such legislation would not unreasonably damage insurance companies' legitimate interest in identifying fraudulent claims.

A. Unrepresented Claimants in Arizona Are Unable To Successfully Counter a Biased IME

Unrepresented claimants are especially susceptible to bad faith practices, as evidenced by how far insurance companies stretch to keep claimants and lawyers from working together. The IME can be a powerful device against those without an attorney because the "principal safeguard" against biased expert opinion is cross-examination.[169] But this principal safeguard only exists after bringing a lawsuit, either at a deposition or trial. Thus, cross-examination provides no real benefit for an unrepresented claimant during his IME because he would not normally get the chance to cross-examine the ME. Likewise, the other potential checks on biased MEs are litigation-based,

168. *Id.*

169. Sears v. Rutishauser, 466 N.E.2d 210, 212 (Ill. 1984).

relying on claimants eventually obtaining representation and holding insurers accountable in court.[170]

In contrast, the represented claimant will have a lawyer who understands her rights and available remedies. The attorney can advise her what to expect during an IME and how the examinee should conduct herself. A lawyer can also try to encourage fair treatment, such as accompanying the claimant and taking notes or videotaping the exam.[171] And merely having representation might reduce how blatantly favorable the ME will be for an insurer through the implicit threat of having this bias exposed during subsequent deposition and cross-examination.[172]

While protection against biased examiners would be beneficial for both represented and unrepresented claimants, the legislature is more likely to enact a focused, incremental added protection than a broad, revolutionary change affecting all policyholders.[173] It will take more than one correction to bring the insurance industry back to first principles.[174] As a result, to maximize both approval chances and positive effect, any proposed protection should focus first on assisting those who are the most defenseless and exploitable.

Finally, the penalties under the Arizona unfair practices statutes are not a strong enough deterrent to outweigh the financial rewards of using biased MEs to lowball or deny claims.[175] A maximum $100,000 fine each year is a pittance compared to the billions taken out of claimants' pockets annually. And the fines do nothing to make the policyholder whole after the loss.

B. No Existing Approach Is Complete Enough To Address Biased IMEs

Unfortunately, there seems to be gaps in state attempts at a solution. For example, Hawaii's mutually agreed ME selection depends on the lay claimant either having representation or having the knowledge and expertise to evaluate proposed MEs and negotiate an agreement effectively with the

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170. *See* Martinez v. Lewis, 969 P.2d 213, 219 (Colo. 1998) (suggesting that bad faith and breach of contract lawsuits brought by aggrieved claimants will sufficiently counter any "significant concerns" raised by the biased ME).

171. AIDMAN, *supra* note 81, at 147.

172. *See generally* RICK FRIEDMAN, POLARIZING THE CASE: EXPOSING & DEFEATING THE MALINGERING MYTH 73–75, 143–46 (2007) (presenting specific tips and techniques for plaintiffs' attorneys when deposing and cross-examining insurance-appointed MEs).

173. *See* Charles E. Lindblom, *The Science of "Muddling Through,"* 19 PUB. ADMIN. REV. 79 (1959), *reprinted in* 12 EMERGENCE: COMPLEXITY & ORG. 70, 78 (2010).

174. *See* FEINMAN, *supra* note 1, at ch. 11.

175. *See supra* text accompanying notes 116–139.

insurer.[176] But even an attorney serving as an expert witness can face difficulties in determining whether an IME practitioner is biased.[177] In one case applying Arizona law, the plaintiff's expert uncovered the number and results of every previous IME performed by the insurer's examining physician.[178] Even so, the court rejected this data as "merely statistical evidence," irrelevant to bias without the plaintiff's expert also having collected and analyzed "the facts of each of those 151 cases."[179] The court viewed this inquiry and analysis as such a burden that it could not require the insurer to conduct a similar bias review on *one* ME before selection.[180] Yet to hold her own in an adversarial negotiation, an unrepresented, injured claimant would have to somehow shoulder the burden of investigating, evaluating, and vetting *multiple* physicians just to be in a position to knowledgably face an insurer during the mutual selection process. If an insurance company does not have to determine whether its own ME is biased, more should not be expected of a lay claimant told by her own insurer it will be there to help "every step of the way."[181]

Considering the balance of experience and negotiating power, a more reasonable solution would be selecting the ME by neutral appointment. But insurers may still deny insurance benefits based solely on the opinion of a unilaterally chosen ME by simply substituting a medical records review for the in-person examination. For example, Hawaii courts have decided that a medical records review is not an IME.[182] An insurer is free to handpick a biased ME to deny a legitimate claim as long as it simply replaces the face-to-face examination with a paper records review.

Even if a state enacts a compulsory neutral ME appointment, insurers will fight this requirement. The Pennsylvania Supreme Court denied Allstate's attempt to contract around the State's court-selection mandate, concluding the provision was "void as against public policy."[183] This issue originated from a policy clause requiring the claimant, Samantha Sayles, to undergo

176. HAW. REV. STAT. ANN. § 431:10C-308.5 (West 2008).

177. *See* Bronick v. State Farm Mut. Auto. Ins. Co., No. CV-11-01442-PHX-JAT, 2013 U.S. Dist. LEXIS 98319, at *29–30 (D. Ariz. July 15, 2013).

178. *Id.* at *26.

179. *Id.* at *26–27, *30.

180. *Id.* at *30.

181. *File a Claim*, ALLSTATE INS. CO., https://www.allstate.com/claims/report-claim.aspx [https://perma.cc/JQ4N-NEUJ].

182. Gillan v. Gov't Emps. Ins. Co., 194 P.3d 1071, 1084 (Haw. 2008).

183. Sayles v. Allstate Ins. Co., 219 A.3d 1110, 1112 (Pa. 2019).

IMEs conducted by an insurer-selected ME.[184] Allstate, the insurance company, argued that Pennsylvania law allows parties to enter insurance contracts that contain such an IME provision.[185] Ms. Sayles contended that this provision violates the Pennsylvania Motor Vehicle Financial Responsibility Law[186] which mandates, among other things, the court to make the ME selection.[187] The court rejected Allstate's argument that the statutory requirement "applie[d] only when insurance policies do not contain IME clauses" because "[a]llowing such a contractual circumvention . . . would undermine one of the legislature's remedial objectives undergirding the [statute]," that is, "ensur[ing] that victims of accidents are adequately compensated."[188] Although the Pennsylvania policy withstood Allstate's assault, the same result is far from guaranteed in other jurisdictions.[189] And this shows just how willing insurance companies are to resist statutes that enable an equitable ME selection process.[190]

Next, Florida's approach of restricting examiner compensation[191] seems questionable. This could reduce, but would not eliminate, the potential influence of compensation on the ME's opinion. This is because the repeat business incentive still exists, as does the IME's simplicity and lower liability. The insurance company could handpick its ME anyway. Even worse, the compensation cap could have the unintended consequence of reducing the quality of IMEs by discouraging highly skilled and qualified (and normally well-compensated) doctors from performing IMEs altogether.

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184. Sayles v. Allstate Ins. Co., 260 F. Supp. 3d 427, 432 (M.D. Pa. 2017) (invoking the clause, the insurer denied medical payment benefits contingent on the IME results, advising that the "process will take approximately 60 days").

185. *Id.* at 434; *see also Sayles*, 219 A.3d at 1116–18 (recounting Allstate's statutory interpretation and policy arguments).

186. *Sayles*, 260 F. Supp. 3d at 432.

187. 75 PA. STAT. AND CONS. STAT. ANN. § 1796(a) (West 2018).

188. *Sayles*, 219 A.3d at 1124–25 (noting that "accepting [Allstate's] argument that the legislature's deliberate statutory design can be bypassed simply by the insertion of clauses like these in automobile insurance contracts would contravene the well-established tenet of our jurisprudence that 'contracts cannot change existing statutory laws.'") (quoting Generette v. Donegal Mut. Ins. Co., 957 A.2d 1180, 1191 (Pa. 2008)).

189. *See, e.g.*, *id.* at 1122–23 (observing that courts are usually "wary to declare contractual language invalid as against public policy," and that "a challenger who asserts that clear and unambiguous contract provisions, such as the ones at issue in this case, are void as against public policy carries a heavy burden of proof.") (quoting *Generette*, 957 A.2d at 1190).

190. *See, e.g.*, *id.* at 1112–13 (describing a similar case involving Travelers Commercial Insurance Company); Brief of Amicus Curiae in Support of Appellants and Seeking Reversal of the Orders Below, Sayles v. Allstate Ins. Co., No. 17-3463 (3d Cir. Dec. 27, 2019), 2018 WL 1675842, at *3–*4 (submitted by the Pennsylvania Defense Institute, a "statewide association of [insurance carrier] attorneys, independent adjusters and insurance company professionals").

191. FLA. ADMIN. CODE ANN. r. 69L-30.008 (2020); *see supra* text accompanying note 150.

Perhaps the only MEs willing to accept restricted compensation would be those without better paying work. They might be even more susceptible to the pressure of pleasing the hiring insurer to preserve their IME income source.

Turning to judicial controls, the Arizona limited duty approach does not seem to apply to IME-based claim denials. *Stanley* established that an IME doctor may have a duty of reasonable care if, among other things, the claimant relied on the doctor's diagnosis.[192] The *Ritchie* court found the *Stanley* duty applied when the examiner was hired to make treatment recommendations but noted that not every IME physician will have this duty.[193] Reading *Stanley* and *Richie* together, there appears to be a gap for situations in which the claimant does not rely on the ME's diagnosis or treatment recommendations. This is likely to occur when the insurer uses the IME report solely to deny coverage. The personal injury claimant will probably not rely on the twenty-minute IME diagnosis or recommendations because the claimant has already been following his treating physician's diagnosis and recommendations.

Even if Arizona courts were willing to find that an IME establishes a full doctor-patient relationship, this finding would not help unrepresented claimants when their claims are denied. Neither would disqualifying MEs from testifying based on conflicts of interest when unrepresented claimants are denied benefits before ever receiving this protection in court.

Ultimately, private enforcement through lawsuits will be ineffective in countering the use of a biased IME. For one, private enforcement depends on a plaintiff retaining a lawyer despite the insurer systematically discouraging both the claimant and the attorney.[194] Also, there will be no protection for policyholders with small claims that do not justify hiring a lawyer.[195] Even those with representation face biased IMEs, but at least their lawyers have tools to counter some of the biases. And even when those with representation (whether obtained before or after the claim denial) challenge the IME in court and receive a favorable verdict for the fair value of their claim, the insurance company still benefits through simple delay because it has made more interest on float.[196] On top of this, the policyholder may not receive full compensation

192. Stanley v. McCarver, 92 P.3d 849, 853 (Ariz. 2004).

193. Ritchie v. Krasner, 211 P.3d 1272, 1281 (Ariz. Ct. App. 2009).

194. FEINMAN, *supra* note 1, at 199–201.

195. *Id.*

196. Using *Sayles* as an example of how long obtaining a judicial award may take, Ms. Sayles was injured in a car collision on December 11, 2015. Sayles v. Allstate Ins. Co., 260 F. Supp. 3d 427, 432 (M.D. Pa. 2017). Allstate denied payment on May 20, 2016. *Id.* She filed an action in state court on June 20, 2016, which Allstate removed to federal court on July 25, 2016. *Id.* at 433. The U.S. District Court denied Allstate's Motion to Dismiss in part, which the insurer appealed

after attorney's fees and costs, and has possibly covered his own medical expenses during the delay and dealt with the resulting financial strain.[197] In sum, because not all unrepresented claimants will retain a lawyer after facing a biased IME, and even fewer will be fully compensated, purely private regulatory enforcement will not be enough to deter insurers from continuing to cheat policyholders without statutory or punitive damages.[198]

C. The Ideal Approach Would Be To Require Truly Independent MEs by Statute

The most effective way to ensure unrepresented policyholders' claims are not denied based on biased ME reports is to have independent medical examiners. This can be accomplished by a new statute knitting together features from other states' approaches, reinforced by bad faith and punitive damages presumptions, while closing seams through which insurers have slipped through states' restrictions. If the legislature is unable or unwilling to create a statute because of the insurance lobby, it could be implemented by a voter-initiated measure.[199]

The statute would prevent any insurance claim brought by an unrepresented claimant from being denied or reduced benefits based in any part on a medical examination or medical records review, unless the exam or review was conducted by a medical professional appointed by ADOI from a list. The statute should require ADOI to maintain a list of qualified MEs compiled by selecting common names from lists submitted by physicians,

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to the Third Circuit. Brief of Appellant, Sayles v. Allstate Ins. Co., No. 17-3463 (3d Cir. Dec. 27, 2019). The Circuit Court certified a question of state law to the Pennsylvania Supreme Court, which issued its opinion on November 20, 2019. Sayles v. Allstate Ins. Co., 219 A.3d 1110, 1116 (Pa. 2019). Finally, on December 27, 2019, the Third Circuit affirmed the district court's decision, remanding for further proceedings. Order Affirming the District Court's Orders of 05/10/2017 and 10/06/2019 and Remanding for Further Proceedings, *Sayles*, No. 17-3463. From the crash to the Third Circuit's remand, it was four years and two weeks. It is not known whether Allstate paid Ms. Sayles's claim yet.

197. *See, e.g.*, Haberstroh & Mulhern, *supra* note 129, at 44–45 (recounting a chiropractor whose claim was unfairly denied based on a biased IME even though she could not work because of her injury, resulting in her selling her practice, having her car repossessed, being thrown out of her house with her children, and ending up on welfare and food stamps).

198. Feinman, *supra* note 51, at 694–95. The people of Arizona have constitutionally retained the power to directly propose laws through voter initiatives. Cave Creek Unified Sch. Dist. v. Ducey, 295 P.3d 440, 445 (Ariz. Ct. App. 2013); *see also* ARIZ. CONST. art IV, pt. 1, § 1.

199. However, ballot measures are not immune to lobbying. The insurance industry spent $21 million in 2006 and 2007 to influence them. FEINMAN, *supra* note 1, at 211–12.

insurers, and plaintiffs' lawyers.[200] ADOI could update this list by regularly removing those with conflicts of interest, or connections that could cause bias. The appointed ME's opinion would be binding, unless a party shows there was substantial error, omissions fraud, or substantial departure from generally accepted medical practices. There should be a provision expressly preventing these statutory requirements from being contracted around.

The statute should provide a strong deterrent effect against violations, so unrepresented claimants unaware of the law would have some measure of indirect protection from an unscrupulous insurer. Because studies have shown strong bad faith laws influence insurers to comply, the statute would be strengthened by presuming both bad faith and the evil mind required for punitive damages for any violation. Punitive and bad faith damages would also help counter an insurance company's exploitation of the economics of law practice by providing a financial incentive for plaintiffs' attorneys to pursue violations and create the deterrent. This financial incentive would have the added effect of encouraging attorneys to make eligible claimants aware of potential claims based on statutory violations. And the statute could provide the claimant with a time-limited option to void any release given if the insurer used an improperly selected ME. This would provide the remedy to claimants induced to settle based on a biased ME report but who did not know of the protections.

As the case law above establishes, insurance companies will try to find ways around any restrictions on the IME. Thus, preventing the statute from being weakened or circumvented will require support from regulatory and judicial sources. As a result, a statute laying down a strong public policy will be easier to enforce and is more likely to protect unrepresented claimants.[201]

D. Adequate Protections Against Insurance Fraud Would Remain in Place

Insurance companies have a legitimate interest in detecting and denying false claims. They are illegal and should be prosecuted. Insurers may assert the only way to protect against fraudulent claims is by using examiners who

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200. This would be an institutionally managed, standing version of a common process for selecting arbitrators in international arbitration. *See* NIGEL BLACKABY, CONSTANTINE PARTASIDES, ALAN REDFERN & J. MARTIN HUNTER, REDFERN AND HUNTER ON INTERNATIONAL ARBITRATION 241–42 (6th ed., 2015).

201. *Cf.* Calvert v. Farmers Ins. Co. of Arizona, 697 P.2d 684, 687 (Ariz. 1985) (demonstrating the court's willingness to void even express insurance contract exclusions based on "strong public policy mandating coverage for innocent victims from tragic negligent acts of uninsureds" set forth by Arizona statute).

have insurance companies' interests in mind. But a merely independent doctor performing a medical examination or records review should be enough to weed out unmeritorious claims because any doctor not biased for the claimant would detect any malingering or faking. There is no justification for why an insurer—rather than an independent body—must be the one to select the ME.[202]

Turning to the insurance companies, it is also fraudulent to wrongfully deny or undervalue a meritorious claim without a legitimate basis. Yet insurers routinely and intentionally do so without adequate protections for the unrepresented insured. The fraudulent conduct that most needs to be discouraged are those insurance practices that force policyholders to sue just to receive paid-for, legitimately claimed policy benefits.[203] These lawsuits never should have existed because there never should have been the need to bring them, but for insurers' fraudulent conduct.

Even the existing systems in place are much more concerned with detecting and harshly punishing consumer insurance fraud while doing little to ensure insurance companies follow unfair practices acts.[204] For example, ADOI's Consumer Protection Division administers insurance-professional licenses, "renders assistance" to policyholders, and "investigates possible violations of Arizona insurance laws."[205] In contrast, the ADOI Insurance Fraud Division "deters, investigates, and supports prosecution" of fraud, is staffed with certified Arizona peace officers, conducts undercover investigations, interviews witnesses, collects evidence, and refers cases for prosecution.[206] ADOI deploys this robust, quasi-prosecutorial watchdog against policyholders but does not subject insurers to similar scrutiny.

Arizona consumers are supposed to be protected through state investigations into insurers' unlawful actions.[207] But insurers violate the law only if their unfair practices are frequent enough to constitute a general business practice, which would be penalized only by a cease and desist order and optional, limited, non-restitutive fines.[208] In contrast, the government provides Arizona insurers a dedicated enforcement division.[209] A consumer

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202. McLaren, *supra* note 15 ("There is no legitimate need for a 'hired gun' in the process of performing a quality evaluation.").

203. *See* BERARDINELLI, *supra* note 22, at 91.

204. *See supra* text accompanying notes 103–122.

205. LESLIE R. HESS, 2016/2017 ANNUAL REPORT & FIVE-YEAR STRATEGIC PLAN 8 (2017).

206. *Id.*

207. *Id.*

208. ARIZ. REV. STAT. ANN. § 20-461 (2015).

209. HESS, *supra* note 205.

making a single, first-time violation has committed a felony.[210] Often, prosecution leads to "restitution awarded to the defrauded insurers."[211] One of ADOI's fourteen overarching "Strategic Issues" prescribes a "vigorous[ ]" effort to "investigate, prosecute, and otherwise deter insurance fraud."[212] None of the strategic issues have anything to do with investigating insurer violations.[213]

On balance, individual policyholders need extra protection against biased IMEs wielded by advantaged insurers much more than insurance companies need biased IMEs to prevent insurance fraud. Some of an insurer's advantages are inherent and systemic because an insurance company is a repeat player while the claimant is a one-shotter.[214] An insurance company finds value expending resources lobbying to achieve advantageous changes in statutes and regulations, where any individual claimant's expenditure would be inconsequential to effect change.[215] Further, the insurance company writes the policy contract itself with the advantage of vast experience with the claims and litigation process.[216] It also has in-house counsel, negotiates special rates with defense attorneys, and enjoys economies of scale, and so has lower costs for individual cases.[217]

Overall, insurers need not win every case and can maximize long-term strategies, while the claimant's one claim is everything to her.[218] Thus, a satisfactory outcome to a repeat player can be a favorable change in precedent even though the insurer might pay one-time damages, but a one-time claimant will not care about her individual case improving insurance jurisprudence for others.[219]

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210. ARIZ. REV. STAT. ANN. § 13-702 (2020).

211. HESS, *supra* note 205, at 12.

212. GERMAINE L. MARKS, FIVE YEAR STRATEGIC PLAN: FY 2015–FY 2019, at 22–24 (Aug. 30, 2013), https://insurance.az.gov/sites/default/files/documents/files/AgencyStrategicPlan_IDA.pdf [https://perma.cc/H4W5-B9MR].

213. *Id.*

214. Marc Galanter, *Why the "Haves" Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOC'Y REV. 95, 108–09 (1974).

215. *See id.* at 100; FEINMAN, *supra* note 1, at 211–12 (describing how the insurance industry invests in candidates across the board; for example, contributing more than $2 million to each opposing presidential candidate).

216. *See* Galanter, *supra* note 214, at 98.

217. *See id.*

218. *See id.* at 100–01.

219. *See id.* at 110.

CONCLUSION

The insurance industry is in a troubling state because some insurers inappropriately increase their income by violating promises to financially compromised policyholders. Because of the extent of the problem, there is no simple fix, no magic bullet. Still, the public can begin a pushback by protecting the most vulnerable unrepresented claimants against biased IMEs. Those who have innocently suffered a catastrophic loss should not be denied from receiving the benefit of their faithfully paid premiums. It is time to enact a statute to require a truly independent ME before claims can be denied or reduced.