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Insurance Practice

The Bad Faith Sentinel

Standing guard on developments in the law of insurance bad faith around the country

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Southern District Of California: Excess Insurer Liable For Bad Faith For Two Month Delay In Responding To Insured's Demand To Either Pay Negotiated Settlement Or To Take Over Insured's Defense

LMA North America, Inc. v. National Union Fire Insurance Company of Pittsburgh, No. 11-CV-71282-WQH-DHB, 2013 WL 595626 (S.D. Cal. Feb. 15, 2013)

Southern District of California holds that an excess insurer acts in bad faith by delaying two months in responding to an insured's demand for payment of an insured's negotiated settlement or to take over the defense of the insured from the primary carrier.

Beginning in 2007, LMA North America, Inc. ("LMA") and its competitor, Ambu A/S ("Ambu"), engaged in contentious litigation in which LMA initiated a lawsuit alleging patent infringement and Ambu asserted counterclaims against LMA for alleged false and disparaging advertising, with alleged damages of up to $30 million. Ambu's counterclaims were covered claims under LMA's primary and excess insurance polices with CNA (primary) and National Union Fire Insurance Company of Pittsburgh ("National Union"). CNA's primary policy had limits of $1 million and National Union's policy had excess limits of $14 million.

In September 2009, the Court denied both LMA's motion for summary judgment on Ambu's counterclaim and LMA's motion to preclude testimony from Ambu's damages expert. Also in September of 2009, the Court granted Ambu's motion for summary judgment on LMA's patent claim, but that decision was overturned a year later in September 2010. The litigation was stayed during the year in which the case was on appeal.

In November 2010, LMA's counsel posited to National Union that Ambu's counterclaims simply were a bargaining chip. However, because the Court denied LMA's summary judgment motion and concluded that a

jury might find for Ambu, National Union was on notice that Ambu's counterclaims potentially had merit.

In November and December 2010, National Union engaged in discussions with LMA's counsel and CNA regarding their evaluation of Ambu's counterclaims, and settlement/mediation. During these discussions, CNA advised National Union that it did not plan on tendering its full $1 million in policy limits. Because CNA did not intend to tender its policy limits, National Union decided against attending a mediation.

LMA and Ambu mediated their claims over the course of two days from January 10 – 11, 2011. As of January 13, 2011, National Union was under the impression that CNA did not tender its policy limits and that the case had not settled at mediation.

On February 1, 2011, LMA for the first time advised National Union that LMA reached a settlement "terms sheet" with Ambu on January 11, 2011 in which LMA agreed to pay Ambu $4.75 million to settle Ambu's counterclaims, provided that LMA was able to obtain a commitment from CNA and National Union by February 18, 2011 to pay for the settlement. (The February 18, 2011 settlement date subsequently was extended by mutual agreement of the parties.) On February 14, 2011, National Union advised LMA that it was surprised to learn that Ambu's "bargaining chip" turned into a $4.75 million settlement, and National Union required additional information, including a full liability and damages analysis, before it would respond to LMA's settlement request. On February 17, 2011, LMA refused to provide a written updated liability and damages analysis, and instead referred National Union to Ambu's mediation statement and demand letters. On February 18, 2011, LMA agreed to provide National Union access to LMA's confidential documents and discovery.

On March 17, 2011 LMA advised National Union that CNA agreed to tender its $1 million policy limits, and LMA then provided National Union with a written liability analysis. LMA also requested a settlement response from National Union by March 29, 2011, and advised National Union that litigation would resume by April 4, 2011 if a settlement was not reached.

On March 23 and 25, 2011, LMA pressed National Union for a settlement response. On March 25, 2011, LMA advised National Union that LMA reserved its right to pay the settlement itself and seek damages from National Union, and, if the settlement fell through and litigation resumed, National Union would be responsible for defense costs. On March 29, 2011, LMA demanded a settlement response from National Union by April 1, 2011. National Union finally responded on April 7, 2011 by rejecting the settlement.

On April 11, 2011, LMA advised National Union that it intended to pay National Union's $3.75 million portion of the settlement and to seek payment and damages from National Union. LMA told National Union that it had three options: (1) consent to the settlement; (2) agree to defend LMA; or (3) defend litigation commenced by LMA against National Union. On April 19, 2011, LMA advised National Union that on April 18, 2011 LMA agreed to pay National Union's $3.75 million portion of the settlement. On April 21, 2011, National Union for the first time agreed to defend LMA against the counterclaims.

On June 10, 2011, LMA filed suit against National Union over National Union's refusal to pay for LMA's settlement with Ambu, and National Union's alleged bad faith in delaying a response to LMA's settlement agreement with Ambu. The Court denied National Union's request to dismiss LMA's bad faith and punitive damage claims on the basis that "a reasonable jury could conclude that National Union acted unreasonably in delaying its response to LMA's request that National Union fund the contingent settlement or take over the defense of the Counterclaims."

This case is a reminder for excess insurers that they should: (1) stay involved in the insured's settlement discussions before a primary insurer tenders its limits; and (2) promptly respond to an insured's negotiated settlement. Moreover, an excess insurer may be required to take over the defense of an insured after a primary carrier tenders its policy limits.

Western District of Oklahoma: Bad Faith Claim Cannot be Brought Against Holding Company with No Ties to State, Unless It Has Pervasive Control Over Subsidiary's Actions as an Insurer

Harris v. American Int'l Group, Inc., No. CIV-12-470-D, 2013 WL 501354 (W.D. Okla. Feb. 11, 2013)

An insured attempted to bring a bad faith claim against an insurance holding company, AIG, by claiming that the minimum contacts of AIG's subsidiary in Oklahoma should be imputed to AIG. The Western District of Oklahoma held that it did not have personal jurisdiction over AIG because the subsidiary did not act as AIG's alter ego in the subsidiary's actions as an insurer.

Sandra Harris was injured in a motor vehicle collision that she alleged was caused by the negligence of an uninsured motorist. Harris submitted a claim under an automobile insurance policy issued by Granite State Insurance Company ("Granite"). Granite denied her claim and Harris brought suit against Granite. Harris alleged that Granite breached the insurance contract by denying her claim and that Granite acted in bad faith by improperly investigating and handling her claim. Harris also named American International Companies ("AIG") as a defendant, alleging that as the holding company for Granite, AIG owned and controlled Granite such that AIG should be held liable for Granite's conduct.

AIG filed a motion to dismiss for lack of personal jurisdiction. AIG argued that it did not have the requisite minimum contacts with Oklahoma as it was not licensed to do business in Oklahoma, did not maintain an office or own property in Oklahoma, was incorporated in Delaware and had its principal place of business in New York. Harris argued that Granite's minimum contacts with Oklahoma should be imputed to AIG because it controlled Granite.

The Court noted that it could not automatically exercise jurisdiction over a parent corporation simply because it had jurisdiction over a subsidiary. However, a company conducting business through its subsidiary could qualify as transacting business in a state, provided that it exercised sufficient control over the subsidiary. In order for the court to have jurisdiction, the non-resident parent must exercise pervasive control over and so dominate the affairs of the resident so as to cause the subsidiary to act as the non-resident parent's alter ego.

In reviewing Plaintiff's evidence, the Court noted that while the SEC filings and other documents reflected a financial relationship between AIG and Granite, such evidence did not demonstrate the necessary pervasive control over Granite's business. Notably absent was any evidence that AIG had been involved in the issuance of policies, review of claims, decisions regarding whether a claim will be paid, or other ongoing activities of an insurance subsidiary doing business in Oklahoma. Consequently, the Court granted AIG's motion to dismiss.

Middle District of Pennsylvania: Allegations Sufficient to Maintain Bad Faith Claim Against Holding Company

Dolph v. Illinois Nat'l Ins. Co., No. 3:12-2167, 2013 WL 528094 (M.D. Pa. Feb. 11, 2013)

AIG claimed that it was merely a holding company for its subsidiary and therefore was not an "insurer" under the Pennsylvania bad faith statute. The Middle District of Pennsylvania, however, found that Plaintiffs' allegations that AIG had a contract with insured and had assigned a claims manager in the underlying litigation were sufficient to prevent the dismissal of the bad faith claim.

Michael, Marjie and Shawn Dolph were injured in an automobile accident caused by Austin Smith, who died as a result of the accident. On March 16, 2012, the administratrix of Smith's estate, Diane Smith, assigned to the Dolphs her

claims against Illinois National Insurance Company ("Illinois National") and American International Group, Inc. ("AIG"). The Dolphs brought suit against the insurers alleging that a contract of insurance existed between Diane Smith and defendants and that the defendants assigned Bob McCaughan as a Claim Representative. In the underlying litigation, the Dolphs' attorney corresponded with McCaughan and demanded settlement at the policy limits of $50,000 and also offered to provide Diane Smith and the Estate with a full release. The discussions became protracted and the case proceeded to trial, where the Dolphs were awarded nearly $2 million in damages. The Dolphs claimed that the insurers breached the insurance contract and also acted in bad faith, pursuant to a Pennsylvania statute (42 Pa.C.S. § 8371).

AIG filed a motion to dismiss the action, claiming that it was not an "insurer" as required under the Pennsylvania bad faith statute and that there was no privity of contract between the parties on which to base a breach of contract claim. AIG argued that it was merely a holding company of Illinois National, and was not itself an insurer.

In determining whether a party is an insurer under the Pennsylvania bad faith statute, courts have examined the extent to which the party was identified as the insurer on policy documents, and the extent to which the company acted as the insurer. A party acts as an insurer when it issues policies, collects premiums and assumes certain risks and contractual obligations. AIG asserted that it was not licensed to perform insurance services in Pennsylvania and did not issue policies or collect premiums. However, the Dolphs alleged that AIG had a contract of insurance with Diane Smith and that AIG had assigned a claim manager to handle negotiations with their attorney. Noting that dismissal would be appropriate if the Court could determine that a corporate entity was not acting as an insurer, the Court found that questions remained as to AIG's role with respect to the insurance claims at issue. Accordingly, the Court declined to dismiss the bad faith claim against AIG. The Court also refused to dismiss the breach of contract claim against AIG, finding that the Dolphs' assertion that a contract of insurance existed between Diane Smith and AIG was sufficient to hold AIG in at the pleading stage.

Nevada Court Holds That Insurers Must Produce Claims, Investigation And Underwriting Files In Response To Discovery Requests Despite Limited Relevance To Breach Of Contract Claim

Renfrow v. Redwood Fire and Cas. Ins. Co., No. 2:12-cv-00632, —- F.R.D ——, 2013 WL 438810 (D. Nev. Feb. 1, 2013)

The District Court for the District of Nevada holds that discovery relevant only to bad faith claim must be produced before resolution of the breach of contract claim.

Renfrow was in a car accident and suffered injuries allegedly causing him loss of earning capacity, lost wages, physical impairment, mental anguish and loss of enjoyment of life. After the insurer for the negligent third-party who caused the accident paid the limits of its policy, which were insufficient to cover his claimed damages, Renfrow demanded underinsured policy limits from his insurer Redwood Fire and Casualty Insurance Company ("Redwood"). Redwood refused. In March 2012, Renfrow filed suit against Redwood and its parent, Berkshire Hathaway Homestate Companies ("Berkshire") (collectively with Redwood, "the insurers"), alleging that Redwood failed to make fair payment as required under the policy at issue and that the refusal was unreasonable and made in bad faith.

On September 19, 2012, Renfrow served his first set of requests for production of documents. Redwood and Berkshire did not respond to the requests, and three days after the response deadline, Renfrow's counsel contacted the insurers' counsel about the matter. Insurers' counsel informed

Renfrow's attorney that a new attorney would be taking over the file and would address the outstanding discovery. Renfrow did not hear from the insurers again until November 9, 2012, when the insurers' new attorney agreed to serve responses by November 13, 2012.

Renfrow finally received discovery responses on November 15, 2012. Renfrow deemed the November 15 responses unsatisfactory and contacted the insurers' counsel, who indicated that no additional material would be provided. Renfrow then filed an emergency motion to compel. At issue in the motion were Renfrow's requests for: (1) claim and investigation files; (2) underwriting files; (3) claim manuals; (4) claim analyses; (5) financial statements indicating net worth and net income; and (6) any statements relating to Renfrow's claim. In response to the motion to compel, Redwood and Berkshire filed a brief in opposition and a motion to bifurcate, or in the alterative stay discovery of the extra-contractual claims.

In their opposition, Redwood and Berkshire first argued that the extra-contractual issues raised in the complaint should be bifurcated from the breach of contract action and that any related discovery should be stayed. The insurers then argued that because bifurcation was warranted, their refusal to produce certain documents was permissible. With respect to the request for claim and investigation files and claims analyses, Redwood and Berkshire argued that the request was premature pending resolution of the UIM/contract claim. Specifically, the insurers argued that the information sought was not relevant to the UIM/contract claim, which involved only a dispute as to the value of Renfrow's injury and wage loss claims. According to the insurers, any claims analysis contained in the files was legal in nature and thus protected from disclosure. The insurers then argued that their underwriting files, net worth and financial statements were irrelevant because Redwood had not disputed UIM coverage and in fact paid the medical benefits to Renfrow.

As a preliminary matter, the Court noted that it was improper for the insurers to base their objections to the discovery requests on a motion to bifurcate that they intended to file without filing a motion for protective order asking the court to forbid or limit the discovery on the bad faith claim due to an alleged undue burden, expense or prematurity. The Court then held that the claims file was relevant to the bad faith claim and that the insurers were required to produce all non-privileged documents. The Court also found that the underwriting files, claim manuals and statements from the parties and witnesses were relevant to both the breach of contract and bad faith claims and must be produced. With respect to the request for the production of financial statements, the Court determined that the documents would be relevant only if there was a finding at trial that punitive damages are appropriate. As such, the Court ordered that the insurers file responsive documents under seal in conjunction with the eventual filing of the Joint Pretrial Order.

The Court then turned to the motion to bifurcate and concluded that bifurcation would require the parties to present much of the same evidence twice, have the same witnesses testify twice, make many of the same arguments twice, and pay the cost of litigation twice. Accordingly, the court denied the motion.

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