July 12, 2012

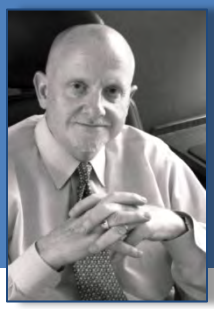
SELECTED BAD FAITH CASES AND ISSUES FROM WEEK OF JUNE 25, 2012

Minter v. Liberty Mutual Fire Ins. Co.
2012 WL 2430471
(U.S. D.Ct., W.D.KY., June 26, 2012)

Although the memorandum opinion does not contain a statement of facts, Liberty Mutual apparently withheld from discovery several documents and portions thereof from an underlying claims file – presumed not to be the bad faith claims file – by assertion of attorney-client privilege and the work product doctrine. The court ordered production of the claims file and observed that first-party bad faith actions against an insurer can only be proved by showing exactly how the company processed the claim and arrived at its decision. "Without the claims file," the court stated, "[it] is difficult to see how an action for first-party bad faith could be maintained without requiring an overwhelming number of depositions, whose costs would thereby render all but the rare wealthy few first-party claimants financially able to proceed." Thus, the assertion of attorney-client privilege did not shield materials contained in the underlying claims file. Moreover, the court took a firm hand in respect to attorney work product in the file (documents created before the plaintiff filed her bad faith complaint) and stated that the defendant was overly broad in asserting the privilege. For example, the court ordered production of a master medical chronology prepared by defendant's counsel, and while noting that this was "unquestionably attorney-work product," it contains "no extraneous commentary regarding the significance of any entry."

Miller v. Safeco Ins. Co. of America
2012 WL 2370104
--- F.3d --- (7th Cir. June 25, 2012)

The Millers closed on a purchased home on July 1, 2005. Safeco issued a homeowner's policy the day before which went into effect on the closing date. The Millers never saw their policy or read its terms until they were mailed a copy at the end of July. Before receiving the policy and sometime after beginning renovation of the home on July 5, however, they discovered severe inner wall water leaks and water infiltration on three exterior walls. The Millers filed a claim with Safeco for water damage, mold, and lost use of the home. Safeco denied the claim, relying in part on a buyer's pre-purchase inspection report that "confirmed multiple areas of water damage that were in need of attention," and also that the loss qualified as a pre-existing condition "that occurred outside of the policy period." The district court found that the policy covered the loss, that the exclusions did not apply, and Safeco acted in bad faith. The 7th



P. Ted Colquett
Wilson & Berryhill, P.C.
One Metroplex Drive, Suite 250
Birmingham, Alabama 35209
(T) 205.252.4441
www.tedcolquett.com
ted@wilsonberryhill.com

Circuit affirmed.

In finding coverage, the court upheld the trial court's use of continuous trigger theory to determine the date of harm based on the policy's language limiting coverage to "losses occurring during the policy period." Although the home was a total loss when the Millers discovered the problem and, therefore, Safeco argued that the water leakage and mold growth could not have caused any direct physical loss during the policy period, the court found that the point at which the property became a total loss mattered for determining whether the Millers took appropriate steps to mitigate the damages, not whether the "accidental direct physical loss to" the home occurred "during the policy period." That the degree of damage put the home beyond repair did not mean water leakage was not still causing further direct physical loss to the property during the policy period.

In respect to the exclusions which Safeco sought to enforce, the court found that it failed to tell the Millers about the same – whether by delivering the policy or by any other means – until after they discovered the damage. "And just as an insurer couldn't amend a policy's terms to exclude a loss after the insured discovers that loss," the court said, "an insurer cannot refuse coverage by pointing to an exclusion that the insured didn't know about until after the insured discovered the loss."

As to bad faith, Safeco maintained that the coverage issue was fairly debatable. First, Safeco asserted that the damage was a pre-existing condition that the Millers knew about, precluding coverage under the known loss doctrine. The court observed that there was no dispute that the damage was in existence before closing. But there was no evidence that the Millers knew about it until after closing. Second, Safeco pointed to the four months between discovery and the filing of the claim as justifying denial. The court countered that the Millers did not sit on their claim, but took the time to prepare it by contacting an attorney and having professionals assess the damage. Safeco also pointed to the policy's exclusions as a basis for denial. "But Safeco never showed where it ever actually relied on the exclusions. Safeco 'cluttered' the claim file with language from the exclusions but that didn't mean that it reasonably investigated or considered their applicability. Indeed the court considered it 'rather iniquitous for Safeco . . . to rely upon bases that were not fairly considered or reasonably asserted as reasons for denying the' claim."

In concluding, the court stated, "Given that Safeco does not show where the district court erred in debunking its reasons for denying the Millers' claim, we have no basis for finding the coverage issue fairly debatable."

Jackson v. American Family Mut. Ins. Co.
2012 WL 2415537
(U.S.D.Ct., NV., June 26, 2012)

The plaintiff's claims arose from an automobile accident in Clark County, Nevada. Alleging that he suffered serious injuries after being struck by an uninsured motorist, plaintiff made a policy limit demand of $25,000 based on accrued medical expenses of $11,738.80 and his claim that future medical costs entitled him to an additional $9,600.

American Family ultimately offered $16,000 in settlement, basing its offer on the accrued medical expenses, the police report citing plaintiff as partly at fault along with the other driver, its assessment of comparative fault, and a report from a registered nurse that future medical treatment was unnecessary.

In granting American Family's motion for partial summary judgment on bad faith, the trial court reviewed the requirement that bad faith be more than an unreasonable act – that it requires the insurer to act in a deceitful manner with the

awareness that the act was unreasonable. The evidence before the court established only that the plaintiff disagreed with American Family's valuation and settlement offer. Because the plaintiff failed to submit evidence that the insurer acted unreasonably, "let alone with the knowledge that there was no reasonable basis for its conduct," summary judgment was proper.

Houchin v. Allstate Indemnity Ins. Co.
2012 WL 24330474
(U.S.D.Ct., W.D.KY., June 26, 2012)

In a case where there was no doubt that the plaintiff-insureds were guilty of arson and insurance fraud in the destruction of their home (they were convicted of the same in Kentucky state court), Allstate argued that the court should recognize the cause of action of reverse bad faith in the insurance context and award it damages associated with the fraudulent claim.

Allstate maintained that there is a strong public policy against allowing insureds to profit from their own wrongdoing while simultaneously subjecting insurers to inordinate increased costs for investigation, defense, and litigation. The court found, however, no Kentucky case that has adopted the claim by an insurer for reverse bad faith against and insured. "In fact, the Court is not aware of any jurisdiction that has recognized a cause of action for reverse bad faith." Accordingly, the Kentucky court declined to do so and dismissed Allstate's claim for reverse bad faith.

Doe v. Northwestern Mut. Life Ins. Co.
2012 WL 2405510
(U.S.D.Ct., SC., June 26, 2012)

Plaintiff's claims arose from a disability from a medical condition caused by electroconvulsive therapy (ECT) treatments and Northwestern's alleged improper denial of coverage for the condition based on an inappropriately applied 24-month limitation period. Among many other claims asserted by the plaintiff was the allegation of bad faith; in a mixed ruling, the court found the plaintiff to have established a genuine issue of material fact regarding whether Northwestern unreasonably denied her coverage based upon its medical expert's findings or lack thereof.

"A reasonable jury could conclude that the defendant acted in bad faith or unreasonably denied coverage based upon deficiencies in the report of defendant's only expert on ECT related impairments and defendant's failure to investigate further in light of these deficiencies. The expert report, viewed in the light most favorable to plaintiff, indicates that defendant's ECT expert was unaware of key studies in the field (which plaintiff had provided to defendant), that the expert misunderstood or was unaware of certain material facts (for instance, the reason Doe's medical license was reinstated), and that some of his other statements concerning ECT treatments' long term effects were ambiguous. As noted above, defendant did not follow up on these problems."

In dicta, the court noted that Northwestern claimed that it was not bad faith to require its expert to speak with the plaintiff or her treating physicians because these steps would not have provided any material information which could have changed the expert's mind or the final outcome.

But, the court continued, "[t]his argument brings to mind the saying, 'Don't confuse me with the facts, my mind's made up.' In this court's [previous] order, the court discussed that retrograde amnesia is typically diagnosed by a patient's self-reports and observations of treating physicians. Therefore, drawing all reasonable inferences in plaintiff's favor, an evaluation of plaintiff or speaking with plaintiff's treating physicians could have

changed the expert's mind regarding her condition."

This decision points to a too-often recurring theme in many bad faith cases. That is, the failure to provide or require an expert to obtain and review all relevant information before relying upon the opinion.

At a recent CLM event in Birmingham, Alabama, I discussed several important steps for an insurer to take in respect to experts.

The first level of inquiry for the insurer should be an analysis of whether an expert is reasonably required to assist in the evaluation of the claim. Unnecessary use of experts could be characterized as unfair to the insured, particularly if this results in significant delay in processing of the claim. On the other hand, failing to utilize an expert where one is reasonably required to evaluate the issue may also be characterized as unfair to the insured.

Choice of experts can be an integral component to the insurer discharging its duty to assess the merits of the claim in a balanced and reasonable manner. Selection of an expert that is not appropriately qualified not only undermines the insurer's chance of succeeding on the merits of the contractual claim, but also has potentially significant ramifications in bad faith litigation.

Assuming the expert retained is appropriate in the circumstances, it is critical that the expert be given access to all potentially relevant information. As seen from the case law, keeping evidence favorable to the insured from the expert can be very damaging to the insurer in bad faith litigation. There is simply no excuse for not making all relevant evidence available to the expert.

This includes evidence that may be acquired after the expert has provided an initial report. It is quite common for an insured to provide information why they believe the expert's report is flawed. The expert retained by the insurer should know about this information and be able to rationally explain it in the context of his or her opinion.

It is preferable that if the expert is provided with the actual evidence – statement transcripts, medical reports, etc., rather than a summary prepared by the insurer. If there are specific factual issues to which the insurer wishes to draw the expert's attention, same can be done in a neutral manner such as, "In preparing your opinion can you please comment on what significance, if any, there is to fact . . ."

While the insurer is certainly not obligated to go into the expert's realm and second guess its own expert, there is a positive duty upon the insurer to evaluate and provide appropriate weight to their expert opinion.

The insurer should carefully scrutinize their report to make sure the expert has not made any errors outside of the realm of their expertise.

Even if the insurer has acted diligently in identifying, retaining and using an expert and has received an expert report which supports the denial of the claim, the insurer may still be exposed to a punitive damage claim if it fails to evaluate its position in the face of changing circumstances.

A distinction needs to be made between a situation where the factual premise of the case has changed to the point where the denial is no longer reasonably viable from a case where, notwithstanding the change in factual circumstances, the insurer's position remains viable. In the latter situation, the insurer is entitled to continue to contest the claim. In the former situation, however, the insurer's obligation would be to withdraw the denial and make prompt payment.

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