AUGUST 2014

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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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Northern District of Texas Dismisses Bad Faith Claims in Well-Control Policy Dispute

Eagle Oil & Gas Co. v. Travelers Prop. Cas. Co. of Am., No. 7:12-cv-00133-O (N.D. Tex. Jul. 14, 2014).

Northern District of Texas dismisses bad faith claims against insurer and adjuster in dispute over coverage for well blowout under well-control policy.

Defendant Travelers Property Casualty Company of America ("Travelers") issued a Control of Well Policy to Plaintiff Eagle Oil & Gas Company ("Eagle Oil"), which, among other things, provided protection against oil well blowouts and reimbursement for expenses incurred in bringing the well under control related to a well in Reeves County, Texas. Plaintiffs Eagle Wolfbone Energy Partners, LP and Eagle Oil & Gas Partners, LLC were non-operating working-interest owners in the well and were additional insureds under the Travelers policy. Following a September 22, 2011 well blowout, Plaintiffs incurred costs and expenses in attempting to regain control of the well, drilling a replacement well, cleaning up pollution, and in regard to damaged oil field equipment owned by others. Plaintiffs submitted their losses to Travelers, and Travelers assigned BC Johnson Associates (a trade name of Defendant York Risk Services Group) to investigate the claims. BC Johnson's preliminary report concluded that Eagle Oil may have violated the policy's "due care and diligence" clause and, in so doing, caused the blowout. Travelers then hired Greg Sones, a petroleum engineer, to further review the information regarding the cause of the blowout. Sones concluded that Eagle Oil caused the blowout, and Travelers denied coverage.

Plaintiffs brought suit alleging (1) breach of contract for denial of the claim, (2) breach of the common law duty of good faith and fair dealing, (3) violations of sections 541 and 542 of the Texas Insurance Code, and (4) violations of the Texas Deceptive Trade Practices Act. Claims (2) through (4) encompassed Plaintiffs' allegations that Travelers engaged in bad faith by denying their claims without a reasonable basis. Travelers moved for summary judgment on Plaintiffs' bad faith claims, and the court granted Travelers' motion.

The court found that Travelers had a reasonable basis to deny coverage. In denying coverage under the policy's "due care and diligence" clause, Travelers relied on the report of a licensed, professional petroleum engineer (Greg Sones). After reviewing well records and meeting with Eagle Oil's engineers, Sones concluded that Eagle Oil had exceeded industry-standard maximum pressure allowances for casing, and Eagle Oil's own maximum pressure tolerance for the well, and failed to follow prudent engineering practices. Plaintiffs argued that it was unreasonable for Travelers to rely on Sones's opinion to deny coverage under the "due care and diligence" clause because: (1) the opinion was not in written form; (2) Sones was retained by, and worked with, Travelers' coverage counsel; (3) the claim notes did not reflect the substance of Sones's opinions, creating the impression that Travelers did not know the basis for the expert opinion when it denied coverage; (4) Plaintiffs' experts disagreed with Sones's opinions; (5) Sones was biased against operators who use certain engineering standards; and (6) Sones ignored critical facts and/or failed to relay critical facts to Travelers.

The court rejected each of these arguments, explaining that "courts are concerned with whether the insurer knew or had reason to know that the substance of the opinion was unreasonable or unreliable, or demonstrated bias." In evaluating bias, Texas courts "look to the expert's qualifications, methodology and whether the expert has a reputation for reaching a certain conclusion." In this case, Sones reviewed all information that Plaintiffs made available to him. The court also noted that "[c]onflicting expert opinions, by themselves, do not establish that the insurer acted unreasonably in relying on its own expert" and that disagreement about the meaning of contractual terms (here, the "due care and diligence" clause) does not give rise to a bad faith claim. The court concluded that, having failed to present evidence that Travelers lacked a reasonable basis to deny coverage, and thus having "failed to present evidence that establishes a genuine issue of material fact concerning their claim for breach of the duty of good faith and fair dealing . . . [Plaintiffs'] Texas Insurance Code section 541 and [Deceptive Trade Practices Act] claims fail."

Alternatively, the court held that even were the denial of coverage found to be unreasonable, it would grant summary judgment in Travelers' favor because Plaintiffs failed to raise a fact issue that Travelers' actions caused them injuries independent of the unpaid insurance policy proceeds. Plaintiffs' only allegation of independent tort damages is that Travelers' delay in making a coverage decision caused them to drill a vertical replacement well instead of a more profitable horizontal well. Plaintiffs, however, provided the court with no evidence that they had the necessary lease acreage to redrill a horizontal well. Furthermore, under the policy, Travelers had no duty to decide coverage or advance funds for a redrill claim before the redrill costs were incurred. For this reason, too, the court concluded that summary judgment for Travelers was appropriate.

The court also granted summary judgment in favor of Defendant York Risk Services Group on Plaintiffs' common law and statutory bad faith claims against it because Plaintiffs similarly failed to raise a genuine issue of material fact of an injury independent of the insurance benefits. The summary judgment evidence demonstrated that Plaintiffs' damages (if any) arose "from Travelers' denial of policy benefits based on Sones's engineering opinion, not from B.C. Johnson's [the division within York that performed the investigation and adjustment] preliminary investigation and report." The court explained that "[t]here can be no recovery for extra-contractual damages unless the complained of actions or omissions caused injury independent of that which would have resulted from a wrongful denial of policy benefits." Because Plaintiffs failed to provide "any evidence that York's actions or omissions were the producing or proximate cause of an injury separate from the denial of policy benefits," the court granted summary judgment on Plaintiffs' bad faith claims in favor of York.

District of South Dakota: Denying a Claim for Reasons Known to be False is Not a Reasonable Basis to Deny a Claim

Lewison v. W. Nat'l Mut. Ins. Co., Civ. No. 13-4031-KES, 2014 WL 3573403 (D.S.D. July 21, 2014).

The District of South Dakota grants in part and denies in part an insurer's motion for summary judgment on two plaintiffs' bad faith claims, where one plaintiff's entitlement to benefits was "fairly debatable" at the time of the denial and the other plaintiff's claim was denied for reasons the insurer knew to be false.

Clinton and Beverly Lewison (the "Lewisons") were involved in an automobile accident on August 24, 2010. The other driver in the accident was entirely at fault. Neither of the Lewisons went to the hospital immediately after the accident, but both sought medical care shortly thereafter. Mr. Lewison attended physical therapy for knee, shoulder, back, hip, and neck pain, and also received chiropractic care. Due to persistent knee pain, Mr. Lewison saw an orthopedist on December 22, 2010, and had total knee replacement surgery on February 14, 2011. He continued to attend physical therapy until March 31, 2011. Mrs. Lewison also attended physical therapy and received chiropractic care following the accident. She completed all treatment on January 6, 2011.

The Lewisons were insured by Western National Mutual Insurance Company ("Western National"). Western National was notified of the accident on the day it happened. The motorist who caused the accident had a policy with another insurance company with policy limits of $25,000 per person. The at-fault driver's insurer offered to settle with the Lewisons for the full amount of the policy. Western National advised the Lewisons' attorney that the Lewisons were free to agree to this settlement. After settling with the driver, the Lewisons submitted underinsured motorist ("UIM") claims to Western National. Western National paid each of the Lewisons $5,000 toward medical expenses but denied their UIM claims.

Western National based its denial of Mr. Lewison's UIM claim on an independent medical examination ("IME") conducted by an orthopedic surgeon. The doctor who performed the IME concluded that Mr. Lewison's knee injury was not caused by the accident and that he would have needed a knee replacement in any event. As to Mrs. Lewison, Western Mutual determined that she had fully recovered from all injuries caused by the accident and that the $30,000 she had received was sufficient to cover the entirety of the damages she suffered.

Following the denial of their UIM claims, the Lewisons filed suit against Western National for breach of contract. The parties were able to reach an agreement under which Western National paid Mr. Lewison the limits of his UIM coverage, $75,000, and paid Mrs. Lewison $30,000 on her claim. After entering into the agreement, the Lewisons filed suit in the District of South Dakota alleging bad faith for Western National's denial of the UIM claims. Western National moved for summary judgment on both of the bad faith claims.

The court denied the motion for summary judgment as to Mr. Lewison, but granted summary judgment in Western National's favor on Mrs. Lewison's bad faith claim. The court explained that bad faith would only be found where there was a lack of a reasonable basis for the denial of policy benefits. Further, if an insured's claim was "fairly debatable" either in fact or law, the insurer would not be found to have acted in bad faith.

As to Mr. Lewison, the court noted that Western National's denial was based on the IME's conclusion that Mr. Lewison did not complain of any knee pain until several months after the accident. The court found that Western National knew this assertion was false, because it had a copy of Mr. Lewison's medical records. Moreover, in its request for the IME, Western National told the examining orthopedist that Mr. Lewison complained of knee pain as early as three days after the accident. Western National argued that it would have denied Mr. Lewison's claim regardless of when he first complained about his knee. The court, however, rejected this argument, reasoning that an insurer who denies a claim for reasons known to be false cannot be said to have had a "reasonable basis" for denying the claim. Accordingly, there was a triable

issue of fact as to whether Western National had reasonably denied the claim and the motion for summary judgment was denied.

Unlike Mr. Lewison's claim, the court found that whether Mrs. Lewison was entitled to UIM benefits was fairly debatable at the time her claim was denied. Mrs. Lewison argued that Western National acted in bad faith by failing to interview her or speak with any of her treating physicians prior to denying her claim. The court rejected this argument, noting that when Western National requested an examination under oath, Mrs. Lewison's counsel refused and accused the company of bad faith conduct. Moreover, Western National had total access to Mrs. Lewison's medical records, which indicated that she was doing well at the time she stopped receiving treatment. The court emphasized that while Western Mutual could have spoken to Mrs. Lewison's physicians in addition to reviewing her records, the law requires an insurer's investigation of a claim to be reasonable, not perfect. Because Western Mutual acted reasonably and the question of whether Mrs. Lewison was entitled to UIM benefits was fairly debatable, Western Mutual was entitled to summary judgment on her bad faith claim.

Northern District of Ohio: No Reasonable Jury Could Conclude That Insurer's Denial of Coverage For Two Arsons Was Not Justified

***Givens v. West Bend Mut. Ins. Co.*, No. 4:13 CV 1287, 2014 WL 2946672 (N.D. Ohio Jul. 1, 2014).**

The Northern District of Ohio concludes that insurer was justified in denying claim for two fires that were undisputedly set by insured.

On August 11, 2011, Nina Givens, the administrator of A Mother's Touch Daycare, contacted her insurance agent, Christina Heed, for a business coverage quote. During discussions with Ms. Heed, Ms. Givens asked multiple times whether she and her husband would be able to rebuild the daycare at a different location if the daycare were ever destroyed by fire. West Bend ultimately issued a business coverage insurance policy to A Mother's Touch.

In April 2012, two fires occurred at A Mother's Touch. The Youngstown Fire Department determined that the first fire, which occurred on April 7, was intentionally set, primarily because (1) upon arriving on the scene, the fire department found all the windows and doors were secure and there was no forced entry; (2) an accelerant was used to start the fires; and (3) there were fires in the house at three distinct locations, one of the locations being the stairs to the second floor.

The day after the fire, Ms. Givens reported the fire to her insurance agent. When West Bend's adjustor spoke to the Youngstown Fire Chief, he had already determined that the fire was arson and that the building was damaged, but not a total loss. On April 10, Ms. Givens met the West Bend adjuster at the property and asked if the daycare could be rebuilt at a different location if the building was a total loss. The adjuster responded that the building was repairable and proceeded to secure estimates for completing the repairs.

On April 29, Ms. Givens called the police to report that during a routine check of the property, she smelled smoke coming from the basement. Upon arrival, the fire department discovered a fire in the basement that had burned itself out. The fire department determined that the fire, like the first, was an arson because an accelerant was present and there were not possible accidental ignition sources.

West Bend proceeded to take statements from both Ms. Givens and her husband, the sole owner of A Mother's Touch. In her statement, Ms. Givens described a 20 percent decline in profits from A Mother's Touch. Five months after the first fire,

West Bend denied the claim. West Bend based its denial on three primary grounds: (1) the policy was void because material facts were concealed or misrepresented on the application; (2) coverage did not include dishonest or criminal acts; and (3) the Givenses, or individuals acting on their behalf, intentionally caused the fire.

After the denial, the Givenses sued West Bend for breach of contract, intentional infliction of emotional distress, loss of consortium, and bad faith, both as individuals and on behalf of A Mother's Touch. West Bend filed two motions for summary judgment on the bad faith claims — one motion as to the Givenses and another as to A Mother's Touch.

The court granted summary judgment in West Bend's favor finding that West Bend had a reasonable justification for denying the claim. According to the court, no reasonable jury could conclude that West Bend's denial of the claim for the two fires lacked reasonable justification and was arbitrary and capricious based on four reasons. First, there was no dispute that when she applied for an insurance policy, Ms. Givens inquired whether she could rebuild the daycare at a new location if it was destroyed by fire. Second, there was no dispute that both fires were arson. Third, there was no dispute that after the first fire Ms. Givens asked the adjuster whether she could rebuild the center at a new location. Fourth, there was no dispute that the Givens' income from the daycare had declined.

Eastern District Of Pennsylvania: Closing Protection Letter Does Not Constitute "Insurance" For Purpose Of Statutory Bad Faith Claim In Pennsylvania

Bancorp Bank v. Lawyers Title Insurance Corp. **, No. 13–6103 , 2014 WL 3325861 (E.D. Pa. Jul. 8, 2014).**

Eastern District of Pennsylvania explains that while Closing Protection Letter may be an indemnity contract, it is not an insurance policy.

In February 2006, a borrower requested a loan in the amount of $1,750,000 from plaintiff Bancorp to finance the purchase of a commercial building located in Florida. The loan application submitted to Bancorp listed the purchase price of the property as $2,100,000. Based upon this purchase price, Bancorp agreed to lend the Borrower $1,750,000, approximately 83 percent of the purchase price.

The next month, PA/NJ Abstract, Inc., the authorized Issuing Agent for Defendant Lawyers Title Insurance Corporation ("Lawyers Title"), delivered to Bancorp a commitment for title insurance for the principal loan amount of $1,750,000. This title insurance policy covered Bancorp in the event of a loss. The Issuing Agent also gave Bancorp a copy of a separate commitment for title insurance that was issued to the borrower insuring $2,100,000, the purported purchase price of the property.

Lawyers Title then issued a Closing Protection Letter (the "CPL") to Bancorp in connection with the title insurance policy. The CPL stated that Lawyers Title would reimburse Bancorp for losses incurred in connection with the closing of the real estate transaction under either of the following two circumstances: (1) "Failure of said Issuing Agent or Approved Attorney to comply with your written closing instructions to the extent that they relate to (a) the status of title to said interest in land or the validity, enforceability and priority of the lien of said mortgage on said interest in land, or (b) the obtaining of any other document, specifically required by you, but not to the extent that said instructions require a determination of the validity, enforceability or effectiveness of such other document, or the collection and payment of funds due you"; or (2) "Fraud dishonesty [sic] of said Issuing Agent or Approved Attorney in handling your funds or documents in connection with such closing."

Two years after Bancorp's title insurance policy took effect, the borrower defaulted on the loan on the property. However, upon investigation, Bancorp learned that Lawyer's Title's Issuing Agent prepared closing documents that falsely listed $2,100,000 as the purchase price of the property, while the

borrower only paid $1,750,000. Bancorp sent a claim (the "CPL Claim") to Lawyers Title based on the Issuing Agent's alleged fraud, a triggering event in the CPL that would require indemnification to Bancorp. Pursuant to the CPL, Bancorp sought recovery on the grounds that it incurred a loss on the loan transaction as a result of the Issuing Agent's fraud and dishonesty.

Defendant Fidelity National Title Insurance Company ("Fidelity National") handled Bancorp's CPL Claim exclusively. After the property was sold at auction for an amount less than the balance owed on the loan, Bancorp contacted Fidelity National and demanded compensation on the CPL Claim. Bancorp alleged that it was entitled to recoup $1,511,083.19 from Lawyers Title based on the Issuing Agent's alleged fraud in connection with the closing and loan transaction. Fidelity National refused to compensate Bancorp for the losses it allegedly suffered due to the fraud.

Bancorp then filed suit against Defendants in the Philadelphia Court of Common Pleas. Defendants removed the case to the Eastern District of Pennsylvania, which in turn granted Defendants' Motion to Dismiss on the claims of negligence and bad faith. With regard to the bad faith claim, the question before the court was whether the CPL constituted an "insurance policy" under Pennsylvania law – a requirement for a bad faith claim. The court agreed with the Defendants' argument that the CPL was not an "insurance policy" and therefore the bad faith claim could not succeed.

The court first looked to Pennsylvania's statutory definition of "insurance." While the term "insurance policy" is not defined in Pennsylvania's bad faith statute, "title insurance" is described elsewhere as, in part, "insuring, guaranteeing or indemnifying against loss or damage suffered by owners of real property or by others interested therein by reason of liens, encumbrances upon, defects in or the unmarketability of the title to said real property; guaranteeing, warranting or otherwise insuring the correctness of searches relating to the title to real property; and doing any business in substance equivalent to any of the foregoing in a manner designed to evade the provisions of this article." 40 Pa. Stat. Ann. § 910–1(1). In contrast, the court cited one treatise's definition of a "closing protection letter" as "an agreement by a title insurance company to indemnify a lender, or in some cases a purchaser, for loss caused by a settlement agent's fraud or dishonesty or by the agent's failure to follow the lender's written closing instructions."

The district court further noted that courts appear to be divided over whether CPLs are entirely distinct instruments from title insurance policies. Looking to the law of other jurisdictions, the court acknowledged that one line of cases holds that CPLs, while related, are not the same as title insurance policies; nevertheless, other courts have held that because CPLs are so closely related to title insurance policies, both instruments may sometimes be treated as one and the same.

The district court ultimately relied upon a case decided by the *Supreme Court of Alabama, Metmor Fin., Inc. v. Commonwealth Land Title Ins. Co.*, which addressed a similar factual scenario and found that a letter similar to the CPL did not constitute insurance. The district court reasoned that first, while there was an insured/insurer relationship between the parties, that relationship arose from the title insurance policy (not the CPL). Similar to the Alabama statute quoted in *Metmor*, Pennsylvania defines title insurance as protecting against losses which arise from liens, encumbrances, or defects which render title unmarketable. In contrast, the CPL only protects against losses caused by: 1) the Issuing Agent's failure to comply with Bancorp's written closing instructions; and 2) the Issuing Agent's fraud or dishonesty in handling Bancorp's funds or documents in connection with the closing. As the court found in *Metmor*, the District Court found that the CPL was not a title insurance policy. And, while acknowledging that the CPL may be an indemnity contract, the court held that since it was not an insurance policy, Bancorp could not maintain its bad faith claim.

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