NOVEMBER 2014

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Saul Ewing LLP

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 Denies Motion to Dismiss Bad Faith Claim in Homeowners Policy Dispute

Eastman v. Allstate Ins. Co., No. 14cv0703, 2014 WL 5355036 (S.D. Cal. Oct. 20, 2014).

Southern District of California denies motion to dismiss bad faith claim in connection with coverage dispute under homeowners policy.

Plaintiffs suffered severe fire damage to their home and submitted a claim to Allstate Insurance Company under a Deluxe Plus Homeowners Policy. Plaintiffs alleged that Allstate "caused significant delays in handling and resolution of Plaintiffs' claim and . . . generally mishandled the claim," by failing "to immediately assign an experienced adjuster" and delaying "in acknowledging, recognizing, or classifying Plaintiffs' loss as a major claim or major loss." Plaintiffs also charged Allstate with failing "to conduct a prompt, full and complete investigation of the facts and circumstances giving rise to Plaintiffs' claims," and "[u]sing improper standards to deny Plaintiffs' claims."

Plaintiffs claimed that Allstate initially "grossly undervalued" their loss, and as a result, the parties entered into a Stipulation providing that a neutral appraiser would determine a binding cost of repair of Plaintiffs' loss. The neutral expert prepared a report concluding a total loss of $718,613. Allstate allegedly only tendered to Plaintiffs the sums of $348,888 and $191,147, and paid Plaintiffs' storage fees of $1,000 per month "for a time, and then without notice, ceased payment."

Plaintiffs brought eight causes of action against Allstate, including claims for breach of the covenant of good faith and fair dealing related to the Policy (characterized as bad faith breach of the Policy) and breach of the covenant of good faith and fair dealing related to the Stipulation (characterized as bad faith breach of the Stipulation). Allstate moved to dismiss several of Plaintiffs' claims, including the claim for bad faith breach of the Stipulation. Allstate argued that "Plaintiffs cannot maintain a bad faith claim for breach of the Stipulation because bad faith claims against an insurer are limited to bad faith breaches of an insurance policy." Plaintiffs countered that "the Stipulation is an insurance contract, and insurers can be liable in tort for bad faith breaches of insurance contracts other than insurance policies."

The court examined the Stipulation, which provided that the "scope and cost of repair of fire-related damages [determined by the neutral expert] is binding as to all parties and may be introduced into evidence at any Court or arbitration proceedings," and that "Allstate will tender the covered cost of repair of fire-related damages up to the covered policy limits, minus previously paid policy benefits, within fourteen days." The court determined that "[w]hether the [S]tipulation is construed as a modification of the Policy or a separate settlement agreement between insurer and insured, the Stipulation is an alleged contract, which imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement" (internal quotations omitted). Allstate had not offered any authority "for the proposition that tort damages are limited to bad faith breaches of insurance policies in their original form and do not extend to bad faith breaches of other contracts between insurer and insured." The court explained that "*[a]ll* insurance contracts contain an implied covenant of good faith and fair dealing which requires each contracting party to refrain from doing anything to injure the right of the other to receive the benefits of the agreement" (internal quotations omitted) (emphasis in original). The court also noted the public policy underlying its ruling: "If tort liability was limited to bad faith breaches of original insurance policies, insurers could avoid tort liability by simply entering into modified contracts with the insured."

After finding that Allstate could be held liable for a bad faith breach of the Stipulation, the court proceeded to analyze whether Allstate could be found to have acted in bad faith under the facts alleged. "[B]efore an insurer can be found to have acted tortiously (i.e., in bad faith), for its delay or denial in the payment of policy benefits, it must be shown that the insurer acted *unreasonably* or *without proper cause*" at the time the claim was delayed or denied (emphasis in original). The court concluded that the complaint stated a plausible claim for bad faith breach of the Stipulation by alleging that Allstate "agreed to a neutral evaluator that would determine a binding cost of repair, but inexplicably reneged on its promise after the neutral evaluator determined a binding cost of repair." As a result, the court denied Allstate's motion to dismiss Plaintiffs' claim for bad faith breach of the Stipulation.

Northern District of Indiana: No Bad Faith Where Insurer Has a Rational Basis for its Coverage Position

***Thorne v. Member Select Ins. Co.*, No. 2:09 CV 87, 2014 WL 4700873 (N.D. Ind. Sept. 22, 2014).**

The Northern District of Indiana denies an insured's motion for reconsideration of the court's entry of summary judgment in the insurer's favor on a bad faith claim.

David Thorne's home was destroyed in a fire. Thorne had a homeowner's policy with Member Select Insurance Company ("Member Select"). Member Select denied Thorne's claim, concluding that the fire was either intentionally set by Thorne or someone acting at his direction. Thorne filed suit in the United States District Court for the Northern District of Indiana, asserting causes of action for breach of contract and breach of the duty of good faith and fair dealing. Member Select filed a motion for summary judgment, asserting that it did not act in bad faith. The court granted Member Select's motion and entered judgment in its favor on the bad faith claim; the court allowed the breach of contract claim to move forward.

Following the court's ruling on Member Select's motion for summary judgment, Thorne filed a motion for reconsideration. Thorne argued that two items of new evidence had come to light that created issues of fact regarding whether Member Select acted in good faith. Accordingly, Thorne argued, that issue should be submitted to a jury. Specifically, Member Select's denial was based in part on the claims investigator's view that Thorne acted suspiciously by refusing to allow Member Select to run a credit check and refusing to produce a copy of his cell phone records. Following the summary judgment ruling, Thorne had received and reviewed an audio recording of a phone conversation where the claims investigator requested that information from Thorne but told him that production was "totally up to you." Thorne argued that it was not suspicious for him to act consistent with that advice and that it was a deceptive practice for the investigator to give him the advice and then draw an adverse inference when he followed it.

Thorne's next piece of new evidence was a page from the local police department's report following the fire, wherein the investigating detective noted that Thorne refused to take a polygraph test. While Member Select cited that refusal as further justification for its denial of Thorne's claim, that page had not been previously produced in discovery, and, Thorne argued, was the only source from which Member Select could have learned of the polygraph refusal. Accordingly, Thorne asserted that Member Select had purposely withheld evidence.

The court began its analysis of Thorne's motion by emphasizing that a bad faith claim is not generated by every erroneous denial of benefits. So long as the insurer has a rational basis for its coverage position, there is no bad faith. The court rejected Thorne's argument regarding the "new evidence." First, the court noted that Thorne's recorded conversation with the claims investigator was contentious and the investigator made it clear that he wanted the information Thorne chose to withhold. Accordingly, the interview provided no new evidence of bad faith and provided no basis for reconsideration of the court's prior ruling.

The court came to a similar conclusion regarding the police report. Member Select argued that this was a public document to which Thorne had equal access, and also asserted that it had, in fact, never seen the specific page on which Thorne relied. The court held that there was no evidence to suggest that Member Select had ever actually seen that page, and could have learned the information from another source. The court further reasoned that Thorne had a file showing that Member Select had not identified a source of its information regarding the polygraph at the time that he responded to the original motion for summary judgment. The court noted that a motion for reconsideration is not a proper vehicle to raise arguments that could have been asserted sooner but were not and further found that Member Select had a rational basis for its coverage position. Accordingly, the motion for reconsideration was denied.

Middle District of Florida: Court Denies Summary Judgment For Insured On First-Party Bad Faith Claim Where Permanence Of Injury Was Initially Unclear

Cadle v. Geico Gen. Ins. Co., No. 6:13-CV-1591-ORL-31G, 2014 WL 4983746 (M.D. Fla. Oct. 6, 2014).

Middle District of Florida finds that insured's bad faith claim for first-party failure to settle could not properly be resolved at the summary judgment stage, noting that such claims can rarely be resolved as a matter of law.

On July 27, 2007, a vehicle driven by Catherine Cadle was rear-ended. Over the next 28 months, Cadle underwent a variety of medical procedures for neck and back issues, including surgery in December 2009. Cadle provided notice of the accident to her auto insurer, GEICO General Insurance Company ("GEICO"), on the day of the accident. Cadle's policy with GEICO provided for $75,000 in underinsured motorist ("UM") coverage.

The driver who rear-ended Cadle had an insurance policy with a liability limit of $25,000. On May 6, 2008, the driver's insurer tendered its $25,000 limit to Cadle. Cadle also received $10,000 in Personal Injury Protection ("PIP") coverage. Thereafter, on June 8, 2008, GEICO offered Cadle $500 to settle her claim. At the time, this represented the difference between the amount of GEICO's evaluation of Cadle's then-accrued medical bills and the amount she had received from the other driver's insurer and PIP coverage.

On June 11, 2008, Cadle submitted a formal demand for the entire $75,000 limit to GEICO. GEICO raised its offer only to $1,000. Cadle sent a notice to GEICO in June 2008 informing the insurer that her medical bills now exceeded $50,000, but GEICO made no response. Cadle filed suit on March 19, 2010 in Florida state court, alleging first-party bad faith.

On February 2, 2010, after learning that Cadle had undergone surgery, GEICO authorized payment of the entire $75,000

limit to settle Cadle's claim. Cadle rejected the offer, and the case proceeded to trial. On March 8, 2013, the jury returned a $900,000 verdict for Cadle against GEICO, but judgment was only entered for $75,000, the amount of the UM policy limit. Cadle then filed a second lawsuit on October 15, 2013 in the U.S. District Court for the Middle District of Florida, seeking to recover the rest of the verdict rendered in the state court case. In that suit, Cadle filed a motion for summary judgment on her bad faith claim.

The district court observed that, under Florida statutes, an insurer owes a duty to act in good faith in its handling of first-party claims by acting fairly and with due regard for the insured's interests and by attempting to settle such claims when possible. Further, it noted that a finding of bad faith requires not just mere negligence on the part of the insurer, but also knowledge of its own liability to the insured and delay. The inquiry, the court said, is fact-driven and based on the totality of the circumstances, which makes resolution of such claims rarely possible as a matter of law.

With these principles in mind, the district court denied Cadle's summary judgment motion due to the presence of genuine issues of material fact. It noted that although Cadle had undergone a series of treatments when she made her demands, GEICO had reason at the time to believe that her injury was not permanent, in which case her UM recovery under the policy was limited to medical bills. Given GEICO's calculation of those bills and the funds Cadle had received from the other driver's insurer and PIP coverage, the court said that GEICO's offers to Cadle prior to her surgery were not "patently unreasonable."

Middle District of Pennsylvania: Mere Delay Does Not Constitute Bad Faith

***Shaffer v. State Farm Mut. Auto. Ins. Co.*, No. 1:13-CV-01837, 2014 WL 5325340 (M.D. Pa. Oct. 20, 2014).**

Court grants summary judgment to insurer where lengthy investigation was required to determine causation for UIM claim, despite insurer previously paying first-party benefits.

Barry Shaffer, a 45-year-old veteran who, due to his military service, suffered from a variety of physical ailments, was involved in a head-on automobile crash on September 5, 2008. The other driver involved in the crash was primarily at fault. The day after the accident, Shaffer reported the crash to State Farm Mutual Automobile Insurance Company. Amongst other coverage, State Farm provided medical coverage and "stacked" UIM coverage.

State Farm approved Shaffer's first-party medical coverage to cover ongoing, conservative medical treatment. However, after approximately one year, Shaffer advised State Farm that he might require back surgery, and requested that State Farm inform him if he was close to exhausting his medical coverage. After several more months, counsel for Shaffer and a State Farm claim representative discussed a potential UIM claim, which was the first time the parties discussed such an action. Shaffer's counsel stated that he would inform State Farm if a UIM claim became necessary. On December 10, 2010, after several months of silence, State Farm closed Shaffer's medical payments file.

Four months later, Shaffer's counsel requested State Farm assign an uninsured motorist adjuster to the claim; State Farm then referred Shaffer's claims to the UIM department. Shaffer settled his claim against the other driver, and over the next several months, State Farm continued to investigate Shaffer's medical condition. The review included medical records both predating and postdating the motor vehicle accident and photographs of Shaffer's injuries. In addition, State Farm requested additional documentation regarding Shaffer's health, including a vocational report and records to confirm that claimed medical problems were causally related to the accident. After submitting these records, State Farm requested Shaffer's statement

under oath and more medical records (which Shaffer believed had already been provided).

After almost another year of communications between the parties and some additional medical evidence, State Farm completed its evaluation of Shaffer's claim. The reviewing physician had found that only some of Shaffer's medical conditions had been caused by the automobile crash. On May 20, 2013, State Farm offered Shaffer $10,000 as settlement, which Shaffer rejected. Shaffer procured a report opining that State Farm's delay in investigating and evaluating Shaffer's UIM claim failed to conform to industry standards. Shaffer and his wife then filed suit in the Dauphin County Court of Common Pleas for bad faith and breach of contract. The case was removed to the Middle District of Pennsylvania, and State Farm moved for summary judgment on the bad faith claim.

Despite the lengthy delay in investigation, the district court found for State Farm. Noting that even in bad faith claims involving "a long period of time between demand and settlement," the delay "does not, on its own, necessarily constitute bad faith. Rather, a court should look to the degree to which a defendant insurer knew that it had no reason to deny the claim; if the delay is attributable to the need to investigate further or even simple negligence, no bad faith has occurred." (citations omitted). Here, the court reasoned, Shaffer failed to show that any delay in State Farm's investigation and evaluation of Shaffer's UIM claim was motivated by self-interest or ill-will. On the contrary, State Farm did not know of a possible UIM claim until May 5, 2010, when Shaffer's counsel expressly discussed a potential UIM claim; even at that time, Shaffer did not definitively know whether such a claim would be necessary. Further, based on medical evidence available at the time, State Farm reasonably believed that a UIM claim would not be required. When it became clear that the UIM claim would, in fact, come into play, State Farm opened the file. The Court noted that the two years of investigation of the UIM claim was a long time -- but that "a long period of time does not, on its own, constitute bad faith, and Plaintiffs fail to present evidence suggesting obfuscation, dishonesty, or malice."

Further, the court did not agree that State Farm acted in bad faith when it questioned the causal relationship between Shaffer's injuries and the motor vehicle accident, merely because State Farm had not questioned causality in Shaffer's first party medical claim. Reasoning that "payment of first party benefits does not, in and of itself, constitute an admission of causation," the court held that that an insurer may deny UIM benefits after issuing payment of first party benefits, and that State Farm was entitled to investigate in the UIM claim whether Shaffer's injuries were caused by the motor vehicle accident even after they had issued payment on Shaffer's first party medical claim.

Finally, the district court noted that while the investigatory process "may not be flawless," State Farm had proven that it conducted an investigation sufficiently thorough to yield a reasonable foundation for its action. Indeed, the court noted that if State Farm had not taken the steps of collecting Shaffer's medical records, obtaining Shaffer's statement under oath, or arranging for a review of Shaffer's medical records by an orthopedic surgeon, all of which took time to complete, State Farm would not have had the information it needed to conduct a thorough evaluation of Shaffer's claim -- and would have had a far less defensible position when faced with a claim of bad faith.

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