

THE BASICS OF BAD FAITH

I. WHAT IS BAD FAITH?

A. Basic Definition

First Party Insurance

Refusal to pay a claim without a reasonable basis or even if insurer has a reasonable basis for denial, failing to properly investigate the claim in a timely manner.

Third Party Insurance

Failure to defend or indemnify or settle claim within policy limits without a reasonable basis, or failing to properly and timely investigate or defend the claim.

B. Types of conduct which may be bad faith:

1. Deceptive practices or deliberate misrepresentations to avoid paying claims
2. Deliberate misinterpretation of records or policy language to avoid coverage
3. Unreasonable litigation conduct
4. Unreasonable delay in resolving claim or failure to investigate
5. Use of improper standard to deny a claim
6. Arbitrary or unreasonable demands for proof of loss
7. Abusive and coercive tactics to settle claim
8. Compelling an insured to contribute to settlement
9. Failing to thoroughly investigate the claim in accordance with your own procedures
10. Failing to maintain adequate investigative procedures
11. Failing to disclose policy limits and explain applicable policy provisions or exclusions

C. Sources of bad faith law.

1. Common law

The implied duty of good faith and fair dealing.

2. State legislation

While some states have enacted statutes which generally prohibit bad faith or vexatious refusal to pay policy benefits, others have enacted Unfair Claims Practices Acts which specifically set forth various types of conduct which are prohibited. States may also attempt to control insurance claim adjudication through regulations promulgated by an insurance commission.

Over the past year, an increasing number of states proposed and enacted legislation designed to protect policyholders by creating statutory causes of action for bad faith. In addition, several other states are considering policyholder bills of rights.

3. Federal legislation

The most obvious example of federal legislation which governs insurance practices is the Employee Retirement Security Act of 1974, 29 U.S.C. 1001-1461 (ERISA) which governs group employee benefit plans. ERISA generally preempts any state law claims referencing an employee benefits plan. Hall v. Blue Cross/Blue Shield, 134 F.3d 1063 (11th Cir. 1998).

In the past, it has also been suggested that bad faith conduct by insurance companies might fall within the scope of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961-1968 (RICO).

Senator Trent Lott and other members of the U.S. Congress are now moving to enact additional laws geared towards bad faith.

D. Bad faith may exist even in the absence of coverage.

1. Judah v. State Farm Fire and Casualty, 266 Cal.Rptr. 455 (Cal. App. 1990). Judah v. State Farm has been rejected by many courts, including California courts, but this principle was supported in Lloyd v. State Farm Mutual Automobile Ins. Co., 943 P.2d 729 (Ariz. Ct. App.

1996).

2. Even if there is no coverage, the manner in which the claim is handled as opposed to the fact that the claim is denied may subject the insurer to a bad faith claim.
3. Determination of whether an incident or occurrence is "covered".

E. Conduct occurring after litigation is filed may be considered.

1. "White" Bad Faith and "White Waivers"

The California Supreme Court found that an insurer can be held liable for bad faith conduct occurring during litigation between the insurer and the insured. White v. Western Title Insurance Co., 710 P.2d 309 (Cal. 1985). Finding that the contractual relationship between the insurer and the insured does not end with when litigation starts, the court found:

When plaintiffs filed suit, defendant responded with a motion for summary judgment. After losing that motion, defendant was faced with both a ruling of the trial court rejecting its narrow reading of the policy and a unanimous body of case law establishing liability for negligence. Defendant nevertheless offered only nuisance-value settlements, and made no attempt to appraise plaintiffs' loss until the issue of liability had been tried and decided in plaintiffs' favor.

Subsequent to this decision, insurers began obtaining "White waivers" in the course of mediation or settlement discussions to prevent allegations that conduct in the discussions could constitute bad faith.

2. Pennsylvania

A Pennsylvania Court declared that a jury may consider evidence of an insurer's bad faith conduct occurring during the pendency of litigation. O'Donnell v. Allstate Insurance Co., 734 A.2d 901 (Pa.App. 1999). O'Donnell was decided in the context of a general statute which provided several penalties if the "insurer has acted in bad faith toward the insured." In O'Donnell, the appellate court found that the broad language of this statute was designed to remedy all acts of bad faith, whether those acts occurred before or after litigation was filed. Based upon this reasoning, the court found that the insurer's duty to act in good faith does not end upon the initiation of a suit by its insured. The appellate court further found, however, that the

insured's allegations of post-filing bad faith were insufficient as a matter of law where those allegations were premised solely upon the insurer's attorneys propounding allegedly frivolous interrogatories and the insurer's failure to pay or deny the claim after the person acting under power of attorney for the insured was deposed at length.

Months after the O'Donnell decision, a federal court in Pennsylvania relied upon it in determining the scope of permissible discovery in a bad faith case arising out of an uninsured motorist claim. Adams v. Allstate Insurance Company, 189 F.R.D. 331 (E.D.Penn. 1999). In refusing to respond to certain written discovery requests, the insurer argued that the insured was not entitled to discover documents and information beyond the filing date of the insured's complaint. Ordering the insurer to respond to the discovery, the court first recited the holding in O'Donnell that bad faith claims may include evidence of conduct occurring after the filing of the complaint and concluded "defendant's documents and files after the filing of plaintiff's complaint could bear on plaintiff's conduct during that period."

Even more recently, another Pennsylvania federal court refused to strike an insured's claim of bad faith premised upon the insurer bringing a counterclaim for fraudulent application to the insured's complaint. Krisa v. Equitable Life Assurance Society, 2000 WL 1146146 (M.D.Penn. May 23, 2000).

F. Unenforceable Provisions

One potential source of bad faith claims is attempting to enforce a provision of an insurance policy which is not enforceable. Provisions contained within the may still be unenforceable if they are contrary to the law or impossible of performance.

G. Bad Faith Law From Selected States

1. California Bad Faith Law

California is generally recognized as a leader in bad faith insurance law. Many aspects of bad faith which have been adopted in the majority of states began in California.

California has addressed bad faith insurance conduct through both legislation (unfair claims practices) and by common law (implied covenant of good faith and fair dealing).

California Bad Faith Statutes

In 1972, California adopted its Unfair Claims Practices Act which sets forth specific types of conduct which are considered by definition unfair.

In its present form, Section 790.03 of the California Insurance Code provides in part as follows:

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the

insured, his or her representative, agent or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

Although the California Supreme Court initially held that a private right of action existed under the Unfair Claims Practices Act for both first and third party claims, Royal Globe v. Superior Court, 592 P.2d 329 (Cal. 1979), it subsequently reversed this decision for both third party

claims, Moradi-Shalal v. Fireman's Fund Ins. Cos., 758 P.2d 58 (Cal. 1988), and first party claims, Zephyr Park, Ltd. v. Superior Court, 262 Cal. Rptr. 106 (Ct. App. 1989). Thus, neither an insured nor a third party beneficiary may bring an action against an insurer for violations of the Unfair Claims Practices Act, although as noted below, the common law action of breach of implied covenant of good faith and fair dealing most likely applies to violations of the Act.

Shortly after the California Supreme Court disavowed a private right of action under the Unfair Claims Practices Act, California voters adopted Insurance Code Section 1861.03(a) which provides:

The business of insurance shall be subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act (51-53, inclusive, of the Civil Code), and the antitrust and unfair business practices laws (Parts 2 (commencing with 16600) and 3 (commencing with 17500) of Division 7 of the Business and Professions Code).

California Common Law

An insured can sue an insurer for breach of the implied covenant of good faith and fair dealing. Communale v. Traders & General Ins. Co., 328 P.2d 198 (Cal. 1958).

The implied covenant creates a duty on the part of an insurer toward the insured to accept a reasonable offer to settle a third party liability case within policy limits, and a wrongful refusal to settle may make the insurer liable for the full amount of judgment, regardless of policy limits. Communale v. Traders & General Insurance Co., 328 P.2d 198 (Cal. 1958).

The obligations of good faith and fair dealing encompass qualities of "decency and humanity" inherent in the responsibilities of a fiduciary. Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141 (Cal. 1979).

The courts recognize in every insurance contract an implicit provision that neither party will do anything to injure the right of the other party to receive the full benefits of the contracts - "benefit of the bargain" idea. Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141 (Cal. 1979).

California is among the jurisdictions that applies an objective standard in determining the existence of bad faith, evaluating whether the conduct of the insurer was objectively unreasonable. If an insurer unreasonably denies or delays payment without proper cause, they

will be found to have committed bad faith. McCormick v. Sentinel Life Ins. Co., 200 Cal. Rptr. 732 (Cal. Ct. App. 1984); Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973). The evaluation of whether an insurer acted reasonably is based upon the circumstances as they existed at the time of the action or decision in question. R&B Auto Center, Inc. v. Farmers Group, Inc., 22 Cal. Rptr. 3d 426 (Cal. Ct. App. 2006); Century Sur. Co. v. Polisso, 43 Cal. Rptr. 3d 468 (Cal. Ct. App. 2006).

California courts have extended the application of the implied covenant of good faith and fair dealing to cover many of the claims settlement practices enumerated in the California Unfair Claims Practices Act:

Wilson v. 21st Century Ins. Co., 38 Cal. Rptr. 3d 514 (Cal. Ct. App. 2006); Egan v. Mutual of Omaha, 620 P.2d 141 (Cal. 1979) (duty to investigate a claim (Cal. Ins. Code 790.03(h)(3)))

Neal v. Farmers Ins. Exch., 582 P.2d 980 (Cal. 1978) (refusal to settle one portion of claim to influence settlement of other portions of the claim (Cal. Ins. Code 790.03(h)(12)))

Bodenhamer v. Superior Court, 238 Cal. Rptr. 177, 181 (Ct. App. 1987) (delay in adjusting claim for jewelry loss caused damage to business, even if outcome within policy limits)

Delgado v. Heritage Life Ins. Co., 203 Cal. Rptr. 672, 681-82 (Ct. App. 1984)(duty to communicate on claims matters (Cal. Ins. Code 790.03(h)(2) and (13)))

Wilson v. 21st Century Ins. Co., 38 Cal. Rptr. 3d 514 (Cal. Ct. App. 2006); Richardson v. GAB Business Servs., Inc., 207 Cal. Rptr. 519, 522 (Ct. App. 1984) (delays in claims processing (Cal. Ins. Code 790.03(h)(2),(3),(4) and (11)))

Delos v. Farmers Ins. Group, 155 Cal. Rptr. 843, 857 (Ct. App. 1979) (misrepresentation of policy terms and conditions (Cal. Ins. Code 790.03(h)(1)))

California courts have refused, however, to permit third-party claimants to sue insurers directly for breach of the implied covenant of good faith and fair dealing, which is solely for the benefit of the insured. Murphy v. Allstate Ins. Co., 553 P.2d 584 (Cal. 1976) However, the third party may still sue the insurer directly as long as there is some contractual basis to do so, such as a third-party

beneficiary relationship. Hunt v. First Ins. Co., 922 P.2d 976 (Haw. Ct. App. 1996). Also, the insured may be able to assign their interest in a bad faith action to a third-party claimant.

2. Kansas Bad Faith Law

Kansas does not recognize a common law action for bad faith. Spencer v. Aetna Life & Casualty, 227 Kan. 914 (1980). Kansas has adopted a Uniform Trade Practices Act which includes a section identifying and prohibiting unfair claim settlement practices. K.S.A. 40-2404(9). Courts have found, however, that this Act does not give rise to a private right of action as the sole authority under the Act to redress violations is granted to the Kansas Insurance Commissioner. Bonnel v. Bank of America, 284 F.Supp.2d 1284, 1289 (D.Kan. 2003); Earth Scientists v. United States Fidelity & Guarantee, 619 F.Supp. 1465, 1468 (D.Kan. 1985).

In Kansas, the sole remedy for an insured with a first party claim against an insurance company is for breach of the contract and/or to report the insurer to the Kansas Insurance Commissioner under the Unfair Claim Settlement Practices Act. However, Kansas law does provide for extra-contractual damages for first party claims under certain circumstances through K.S.A. 40-256:

That in all actions hereafter commenced, in which judgment is rendered against any insurance company as defined in K.S.A. 40-201, and including in addition thereto any fraternal benefit society and any reciprocal or interinsurance exchange on any policy or certificate of any type or kind of insurance, if it appear from the evidence that such company, society or exchange has refused without just cause or excuse to pay the full amount of such loss, the court in rendering such judgment shall allow the plaintiff a reasonable sum as an attorney's fee for services in such action, including proceeding upon appeal, to be recovered and collected as a part of the costs: Provided, however, That when a tender is made by such insurance company, society or exchange before the commencement of the action in which judgment is rendered and the amount recovered is not in excess of such tender no such costs shall be allowed.

Determination of whether the refusal was “without just cause or excuse” is based on the facts and circumstances of each case. “If there is a bona fide and reasonable factual ground for contesting the insured’s claim, there is no failure to pay without just cause or excuse.” Evans v. Provident Life & Accident Ins. Co., 249 Kan. 248, 261 (1991). “When an insurance controversy involves an issue of first impression, the award of attorney fees is inappropriate.”

O'Donoghue v. Farm Bureau Mut. Ins. Co., 30 Kan.App.2d 626, 636 (2002). The presence of an issue raised in good faith bars an award of attorney fees under K.S.A. 40-256. *Id.*

3. Missouri Bad Faith Law

The tort of bad faith in first party disability insurance cases has not been recognized in Missouri (although a tort claim for bad faith refusal to settle is recognized in Missouri). Rossmann v. GFC Corp. of Missouri, 596 S.W.2d 469 (Mo.App.E.D. 1980). Missouri does provide a statutory claim for "vexatious refusal" through RSMo. 375.420:

In any action against any insurance company to recover the amount of any loss under a policy of automobile, fire, cyclone, lightning, life, health, accident, employers' liability, burglary, theft, embezzlement, fidelity, indemnity, marine or other insurance except automobile liability insurance, if it appears from the evidence that such company has refused to pay such loss without reasonable cause or excuse, the court or jury may, in addition to the amount thereof and interest, allow the plaintiff damages not to exceed twenty percent of the first fifteen hundred dollars of the loss, and ten percent of the amount of the loss in excess of fifteen hundred dollars and a reasonable attorney's fee; and the court shall enter judgment for the aggregate sum found in the verdict.

The vexatious penalty cannot be used as a weapon to intimidate insurers from asserting a good faith defense. Hammontree v. Central Mutual Insurance Co., 385 S.W.2d 661, 668 (Mo.App. 1965). An insurer "has the right to defend a suit with all weapons at its command so long as it has reasonable ground to believe its defense is meritorious." Loulos v. United Security Insurance Co., 350 S.W.2d 87, 89 (Mo.App. 1961) (citing Suburban Service Bus Co. v. National Mut. Casualty Co., 183 S.W.2d 376, 378 (Mo.App. 1944)). "[W]hen there is an open question of law or fact, the insurer may insist upon a judicial determination of these questions without being penalized." Mears v. Columbia Mutual Insurance Co., 855 S.W.2d 389, 394 (Mo.App. 1993).

4. Illinois Bad Faith Law

Illinois law regarding the existence of a common law action for breach of the implied covenant of good faith in the context of first party actions is confused. This action was initially recognized by some Illinois courts. In 1996, the Illinois Supreme Court finally concluded that while a common law action for bad faith is available in third party

claims for bad faith failure to settle, Illinois does not recognize such an action for first party claims. Cramer v. Insurance Exchange Agency, 675 N.E.2d 897 (Ill. 1996). The Court did recognize that well established torts (such as fraud) may arise in addition to a breach of insurance contract action from an insurer's conduct. The Cramer decision was based in large part upon the existence of 215 ILCS 5/155 which provides additional remedies for breach of insurance contract:

(1) In any action by or against a company wherein there is in issue the liability of a company on a policy or policies of insurance or the amount of the loss payable thereunder, or for an unreasonable delay in settling a claim, and it appears to the court that such action or delay is vexatious and unreasonable, the court may allow as part of the taxable costs in the action reasonable attorney fees, other costs, plus an amount not to exceed any one of the following amounts:

(a) 60% of the amount which the court or jury finds such party is entitled to recover against the company, exclusive of all costs;

(b) \$60,000;

(c) the excess of the amount which the court or jury finds such party is entitled to recover, exclusive of costs, over the amount, if any, which the company offered to pay in settlement of the claim prior to the action.

(2) Where there are several policies insuring the same insured against the same loss whether issued by the same or by different companies, the court may fix the amount of the allowance so that the total attorney fees on account of one loss shall not be increased by reason of the fact that the insured brings separate suits on such policies.

H. Why bad faith is important - DAMAGES

1. An insurer which is found to have operated in bad faith could be liable for damages far in excess of the policy limits.
2. The types of damages a plaintiff is allowed to seek in a bad faith claim vary from state to state. They include:
 - a. Statutory penalties.
 - b. Statutory interest.

- c. Liability for judgments in excess of the policy limits.
- d. Attorneys fees.
- e. Emotional distress.
- f. Economic loss. This may include loss of credit reputation, loss of business and loss of property.
- g. Punitive damages.

Juries and judges have shown a tremendous willingness to enter huge punitive damage awards against insurers when they perceive that the insurer acted in bad faith.

Punitive damages are assessed against an insurer based on the insurer's assets or wealth, not on the losses incurred by the claimant.

Perez v. Farmers Groups of Insurance Companys d/b/a Fire Insurance Exchange (Tulare County, California, 2003)

Plaintiff sought representation through his homeowners policy after he was sued in connection with a collision between a tractor trailer and a farm tractor borrowed by plaintiff from a farm at which he was employed and operated by a non party after it stalled on a state highway. Plaintiff claimed that the default judgment entered against him after defendant refused to defend him caused emotional distress. Jury returned a verdict for \$327,231 pain and suffering, \$535,769 for the default judgment and \$25,000,000 in punitive damages for insurance bad faith.

Amoco Chemical Co. v. Certain Underwriters at Lloyd's of London (Cal. Super. Ct. 1993)

Jury returned a verdict of \$425,600,000 for refusal to defend and indemnify in a series of lawsuits. This included \$386M in punitive damages which the trial court later lowered to \$71M.

Fox v. Health Net (Cal. Super. Ct. 1993)

Total verdict of \$89,320,000 (\$12.32M in compensatory damages and \$77M in punitive)

Even small coverage questions can balloon into huge punitive damage awards for the insured.

Principal Fin. Group v. Thomas, 585 So.2d 816 (Ala. 1991)

Refusal to pay burial expenses of deceased child under life insurance policy (no reasonable basis for denial). \$750,000 punitive damage award for bad faith denial of \$1000 claim. This amount was affirmed on appeal. Court suggested that the very fact that the policy was so small was a reason to impose such severe punitive damages because very few insureds would proceed with such a case and insureds would have an extremely difficult time obtaining an attorney to take a case with such a small policy at issue. This could be a cause of the insurers intentional and reckless failure to properly investigate the claim prior to denying coverage.

Fuller v. Preferred Risk Life Insurance, Montgomery County, Alabama Circuit Court, Case No. CV 88 744

Plaintiff alleged that defendant misrepresented the policy deductible of her health insurance. Plaintiff claimed past medical of \$14,000. Defendant offered \$6,000 prior to trial. Jury returned a verdict of \$14,000 for past medical expenses and \$1,000,000 in punitive damages.

3. Understand that the insurer/insured relationship is one which invokes sympathy for the insured and not the insurer as shown in the following quote from the California Supreme Court:

"As one commentary has noted, 'The insurers' obligations are . . . rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements' Moreover, 'the relationship of insurer and insured is inherently unbalanced: the adhesive nature of insurance contracts places the insurer in a superior bargaining position.'" Hunter v. Up-Right Inc., 864 P.2d 88, 90 (Cal. 1993).

I. **Appearance is everything**

It is easy to avoid *actually* acting in bad faith in administering claims. However, given the apparent willingness of juries to return astronomical bad faith verdicts and a judicial willingness to allow bad faith claims to proceed to a jury, not acting in bad faith may not be sufficient to avoid a bad faith verdict. The mere appearance of impropriety must also be avoided.

II. INVESTIGATING THE CLAIM

A. Duty to Investigate - The duty to investigate, and the specific conduct which is required to fulfill that duty, arise from a variety of sources:

1. statutes
2. .internal claim handling policy
3. common law - implied covenant of good faith and fair dealing

B. Timing

1. Investigation should begin as quickly as possible following notice of the claim.
2. Investigation itself should progress in a timely manner.
3. Timely decision to deny coverage must be made, particularly in the context of third party claims where the insured may be prejudiced by a last minute denial of coverage.

C. Evaluating the investigation

1. Principal yard stick is whether the investigation was "reasonable".
2. Does it appear that the claims adjuster was investigating the claim to determine if coverage existed, or investigating the claim to determine that no coverage existed.

D. Develop evidence of the insured's bad faith

1. Some courts have recognized the application of comparative bad faith in which the amount of the insured's bad faith will reduce the damage award against the insurer and may even act as a complete bar to the insured's bad faith claim.

2. Examples of insured's bad faith:
 - failure to completely fill out relevant information on claims forms when that information would harm insured's chances of coverage
 - misrepresentation of relevant information
 - abusive conduct by insured (profanity, yelling, threats, etc.)
 - failure to cooperate

3. Reverse bad faith:

At least one court has even recognized that an insurer may bring a claim against its insured for bad faith. Liberty Mutual Insurance Co. v. Altfillich Constr. Co., 139 Cal Rptr. 91 (Cal. App. 1977) (doctrine of bad faith creates an independent tort that allows the insurer to seek affirmative relief for an insured's breach of the duty of good faith and fair dealing).

E. Third party coverage - two part investigation

1. Is the insured required to defend and indemnify?

Duty of defense arises for claims that are even potentially within coverage.

2. If there is coverage, what is the extent of the insured's (and therefore the insurer's) liability?
3. Excess coverage - Second part of analysis is central to an insurer's liability in excess of the policy limits for failure to settle within policy limits.

An insurer who fails to accept a settlement within the policy limits by not giving the insured's interests at least as much consideration as its own, is liable for any resulting judgment against its insured regardless of policy limits. Crisci v. Security Ins. Co. of New Haven, 426 P.2d 173 (Cal. 1967). One test that has been applied is to consider whether a prudent insurer without policy limits would have accepted the settlement offer.

Court reinstated a \$590,000 bad faith judgment against an insurer, finding that a jury may consider an insurer's failure to inform its insured of a settlement offer as "some evidence of bad faith. Smith v. General Accident Ins. Co., 697 N.E.2d 168 (N.Y. 1998).

Courts have delineated several factors used to determine if an insurer's failure to settle was "reasonable".

Brown v. Guarantee Insurance Co., 319 P.2d 69 (Cal. App. 1958)

- (1) strength of the injured claimant's case on the issues of liability and damages;
- (2) attempts by the insurer to induce the insured to contribute to a settlement;
- (3) failure of the insurer to properly investigate the circumstances so as to ascertain the evidence against the insured;
- (4) the insurer's rejection of advice of its own attorney or agent;
- (5) failure of the insurer to inform the insured of a compromise offer;
- (6) the amount of financial risk to which each party is exposed in the event of a refusal to settle;
- (7) the fault of the insured in inducing the insurer's rejection of the compromise offer by misleading it as to the facts; and
- (8) any other factor tending to establish or negate bad faith on the part of the insurer.

Some courts will look beyond the settlement context to evaluate the reasonableness of the insurer's failure to settle.

Commercial Union Insurance Co. v. Liberty Mutual Insurance Co., 393 N.W.2d 161 (Mich. 1986)

- (1) failure to inform the insured of relevant litigation developments;
- (2) failure to keep the insured informed of all settlement demands outside policy limits;
- (3) failure to solicit a settlement offer or to initiate settlement negotiations when warranted;
- (4) failure to accept a reasonable compromise offer of settlement in situations when the facts demonstrate blatant liability and serious injury;

- (5) rejecting a reasonable settlement offer within policy limits;
- (6) attempting to coerce or obtain an involuntary contribution from the insured in order to settle within policy limits;
- (7) failure to properly investigate a claim before rejecting a serious and recurrent negligence by the insurer;
- (8) disregarding the advice of an adjuster or attorney;
- (9) serious and recurrent negligence by the insurer;
- (10) undue delay in accepting a settlement offer within policy limits where the potential verdict is high;
- (11) refusing to settle a case within policy limits following an excessive verdict when the chances of reversal on appeal are slight;
- (12) failing to appeal following a verdict in excess of policy limits where there exist reasonable grounds for such an appeal.

III. AVOIDING BAD FAITH IN FIRST PARTY INSURANCE

A. Documenting files

1. To avoid successful claims of bad faith, you must do more than just act reasonably, you must be able to prove you acted reasonably.
2. It is important to keep accurate and complete records of the claim as litigation can occur years later. Important events could easily be forgotten over time if they are not reflected in the claims file.
3. Date stamp all materials received into file. The importance of being able to effectively reconstruct when certain materials were received, sometimes several years after the fact, cannot be overstated. While the underlying breach of contract claim will be determined by looking at all the evidence developed at the time of and after the claims decision, a bad faith claim is decided by examining what information was available at the time the claims decision was made. In addition, allegations of specific conduct which might be bad faith (e.g. failure to timely respond to demand letter) may rely upon when certain materials were received and how quickly they were acted upon.
4. Keep complete and accurate phone memorandums, even if the

person called is not reached.

It is important to keep record of all attempted calls as it shows diligence in the administration of the claim. Failure to keep such memorandums may allow the insured to argue that relevant phone calls were never returned when in fact the adjuster attempted unsuccessfully to reach the insured.

5. Make notations of activity undertaken in connection with the claim.
6. Assume that everything in the claims file will be discovered by the insured in the event of litigation.

- a. Courts are particularly generous in granting all records made prior to the date litigation begins or the date benefits are terminated to the insured in bad faith cases.

- b. Example

"Bad faith actions against an insurer, like actions by client against attorney, patient against doctor, can only be proved by showing exactly how the company processed the claim, how thoroughly it was considered and why the company took the action it did. The claims file is a unique, contemporaneously prepared history of the company's handling of the claim; in an action such as this the need for the information in the file is not only substantial, but overwhelming." (Prisco Serena Sturm Architects, Ltd. v. Liberty Mutual Insurance Company, No. 94 C 5716, 1996 U.S. Dist. LEXIS 2216, at *1 (N.D. Ill. February 26, 1996) (citing Brown v. Superior Court In and For Maricopa County, 670 P.2d 725, 734 (Ariz. 1983)).

- c. Do not make gratuitous comments in correspondence or internal memorandums.

Ex: "Who does this guy think he's kidding?"
"Give me a break."
"This lady is such a liar."
"I am sick of this guy."

7. Protect the sanctity of the independent medical evaluation.
 - a. Denial of claims will often be based at least in part on the opinions of doctor retained by you to review the medical records. The insured and his or her attorney will already be highly suspicious of the doctor's opinions and will consider him

your accomplice.

- b. Deal at arms length in all written communications.
- c. Only set forth the facts in correspondence with the doctor. Do not state your opinions.

8. Denying coverage.

- a. Clearly state all bases upon which the claim can be denied.

Failure to cite all bases upon which it is denied may not foreclose the opportunity to argue all grounds in defense to a breach of contract action, but could limit defenses in a bad faith claim.

- b. Cite the specific language of the policy upon which you are relying in denying coverage. Do not paraphrase.

A possible ground for bad faith is denying coverage for reasons not in the policy. A loose paraphrase of the actual policy provision might lead to this appearance.

9. Ensure that relevant portion of policy is enforceable.

- a. Generally the state law of the state in which the policy was issued will control. Each state's insurance act may have provisions which apply to the policy in question. If these provisions are found to apply to the policy they may:

- (i) require certain provisions which are read into the policy even if they are not expressly stated in the policy

- (ii) prohibit certain provisions or exclusions

- (iii) allow some types of provisions or exclusions to be enforced only under certain circumstances (e.g., certain language used in policy)

- b. If coverage is denied based upon a policy provision or exclusion which is not enforceable under the applicable state law, this may be strong evidence in favor of bad faith.

An insurer is generally deemed to have knowledge of the applicable state's law because it has issued and/or administered a policy in that state. Ignorance of the law is

generally not a defense.

c. Examples:

Intoxication exclusions:

States typically have provisions specifying when coverage may be denied in cases of intoxication or the use of narcotics. These provisions generally provide that coverage may be denied in situations where the loss sustained or contracted was in consequence of the insured being intoxicated or under the influence of narcotics. See, e.g., Cal. Ins. Code sec. 10369.12.

Exclusions have been rendered invalid when they are less favorable than the statute permitting the exclusion. Olson v. American Bankers Ins. Co., 35 Cal. Rptr.2d 897 (Cal Ct. App. 1994). In Olson, the exclusion was rendered invalid because it excluded loss sustained, in whole or in part, directly or indirectly, from any intoxicant, whereas the statute only allowed exclusion for loss sustained in consequence of the insured intoxication.

Pre-existing condition provisions:

State law generally imposes time limits for how long a person may be barred from recovering on a pre-existing condition. These time limits are often between 6 and 18 months. Permanent exclusion of a pre-existing condition would run contrary to state statute. See, e.g., Cal. Ins. Code sec. 10232.4.

B. Administering the claim

1. Obtain and document all useful information from claimant and others.
2. Medical history
 - a. Follow all medical leads. Look for references to other doctors in medical records and request records.
 - b. Communicate with treating doctors and if necessary explain the relevant portions of the policy.
 - c. Confirm as often as possible with the insured his or her medical history from first receipt of claim and as appropriate

thereafter.

d. Use Report of Claim Form.

3. Follow written procedures carefully.

a. Written procedures are established as a uniform method of carefully and effectively administering claims.

b. If the insured's attorney asks for claims handling procedures in subsequent litigation he will get them.

c. Even conduct which is not inherently poor claims handling could look suspect if it is contrary to the written procedures.

d. Example

Court denied insurer's motion for summary judgment on the bad faith claim and granted the insured's motion for summary judgment on the bad faith claim. One of the reasons stated was the fact that the insurer failed to take action over an extended period of time contrary to its internal policy of responding to an insured's request for coverage within 45 days. Prisco Serena Sturm Architects, Ltd. v. Liberty Mutual Insurance Company (N.D. Ill. 1996).

4. Be cooperative, courteous and professional.

C. Patterns or Practices of Bad Faith

1. Increasingly, attorneys will seek not only to establish that the handling of a particular claim was bad faith, but also will try to establish a pattern or practice which goes beyond the claim at hand.

2. To support this strategy, attorneys may seek discovery of one or more of the following:

-claims handling procedures

-training material for newly hired employees

-other claims denied for the same or similar reasons

-Department of Insurance consumer complaints

-claim payment goals and incentive programs

- performance evaluations
- incentive plans
- operation reports
- management conference handouts/presentations
- communications with insurance rating companies

IV. SUBROGATION/ASSIGNMENT/REIMBURSEMENT

A. Generally

The ability to recover benefits paid to the insured will vary according to state law. Many states prohibit subrogation by health insurance policies or health and accident insurance policies which requires examination of the state's insurance statutes to determine whether the policy at issue falls within the definition of a health policy.

Several states recognize a common law prohibition against assignment of personal injury claims. In some instances these common law prohibitions have been adopted statutorily by the legislature or in regulations by the insurance commissioner. The insured will argue that an attempt to reimburse is an "assignment" and therefore contrary to statute public policy.

B. Missouri

Missouri law prohibits assignment of bodily injury claims as a matter of public policy. Schweiss v. Sisters of Mercy, St. Louis, Inc., 950 S.W.2d 537, 538 (Mo. Ct. App. 1997). Based upon this common law background, Missouri courts have held "that an insurer may not acquire part of the insured's rights against a tortfeasor...by reason of payment of medical expenses, either by assignment or by subrogation." Waye v. Bankers Multiple Line Insurance Co., 796 S.W.2d 660, 661 (Mo. Ct. App. 1990). Statutory exceptions exist for hospital liens, workers' compensation liens, underinsured and uninsured motorist coverage, and Medicare and Medicaid coverage, but none of these exceptions specifies occupational accident plans. Insureds therefore argue that any subrogation provision equates to an assignment which is prohibited by public policy and for which no exception is allowed by statute.

We have argued in favor of "reimbursement" under occupational accident plans. Missouri courts have noted a difference between the assignment of

causes of actions and subrogation to a claim. When there is an assignment of a claim, there is a complete divestment of all rights from the assignor, and a vesting of the same rights in the assignee. In the case of subrogation, however, only an equitable right passes to the subrogee and the legal title to the claim is never removed from the subrogor. Hayes v. Jenkins, 337 S.W.2d 259 (Mo. App. 1967). In conjunction with this distinction, we argue that since the insurer is only seeking reimbursement for benefits paid, the “reimbursement” clause does not divest the insured of a right of action or of any recovery for the action and therefore does not violate Missouri public policy.

C. Kansas

Kansas common law prohibits subrogation for accident and health policies but not for indemnity policies. This common law position was codified by the Kansas Insurance Commissioner in Kansas Administrative Regulation 40-1-20:

An insurance company shall not issue contracts of insurance in Kansas containing a “subrogation” clause applicable to coverages providing for reimbursement of medical, surgical, hospital or funeral expenses.

A subsequent opinion from the Kansas Attorney General found that the Kansas Insurance Commissioner had the authority to issue this regulation. In that opinion, the Attorney General opined that authority existed based upon statutes regulating uniform policy provisions for “accident and sickness insurance” which do not include a subrogation provision and prohibit inclusion of additional provisions which would be less favorable to the insured.

Kansas courts have found Regulation 40-1-20 preempted to the extent there is an express statute authorizing subrogation for a particular type of policy. Hall v. State Farm Mutual Automobile Insurance Co., 8 Kan.App.2d 475 (1983). Kansas authorizes subrogation for workers’ compensation, uninsured motorist benefits and personal injury protection benefits.

To the extent a policy is considered an “accident or sickness” policy, subrogation may be prohibited. Kansas defines “accident and sickness” policies to include “any policy or contract insuring against loss resulting from sickness or bodily injury or death by accident, or both, issued by a stock, or mutual company or association or any other insurer.” K.S.A. 40-2201(a).

D. Illinois

Illinois law does not allow for the assignment of a personal tort. In re

Estate of Scott, 208 Ill. App. 3d 846, 849, 567 N.E.2d 605, 607 (Ill. Ct. App. 1991). Further, courts have traditionally held that life, accident, medical, and health insurers do not have equitable or implied rights to subrogation. American Family Ins. Group v. Cleveland, 356 Ill. App. 3d 945, 950, 827 N.E.2d 490, 494 (Ill. Ct. App. 2005). However, when an insurance policy contains an unambiguous contractual provision that provides for subrogation rights, the courts will enforce such rights. *Id.* In these cases, the courts regard an insurance company's claim for subrogation to be distinct and separate from an assignment. Scott, 208 Ill. App. 3d at 849, 567 N.E.2d at 607. The only public policy exception to this rule is that subrogation cannot exist in wrongful death cases.

Although subrogation is permitted under Illinois law, the full assignment of rights is not. Thus, it is important that contractual language reflects only what is permissible by law. Scott, 208 Ill. App. 3d at 850, 567 N.E.2d at 607. Subrogation clauses should call for reimbursement for benefits paid under the policy, but must not extend to suggest that the insurer will be assigned its insured's rights. Likewise, courts will enforce subrogation rights provided for in a contract, but will not create additional common law rights to subrogation not included in contractual language. Spirek v. State Farm Mut. Auto. Ins. Co., 65 Ill. App. 3d 440, 449, 382 N.E.2d 111, 117 (Ill. Ct. App. 1978).