

INSURANCE COVERAGE & BAD FAITH



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AVOIDING THE PITFALLS OF BAD FAITH

By Rosemarie Lewis

Bad faith claims, or the potential for bad faith litigation continues to be of serious concern to insurers. These types of claims not only affect loss ratios, but reputations as well. These claims and suits are costly no matter what the outcome. In fact, in a typical bad faith case, an insurance company's conduct is really what is on trial, more so than the actual decision or particular coverage issue that may have led to the bad faith lawsuit. The insurer is usually faced with potential liability well beyond that represented by policy limits. The worse case scenario in a bad faith litigation hit home for many insurance companies in late 2002, when a Texas court awarded \$32 million to the plaintiffs in a lawsuit involving mold damage to their home. While the Texas Court of Appeal later reduced the award to \$4 million, the *Ballard v. Farmers Insurance Co.* case grabbed the industry's attention in a big way. The lion's share of that award was not to compensate the Ballard's for mold damage, rather for punishing the insurer for bad faith in the handling of their claim.

As such, the concept of bad faith litigation is particularly attractive to plaintiff attorneys because recovery against insurers usually result in awards well in excess of policy limits, and may also include awards of punitive damages. In recent years, trial lawyers across the country have spent untold amounts of money in an attempt to pass "bad faith" legislation. So far, California voters have overwhelmingly rejected proposals which could grant third parties the right to sue not only the person allegedly responsible for their injuries, but those parties' insurance carriers as well. However, a reality check is indeed necessary in the insurance industry. The California Department of Insurance reports that it continues to see a rise in complaints as a result of first-party claims handling, notwithstanding the fact that the California Fair Claims Practices Act, among the toughest in the nation, already protects individuals from insurers who engage in unfair claims handling practices.

WHAT IS BAD FAITH?

Generally speaking, bad faith is the failure of any party to fulfill the terms of a contract, or an obligation. In terms of the insurance industry, the "contract" refers to the applicable policy of insurance.

Bad faith claims and lawsuits typically involve an insurance company and its insured, and generally arise out of the handling of the claim. Bad faith can arise from the handling of both first- and third-party claims, although first-party actions are more common. First-party claims might involve the deliberate

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Rosemarie S. Lewis is the Managing Partner of Borton Petrini, LLP's Orange County office. She did her undergraduate work at the University of Southern California and received her J.D. from Western State University in 1991 with an emphasis in tax law.

Rosemarie's practice has given her experience in several categories, including insurance coverage and bad faith claims.

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Southern California Defense Counsel, and the Hispanic National Bar.

Rosemarie is married to Jeffrey Lewis, and their two children are Casey and Evan.

RECENT COURT DECISIONS

CALIFORNIA SUPREME COURT:

Court Interprets “Ambiguity” in Policy Language

The Supreme Court, in *Antone Boghos v. Certain Underwriters at Lloyd's of London*, 36 Cal.4th 495; 115 p.3d 68, 30 Cal.Rptr.3d 787 (2005), reviewed a Court of Appeal ruling which affirmed a trial court's refusal to compel arbitration of contract and tort claims brought by an individual claiming benefits under a disability insurance policy.

A clause in the insurance policy provided that, notwithstanding any other item, any dispute that arose was to be settled in binding arbitration. The policy also included a service-of-suit clause whereby the underwriters, in the event of their failure to pay under the policy, agreed to submit to the jurisdiction of a court of competent jurisdiction within the United States. The court gave effect to the parties' clear language, in accordance with California Civil Code sections 1636 and 1638. The court found no conflict between the service-of-suit clause and the arbitration clause. The court noted its preference to enforce valid agreements to arbitrate. The service-of-suit clause was not surplusage under California Civil Code section 1641, nor was it duplication of statutory rights under California Code of Civil Procedure section 1293. Because there was no inconsistency, the rule that more specific contractual provisions controlled over more general ones did not apply. (Pursuant to CCP §1859.) The cost-shifting rule for arbitration of certain statutory claims, a judicially-created exception to California Code of Civil Procedure section 1284.2, did not extend to common law claims generally. Thus, the court reversed the judgment of the Court of Appeal.

OTHER APPELLATE COURT DECISIONS

Property Insurers Adjustment of the 1994 Northridge Earthquake Loss Did Not Constitute Bad Faith

In *Lincoln Fountain Villas Homeowners' Association v. State Farm Fire & Casualty Insurance Company*, __ Cal. App. 4th __ (2006), the California Second District Court of Appeal ruled that legislation reviving certain time-barred Northridge earthquake insurance claims did not authorize an insured to sue where the claim was originally adjusted for an amount that all parties agreed at the time was adequate and that was paid. The court affirmed the trial court's entry of summary judgement in favor of State Farm in connection with a complaint for bad faith filed by Lincoln Foundation Villas Homeowners Association. The appellate court affirmed the trial court's ruling that the insured failed to establish triable issues of fact with regard to its claim for breach of contract and bad faith, based on the later revelation of additional earthquake damage not discovered in connection with the original claim.

In 1994, after the parties mutually agreed to settle the Homeowners Association claim for earthquake-related damage with State Farm, the monies had been paid, and the Association notified State Farm that repairs to the complex were complete. The Association presented State Farm with a subsequent claim for additional repairs. State Farm rejected this “new claim.”

As a result of the enactment of California Code of Civil Procedure section 340.9 extending the statute of limitations for filing bad faith complaints related to the 1994 Northridge earthquake, the Homeowners Association took advantage of the revival statute. The Homeowners Association sued for bad faith. They alleged that State Farm was negligent in its experts' failure to discover the damage sustained by the complex in the earthquake. State Farm filed a motion for summary judgement asserting that the Homeowners Association had received money sufficient to make the necessary repairs as obligated under the policy. The trial court agreed.

In its ruling, the appellate court noted that California Code of Civil Procedure section 340.9 does not impose a new duty to investi-

gate on the part of insurance companies. Furthermore, the court found that where the parties had previously mutually agreed upon the scope, nature and cost of repair, there could be no bad faith.

Failure to Properly Investigate Claims is Bad Faith

Wilson v. 21st Century Insurance Company (January 30, 2006 Daily Journal DAR. 1290) involved allegations of bad faith in a delayed payment of uninsured motorists' coverage. In reversing the trial court's granting of summary judgement, the appellate court ruled there was a triable issue of fact as to the sufficiency of the investigation raised by the insurer's purported failure to have the insured examined by a doctor of its choice, or to consult with her own treating physician. The insured further claimed that the carrier failed to have the claim evaluated by an experienced personal injury attorney to objectively evaluate insured's pain and suffering, and failed to use its own computer program to determine the reasonable value of the claim and further establish the existence of triable issues of fact as to whether the insurer failed to thoroughly investigate and evaluate the claim.

The Court of Appeal ruled that the trial court erred in not allowing plaintiff to conduct discovery into the insurer's use of its computer software program in the evaluation of bodily injury claims where such discovery appeared reasonably calculated to lead to the discovery of admissible evidence on the issues of breach of contract, bad faith and punitive damages.

Policyholder May Not Pursue a Claim for Bad Faith and Breach of Contract Against Worker's Compensation Insurer Based on Insurer's Failure to Pursue Subrogation

In *Tilbury Constructors Inc. v. State Compensation Insurance Fund* __ Cal. App. 4th __ (March 7, 2006), the California Third District Court of Appeal affirmed the trial court ruling in dismissing a lawsuit after sustaining demurrer brought by State Compensation Insurance Fund without leave to amend.

The dispute arose out of State Compensation Fund's compromise of a lien for workers compensation benefits paid by State Fund under the policy issued to the Plaintiff's for \$10,000.00 when the benefits paid by State Fund actually exceeded \$500,000.00. As a result of State Funds failure to pursue subrogation against the third party causing injury to plaintiff's employee, the plaintiff's workers' compensation premiums dramatically increased.

In affirming the trial court's decision to dismiss the lawsuit, the Court of Appeal found that the right of subrogation was not a duty under the contract, and the decision on when and how to pursue subrogation, including the decision not to pursue subrogation at all, was the right of State Fund. Thus, a party cannot state a cause of action for tortious breach of the covenant of good faith and fair dealing based on another party's alleged failure to diligently and properly pursue its own right.

MORE EARTHQUAKE LITIGATION

Finally, in *1231 Euclid Homeowners' Association v. State Farm Fire & Casualty Company*, the Second District Court of Appeal ruled that where, after a preliminary inspection by representatives of both insurer and insured, it was determined that damage sustained as a result of an earthquake was largely cosmetic and totaled an amount that was well below the deductible under the policy, and the insured thereafter withdrew its claim, the insured closed its file, and the insured took no further action until it sued the insurer eight years later, withdrawal of the claim excused the insurer from further performance of any coverage obligation under the policy and precluded any claim for breach of contract or bad faith. Insured's conclusory allegations of breach of contract, bad faith, fraud, malice and oppression did not create a triable issue of fact as to any of insured's causes of action. ❖

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concealment by the insurer of coverage or wrongful denial of coverage. In third-party cases, it could stem from an insurer's failure to protect the insured by not settling a lawsuit within the limits of a policy, resulting in a trial verdict for the plaintiff in excess of those limits and subjecting an insured to personal liability.

AVOIDING BAD FAITH:

Successful carriers know that their ability to respond effectively can make a big difference in limiting the amount of loss, retaining insureds, and avoiding bad faith claims. The potential for opening a claim up to bad faith scrutiny can be found in virtually all areas of claims handling. Taking a pro-active approach to conducting the fundamental steps of investigation, evaluation and timely disposition of claim in a thorough manner as well as specially and appropriately documenting files can help avoid problems. Training and supervision are critical to the process. This article shall examine the potential for bad faith conduct that can lead to bad faith claims, while identifying steps to avoid or minimize the chances that conduct will result in adverse action against insurers.

INVESTIGATION:

The investigation of a claim (both for first and third-party claims) must be thorough and complete and address both the liability issues and the damages portion of the claim. The amount of investigation undertaken should be dictated by the nature and extent of the claim. Keeping in mind that the claim file itself is ordinarily discoverable, the file should not only be complete, but it should establish that sufficient information exists to allow the claims-handling person to make an intelligent decision based upon the facts. If a file is incomplete, it could be an indicator that the insurer could have made an improper decision because the appropriate information was lacking. The claims handler should be careful not to cut corners and comply with proper claims practices and procedures.

When a conflict exists between the insured and the company, and litigation is involved, then separate counsel needs to be employed to protect the interests of each party. If a third-party claim cannot be settled within the policy limits, the insured has a right to know the status of the case and should be given an opportunity to participate in reaching a settlement.

Remember, in a bad faith action, the plaintiff (usually the insured) may discover the insurer's claim file including the investigation file, notes, and memorandum. Even the most innocent of mistakes could establish proof of inadequate investigation and failure to adequately protect the insured. The claims handler should always comply with proper practices and procedures.

HANDLING OF SETTLEMENT NEGOTIATIONS:

Another potential source of bad faith is the conduct during settlement negotiations, particularly with regard to third-party liability claims. The typical concerns or complaints by insureds are that they have not been kept "in the loop" with respect to the status of settlement negotiations. Again, if a conflict exists between the insured and the insurer, and litigation is involved, separate legal counsel should be employed to protect the interests of each party. If third-party liability claims cannot be settled with the policy limits, the insured has a right to know the status of the case and should be given an opportunity to participate in reaching a settlement. If undisputed portions of the claim

can be resolved, then they should be resolved if it is in the best interest of the insured. Claims professionals should respond promptly, and in writing, to all settlement demands, even if those demands are unreasonable. If a demand letter includes a time limit, then the insurance professional should respond in writing within the time specified, even if it is only to ask for an extension to complete investigation. Claims should be evaluated strictly upon merit and without consideration of policy limits. Files should be well-documented as to conversations with either the claimant, the plaintiff, plaintiff's attorney and the insured.

INADEQUATE DEFENSE:

Often, insurers may be uncertain regarding whether or not coverage applies until the outcome of trial or some other proceeding (arbitration, mediation, settlement). Insurers cannot refuse to defend claims involving questions of coverage as they will likely subject themselves to bad faith claims. In these situations, insurers should defend the insured under a reservation of rights or non-waiver. Thus, the insured is on written notice that a coverage question exists. Failure by an insurer to reserve its rights will prohibit it from denying a claim after trial (or other resolution) even when the facts may reveal that no coverage applied. Moreover, the insured should be notified *in writing* not only that a coverage question exists, but of their right to seek legal counsel to protect their interests.

UNFAIR CLAIMS PRACTICE ACTS:

Virtually all states address aspects of claims handling and have adopted some form of unfair claim handling practices legislation. These regulations set forth standards and guidelines for all aspects of claim handling. Essentially, these laws require the insurers to handle claims promptly, that reasonable investigations be undertaken, that settlements be prompt (if possible), and that claims handlers have acted without delay in handling claims. If insurance professionals are to deny a claim, then a reasonable explanation as to why denial or compromise must be made. It is imperative that claims handlers know their unfair claim practice requirements in all applicable jurisdictions.

In California, the Fair Claims Practices Act is among the toughest in the country. The California Department of Insurance strictly regulates the insurance industry, and penalties for violations may be severe.

DOCUMENTING A CLAIM FILE

Because a claims file is discoverable in litigation, claims handlers can unwittingly make written or electronic remarks in their claim file that could come back to haunt them in the event a file is later subpoenaed in a bad faith suit. Professionals must refrain from making derogatory, personal or unprofessional comments in a claim file. They can be potentially embarrassing and possibly inflammatory in front of a jury. Essentially, claims files should be free of emotion and editorial comments.

CONCLUSION:

Bad faith claims are a real danger to insurers. Companies, however, can protect themselves by avoiding placing their files in bad faith situations. To avoid bad faith, companies should engage in careful, thorough, timely, and professional claim handling. Training, communication and continuing supervision of investigation, settlement evaluation/negotiations and knowledge of the applicable laws are vital to achieving this goal. The key is to recognize potential problems early on, and undertake the best possible course of action to avoid these pitfalls. ❖

DISCLAIMER: THE INFORMATION PROVIDED IN THIS UPDATE IS NOT A SUBSTITUTE FOR LEGAL ADVICE. READERS SHOULD BE ADVISED THAT IF THEY HAVE QUESTIONS ABOUT THIS OR ANY OTHER AREA OF INSURANCE COVERAGE AND BAD FAITH LAW, THEY SHOULD SEEK THE ADVICE OF COMPETENT COUNSEL SPECIALIZING IN INSURANCE COVERAGE LAW.

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