TRAVELERS

Recent trends in Bad Faith

WHITE PAPER

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Bad faith is a cause of action in the US and this paper explores recent trends of bad faith claims in the US, which have seen a significant increase in the last several years. By way of background, insurance is not regulated on a federal level, but it is regulated at a state level, with each state having an insurance commissioner. In light of this, the bad faith laws and regulations vary from state to state. Some states can be described as being "safe" bad faith states (e.g. New York) whereby the plaintiff would need to prove that the insurance company acted with gross disregard of the insured's interests. This is very difficult to prove as no reasonable insurance company would act that way. Other states are more radical in terms of allowing bad faith actions to proceed. In these states (in order of most radical: Florida, Washington, Missouri, California, Texas), when insurance companies do not settle claims when they had an opportunity to do so, most likely they would be found liable unless they can prove that it was reasonable to take that case to trial. Most states treat bad faith claims in the same way as they would treat negligence claims (i.e. what would a reasonable insurance company have done?). If the court finds that a reasonable insurance company would have settled and the company in question didn't, that would amount to bad faith.

This paper summarises thirteen trends in the bad faith sector as identified by bad faith expert, and Vice President and Associate Group General Counsel for Travelers, Bill Kobokovich.

1. Litigation between primary and excess carriers

Litigation between these carriers typically arise when the primary carrier has the opportunity to resolve a case within its coverage limit. To illustrate, such litigation would arise when the primary insurer has a $1,000,000 policy limit and the excess layer insurer has a limit of $5,000,000 in excess of this. A truck accident occurs and the plaintiff's attorney offers to settle for the primary policy of $1,000,000. The primary carrier offers $750,000 which the plaintiff rejects and the case goes to trial. The jury finds in favour of the plaintiff for $5,000,000. In terms of costs, the primary carrier is liable for their policy limit of $1,000,000, and the excess layer insurer is liable to pay the balance of claim amount, being $4,000,000. With the initial plaintiff's case settled, the excess carrier sues the primary carrier to recover the excess amount.

Comment

There has been a significant uptake in claims by excess carriers in the US.

The states in the US have been split into three schools of thought: (a) Direct duty of good faith from primary carrier to the excess carrier. The courts have held that a direct duty exists even though there is no contractual relationship between the two carriers. This school represents the minority of the two schools as only courts in New Jersey and New York have adopted this approach; (b) No duty of good faith from primary carrier to the excess carrier. Courts in Alabama and Idaho have dismissed the approach adopted by the courts in New Jersey and New York, on the basis that no duty can exist when there is no contractual relationship. (c) Equitable Subrogation. Courts in 28 states have sought to adopt a middle ground between the approaches identified in (a) and (b) above. Equitable Subrogation allows the excess carrier to stand in the shoes of the insured party. The excess carrier can sue the primary carrier to recover its money, almost as if there was no excess and the insured party would be suing for the excess, because the primary had failed to settle within their coverage. The insured party's claim is "subrogated" to the excess carrier.

The vast majority of US states that have considered claims of excess carriers against primary insurers have adopted this approach. The rationale behind adopting this approach is as follows: (a) giving reasonable settlements; (b) prevents unfair distribution of losses between primary and excess carriers; (c) reduces premiums paid for excess coverage (in the US, excess policies cost significantly less

than primary policies because this cause of action exists) (d) prevents the primary carrier from obstructing settlements in bad faith. This would be the most pertinent reason for which the courts have used equitable subrogation. Using the illustration above, if the primary party quantifies the claim to be in the region of $800,000 (i.e. within its $1,000,000 coverage under the policy), without equitable subrogation (or implying a duty of good faith identified in (a) above) the primary party bears no risk in not trying to settle the claim and therefore allows it to go to trial (i.e. if less than $1,000,000, that's within their coverage and if more than $1,000,000, the excess carrier can pick up the balance). The courts created this cause of action to protect excess carriers from the primary carrier gambling with the excess carrier's money.

The majority of cases, and where US law has developed the most, involve claims brought by the excess carrier against the primary carrier. The increased use by the courts of the doctrine of equitable subrogation means that the days of the primary carrier being able to gamble with the excess carrier's money may be coming to an end. At the point of possible settlement, Insurers will need to scrutinise further the quantum of liability and defer to settlement prior to judicial action rather than gambling with the excess carrier's money in the courts.

Claims by primary carriers against excess carriers.

For the first time in 2013, the theory identified above went the opposite direction in the case American Alternative Ins. Corp. v. Hudson Specialty Ins. Co., 938 F.Supp.2d 908 (C.D.Cal.,2013). In this instance, there was a vast difference between the primary and excess carrier's quantification of the claim (i.e. primary quantified at c. $8,000,000 and the excess carrier at c. $2,500,000). The primary carrier's duty to defend meant they incurred significant defence costs which went beyond their professional indemnity levels. At trial, the court held that the claim was much closer to the primary carrier's quantification. Using equitable subrogation, the primary carrier sued the excess carrier on the basis that they did not act in good faith with regard to settlement negotiations (i.e. they substantially undervalued the plaintiff's claim), thereby dragging the case to the courts and allowing the primary carrier to incur significant defence costs when the case could have been settled for c. $8,000,000.

Comment

No case prior to this has recognised this kind of a cause of action. This may trigger more primary v. excess carrier litigation in the US.

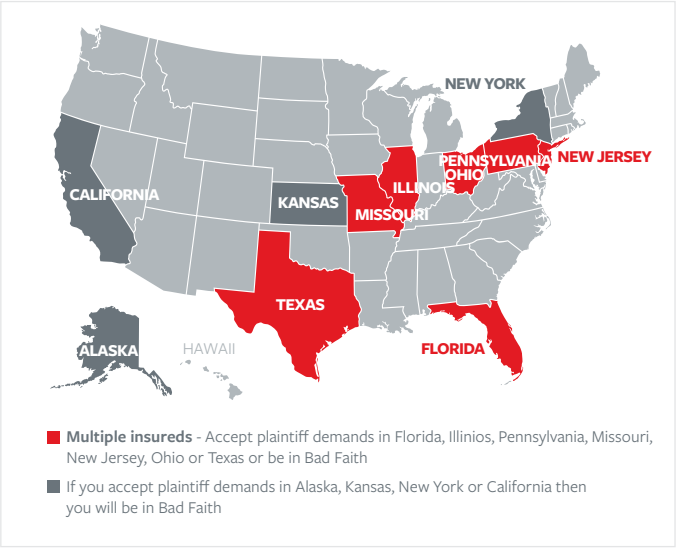
2. Multiple claimants, multiple insureds and inadequate policy limits

Multiple claimants

Using the above illustration, instead of one individual involved in the accident, several individuals covered by the policy are injured. In this example, the combined value of all the claims exceeds $1,000,000. The insurance company can settle for less than all the claims in good faith. The insurance company may settle one or more of the claims against the insured, even if those settlements deplete or totally exhaust the policy limits, as long as they are made in good faith.

However, using the above example, insurance companies may be sued by individuals who are left out of the settlement (e.g. five people are involved in the accident, the insurance company settles the claims of three but leaves two out) on the basis of bad faith. Their argument rests on the fact that the insurance company has artificially depleted the policy limits so as to get out of its own obligations to defend the claim. The insurance company might do this as the defence costs would often outweigh the indemnity costs. The insurance company would need evidence that they have made an effort to settle all the claims in good faith (i.e. maximise the protection from risk as much as possible based upon the funds you have available) if they are seeking to settle for less than the total aggregated claim amount.

Multiple Insureds



In this example, the truck driver involved has been a model employee for a number of years but has a sleep disorder which causes him to fall asleep quickly. The truck driver has never been involved in a major accident with this particular company but has fallen asleep once or twice and caused some minor property damage. In this instance, he fell asleep and killed an individual.

The plaintiff's attorney claims for $1,000,000 and undertakes to release the driver only from liability and not the trucking company on the basis that they ought to have known of the disorder and not allowed him to drive. Can the insurance company accept the plaintiff's demand without committing bad faith?

In the states of Kansas, Alaska, New York or California, if the insured company accepts the plaintiff's demand (i.e. settle for one insured party), the insurance company has committed bad faith.

In Illinois, Florida, Pennsylvania, Missouri, New Jersey, Ohio or Texas if you don't accept the plaintiff's demand, the insurance company has committed bad faith. The more recent judgments are taking this approach and the courts are likely to give greater weight to such precedents rather than the Alaska, New York, California or Kansas approach.

Comment

> *The obvious problem with this approach is that, in the above example, the trucking company paid for the policy but costs are being incurred on settling the case on behalf of their driver, leaving no costs to settle the case against themselves. This is a difficult situation for the insurance company as it could lead to an unhappy customer (i.e. the trucking company will be unhappy accepting the plaintiff's demand) but if the plaintiff's demand is not accepted, the insurance company is acting in bad faith.*

3. Bad Faith set up.

Set-ups: common in Florida, Mississippi, California and Nevada.
In Florida an insurance company must accept all or none of the conditions

These cases often arise where there are relatively low limits of potential exposure. For example, there are very low mandatory limits for auto insurance in the US. In Florida, the minimum amount of coverage required is $15,000. In the event of an accident whereby both sides say they were not in the wrong, but as a result of the accident, plaintiff is now a quadriplegic, the claim could be in excess of several million dollars. As the policy limit is so low, the plaintiff's attorney would not want to settle within the policy limits and would seek to open up the policy limits to one with unlimited coverage (Berges v. Infinity Ins. Co., 896 So.2d 665 (Fla.,2004)). The insurance company in this instance would want to try and settle the case. To avoid settling, the plaintiff's attorney will have very complex demands with multiple conditions (e.g. demand the $15,000 policy limit, demand $10,000 for the car (worth $2,000) because expensive items in the car were destroyed, demand several affidavits from the insurance company etc.).

In Florida, similar to many other states, the insurance company must accept all or none of the conditions. If the insurance company does not accept one of the conditions, the demand has been rejected and the case goes to trial. In this instance, at trial of the underlying case, $10,000,000 is awarded in the plaintiff's favour, along with an assignment to the plaintiff from the insured party of their rights to sue the insurance company for the bad faith failure to settle. The plaintiff then claims the $10,000,000 from the insurance company. This is what we mean by the term "set-up".

A key driver of filing a bad faith claim is that the plaintiff has an option as to whether a judge or jury will hear the case. It is evident that juries are much more inclined to find in favour of a plaintiff than a judge. In the case of a quadriplegic, a jury will look at the $15,000 policy limit and assess whether that amount is ample compensation for the plaintiff for the rest of his/her life. If not, they could find in favour of the plaintiff relying on bad faith so as to not place a limit on the damages available to the plaintiff.

Most prevalent in Florida – but it is spreading to Alabama, Louisiana, Georgia, Mississippi, California and Nevada.

Comment

> *The epicentre of the bad faith "set-up" is in Florida but this is spreading to other states including Alabama, Louisiana, Georgia, Mississippi, California and Nevada. The plaintiff*

attorneys in Florida who are well conversed in "setting-up" bad faith claims are actively marketing in these states by giving seminars to teach attorneys in those states as to how to set-up an insurance company.

4. Institutional bad faith

This is becoming a very big problem in the US. The doctrine of bad faith developed from the 1950s in the US. Prior to then, if the insurance company took the claim to trial and the court held in favour of the insured in excess of the policy limit, the insurance company would pay up to the limit and the insured had no option. In the 1950s, the courts of California established the doctrine of the duty of good faith and fair dealing in insurance contracts. This places the duty on the insurance company to keep the insured's interest the same as their own, and if they fail to do so, they can be sued for bad faith. Following this, for the next half century, the focus on bad faith claims was on the claim handler. The plaintiff attorney would claim that the handler did not perform adequately (e.g. they did not understand the case or they refused to settle the case) and plaintiffs were awarded substantial verdicts. During this period, the claim handler was placed on the stand and the insurance companies attempted to humanise them. To do this insurance companies added narrative to the claim handler's situation. By way of example, a claim handler, Mrs Smith, has been adjusting claims for 25 years during which time she has received thousands of letters thanking her for helping insureds. The current case perhaps wasn't her best, but the insurance company urges the court not to punish her for it. This strategy worked and the number of bad faith claims were reducing as the insurance companies sought to humanise the claim handler. The plaintiff attorney's response was to change the focus from the claim handler to the insurance company.

This is what we mean by "institutional bad faith". The corporate structure and the internal policies of the insurance company are on trial rather than the claims handler. The plaintiff's argument stems from the suggestion that corporate structure and internal policies facilitate and encourage bad faith claim handling. Their argument continues by claiming that the insurance company places its profits above the interests of its insureds. The plaintiff will admit that there is nothing wrong with insurance companies making a profit, but this should be made through good underwriting, and they should not be able to make money from the claim handling (i.e. a claim is worth what a claim is worth so if you intend to make money through handling claims then that is bad faith).

Comment

There has been a shift from individual claims centred around the bad faith of individuals to institutional claims. The benefit of this approach is that when calculating quantum of damages, the plaintiff could look at the substantial assets of the insurance company to inflate the claim amount (e.g. a claim of $100,000,000 would not be significant for an insurance company worth tens of billions of dollars).

There are four areas that plaintiffs focus on to prove institutional bad faith:

1. Improper tracking of indemnity costs (e.g. the tracking of claims costs and the setting of average claims cost goals);
2. Improper goals to reduce claims severity (e.g. the insurance company has a goal to reduce indemnity pay-outs by 15 percent);
3. Improper goals of placing an average amount paid on claims under specific types of coverage;
4. Improper performance measurements that are used to determine salary increases, bonuses and benefits of claim handlers (e.g. overpayment of claims by insurance companies means that the claims handler does not receive an increase in salary thereby incentivising claim handlers to underpay claims).

5. Class Actions

Plaintiff attornies are now attempting to claim institutional bad faith by grouping the claimants. In the Colossus Litigation, the plaintiffs alleged that the insurance industry (i.e. the insurance companies who used the Colossus computer product which calculated quantum of claims) conspired with the manufacturer of Colossus to underpay under-insured and un-insured motorists' claims by around 20 percent, based on the way the Colossus program was set up. By way of example, plaintiff attorneys could claim that there were 100,000 under-insured claims, then would calculate 20 percent of the total quantum of damages paid to reach a very substantial figure. As a result of the number of individuals affected, there can be tens of thousands of claimants brought within the class.

Comment

Class actions of institutional bad faith can be a very dangerous tool against insurance companies due to the significant sums that can be claimed by plaintiff attorneys. As shown by the Colossus Litigation, the basis of a class action institutional bad faith action can be claiming that the computer program of the insurance company is biased in its favour. Insurers need to be aware of the need to keep computer programs under review to ensure their neutrality. In addition, the policies of insurers would need to ensure neutrality. In particular, compensation documents and policies cannot be seen to incentivise the claims handler to underpay claims.

6. Duty to defend, breach and consequences

Duty to defend: Extreme position no need to prove bad faith just prove breach to defend – Missouri and Montanta

This is an alarming development to the doctrine of bad faith. Most polices in the US that are not professional policies (e.g. D&O) have a duty to defend the insured when the insured is sued. In addition to the duty to defend, there is a duty to indemnify the insured.

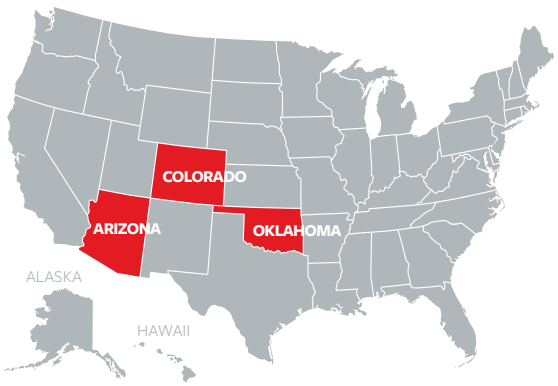
Courts in some states have held that, when insurance companies have mistakenly refused to defend its insured, the defence costs are payable by the insurance company, but it can still contest as to whether the underlying claim is covered.

However, worryingly there is a minority taking two alternate positions, the "middle position" and the "extreme position". To illustrate, the middle position is when the insurance company is found to have breached the duty to defend, and in some states (Illinois), the insurance company is then "estopped" to deny indemnity coverage too (i.e. it cannot raise any coverage defences even if it can prove the claim was not covered by the policy). Therefore, the insurance company is liable for the amount up to the policy limit because of the indemnity. On the other hand, some states have adopted the extreme position, in that in addition to being estopped from raising coverage defences (as in the case of the middle position), the insurance company is liable for the excess amount too because of its breach of the duty to defend.

Comment

> *In light of the "extreme position" as adopted by the courts of Missouri and Montana, there is no need to prove bad faith, merely to prove that the insurance company had breached its duty to defend. The insurance company would then be open for all consequential damages, well in excess of the policy limit. These could be significant amounts. This could be setting a very dangerous precedent as insurance companies could be liable for amounts they did not contract for.*

7. Consent/Rollover Judgments



Consent / Rollover: extreme position - Arizona and Colorado and Oklahoma

Most states in the US take the position that if the insurance company denies coverage (i.e. no defence and no indemnity), the insurer and the insured can opt for a consent/rollover judgment. In this instance, the insurance company and the insured agree a deal whereby a judgment is made against the insured for an amount (usually in excess of the policy limit), in exchange for a covenant not to execute against them or their personal assets. This approach is acceptable if a duty to defend exists.

Similar to above, there are two approaches that have been adopted by the courts. To illustrate, if the insurance company suspects that there is no coverage under the policy, but to be safe, makes an offer to defend while reserving its rights to contest whether it owes a duty to indemnify under the policy. Some states have found that in this instance, where the insured has accepted the defence which reserves the rights of the insurance company to deny indemnity coverage, they can still enter into a consent judgment which settles the underlying case. This is regarded as the "middle ground" as adopted by Arizona and Colorado. The rationale for this is that the reservation of rights is akin to a denial of coverage and so courts allow the insured to enter into the consent judgment.

The "extreme position" (cases in Arizona, Colorado and Oklahoma), where even if the insurance company is defending, has not reserved its rights and accepts the coverage; if the insurance company receives a demand within its policy limit that the insured thinks ought to be accepted and the insurance company rejects it, the insured can enter into a consent judgment and end the case. They would then assign their rights to the person holding the consent judgment and the holder would need to establish that the insurance company acted in bad faith (e.g. by not settling when they could have).

Comment

The implication of the extreme position is that the insurance company is defending without any reservation of rights and the insured can terminate the underlying litigation thereby ending the insurance company's defence.

8. Bad faith in the absence of coverage

Most courts will find that the insurer's obligation of good faith arises out of the insurance contract and so there cannot be a bad faith claim in the absence of coverage. However, there are a minority of states which have adopted a contrary approach (e.g. Washington, Arizona) in that there can be a claim for bad faith even if there is no coverage under the policy and no breach of the duty to defend or indemnify. A court in Washington held that the insurance company acted in bad faith by undertaking an inadequate and improper investigation of the claim which caused damage to the plaintiff.

Comment

This broadening of the doctrine of bad faith is a significant step by the US courts which insurance companies will need to consider when looking at their policies of claims handling to ensure they are not liable for bad faith even in the absence of coverage.

9. Extra contractual liability for actions of adjusters, TPAs and lawyers

Courts in the US have held that the duty of good faith owed by insurance companies is a non-delegable duty. For instance, if an insurance company instructs a third-party administrator (TPA) and they commit bad faith in the way they handled the claim or a lawyer who violates the state's unfair practices in the way it handled the defence of the claim, the insurance company is vicariously liable and can be sued for bad faith for the actions of the TPA or lawyer.

Comment

This can be dangerous if the insurance company does not have adequate protocols for management of the TPA. Such policies will need to be reviewed and scrutinised. In particular, setting minimum E & O insurance thresholds which the TPA must carry.

10. Duty to initiate settlement discussions

Many states (e.g. Louisiana) now are adopting the position that once the insurance company has enough information to determine that liability is "reasonably clear" (i.e. it owes the claim and has an idea of the quantum of the claim), it has a duty to initiate discussions and cannot wait for a demand. Breach of this duty would mean that the insurance company could be sued for bad faith.

Comment

This duty to negotiate is seen in the "silent set-up" whereby plaintiffs can rely on the lack of discussions to initiate bad faith proceedings.

11. Duty to settle when coverage is in question

This is pertinent when an insurance company is deciding whether to settle a claim and it believes it has several coverage defences (i.e. no coverage or some of the claims are not covered). Again, there are two approaches which the courts in the US have adopted.

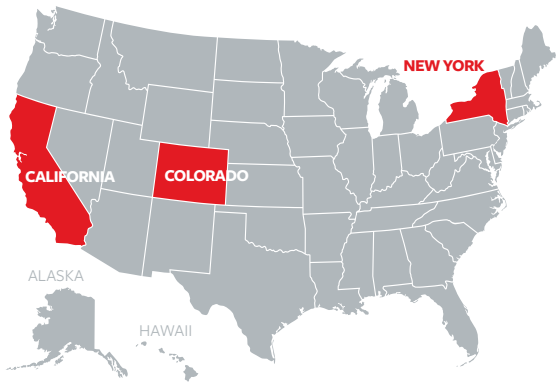
The California approach holds that the insurance company takes coverage into consideration at its own risk. Therefore, if it has the opportunity to settle within policy limits before trial and it does not and at trial it is held that the claim was within its coverage, the insurance company is liable for the whole claimed amount (similar to strict liability).

The Wisconsin approach maintains that the insurance company can take coverage issues into account when determining to settle a claim within its policy limits. However, their position with regards to coverage must have a reasonable basis. The insurance company would be liable up to the policy limit but not in excess. If its position was unreasonable, the insurance company could be liable for the whole amount.

Comment

This elucidates the differing approaches to bad faith adopted by US states.

12. Punitive damages – insurability



Punitive damages – insurance against punitive damages is against the public policy of that state – California, New York and Colorado,

This relates to insurance companies during settlement negotiations on behalf of the insured and their requirement to consider uncovered punitive damages when making settlement decisions. In this instance, the policy itself may exclude coverage for punitive damages or some states have stated that insuring against punitive damages is against the public policy of that state (e.g. California, New York and Colorado).

Some states have adopted a middle-ground, in that punitive damages that are directly assessed against an individual cannot be insured as this would be in breach of the public policy of the state, but punitive damages that are vicariously assessed can be insured. Using the first example of the truck accident, the truck driver was drunk and the injured party was killed. The punitive damages of the driver (on an individual basis) cannot be insured. However, in these states the punitive damages against the trucking company (being vicariously liable) can be insured. The rationale for this is that the trucking company did not directly cause the accident/injury.

13. Bad faith considerations with eroding limits liability policies

These cases involve policies where the defence costs are within the policy limits and each dollar spent on defending the case erodes the settlement amount (e.g. a policy for $1,000,000 and the defence costs erodes the amount available to settle the case). These policies are most common in professional insruance (e.g. E&O, D&O). In these instances, a California judge opined that there are heightened duties of good faith in policies with eroding limits of liability. There are three proposed duties with regard to these types of policies, which are in addition to a typical policy where the defence costs are outside of policy limits:

(a) A duty to keep the insured informed of the defence costs that have been incurred. This is so that the insured will be aware of the amount by which the coverage has been reduced and the risk of excess liability has increased. At the point of settlement and the opportunity to settle with the balance of the policy, the insured must have the opportunity to demand for the insurance company to do so. Insurers should notify the applicable insureds on a regular basis of what remains of the policy limits.

(b) A duty to avoid unreasonable defence costs. The rationale for this is that the policy limits are reduced and so the risk of excess liability is increased. For example, if the insurance company's legal advisors are allocating disproportionate resources to the defence (e.g. several partners to negotiations).

(c) A duty to increase efforts to settle as early as possible. The longer it takes to settle, the greater the defence costs, the greater the erosion. This places a duty on the insurance company to conclude its investigation quickly and to evaluate as to whether to settle or not.

Comment

This is an area where it is probable that there will be a significant increase in bad faith claims in the next few years. The heightened duties mentioned in (a)-(c) above, have not been established by the courts (i.e. there is currently no case law relating to these) but have been proposed by a California legal commentator. It is anticipated that excess carriers will seek to rely on the above duties, in particular (b), by claiming that the primary carrier artificially depleted the coverage available and forced the claim amount to be paid by the excess.