SUCCESSFUL BAD FAITH CLAIMS AGAINST TROUBLED LIABILITY INSURERS: AVOIDING EXPENSIVE FAILURE

by Steven E. Sigalow and Mark J. Andreini

Unlike contract law generally, the law of insurance protects the policyholder from an insurer's bad faith refusal to perform. Indeed, the reliability of an insurance company's promise to pay is of such economic significance that it is an important objective of public policy in all 50 states. State laws and regulations, including unfair claims practices laws, reflect and enforce industry standards of good faith and fair dealing in the handling of claims.

While many incidents of insurer bad faith conduct have been documented, insurance companies will ordinarily comply with standards of good faith and fair dealing not only because state law and regulation may require it, but also because in most instances it is in their economic interests to do so. These economic interests include the positive interests of a going concern, such as future customer relationships, future sales and profits, and, in general, a good business reputation. They also include the interest of a going concern not to be held liable for a pattern of evasion of claims.

But for troubled insurance companies facing sizable claims, there is a common strategy for survival that disregards these long-term interests. The elements of such a strategy can include the insurer's

looking for any conceivable reason not to pay claims, paying on claims as little and as late as possible, raising its financial distress as a negotiating ploy, and aggressively manipulating reserves, alone or together with providing financial incentives for claims personnel to resolve claims for less than those reserves. These are strategies intended to place the interests of the insurer ahead of those of the policyholder—the very essence of bad faith.

Financial distress is everywhere in the insurance industry. AIG owes U.S. taxpayers $150 billion and counting and is now a penny stock. Investors have battered the shares of most other insurers as well. Hartford leads a parade of insurers seeking relief from state regulators from capital requirements. The four largest Japanese insurers reported devastating losses for the fourth quarter of 2008. The fact that many troubled insurance companies will get tougher on claims is hardly surprising and nothing new. Premium dollars are held from point of sale, and as long as a claim is disputed, that money can continue to be held and loss reserves can continue to be "managed."

An increase in litigation between corporate policyholders and their insurers is highly likely. Many policyholders will be moved by anger and frustration to assert bad faith claims, and many of these claims will even be meritorious. Most, however, will be expensive failures. We discuss below some of the important reasons for this. But first, some background on this complicated area of the law.

STATE LAWS OF BAD FAITH ARE INCONSISTENT AND POORLY UNDERSTOOD

The law of bad faith is a hodgepodge of different statutory and common law rules developed independently by each of the 50 states. No national set of common law principles has evolved. The 50 states cannot even agree on whether the cause of action sounds in tort or contract. In many states, the duty of good faith and fair dealing is a covenant implied in the policy of insurance, the breach of which sounds in contract. *See*, *e.g.*, *Twin City Fire Ins. Co. v. Colonial Life & Acc. Ins. Co.*, 839 So.2d 614, 616–17 (Ala. 2002). In such states, proving a breach of the covenant entitles the insured to consequential damages flowing from that breach. *See*, *e.g.*, *Acquista v. New York Life Ins. Co.*, 285 A.D.2d 73, 80, 730 N.Y.S.2d 272, 277 (1st Dep't. 2001).

In other states, a bad faith claim sounds in tort, and in addition to damages for breach of contract, separate damages for the tort may be recovered. *E.g.*, *Anderson v. Continental Home Ins. Co.*, 271 N.W.2d 368, 374 (Wis. 1978). In these states, the tort arises from breach of the positive legal duty that, in turn, arises from the special relationship between an insurer and policyholder. *See*, *e.g.*, *Hoskins v. Aetna Life Ins. Co.*, 452 N.E.2d 1315, 1320 (Ohio 1983). In these states, the policyholder is entitled to damages proximately caused by the insurer's breach of duty that are separate from, and in addition to, the damages caused by the breach of contract. *See*, *e.g.*, *Anderson*, 271 N.W.2d at 374; *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d 397, 401 (Ohio 1994).

Every state regulates insurance, and most address in their statutes or regulations unfair claims practices. In some states, the specific prohibitions and requirements of these regulations provide a separate, and sometimes exclusive, private cause of action for the policyholder. *See*, *e.g.*, Mont. Code § 33-18-242; Tex. Ins. Code Ann. Art. 21.21 § 16; N.M. Stat. Ann. § 59A-16-30; *State Farm Mut. Auto. Ins. Co. v. Reeder*, 763 S.W.2d 116, 118 (Ky. 1988). In other states, they don't. *E.g.*, *Masterclean, Inc. v. Star Ins. Co.*, 556 S.E.2d 371, 377 (S.C. 2001). Indeed, some courts have held that violations of unfair claims practices regulations do not even amount to evidence of bad faith. *See*, *e.g.*, *Furr v. State Farm Mut. Auto. Ins. Co.*, 716 N.E.2d 250, 256 (Ohio App. 1998).

For commercial policyholders with large claims, there are two commonly recurring types of bad faith claims. The first arises from an insurer's unreasonable refusal to settle a third-party claim against the policyholder within policy limits. *See*, *e.g.*, *PPG Indus., Inc. v. Transamerica Ins. Co.*, 20 Cal. 4th 310, 312 (Cal. 1999). Most states recognize this bad faith cause of action, and the measure of damages is straightforward—typically the amount of the judgment in excess of the insurer's policy limits.

The second type of bad faith claim, and one that can increasingly be expected to arise from troubled insurance company claims practices, is an unreasonable or intentional refusal to defend or indemnify a covered loss. Fewer states recognize this type of bad faith cause of action, often on the theory that proving an intentional breach of contract adds nothing to the policyholder's breach-of-contract claim. *See*, *e.g.*, *Johnson v. Federal Kemper Ins. Co.*, A.2d 1211, 1213 (Md.

App. 1998); *Wilson v. Colonial Penn Life Ins. Co.*, 454 F. Supp. 1208, 1213 (D. Minn. 1978).

But even where this type of bad faith cause of action is recognized, the elements of the claim vary widely. In some states, bad faith is merely the refusal to pay or settle a claim without "reasonable justification." *E.g.*, *Zoppo v. Homestead Ins. Co.*, 644 N.E.2d at syllabus ¶ 1. Other states require the insured to show not only that the insurer's action had no reasonable justification, but that the insurer acted with knowledge or in reckless disregard of the lack of reasonable justification. *E.g.*, *McCullough v. Golden Rule Ins. Co.*, 789 P.2d 855, 860–61 (Wyo. 1990). In some of these states, an insurer may escape bad faith liability entirely simply by demonstrating that coverage for the claim was objectively "fairly debatable," regardless of intent or evil motive. *Bellville v. Farm Bureau Mut. Ins. Co.*, 720 N.W.2d 468, 473–74 (Iowa 2005).

Policyholders and their counsel too often poorly understand these complexities. As a result, bad faith claims often are pursued without a clear and effective strategy. Depositions of claims personnel are taken, experts are retained and compensated, and documents are reviewed, only to have the bad claim founder as a matter of law. But the complexity of bad faith law is hardly the only—or even the most important—reason why most bad faith claims are expensive failures. Here are three other important reasons particularly relevant to troubled company claims practices.

WHY MOST BAD FAITH CLAIMS ARE EXPENSIVE FAILURES

Reason 1: Policyholders and Their Counsel Too Often Fail to Understand and Successfully Obtain the Compelling Facts That Explain the Insurer's Wrongful Behavior. Bad faith claims must focus on the insurer's decision-making process: Why did the insurer refuse to pay the valid claim or claims? Even in states where intent is not an element of the cause of action, mere mistake or negligence rarely proves enough. As a practical matter, to overcome the insurer's inevitable motion for summary judgment, and ultimately to persuade the jury, the policyholder should strive to prove not only that the troubled insurance company's claims denial was unreasonable and wrong, but that it was inspired by a strategy for survival that placed its interests ahead of those of the policyholder.

This is not easy. Essential to making this case against a troubled insurer is a deep understanding of the industry, its complicated relationship with state regulation and regulators, and the industry's economic incentives to comply (or not) with established standards of good faith and fair dealing. The policyholder must know what to look for. Where the positive incentives of a going concern are present and the insurer responds to them, one expects to find prompt claims handling and investigation, prompt determination of coverage positions, prompt and clear communications with policyholders, and a claims-handling approach of looking for coverage, all pursuant to internal standards and procedures established by the company for the guidance of claims representatives. But in troubled times, when the usual incentives may be overtaken by a business strategy of survival, one may find instead an absence of prompt and comprehensive claims investigation and handling, long delays in taking definitive coverage positions, compensation or advancement contingent on not paying claims, surplus-enhancing targets for claims departments, and payment of major claims only after protracted coverage litigation—and then only at the lowest amount negotiable in the context of compromising the litigation.

By engaging in these practices, the troubled insurer can realistically hope to achieve important objectives. As long as disputes continue, the insurer will continue to earn income on the money it would otherwise have paid on claims. Reserves (perhaps already aggressively discounted) remain on the books subject to further executive refinement, maintaining the appearance of solvency and satisfying regulators. Protracted litigation raises the policyholder's transaction costs, which can be expected to deter some policyholders from pursuing their rights in the first instance and to prompt others to accept less in settlement than the claim is worth. And if individual cases are isolated by confidentiality agreements and protective orders, the insurer can do all this with minimal risk that the uninitiated policyholder or its counsel will be able to detect—much less prove in court—the pattern of evasion.

But most bad faith litigants lose any realistic opportunity to discover and prove these kinds of facts by insisting that the bad faith claim be litigated at the same time as the breach-of-contract claim. This is the second reason why so many bad faith claims are expensive failures.

Reason 2: Too Many Policyholders and Their Counsel Reflexively Seek to Try Together Their Claims for Coverage and for Bad Faith. Insurers usually want, and some states

favor, bifurcation of the coverage and bad faith claims. Policyholders typically resist. While there are circumstances where this may be the right strategy, often it is not.

In a case involving a denial of coverage, there is no winnable bad faith claim without an insurer's failure to pay in breach of the policy. So the policyholder might as well win the breach-of-contract claim first, thereafter putting the insurer in the unenviable position of arguing that even though it was wrong, it made an honest mistake. Juries tend to exaggerate the competence of big businesses; they tend to believe that businesses don't make mistakes, that they know exactly what they are doing. And if the "mistake" can be shown to be part of a pattern of evasion—part of a business strategy for survival—the insurer's defense of a good faith mistake will almost certainly fall on deaf ears.

Just as important, it is only after a judgment of breach of contract that is then linked to a coherent theory of bad faith that the policyholder is most likely to succeed in convincing a court to allow the type of discovery that will yield important evidence of the insurer's decision-making process and business strategy. This evidence can include the (always assertedly sensitive) reserve information and claims handler performance reviews, as well as privileged communications between the insurer and coverage counsel.

A recent example of how this strategy works is *Brush Wellman Inc. v. Certain Underwriters at Lloyd's, London*, Civ. Action No. 03-CVH-08 (Ohio Com. Pl.). Brush Wellman is a manufacturer of specialty metals. For many years, certain London Market insurers, including Underwriters at Lloyd's of London, had been paying tens of millions in defense and indemnity for claims against Brush alleging liability for plaintiffs' exposure to a potentially hazardous substance, beryllium. Beginning in early 2000, however, the London Market insurers began to deny (or not pay in full) Brush's claims for a variety of new reasons. And because of the London Market insurers' insistence on allocating claims to different years in the manner they selected, Brush was bearing an increasingly large share of the costs of defending and settling the beryllium litigation due to self-insured retentions and uninsured years.

In 2002, the Ohio Supreme Court resolved the allocation issue under Ohio law, holding that the policyholder, not the insurer, has the right to select the policy that will respond to each claim. This ruling allowed insureds to allocate a claim to a single policy period, and not to spread out defense and indemnity costs among multiple years, some insured by different insurers and some even uninsured. When Brush asked the London Market insurers to accept vertical allocation on a going-forward basis, the London Market insurers, led by Equitas, the reinsurer and runoff agent for pre-1993 claims at Lloyd's of London, responded by asserting a variety of new coverage defenses, some of which had the potential to render the coverage valueless.

Proving that Equitas' unreasonable failures to pay the beryllium claims were part of a pattern of evasion resulting from Equitas' business strategy for survival was not going to be easy. Brush would have to obtain documents that no policyholder had ever succeeded in obtaining, documents whose very existence most policyholders may not have suspected. No court was likely to allow such discovery in a breach-of-contract case, even one that appended the obligatory bad faith claim. The court needed to be persuaded first that the insurer had actually breached the contracts.

Brush was quick to agree to bifurcation and then, on summary judgment, won all seven of the coverage issues presented, most of which were matters of first impression in the state. *Brush Wellman Inc. v. Certain Underwriters at Lloyd's, London*, 2006 WL 4455491 (Ohio Com. Pl. Aug. 30, 2006). Following that ruling, the court allowed the unprecedented discovery that Brush sought from Equitas, concluding that this discovery was all relevant to Brush's claim that Equitas' claims denials were part of a pattern of evasion that flowed from its business strategy of survival. Shortly before the start of trial, the London Market insurers settled by not only paying all of the breach-of-contract damages and millions more, but also by replacing the existing coverage, which was riddled with insolvent shares, with a new policy with new (and now reliable) security and $150 million in limits.

But understanding and proving a compelling theory of liability is only half the battle, which brings us to the third reason why so many bad faith claims do not succeed. The policyholder must also prove that the insurer's bad faith conduct caused the policyholder to suffer extracontractual damages beyond the coverage and prejudgment interest that can be recovered in a traditional breach-of-contract action.

Reason 3: Policyholders and Their Counsel Too Often Fail to Appreciate the Difficulty of Establishing Bad Faith Damages in Failure-to-Pay Cases. Extracontractual damages are difficult both to measure and to prove in the unreasonable failure-to-pay bad faith claim. Most of the damages flowing from the failure to pay include various forms of unpaid policy benefits—most commonly, the costs of defending the third-party claim and the costs of judgments and settlements that had to be borne by the policyholder—and in some states, foreseeable consequential damages. But an insured needs no bad faith claim to recover such amounts, and in many states, such contractual damages are not recoverable as damages in a bad faith case anyway. In some states, the legal fees and expenses incurred by the insured to obtain policy benefits can constitute "extracontractual" damages resulting from the insurer's bad faith and can be recoverable in a bad faith case, *e.g.*, *Brandt v. Superior Court*, 37 Cal. 3d 813, 693 P.2d 796, 210 Cal. Rptr. 211 (1985), but in other states, attorney fees can be awarded only if a statutory exception to the American Rule is met; *see*, *e.g.*, *Casson v. Nationwide Ins. Co.*, 455 A.2d 361, 370 (Del. Super. Ct. 1982).

Is it futile, then, to pursue a bad faith claim for an unreasonable or intentional failure to pay a valid claim under a policy? No, but one does need to know what one is doing. Two novel damage theories that led to very successful settlements illustrate the point.

The first is the concept of the "forced loan." When an insurer refuses to pay a covered claim—in many cases years after it is due and payable—the policyholder's balance sheet is damaged by, in effect, having been forced to lend to the insurer the amounts that should have been paid. The elements of this damage include the time value of money and the risk of default. Financial experts can testify that such damages are best measured by the insurer's borrowing cost for incremental unsecured debt, *i.e.*, the costs that the insurer would have had to pay to borrow the funds owed (but not paid) to the policyholder. For an insurer that is at risk for insolvency, that cost will be high indeed and can be measured by the payments that would have accrued on a portfolio of bonds of the same amount and with the same default risk as the forced loan to the insurer.

The "forced loan" analysis is economically appropriate where the policyholder faced no capital constraints, *i.e.*, where the forced loan to the insurer did not divert funds the policyholder needed for other profitable projects. But where the policyholder was capital-constrained, as is increasingly true today, and where the forced loan crowded out other profitable projects, an economically appropriate measure of damages may be the lost expected rate of return on those projects.

The second damage concept is the cost of replacing the coverage that has been rendered uncertain by the insurer's bad faith conduct with reliable coverage providing new, secure protection against liability. *E.g.*, *Chicago HMO v. Trans Pacific Life Ins. Co.*, 622 F. Supp. 489, 493 (N.D. Ill. 1985) ("Compensatory damages for bad faith breach of the duty of fair dealing may include other items as well which are not derived solely from the contract, such as compensation for the cost of procuring other insurance or for the necessity of being self-insured"). Under this concept, the insurer is forced to pay the insured as damages an amount that will allow the insured to replace its existing coverage with new, reliable coverage. Replacement value is a theory particularly appropriate to occurrence-based coverage, where the bad faith insurer and policyholder can reasonably be expected to have to deal with each other in the future because of the likelihood of incurred but not reported, or yet-to-be-asserted, future claims.

Replacement cost is measured by the cost of insuring the same risk, on comparable terms, with new, reliable security for the coverage. Brokers, actuaries, and underwriters, or a combination of them, can provide the necessary expert testimony on these topics. This damages theory, although rarely understood and pursued by commercial policyholders, can provide a basis for recovering extracontractual damages where the insurer, through its bad faith conduct, has destroyed the reliability of the insurance promise. Policyholders should not be required to have to continue to deal with such insurers. As one court explained:

> It would be illogical for the court to find as a matter of law that a prevailing plaintiff in a bad faith case should have to continue to submit to the same treatment in order to receive the future benefits of a contract where [the insured] has complied with its terms and the insurance company has not.

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Hangarter v. Paul Revere Life Ins. Co., 236 F. Supp. 2d 1069, 1089 (N.D. Cal. 2002), reversed in part by *Hangarter v. Provident Life and Acc. Ins. Co.*, 373 F.3d 998 (9th Cir. 2004).

CONCLUSION

Past crises in the insurance industry have resulted in unmistakable cases in which the interests of troubled insurers and their managements and stockholders have prevailed over the interests of policyholders. These are not the priorities recognized in legislative enactments, the case law, or textbooks. In this new period of crisis, we will see many U.S. and non-U.S. insurers embrace these same priorities. As in the past, it will fall to the courts to protect policyholder rights and to punish and deter bad faith practices. But policyholders and their counsel must properly lead the way. Bad faith claims need not be expensive failures. ■

STEVEN E. SIGALOW
1.216.586.7105
sesigalow@jonesday.com

MARK J. ANDREINI
1.216.586.7101
mjandreini@jonesday.com