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Insurance Practice

The Bad Faith Sentinel

Standing guard on developments in the law of insurance bad faith around the country

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Indiana Bad Faith Ruling is Reminder that Resolution of Breach of Contract Claims in Favor of Insurer Does Not Necessarily Require Disposal of Tort-Based Bad Faith Claims

Klepper v. Ace American Ins. Co., No. 15A05-1212-CC-645 (Ind. Ct. App. Dec. 5, 2013)

Indiana Court of Appeals permits class action plaintiffs to pursue theory of bad faith claims handling even after dismissal of the class's breach of contract claim.

Pernod Ricard USA LLC operated a distillery in Lawrenceburg, Indiana from January 2002 until June 2007. During the distillation process, ethanol was released into the air, causing mold to grow on the exterior of nearby buildings. William Klepper's property near the distillery was damaged by the emissions.

In 2005, Klepper brought a class action lawsuit against Pernod on behalf of similarly situated property owners. The class action complaint alleged nuisance, negligence, trespass, and illegal dumping. Pernod tendered the claim to its insurers, XL Insurance America, which insured Pernod from January 1, 2001 to January 1, 2003, and ACE American Insurance Company, which insured Pernod from January 1, 2003 until January 1, 2004. When ACE received the claim in March 2005 it mistakenly classified it as an underage drinking matter and closed its file.

In October 2007, ACE was advised that the claim was not an underage drinking matter and that XL had been providing Pernod with a defense. XL sought contribution from ACE for the cost of defense and ACE agreed to contribute 49 percent of Pernod's defense costs under a full reservation of rights. ACE reimbursed XL for its portion of the previously-incurred defense costs and contributed to ongoing costs until resolution of the underlying lawsuit.

In January 2009, the trial court granted summary judgment for Pernod on the illegal dumping claim, prompting settlement discussions. During those discussions, XL and Pernod asked ACE to contribute

$1,000,000 toward a settlement agreement, but ACE refused and instead offered to contribute $250,000.

A mediation was held on April 14, 2009. ACE attended the mediation, but left before it was over. After ACE's departure, the Class, XL and Pernod reached an agreement whereby judgment in the amount of $5,200,000 would be entered against Pernod. Pursuant to the agreement, Pernod would contribute $1,200,000 and XL would contribute $1,000,000 to a common fund for the immediate use and benefit of the Class. The remaining $3,000,000 was to be collected from ACE "to the extent the damages fall within the scope of the ACE Commercial General Liability Policy."

On May 11, 2009, the Class filed a third amended complaint which included a claim for declaratory judgment regarding coverage under the ACE policy. In August 2009, the Class agreed to dismiss its claims against Pernod with prejudice and to release Pernod and XL from any future claims upon receipt of the $2,200,000 payment. The trial court approved the settlement in September 2009.

On December 29, 2010, the Class filed a fourth amended complaint asking the trial court to declare that up to $3,000,000 in damages, attorney fees, and post-judgment interest may be collected from ACE under its policy. The fourth amended complaint also included bad faith and unfair claims handling allegations against ACE.

By agreement of the parties, the case was assigned to a special master for resolution of six issues, including whether coverage existed under the policy. In its briefing to the special master, ACE relied upon the policy's "legally obligated to pay" and "voluntary payment" provisions to assert that it owed no coverage under the policy. The "legally obligated to pay" provision stated that ACE "will pay those sums that the insured becomes legally obligated to pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies." ACE argued that because, pursuant to the settlement agreement, Pernod was released of liability, Pernod was not legally obligated to pay the $3,000,000 to the Class and, therefore, ACE also could not be liable to pay the unpaid balance. ACE also argued that because Pernod settled the Class's claims without ACE's consent, the "voluntary payment" provision, which stated that "No insured will, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent," precluded coverage.

In response, the Class argued that ACE was not permitted to (1) use the settlement as a tool to avoid coverage under the cited provisions; or (2) challenge Pernod's liability on the damages fixed in the settlement. Instead, the Class argued that the court was tasked not with applying various terms of the policy, but rather with balancing the policyholder's need to protect itself where the insurer refuses to commit to indemnity and the right of an insurer to protect itself from unreasonable settlement.

The special master concluded that ACE properly relied on the policy's "legally obligated to pay" and "voluntary payment" provisions holding, "ACE honored its obligation. As a matter of law, Pernod breached its obligation by entering into the agreed judgment without the consent of ACE and the Class, as its assignee, will have to live with the consequences of Pernod's breach." On October 9, 2012, ACE asked the trial court to adopt the special master's report and to enter final judgment in its favor. On December 17, 2012, the trial court entered an order adopting the report, but declined to enter final judgment on all issues, instead directing entry of only the six specific issues that the parties had agreed would be resolved by the special master. Both Pernod and the Class appealed the trial court's order.

The trial court concluded that ACE neither abandoned Pernod nor breached the policy. The trial court explained that ACE's refusal to contribute more than the offered $250,000 did not constitute an abandonment because ACE took the position that its obligations were limited by a $10,000 per claim deductible, relied on the ongoing nature of the emissions compared to its limited coverage for a 1-year period, and believed that there had not been an "occurrence" as defined by the policy. Likewise the Court held that ACE was not in breach and was permitted to rely on the "voluntary payment" and "legally obligated to pay" provisions of the policy.

Despite affirming the ruling that ACE owed no coverage, the trial court declined to dispose of all of the Class's claims. The trial court agreed with the Class that, regardless of coverage, an insurer may breach the covenant of good faith in ways

other than the wrongful denial of coverage, including, for example, by its handling of the claim. This, the trial court explained, was consistent with the notion that "an insured who believes that an insurance claim has been wrongfully denied may have available two distinct legal theories, one in contract and one in tort, each with separate, although often overlapping, elements, defenses and recoveries." Given the two distinct theories upon which the Class sought to recover, the trial court determined that it could not conclude that the resolution of the contract dispute necessarily disposed of the tort-based bad faith claim for improper claims handling.

Fifth Circuit Court of Appeals: Lulls of Inactivity In An Insurer's Investigation May Constitute Bad Faith

James v. State Farm Mutual Automotive Insurance Company, **No. 11-60458, --- F.3d ----2014 WL 321842 (5th Cir. Jan. 28, 2014).**

5th Circuit holds that an insurer may commit bad faith by periods of inactivity within an investigation of an insured's claim.

On February 3, 2006, plaintiff Faith James suffered injuries as a result of a car accident caused by the negligence of Jarvis Smith. There was no dispute that Smith caused the accident. Smith's insurer denied coverage and James submitted for the full amount of her uninsured/underinsured motor ("UM") coverage, $40,000, with her insurer, defendant State Farm Automotive Insurance Company ("State Farm"). State Farm delayed thirty (30) months before providing James with full coverage under her UM policy.

James filed suit in the Southern District of Mississippi in October 2007 and amended her complaint with a bad faith (delay) claim in February 2008. State Farm paid James the full amount under the UM policy in July 2008 and soon thereafter moved for summary judgment. The District Court granted State Farm's motion for summary judgment and this appeal followed.

The Fifth Circuit reviewed State Farm's conduct on a reasonable or arguable basis standard. State Farm argued that it had legitimate bases for its delay in paying James's claim because it reasonably investigated the claim throughout the 30-month delay. James argued that State Farm had no reasonable basis for the lengthy delay in making payment.
To determine whether State Farm had reasonable bases for its delay, the Court analyzed the 30-month delay in seven separate segments of weeks and months. Reviewing each time period for legitimate investigation activity, the Court found that there was a question of fact as to whether State Farm had a legitimate basis for delay during three of the seven time periods. The first time period ran from July 20 – October 4, 2006, during which time the Court found that State Farm took no investigatory actions, and therefore may have violated its duty to perform a prompt investigation. The second time period ran from January 17, 2007 – July 11, 2007. During this period, State Farm requested James's medical records from James's attorney, without response. However, State Farm never requested information concerning James's pre-existing injuries during this time (which was the cause of State Farm's subsequent eight-month delay). The third time period ran from March 29, 2008 – July 29, 2008, when State Farm made its payment. State Farm took no investigatory actions during this time period before it finally paid the claim in full "in an attempt to resolve and streamline issues of dispute."

This case serves as a warning to insurers that its investigations must be prompt and continuous. A several month delay in activity or several periods of inactivity within an investigation may give rise to a bad faith claim for delaying in making a payment.

Western District of Oklahoma: Bad Faith Claim May Continue Even if Insurer Offers to Investigate Before Suit is Filed

***Moore v. Allstate Ins. Co.*, No. CIV-12-652-D, 2014 WL 200777 (W.D. Okla. Jan. 17, 2014).**

Trial court rules that insurer's failure to perform inspection of insureds' home, even after making an offer to do so, before suit was filed could allow reasonable jurors to conclude that insurer's conduct was in bad faith.

Darryl and Mary Moore's home was damaged by a tornado in May 2010. The Moores submitted a claim to Allstate Insurance Company ("Allstate"), which had issued the insurance policy covering their home.

On June 25, 2010, Allstate received an engineering report from Rimkus Consulting Group, Inc. regarding the structural damages to the Moores' home. The engineer noted that it was necessary to remove the family room ceiling so that a close inspection of the wood framing of the home could be conducted. The report also advised that an engineer should be retained to conduct the inspection of the framing. On October 5, 2010, the Moores submitted their own engineer's report to Allstate. The report advised that sheet rock and insulation must be removed so that the severity of the damage could be determined through observation of the bare walls and joists.

Despite receiving two engineering reports that recommended that walls needed to be torn out to assess and repair the structural damage, Allstate did not hire or offer to hire an engineer to do the inspection work until December 2011.
In January 2012, the Moores filed suit against Allstate for breach of contract and bad faith. Allstate filed a motion for partial summary judgment as to the claims for bad faith and punitive damages, arguing that it offered to perform the inspection before suit was filed. Allstate also argued that it was reasonable for it to rely on its engineer's report, instead of the engineer's report submitted by the Moores. In addition, Allstate asserted that the Moores could not show wanton or reckless disregard for their rights such that punitive damages were warranted.

An insurer has a duty under Oklahoma law to timely and properly investigate an insurance claim, and must conduct an investigation that is reasonably appropriate under the circumstances. If there is conflicting evidence regarding the reasonableness of the insurer's conduct, it is a question of fact to be decided by the trier of fact. The District Court found that there was sufficient evidence to defeat Allstate's assertion of reasonableness. Allstate did not do or authorize the inspection that its own engineer had recommended to determine the extent of the structural damage. Although Allstate had made the offer to tear out walls in the Moores' home to determine the amount of the structural damage, by the date the lawsuit was filed, the tear-out had not been done and the Moores' home had not been repaired. Allstate also failed to make an offer for the repair of structural damage to the home. Allstate had waited 18 months after its engineer's report before agreeing to do the inspection that its own engineer had recommended. Finally, the damage to the Moores' home had been appraised in May 2011 at an amount in excess of $44,000, but the amount was never paid. The court held that reasonable jurors could find that Allstate did not conduct an investigation of the home that was reasonable under the circumstances, and that Allstate unreasonably delayed conducting a proper investigation. The court also held that reasonable jurors could find that Allstate's conduct was in reckless disregard of its duty to deal fairly and in good faith with its insureds. The court denied Allstate's motion for summary judgment.

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