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Contacts:

Matthew M. Haar
717.257.7508
mhaar@saul.com

Joseph C. Monahan
215.972.7826
jmonahan@saul.com

Amy L. Piccola
215.972.8405
apiccola@saul.com

Matthew J. Antonelli
202.295.6608
mantonelli@saul.com

A.J. Kornblith
202.295.6619
akornblith@saul.com

Patrick F. Nugent
215.972.7134
pnugent@saul.com

Meghan Talbot
215.972.1970
mtalbot@saul.com

Saul Ewing LLP

Insurance Practice

The Bad Faith Sentinel

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

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Northern District of New York: Primary Insurer That Waited Nine Years to Tender Policy Limits to Injured Plaintiff Was Liable to Excess Carrier for Bad Faith

Quincy Mutual Fire Ins. Co. v. New York Central Mutual Fire Ins. Co., No 3:12-CV-1041-DEP (N.D.N.Y. March 31, 2014)

The Northern District of New York held that a primary carrier that declined to settle an underlying lawsuit for policy limits multiple times, even in the face of evidence that damages were likely to exceed the combined limits of the primary and excess policies at issue, was liable to excess insurer for bad faith.

On November 21, 2000, Randolph Warden was in an automobile accident in upstate New York in which he failed to stop at a stop sign and struck the vehicle driven by Peggy Horton, causing her serious injuries. At the time of the accident, Warden had a Personal Automobile Liability Insurance Policy issued by New York Central Mutual Fire Insurance Company ("NYC") that provided primary coverage of $500,000. Warden also had a homeowner's policy with Quincy Mutual Fire Insurance Company ("Quincy") that provided excess liability insurance in the amount of $1 million per occurrence. Under the terms of the Quincy policy, Quincy had no obligation to indemnify or defend Warden until the limits of the underlying primary policy were exhausted or tendered.

Timely notice of the accident was provided to both NYC and Quincy, and both carriers accepted coverage. When Horton filed suit against Warden in October 2001, NYC took up Warden's defense, retaining counsel on his behalf. In December 2001, in response to a query from Quincy, a representative of NYC informed Quincy that NYC believed that its policy limits were sufficient to cover Horton's damages. Horton, however, underwent six surgeries to her back and abdomen between 2001 and 2008 that left her with permanent scars. She also suffered mental impairments from the accident, eventually being diagnosed with both Post-Traumatic Stress Disorder and depression. She was unable to return to her job as a nurse and eventually qualified for Social Security disability benefits.

In November 2004, Horton filed for partial summary judgment on the issues of liability and serious injury, and the New York Supreme Court granted her motion in May 2005. NYC directed Warden's attorney to appeal. It was not until December 2005 that NYC authorized Warden's attorney to make its first settlement offer, for $75,000, which Horton rejected. At the time, Horton's demand was $500,000, the limit of the NYC policy.

The appellate court affirmed the trial court's ruling in August 2006. At that point, only the issue of damages remained for trial. In January 2007, Horton increased her demand to $3.5 million. Soon after, Warden retained a personal attorney to monitor the case. Still, NYC kept its settlement offer at only $75,000, even after being apprised of the reports from Warden's own experts that Horton was seriously disabled. NYC also held firm in June 2007, when Horton indicated she would accept a settlement of $1.5 million, the combined limits of the NYC and Quincy policies. At that point, Horton's counsel sent a bad faith letter to NYC. Horton lowered her demand again in July to $750,000, and Quincy indicated it would pay $250,000 toward that amount if NYC tendered its limits, but NYC still refused to raise its offer. Requests from Warden's personal attorney to settle also did not change NYC's position, and NYC ignored Warden's request to be sent copies of any case evaluations.

Because of Horton's surgeries, the trial of the matter was delayed until October 2009. NYC had by this point hired new counsel for Warden and intended to try the case. In September 2009, Horton informed NYC that, in light of its failure to raise its offer above $75,000, she was withdrawing her offer to settle within Warden's policy limits. In response, NYC raised its offer to $200,000. In late September, NYC heard a verdict- potential evaluation from the lawyer it had hired to defend Warden, the first such evaluation performed by or on behalf of NYC concerning the matter in the almost nine years since the accident. At that point, NYC tendered its entire policy limit of $500,000.

Quincy, which by now also faced assertions of bad faith from Horton and Warden, then took over the settlement negotiations. The case finally settled a few weeks later for a total of $1.5 million, with both NYC and Quincy paying their full policy limits.

In June 2012, Quincy filed a bad faith action against NYC in the U.S. District Court for the Northern District of New York, alleging that NYC breached its duty as a primary carrier to an excess carrier to consider the interests of the excess carrier in deciding whether to settle. As the court recognized, this required Quincy to prove that, "had [NYC] acted in good faith throughout the negotiation process, a settlement would have been realized, and that settlement would have required Quincy Mutual to pay less than the full extent of its excess policy."

The court found that NYC acted in bad faith by losing two opportunities to settle with Horton. Citing testimony from Horton's attorney that she would have been willing to settle the case for NYC's policy limits in December 2005, the court found there was an opportunity to settle that NYC ignored. Further, it held Quincy proved that all serious doubts concerning Warden's liability had been removed by that point based on the entry of summary judgment on liability and the findings of several of Warden's own experts. Moreover, despite NYC's failure to perform its own damages evaluation of the case, the court said that NYC should have known by late 2005 based on various developments that Horton's damages would exceed $500,000. Similarly, there was also sufficient evidence to conclude that Horton would have settled in July 2007 for $750,000. By this point, NYC should have been aware that the damages had significant potential to exceed the $1.5 million available under both policies.

NYC argued that Quincy bore some blame for the failure to settle. The court rejected this argument, noting that Quincy's defense and indemnity obligations did not engage until the primary insurer, NYC, either exhausted or tendered its policy limits. The court noted that Quincy, as an excess carrier, did not have a duty to supervise the primary insurer.

As a result of NYC's bad faith, the court ruled that Quincy was entitled to recover its entire $1 million policy limit from NYC.

Middle District of Pennsylvania: Neither Unprofessionalism of Lower-Level Claims Employees Nor Failure to Interview Insured's Employees Alone Constitutes Bad Faith

Honesdale Volunteer Ambulance Corp. Inc. v. Am. Alternative Ins. Corp., CIV.A. 3:11-1488, 2014 WL 1203317 (M.D. Pa. Mar. 24, 2014)

Middle District of Pennsylvania grants summary judgment on bad faith claim where insurer responded to the claim the day after it was made, twice investigated the building in question, acceded to insured's request to review its decision, and reasonably relied upon its expert engineer's report.

On June 23, 2010, an earthquake allegedly damaged Honesdale Volunteer Ambulance Corporation's ("Honesdale EMS") property. On the day of the earthquake, workers at the Honesdale EMS building reported feeling the building shaking and hearing squeaking noises from the walls. They evacuated the building, and, once outside, found issues with the building that Honesdale EMS contended were not preexisting. This damage included cracks in the masonry, loose bricks on window arches, and the window at the top of the west gable wall being dislodged and appearing to be falling into the building. The building was condemned on that day after a preliminary inspection by the town code enforcer accompanied by an engineer.

The day after the earthquake, Honesdale EMS reported its claim to its insurer, American Alternative Insurance Corporation's ("AAIC"). AAIC hired an independent adjustment company, Gerald Williams Adjustment Service ("Gerald Williams"), to assist in investigating the claim. On June 24, 2010, an adjuster from Gerald Williams inspected the property. The following day, Michael H. Queen, P.E., an engineer engaged by AAIC, performed an initial inspection of the building. Queen concluded that the building had not been damaged as a result of the earthquake. Based on the initial inspections, AAIC denied Honesdale EMS's claim on July 9, 2010. Honesdale EMS requested additional consideration of the claim following the July 9 denial, and AAIC agreed to consider the claim further. The building was re-inspected on July 23, 2010. Queen submitted a supplemental report addressing the re-inspection and an engineer's report submitted by Honesdale EMS, and again concluded that the building was not damaged as a result of the earthquake. As a result, AAIC maintained its prior denial of the claim on August 10, 2010.

Following the second denial of the claim, Honesdale EMS sued AAIC for breach of contract and bad faith. Honesdale EMS alleged that AAIC determined that it would deny the claim before making any investigation, that AAIC's investigators ignored the testimony provided by those present in the building on the day of the earthquake, and that AAIC failed to conduct a proper investigation of Honesdale EMS's claim. AAIC filed a motion for summary judgment on both claims

With respect to Honesdale EMS's bad faith claim, the district court found that Honesdale EMS had not met its "substantial burden of showing by clear and convincing evidence that defendant acted in bad faith." The court noted that "[f]irst, and most importantly, an insurer's reasonable reliance on an engineering expert's report for a coverage decision does not constitute bad faith." The court discussed Queen's inspection of the building independently two days after the earthquake, and his re-inspection of the building in July, noting that his "opinion was consistent throughout" this process.

Moreover, the court gave no weight to the objectionable attitudes and behaviors of the other Gerald Williams employees. Employees for Honesdale EMS's insurance agent testified that one of the Gerald Williams employees was an "advocate for non-payment," that he was abrasive and unprofessional, and that he used foul language and expletives. Further, Gerald Williams's employees had referenced anonymous blog posts critical of executive director of Honesdale EMS, and newspaper articles indicating that EMS had been attempting to relocate from its current building for some time. The testifying witness believed that the Gerald Williams employee was using those posts and items as justifications for not paying the claim.

The court held that the plaintiff put "forth no evidence that [engineer] Mr. Queen shared in this behavior or otherwise acted in a biased or improper way." Rather, Queen's reports were indicative of having undertaken a reasonable investigation, and therefore it was reasonable for AAIC to rely on those reports. Likewise, the court found that the unprofessional behaviors of Gerald Williams employees were not indicative of bad faith where the Honesdale EMS could not show that those employees had responsibility for the coverage decision; "[t]he attitude of a lower level claims representative, who lacked the authority to make final decisions on the claim and who handled the claim preliminarily, is not enough to show bad faith." The court also held that looking at anonymous blog posts was not evidence of bad faith; there is no case law in the Third Circuit or Pennsylvania prohibiting claim investigators from researching on the internet.

Finally, the court rejected the argument that AAIC's investigation was inadequate because the employees working in the building on the day of the earthquake were not interviewed by defendant. While acknowledging that interviewing the employees may have been helpful in evaluating the claim, the court stated that the defendant "need not show that the process used to reach its conclusion was flawless or that its investigatory methods eliminated possibilities at odds with its conclusion. Rather, an insurance company simply must show that it conducted a review or investigation sufficiently thorough to yield a reasonable foundation for its action."

Eastern District of New York Dismisses Bad Faith Claims in Dispute Over Property Damage Caused by Hurricane Sandy

433 Main St. Realty, LLC v. Darwin Nat'l Assurance Co., No. 14-cv-587 (NGG) (VMS) (E.D.N.Y. Apr. 22, 2014)

Eastern District of New York dismisses claims for breach of the covenant of good faith and fair dealing and violation of § 349 of the New York State General Business Law, regarding deceptive business practices, in dispute arising from property damage caused by Hurricane Sandy.

433 Main Street Realty, LLC and Cord Meyer Development Company (collectively, "433 Main") are owners of a construction project for a residential building located in Port Washington, New York. Darwin National Assurance Company issued a commercial inland marine insurance policy to 433 Main. The policy contains a $10,000 deductible, except for loss caused by flood, which is subject to a $250,000 deductible. 433 Main claimed that, on October 29, 2012, high winds from Hurricane Sandy blew down or damaged fencing, formwork, and the waterproof membrane at the construction site, and water backed up in a nearby sewer, causing it to overflow and discharge water into the excavated foundation. 433 Main filed a claim for coverage of their loss. Darwin agreed that the policy covers 433 Main's loss, but insisted that the damage was caused by flood, and thus the $250,000 deductible applies. 433 Main argued that the standard $10,000 deductible applies because high winds and the overflow of a sewer system caused the damage.

For eight months following Hurricane Sandy, Darwin refused to issue payment to 433 Main. 433 Main threatened litigation, then met with Darwin's claims adjuster, who requested additional documentation. Darwin made subsequent requests for documents over the next four months, which 433 Main claims it satisfied. 433 Main believed Darwin was delaying and did not intend to honor the claim. 433 Main then commenced this action in the Supreme Court of New York, and Darwin removed to federal district court. 433 Main sought a declaratory judgment that the policy's $10,000 general deductible applies to its claims and allege breach of contract, breach of the covenant of good faith and fair dealing, and violations of § 349 of the New York State General Business Law, which prohibits "deceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in [New York]."

The case was designated a "Hurricane Sandy Case" and subject to a case management order directing plaintiffs in

Hurricane Sandy cases to voluntarily withdraw various state law claims, including those alleging bad faith, or submit a letter explaining the legal basis for continuing to pursue such claims. 433 Main submitted such a letter in support of its claims for breach of the implied covenant of good faith and fair dealing and violation of New York General Business Law § 349. Darwin contended that 433 Main has not adequately pleaded these claims. The District Court agreed and dismissed both claims without prejudice.

New York law implies into every express contract a duty of good faith and fair dealing. New York law does not, however, recognize a separate cause of action for breach of the implied covenant of good faith and fair dealing when a breach of contract claim, based upon the same facts, is also pled. 433 Main labeled Darwin's conduct as "mishand[ling]" or "unreasonable delay" but failed to substantiate these conclusions with facts showing bad faith that differed from the facts supporting their breach of contract claim. The court therefore dismissed without prejudice 433 Main's claim for breach of the covenant of good faith and fair dealing as redundant.

To state a claim under § 349 of the New York General Business Law, a plaintiff must allege that "(1) the act or practice was consumer-oriented; (2) the act or practice was misleading in a material respect; and (3) the plaintiff was injured as a result." Monetary loss may satisfy the injury requirement, but only if that loss is independent of the loss caused by the alleged breach of contract. Here, the court found that 433 Main did not state any specific facts concerning loss or injury caused by Darwin's allegedly deceptive acts, lacking most importantly any allegations of how the injury is independent from the loss caused by Darwin's alleged breach of contract. The court therefore also dismissed without prejudice 433 Main's claim for violation of New York General Business Law § 349.

Northern District of Iowa: Litigation "Reasonably Foreseeable" After Insured Accuses Insurer of Acting in Bad Faith

Meighan v. TransGuard Ins. Co. of Am., Inc., **No. C13-3024-MWB, 2014 WL 1199596 (N.D. Iowa Mar. 24, 2014)**

The Northern District of Iowa finds that claim reserves and settlement information created after litigation was reasonably foreseeable is protected by the work product doctrine, but that documentation of an insurer's factual investigation and surveillance of the insured must be produced.

TransGuard Insurance Company of America, Inc. began making benefits payments to Michael Meighan in November 2011, after Meighan sustained injuries covered by his occupational injury policy. TransGuard ceased making payments in early 2012 because of Meighan's failure to provide TransGuard with updated medical records. TransGuard resumed making payments after discussions with Meighan's attorney, including a discussion in which the attorney accused TransGuard of acting in bad faith. TransGuard's payments continued for a little more than a month, again stopping payment after a doctor reported that Meighan's disability resulted from a pre-existing condition, not his on-the-job injury. After TransGuard denied his claim, Meighan filed suit in the Northern District of Iowa alleging breach of contract and bad faith.

During discovery, TransGuard produced its complete claims file for the period from October 28, 2011 through March 9, 2012, the day that Meighan's attorney first contacted TransGuard to inquire why TransGuard had ceased making disability payments. TransGuard produced the remainder of its claims file in heavily redacted form. The redacted portions of the file consisted of three categories of documents: 1) claim reserves information; 2) communications related to settlement or mediation; and 3) communications regarding investigation and coverage. TransGuard claimed that the documents it redacted and withheld were protected work product or were subject to attorney-client privilege. Meighan filed a motion to compel and argued that the privilege did not apply because TransGuard's outside counsel's work consisted of investigating and adjusting the claim rather than giving legal advice.

In considering Meighan's motion to compel, the Court was first required to determine the date on which: (1) TransGuard and its counsel established an attorney-client relationship; and (2) litigation between the parties became "reasonably foreseeable." First, the Court concluded that TransGuard and its outside counsel established an attorney-client relationship when counsel accepted TransGuard's request for "legal assistance" in "handling the file" on March 12, 2012. Next, the Court found that litigation was "reasonably foreseeable" on March 13, 2012, when Meighan accused TransGuard of acting in bad faith.

With respect to TransGuard's claims of work product protection, the Court found that claim reserves information that was noted in the file after March 13, 2012 was protected work product. In so doing, the Court explained that the Eighth Circuit draws a distinction between individual case reserves, which are typically prepared in anticipation of litigation and thus protected from discovery, and aggregate reserve information used for business-planning purposes. The Court held that because the withheld reserves information was related to Meighan's particular claim and was documented after litigation was reasonably foreseeable, it was protected regardless of the fact that a non-attorney claims adjuster documented the information.

The Court also held that all documents, including file notes regarding settlement authority, created prior to the date that litigation became reasonably foreseeable had to be produced. Any documents concerning settlement and mediation created after that date, however, were prepared in anticipation of litigation and protected as work product. The third category of documents for which TransGuard claimed work product protection were related to surveillance of Meighan and to TransGuard's investigation of the extent and nature of Meighan's injuries. The Court found that while these documents were created after the date that litigation became reasonably foreseeable, they consisted of "pure factual investigation of the claim" and were therefore not prepared in anticipation of litigation.

Meighan also moved to compel certain communications between TransGuard employees and outside counsel that TransGuard claimed were protected from disclosure by the attorney-client privilege. Meighan argued that TransGuard hired the outside attorney to step into the shoes of the claims adjuster to perform a non-legal investigation and adjustment of the claim. The Court rejected Meighan's argument and held that the correspondence at issue was protected by attorney-client privilege. Central to the Court's reasoning was the adversarial relationship between the parties and the fact that TransGuard conducted the initial investigation on its own and only retained outside counsel after Meighan's attorney became involved. The Court noted that if attorney-client privilege did not apply in this situation, this would have a chilling effect on an insurer's decision to seek legal advice regarding close coverage questions.

Update: Supreme Court of Pennsylvania Accepts Third Circuit's Certified Question on Assignability of Statutory Bad Faith Claims

As reported in the April edition of the *Bad Faith Sentinel*, the Third Circuit Court of Appeals petitioned the Supreme Court of Pennsylvania to decide whether an insured tortfeasor can assign his or her statutory bad faith claim against an insurer to an injured third party. On April 24, 2014, the Supreme Court granted the Third Circuit's Petition. Briefing from the parties to the underlying suit is anticipated later this summer. In addition, the Supreme Court has invited the Pennsylvania Insurance Commissioner to file an *amicus curiae* brief. *Allstate Prop. & Cas. Ins. Co.*, No. 39 MAP 2014 (Pa.)

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Baltimore, MD 500 East Pratt St. Charles O. Monk, II 410.332.8668
Boston, MA 131 Dartmouth St. Richard D. Gass 617.723.3300
Chesterbrook, PA 1200 Liberty Ridge Dr. Michael S. Burg 610.251.5750 Nathaniel Metz 610.251.5099
Harrisburg, PA 2 North Second St. Joel C. Hopkins 717.257.7525
Newark, NJ One Riverfront Plaza Stephen B. Genzer 973.286.6712
New York, NY 555 Fifth Ave., Michael S. Gugig 212.980.7200
Philadelphia, PA 1500 Market St. Bruce D. Armon 215.972.7985
Pittsburgh, PA One PPG Place Charles Kelly 412.209.2532 David R. Berk 412.209.2511
Princeton, NJ 750 College Rd. E Marc A. Citron 609.452.3105
Washington, DC 1919 Pennsylvania Ave, NW Mark L. Gruhin 202.342.3444 Andrew F. Palmieri 202.295.6674
Wilmington, DE 222 Delaware Ave. Wendie C. Stabler 302.421.6865 William E. Manning 302.421.6868