FirstLook

Issues and Developments in Insurance Law

STEPTOE & JOHNSON

A word from the Insurance Company Team

According to the FBI, "The total cost of insurance fraud (non-health insurance) is estimated to be more than $40 billion per year. That means Insurance Fraud costs the average U.S. family between $400 and $700 per year in the form of increased premiums." https://www.fbi.gov/stats-services/publications/insurance-fraud (Retrieved on April 14, 2020). According to the NICB (National Insurance Crime Bureau), "[a] good number of potentially fraudulent claims are paid each year without being investigated due to the desire and requirements to make payments in a timely fashion and the difficulty in proving fraud. As a result, we only see a small percentage of those claims—and an even smaller percent are ever prosecuted." https://www.nicb.org/news/blog/just-how-much-fraud-there-p-c-industry (Retrieved on April 14, 2020).

An effective tool for claim investigation is the EUO (Examination Under Oath). This issue is designed to provide a "First Look" at EUOs, from EUO notice requirements, through some ways to use EUOs, to pitfalls that can occur from their usage. Katherine Smith's article will provide EUO notice requirements and other practical considerations, while Mitch Moore's article will discuss the delicate matter of SIUs and working with law enforcement during investigations. Gregory Jackson's article outlines one case in Kentucky where an EUO was used effectively, and the need for support such as that found in an EUO in some aspects of Kentucky PIP (personal injury protection) claims.

In short, this issue will highlight how an EUO is an invaluable tool in an insurer's toolbox. Members of the Insurance Company Team are here to help if you should have any questions about securing EUO testimony.

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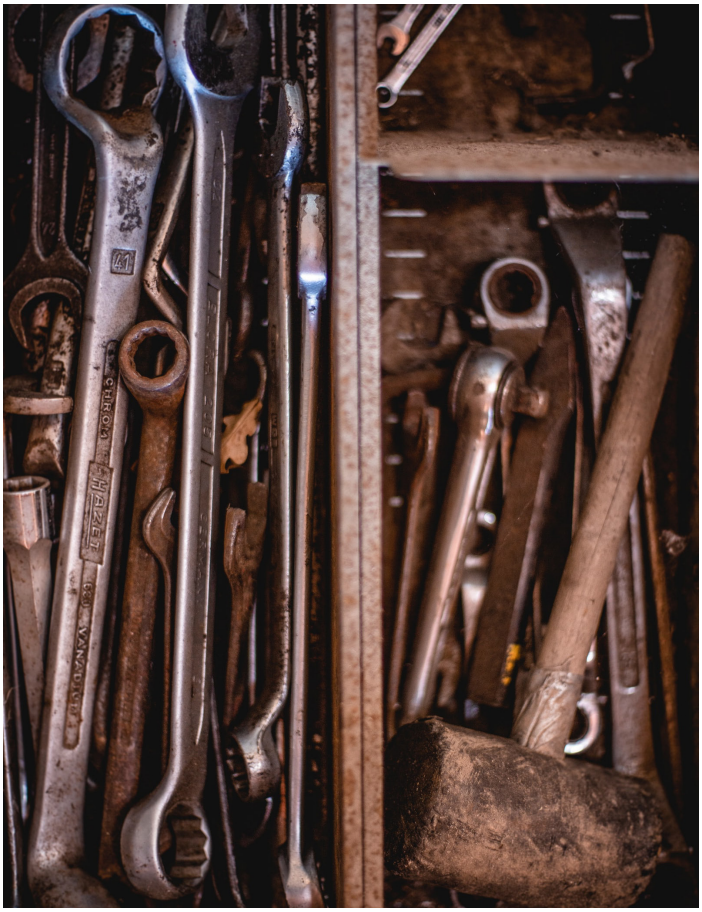
EUO—A necessary tool in every insurer's toolbox



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IN THIS ISSUE

Examinations Under Oath: Notice Requirements and Practical Considerations

By Katherine M. Smith

An examination under oath ("EUO") is a very useful tool for insurers to obtain relevant and material information from their insureds about the circumstances surrounding an alleged loss. Importantly, an EUO enables the insurer to explore the facts of the underlying loss and determine its obligations under the policy.[1] It also allows for discovery into whether a submitted claim is false or fraudulent.[2] Moreover, an EUO may be used strategically to impeach testimony in future litigation.[3] This article addresses the information required to be present in EUO notices, as well as other general, practical considerations for the effective utilization of EUOs.

EUO Notice Requirements and Best Practices

If an insurer intends to examine its insured under oath, it is required to provide notice prior to the examination. The notice should be in writing and must be provided to the individual insured and his or her attorney.[4] In addition, the following information must be provided in every EUO notice:

- the name of the insured, or the insured's representative, who will be examined, and
- the date, time, and location of the examination.[5]

The time and location of the examination must be reasonable and convenient,[6] and it is typically taken in the county where the property is insured, the county where the loss occurred, or another location mutually agreed upon by the insurer and insured.[7]

Although not mandatory, it is good practice to quote the applicable policy language regarding EUOs and provide a list of documents requested to be produced by the insured.[8] In addition to, or in lieu of, a request for document production, the insurer may obtain the insured's execution of a release that the insurer may use to obtain documents from third parties such as banking institutions.[9]

Insurers should make efforts to conduct their investigations, make contact with their insureds, and provide notices of EUOs as soon as possible after the event triggering the insured's alleged loss.[10] This is because some courts have held that when an insurer fails to notice an EUO within a "reasonable time" after the insured's submission of his or her claim, the insured is under no duty to participate or cooperate in the investigation.[11] Whether the passage of time is reasonable is a fact-specific inquiry and varies from case to case.

For example, in *Lorenzo-Martinez v. Safety Insurance Company*, the Massachusetts Appeals Court found the passage of nine months prior to an insurer's request for an EUO to be reasonable because, prior to the request, the insurer made seven separate attempts to obtain a recorded statement, which were all ignored by the insured.[12] Dissimilarly, in the same case, the court found the passage of thirteen months prior to another insurer's request for an EUO to be unreasonable where there was no evidence that the insurer "made any attempt to contact [its insured] or investigate her claim after receipt of her notice of claim."[13] Thus, a court's determination of whether a particular passage of time before requesting an EUO is reasonable will likely hinge on the insurer's promptness in commencing its investigation and attempted contact with its insured.

It should be noted that in West Virginia, § 114-14-6.2(b) of the Code of State Rules requires insurers, within fifteen (15) working days of receiving notice of a claim, to "provide to every first-party claimant, or to the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant."[14] It is possible that this Section could be construed to apply to an insurance company's notice of the need for EUOs.

Some courts, though it appears not many, have found EUOs unnecessary when certain other examinations have been taken, or when the EUO requirement is not material to the investigation or handling of the claim.[15] For example, in *Mier v. Niagara Fire Insurance Company*, the United States District Court for the Western District of Louisiana held that "[t]he purpose of the oral examination of the insured is to protect the insurer against fraud," and, thus, an examination performed by a state fire marshal in tandem with "a party acting not for the [fire marshal], but rather on behalf of the insurer" who "assist[ed] the marshal in his investigation" amounted to an examination by the insurer

for the purpose of fulfilling the oral examination clause of the policy.[16] In addition, in *Puckett v. State Farm General Insurance Company*, the Supreme Court of South Carolina held that, in light of the specific terms of the policy at issue, the court would not construe the EUO provision to establish a condition precedent to suit because doing so "would effect an absolute forfeiture of coverage," and "[f]orfeitures of insurance contracts are not favored in South Carolina."[17] Instead, the court held "that an insured's failure to cooperate may bar recovery under a policy where the insurer can show prejudice therefrom."[18] Finally, in *Staples v. Allstate Insurance Company*, the Supreme Court of Washington held that "[g]iven the quasi-fiduciary nature of the insurance relationship, we hold that if an EUO is not material to the investigation or handling of a claim, an insurer cannot demand it."[19]

Practical Considerations for Conducting EUOs

In general, EUOs are broad in scope[20] and may include questioning that is related to all matters "relevant and material" to the alleged loss.[21] In other words, EUO questioning "is not restricted to amount of loss."[22] Permitted topics include those related to potential motives for the alleged loss, such as the insured's financial circumstances and claim history.[23] Other material matters are those that aid in determining whether a policy exclusion applies, thereby negating insurer liability.[24]

Disclosure of relevant and material information may be requested and required even in the face of an insured's assertion of his or her Fifth Amendment right against self-incrimination.[25] For example, in *U.S. Specialty Insurance Company v. Skymaster of Virginia*, the insured refused to answer questions regarding his medical certificate, which he was required to maintain as a condition under his insurance policy.[26] As bases for his refusal, he argued that such questions were immaterial "and that he had a right to invoke the Fifth Amendment."[27] The Fourth Circuit Court of Appeals held that the insured could "not rely on the Fifth Amendment to avoid a contractual obligation to cooperate by submitting to an EUO."[28] Specifically, the Court acknowledged that, although insureds may choose to invoke the Fifth Amendment, that invocation "may ultimately cost them insurance coverage under the terms of the contract for which they and [the insurer] bargained."[29]

Indeed, refusing to answer any questions based on the invocation of the Fifth Amendment may be a violation of the insurance policy's "cooperation" clause.[30] Relatedly, refusing to answer *material* questions—regardless of whether the refusal to answer is based on the insured's assertion of his or her Fifth Amendment rights—is also likely a violation of the cooperation clause. This is because EUOs are subject to contract—not process.[31] "There are numerous occasions in which investigation of an insurance claim takes place at the same time as an investigation by a law enforcement agency concerning the criminal components of a particular claim."[32] In these instances, if the insurer decides to "mov[e] forward with its investigation and determines that the timing is correct for an Examination Under Oath, the insured must make a choice as to whether or not to submit to such an Examination Under Oath . . . and carefully attempt to avoid answering questions that may appear to . . . provide incriminating information and thus the accompanying need to attempt to assert a 5th Amendment privilege against self-incrimination."[33] In such cases, "[t]he case law . . . is heavily favorable to insurance carriers."[34] Various courts have repeatedly "rejected the contention that the insured should be excused or justified in not submitting to an Examination Under Oath or in refusing to answer material questions asked at the examination on the basis that the insured was exercising his or her privilege against self-incrimination."[35] Just as with any contract, if an insured fails to fulfill his or her duties thereunder (*e.g.*, fails to cooperate in answering questions and providing testimony under oath as required by the policy's cooperation clause), then the contract may be void.[36] In summary, an insured's refusal to answer relevant and material questions during examination, even after invoking the Fifth Amendment, can void the obligation to provide coverage under the policy, and the insurer may rightfully decline to pay the claim.

In contrast, questions regarding losses not covered under the policy and amounts of the insured's other insurance settlements have been found to be immaterial and impermissible topics of inquiry.[37]

In conclusion, insurers should look to EUOs with favor and utilize them in a prompt manner to obtain valuable information that will aid their loss investigations. Eliciting sworn testimony from insureds is a powerful tool for resolving questions of false claims, assessing the applicability of certain policy exclusions, and determining insurer obligations under specific policy provisions.

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1 *See, e.g.*, *Claflin v. Commonwealth Ins. Co.*, 110 U.S. 81, 94–95, 3 S. Ct. 507, 515 (1884) (explaining that the purpose of an examination under oath is to "enable the company to possess itself of all knowledge, and all information as to other sources and means of knowledge, in regard to the facts, material to [its] rights, to enable [it] to decide upon [its] obligations, and to protect [it] against false claims").
2 *See id.*
3 *See, e.g.*, *United States v. Gibson*, 84 F. Supp. 2d 784, 789 (S.D. W. Va. 2000).
4 13A Couch on Insurance § 196:9 (3d ed.) (updated through June 2019); 1 Law and Prac. of Ins. Coverage Litig. § 3:27 (June 2019 update).
5 *See* Couch, *supra note* 4, at § 196:8; *see also* W. Va. Code § 33-2-4(c)(2).

6 *See* Couch, *supra note* 4, at § 196:8; Law and Prac., *supra note 4*, at § 3:46.
7 *See, e.g.*, Couch, *supra note* 4, at § 196:16; Law and Prac., *supra note 4*, at § 3:27; 16 A.L.R. 5th 412 §§ 2[b], 19[b] (originally published in 1993); Benjamin Love, *Components of an Effective Examination Under Oath*, 23 No. 13 Ins. Litig. Rep. 393 (2001); Michael A. Hamilton, *Property Insurance: A Call for Increased Use of Examinations Under Oath for the Detection and Deterrence of Fraudulent Insurance Claims*, 97 Dick. L. Rev. 329, 337 (Winter 1993).
8 *See* Law & Prac., *supra note* 4, at § 3:21.
9 *See id.*
10 *See, e.g.*, *Knight v. CNA Ins. Co.*, 2003 Mass. App. Div. 198, 2003 WL 22962439, at *4 (Mass. Dist. Ct. 2003).
11 *See, e.g.*, *Lorenzo-Martinez v. Safety Ins. Co.*, 58 Mass. App. Ct. 359, 790 N.E.2d 692 (Mass. App. Ct. 2003); *Knight*, 2003 WL 22962439, at *4.
12 *See Lorenzo-Martinez*, 58 Mass. App. Ct. at 364–65, 790 N.E.2d at 696–97.
13 *See id.* at 366, 790 N.E.2d at 697.
14 W. Va. Code St. R. § 114-14-6.2(b).
15 *But see Hamilton v. State Farm Fire and Cas. Co.*, No. 11-00024, 2011 WL 5078963, at *2 (E.D. La. Oct. 24, 2011) (finding insureds failed to uphold their obligations under the insurance policy when they provided statements but refused to submit to examinations under oath); *Staples v. Allstate Ins. Co.*, 176 Wash.2d 404, 424, 295 P.3d 201, 211 (Wash. 2013) (differentiating between unsworn examination and an EUO and advising that the former does "not constitute sufficient compliance with the provisions of the policies to excuse appellant after demand made upon it to submit to examination under oath" (internal quotation and citation omitted)); *Thomson v. State Farm Ins. Co.*, 232 Mich. App. 38, 50–51, 592 N.W.2d 82, 88 (Mich. Ct. App. 1998) (emphasizing "that in future cases it will not be sufficient to volunteer, or even to participate in giving, unsworn statements to the insurer"); *see also Watson v. Nat'l Sur. Corp. of Chicago*, 468 N.W.2d 448, 451–52 (Iowa 1991) (collecting cases).
16 *See* 205 F. Supp. 108, 110 (W.D. La. 1962).
17 314 S.C. 371, 374, 444 S.E.2d 523, 524 (S.C. 1994).
18 *Id.*; *see also Roberts v. Am. Gen. Prop. Ins. Co.*, 81 F.3d 151, at *3 (4th Cir. 1996) (unpublished table decision) (affirming jury verdict returned in favor of insured and against insurer, in part, because, although insured did not submit to examination under oath prior to filing lawsuit against insurer, the insured's deposition was taken and the insurer did not show any prejudice).
19 176 Wash.2d 404, 414, 295 P.3d 201, 206–07 (Wash. 2013).
20 *See* Couch, *supra note* 4, at § 196:11 (advising that, although questions should be tailored to facts and information that are "relevant and material to the loss," the insurer is "entitled to conduct a *searching* examination" (emphasis added)).
21 *See id.*
22 *Powell v. U.S. Fid. & Guar. Co.*, 88 F.3d 271, 273 (4th Cir. 1996) (internal quotation omitted) (quoting 5A John A. Appleman & Jean Appleman, Ins. Law & Prac. § 3552, at 561).
23 *See id.* at 273–74.
24 *U.S. Specialty Ins. Co. v. Skymaster of Va.*, 26 F. App'x 154, 158 (4th Cir. 2001) ("The potential existence of an exclusion negating liability for an insurer is a material matter.").
25 *See id.* at 157–58.
26 *See id.* at 156.
27 *See id.* at 157.
28 *Id.* at 158.
29 *See id.* (internal quotation omitted) (quoting *Powell*, 88 F.3d at 274).
30 *See generally Duty to Cooperate*, The Claims Adjuster's Automobile Liability Handbook § 2:13 (Aug. 2019 update) ("Standard insurance policies require the insured to cooperate with the insurance company in the investigation, settlement, or defense of a claim or suit. This assistance is required by the policy's 'cooperation' clause."); *Cooperation with Insurer Under First-Party Contracts*, Miss. Ins. Law and Prac. § 9:1 (June 2019 update) ("Duties of cooperation include the duty to submit to an examination under oath, the duty to respond to reasonable requests for information and documents, and the duty of candor which would prohibit the insured from concealing material information from the insurer or from providing false information in support of the insured's claim."). Cooperation clauses are commonly found in insurance policies and their validity has become well established. *See, e.g.*, *Stover v. Aetna Cas. and Sur. Co.*, 658 F. Supp. 156, 159 (S.D. W. Va. 1987) ("The reason for including a cooperation clause in the policy and for conducting examinations pursuant to it is obvious enough. The company is entitled to obtain, promptly and while the information is still fresh, all knowledge, and all information as to other sources and means of knowledge, in regard to the facts, material to their rights to enable them to decide upon their obligations, and to protect them against false claims." (internal quotation and citation omitted)). An insured's failure to cooperate may be "manifested," for example, "by a refusal to submit to an examination under oath." *Id.* (citations omitted).
31 *See generally* Law and Prac., *supra note 4*, § 3.1 ("Insurance policies written in this country contain certain rights, responsibilities, and obligations apportioned between the insurance company and the insured.").
32 Benjamin Love, *Components of an Effective Examination Under Oath*, 23 No. 13 Ins. Litig. Rep. 393 (2001).
33 *Id.*
34 *Id.*
35 *Id.*
36 *See, e.g.*, *U.S. Fid. & Guar. Co. v. Wigginton*, 964 F.2d 487, 491 (5th Cir. 1992) (stating that "[c]onstitutional immunity has no application to a private relationship arising out of a contractual relationship" and holding that the insured's "failure to submit to examination voided the policy as a matter of Mississippi law"); *Pervis v. State Farm Fire and Cas. Co.*, 901 F.2d 944, 947 (11th Cir. 1990) (holding that the insured who "seeks to recover proceeds based on the insurance contract to which he is a party . . . must be held to the express terms of the agreement. He is not compelled to incriminate himself. He is, however, bound by the provisions to which he stipulated when he signed the insurance agreement and cannot expect State Farm to perform its obligations under the contract, by being subject to suit for payment of proceeds, without compliance on his part."); *Saucier v. U.S. Fid. & Guar. Co.*, 765 F. Supp. 334, 336 (S.D. Miss. 1991) ("[T]he plaintiff failed to submit to an examination under oath, and that failure was not legally excused. Under the law of Mississippi, then, the insurance policy at issue is void . . . .").
37 *See* Couch, *supra note* 4, at § 196:11.

Kentucky Supreme Court Finds Contradictory EUO Testimony Support IME & Signals Increased Scrutiny of PIP Denials for Lack of Causation

By Gregory A. Jackson

The Kentucky Supreme Court recently found that an examination under oath ("EUO") provides good cause for ordering an independent medical examination ("IME") where the insured's testimony creates a reason to question the relation of the claimed injuries to the accident. In the unreported case *Streeval v. Edwards*, Allstate Property & Casualty Insurance Co. ("Allstate") questioned whether Jeffery Streeval's injury was caused by the subject accident for which he sought basic reparations or PIP benefits.[1] Allstate initially petitioned the trial court for an examination under oath pursuant to KRS 304.39-280(3), which was granted. During his examination, Streeval testified that he did not feel the claimed leg pain for two to five days after the accident and that he experienced similar pain many years prior after a work accident. Thereafter, Streeval counterclaimed for PIP benefits, and Allstate moved for a Kentucky Rule of Civil Procedure 35.01 IME based on Streeval's testimony. After the trial court granted Allstate's motion, Streeval sought a writ of prohibition with the Court of Appeals to prevent enforcement of the trial court's order. When the Court of Appeals denied his writ, he appealed to the Kentucky Supreme Court.

Under Kentucky Rule of Civil Procedure 35.01, the movant must affirmatively show there is good cause for ordering an IME. This requires a showing that necessary additional information will be gleaned from the IME and that there is no other way to obtain the information. After review of the EUO testimony, the Kentucky Supreme Court concluded that Streeval's contradictory EUO testimony created a question of causation supporting an IME and establishing good cause.

More importantly, however, the Kentucky Supreme Court opined on its April 2019 *Government Employees Insurance Company v. Sanders* ruling, demonstrating a willingness to expand that ruling to causation of claimed injuries and potentially making denying PIP more difficult in Kentucky.[2] The *Streeval* Court stated that "arguably a mere record review would not be sufficient to deny benefits based on a belief that the automobile accident did not cause the injury."[3] Although an IME may be appropriate where good reason to question causation exists, the Court noted there was little difference between challenging PIP benefits for causation and the necessity of medical treatment received. This language indicates the Court's recent shift on PIP benefits may soon be expanded, at least partially, to controversies where the relation of the claimed injury to the accident is questioned. However, the cases indicate any expansion may be limited to a prohibition on medical records review denials, with IMEs being permitted to challenge causation of claimed injuries.

The Kentucky Supreme Court altered the Kentucky PIP claims landscape when it issued its *Sanders* opinion in April 2019. Demonstrating its displeasure with the carrier's treatment of two PIP claims, the Court held that the Kentucky Motor Vehicle Reparations Act ("KMVRA") prevented carriers from relying on medical records reviews to deny benefits based on a belief that treatment was not necessary. Instead, carriers must pay for treatment received and seek recourse for any improperly paid benefits later.

In *Sanders*, Jordan Sanders and Anita Houchens were both injured in a July 28, 2011, car accident.[4] Both saw chiropractors for injuries they sustained in the accident and submitted bills to Government Employees Insurance Company ("GEICO") for payment under their PIP coverage. Around the middle of October, GEICO retained a third-party medical consulting company to review Houchens's and Sanders's medical records.

An orthopedic surgeon reviewed Houchens's records and determined her treatment after August 17, 2011, was not reasonably necessary. Relying on the surgeon's review of medical records, GEICO notified Houchens on November 15, 2011, that it was cancelling her PIP benefits retroactively to October 14, 2011. As a result, GEICO paid $4,442 for Houchens's treatment, and left Houchens liable for a balance of $4,710. Similarly, an orthopedic surgeon also reviewed Sanders's records and found her treatment became unnecessary after September 28, 2011. After paying $3,680 in benefits, GEICO retroactively terminated Sanders's PIP benefits effective September 28, 2011, and left Sanders with an outstanding bill of $3,680 for her treatment.

The Kentucky Supreme Court held the denials were improper because the KMVRA created a presumption that treatment for an injury and the resulting medical expense were reasonably necessary.[5] The Court further found that the KMVRA created a legal presumption that only a court could rebut. Accordingly, a carrier could not unilaterally deny PIP benefits because it believed a claimant's treatment or the bills were

not reasonably necessary based on a review of medical records:

> If the medical bill submitted is presumed to be reasonable, what is required for GEICO to be able to overcome the presumption? The presumption is enough to establish a starting point that the medical treatment is reasonably needed and the bill is reasonable for what has been provided, as "a presumption imposes on the party against whom it is directed the burden of going forward with evidence to rebut or meet the presumption...." KRE 301. Since a legal presumption must be overcome in order to deny a medical bill or expenses, an action would have to be filed with the courts—and GEICO would be required to present evidence to rebut said presumption. Because the bills are presumed reasonable, this would prevent GEICO from unilaterally denying medical treatment or bills based upon a paper review of the medical record, or a mental or physical examination. To hold otherwise and to yield to GEICO's position would, as the Court of Appeals opined, "essentially make [GEICO] the judge, jury and executioner." As that court stated, "[w]e are of the opinion that such violates the intent and purpose of Kentucky's MVRA."[6]

Turning back to the KMVRA, the Court went further, finding that carriers "must pay based on the statutory presumption."[7] In the event an invoice for medical treatment misrepresented the need for the treatment, the reasonable cost of the treatment, or any other material fact, the carrier could bring an action to recover its payment for improper benefits later. The purpose of the KMVRA required prompt payment of medical invoices. This required carrier to pay first and seek "recovery of any improper payment … by filing an action in court … against the party who made the misrepresentation of material fact causing the improper payment."[8] In most cases, the Court conjectured, this would be the medical providers, but, where a claimant misrepresented material facts or knew of a misrepresentation, the carrier could sue the claimant for recovery of improper payment of benefits. In sum, the Court interpreted the KMVRA as requiring carriers to pay PIP benefits first and try to recover improper payments after the fact—making denial, based on a belief that medical treatment or bills were not reasonably necessary, nearly impossible.

Notably, however, GEICO did not challenge whether the claimants' injuries were caused by the July accident. As causation was not at issue in *Sanders*, the door was left open for denial of PIP claims based on a lack of causation. As noted above, however, the Court's recent unreported *Streeval* decision suggests Kentucky is on the path to making denials for causation somewhat mirror the approach outlined in *Sanders*.

In *Streeval*, the Court opined on its *Sanders* ruling:

> Earlier this year, this Court issued its opinion in *Gov't Employees Ins. Co. v. Sanders* holding that insurers cannot deny basic reparations benefits based only on a paper review of the medical record. 569 S.W.3d 923, 928 (Ky. 2018), *reh'g denied* (Apr. 18, 2019). In *Sanders*, the issue was the necessity of the medical treatment received, whereas the issue in this case is causation of the injury. This, however, is a distinction without a difference. Just as a record review was not sufficient for an insurer to deny benefits based on a belief that the treatment received was not necessary, arguably a mere record review would not be sufficient to deny benefits based on a belief that the automobile accident did not cause the injury. Therefore, this leads to the conclusion that when causation is in controversy, an independent medical examination may be appropriate. In this case, Allstate cited enough evidence to place causation at issue and supplied good cause for the trial court to order an independent medical examination.[9]

The appropriateness of denying for want of causation based on medical records review, or even an IME, was not before the Court. Nonetheless, the Court suggested that denying for a lack of causation based on a medical records review would "arguably" not comport with the KMVRA. The Court going out of its way to provide this comment certainly implies an intent to apply the *Sanders* ruling, at least partially, to prevent the use of medical records reviews to deny PIP benefits based on the non-relation of the claimed injury to the accident. However, the Court noted in *Sanders* that unrelated injuries do not qualify for PIP coverage and indicated that IMEs were appropriate where causation is reasonably questioned in *Streeval*.[10] Combined, these excerpts suggest the Court will consider challenges to causation using the IME discovery tool provided under KRS 304.39-270 appropriate under the KMVRA. While a ruling limiting causation challenges to IMEs would be less than ideal and increase the burden on carriers, it would at least preserve one method for challenging the relation of injuries.

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1 *Streeval v. Edwards*, 2019 WL 4072961 (Ky. 2019) (unreported).
2 *Government Employees Insurance Company v. Sanders*, 569 S.W.3d 923 (Ky. 2018).
3 *Streeval*, 2019 WL 4072961, at 4.
4 *Sanders*, 569 S.W.3d at 929-930.
5 *Id.* at 928.
6 *Id.*
7 *Id.* at 930.
8 *Id.* at 931.
9 *Id.*
10 *Sanders*, 569 S.W.3d at 928; *Streeval*, 2019 WL 4072961, at 4.

Where Is the Line? Discoverability of Special Investigation Unit Files and the Dangers of Alleged Collusion with Law Enforcement

By R. Mitch Moore

Insurance claims often place the insurer in a precarious situation—having to investigate a claim made by an insured with whom the insurer otherwise is engaged in a successful business relationship. Even worse, that insurer is sometimes compelled to litigate against a party that was once a business ally, and defend itself against unsubstantiated and uncovered losses. Of course, before any litigation begins, the insurer may, after being notified of an occurrence or loss, employ contractual provisions to aid in its investigation of a claim.[1] One tool used by many insurance companies are special investigation units ("SIU"), which allow the insurer to employ personnel and allocate resources with the sole mission of investigating and preventing insurance fraud.[2] In addition to the SIU, state and federal law enforcement agencies also have a legitimate interest in investigating and preventing insurance fraud. Often, the goals of the SIU and of the law enforcement agencies are synonymous. While those two bodies may have similar goals, it is imperative that the insurer remain independent and autonomous from law enforcement, as a failure to do so can prove costly—both for the reputation and for the bottom line of the insurer. This article addresses the ability of a civil litigant to obtain SIU files in discovery, and how the work product protection may prevent that same litigant from doing so, and also considers the danger of conducting investigations too closely with law enforcement, such that cooperation turns into costly collusion.

Work Product Protection and Waiver

The first "line of demarcation" considered by this article is the point in time in which an insurer's claim file transitions from being an investigatory tool for the insurer into protected work product. Claim files become protected at the point when the investigation into a claim shifts to one that anticipates a future lawsuit. One factor that a court may look to in drawing this invisible line in the sand is the point in time in which the insurer's SIU becomes involved in the case. While this is a helpful factor, the ultimate test considers whether the documents "are prepared in anticipation of litigation or reveal the mental impressions, thoughts and conclusions of specified representatives in evaluating legal claims."[3] "Anticipation of litigation" can be difficult to analyze in insurance cases because "while it is in their ordinary course of business to investigate reported losses, insurance companies may reasonably anticipate that they will face litigation when they decide to deny coverage."[4]

While it may seem that a pre-suit investigation should trigger the work product protections, the mere occurrence of an investigation does not automatically grant work product protection.[5] As has been noted by at least one court, "management [at the beginning of the claim cycle] is primarily concerned not with the contingency of litigation, but with deciding whether to resist the claim, to reimburse the insured and seek subrogation of the insured's claim against the third party, or to reimburse the insured and forget about the claim thereafter."[6] However, the longer a claim lives without resolution, the more likely it becomes that the insurer's mindset as to the claim will shift from an evaluation of the claim to taking actions in anticipation of litigation.[7] Of course, this point is not fixed on a stationary matrix, but rather it depends on the facts of the claim.[8] Making the determination will be an exercise for the court, and will depend on the individual facts of the case, the judge, and the jurisdiction in which the claim is made.

One cautionary tale in this regard comes from a district court in Florida, which ultimately held that an insurer failed to produce sufficient evidence that documents in a particular claim file were prepared in anticipation of litigation. In *Wingo Holdings, LLC v. Northfield Ins. Co.*, No. 05-80587, 2006 WL 8433647 (S.D. Fla. Apr. 27, 2006), the court granted a motion to compel an insurer's complete underwriting file, entire claim file, and investigation file because it found that the insurer failed to produce evidence in support of its argument that its internal documents related to a claim involving an alleged arson were protected by the work product privilege.[9] In *Wingo Holdings*, the court found that the evidence produced by the insurer—including a privilege log, and an affidavit by an employee—were not sufficient to show that the documents withheld from Plaintiff were actually prepared *solely* in anticipation of litigation, and not simply in the ordinary course of the insured's business.[10] The aforementioned affidavit, though more persuasive than the privilege log, also failed to persuade the court to extend protection to the documents as the adjuster admitted in sworn testimony that no arson defense had been raised, nor was any evidence of the fire found.[11] Due to the insurer's failure to produce evidence showing that it prepared documentation *solely* in anticipation of litigation

and instead of merely doing so as an ordinary part of its business, the court ordered that all of the insurer's documents related to this claim be made available to Plaintiff.[12]

A more helpful decision can be found in *Marshall v. Safeco Ins. Co. of Indiana*, 2013 WL 12180600 (S.D. Ga. May 14, 2013), which held that that various documents within the insured's claim file and in its possession were excluded from discovery and protected by the work product doctrine.[13] A major distinction between *Marshall* and *Wingo Holdings,* is that the *Marshall* insurer assigned the case to an investigator in the SIU a mere four days after learning of the insured's alleged misrepresentations.[14] Moreover, the insurer successfully argued that "evidence of material representations is not a normal or routine part of the claims investigation and adjustment procedures," such that the court "drew the line" for work product protection at the moment that the claim turned from an investigation of the claim to the anticipation that the case would need to be litigated in light of the misrepresentation.[15]

While proving that a document should be afforded protection from discovery, an insurer must also take caution to maintain the protection once established. One common way in which the protection may be waived is via disclosure of the protected document to a third party.[16] However, documents that are otherwise protected by the work product doctrine but are provided to law enforcement do not become discoverable simply because of their disclosure.[17] In *Chambers v. Allstate Ins. Co.*, 206 F.R.D. 579 (S.D. W. Va. 2002), the court considered this exact question when an insurer provided documents prepared in anticipation of litigation to the State Fire Marshal and the Prosecuting Attorney related to an insured's suspected arson of a covered property.[18] The court concluded that, while the documents had been prepared in anticipation of litigation, because of the fact that the insurer, the Fire Marshal, and the Prosecutor all had a common interest—*i.e.,* determining the root cause of the fire that destroyed the covered property—the work product protections had not been waived, and the Plaintiff would not be permitted to review the insured's documents.[19]

In sum, the essential query for an insurer to establish a protection for a document asks whether that document had been prepared *solely* in anticipation of litigation. The timeline in which the anticipation of litigation begins is often tricky, but employing a special investigator to investigate suspicious claims may be a strong trigger to the work product protection. This is undoubtedly an important bar to meet, as establishing that a set of documents was prepared in anticipation of litigation protects the impressions, thoughts, and conclusions of the SIU, which, without the protections, may lack the candor that the insurer requires to adequately evaluate a claim. This determination, however, is often contentious, and without much concrete guidance, as courts will only afford an insurer the applicable protection on a case-by-case basis.[20]

The Costly Line between Cooperation and Collusion with Law Enforcement

An insurer's decision to involve its SIU is not one to be taken lightly, and, in fact, in most situations in which the SIU is involved, local law enforcement likely also has an interest in the investigation of the facts giving rise to the insurance claim. While most states require insurers to report knowledge of arson or suspected insurance fraud, insurers may not want to extend its relationship with law enforcement beyond that original report. A decision to proceed otherwise may result in the insurer's exposure to lengthy and expensive litigation.

West Virginia law requires any insurer with "knowledge or a reasonable belief that fraud or another crime related to the business of insurance is, will be or has been committed" to supply that information to the insurance commissioner, and it provides immunity from civil liability from doing so, provided the report was made in good faith.[21] This immunity does not extend to bad faith disclosure, which is defined under West Virginia law as, "materially incorrect statements made maliciously or fraudulently" by a mandatory reporter, *i.e.*, individuals engaged in the business of insurance.[22] Similarly, the State Fire Marshal can request information from insurers relative to an investigation, and insurers are required to report suspected incendiary losses to the State Fire Marshal.[23] This disclosure is protected unless fraudulent.[24]

The good-faith requirement in the Code is important, and a deviation therefrom may result in an insurer being sued under the theories of defamation,[25] civil conspiracy,[26] negligence,[27] or malicious prosecution.[28] While "collusion with law enforcement" is not a recognized cause of action,[29] the law may punish an insurer for an extensive involvement with law enforcement in the investigation of a claim. Importantly, courts deciding the issue have noted that there should be "no appearance of the SIU investigator directing or in any fashion managing or assisting in the managing of the criminal investigation being conducted by law enforcement and by the same token that no law enforcement official is managing or assisting in the direction of the investigation being conducted by the insurance carrier."[30]

The importance of good-faith reporting is illustrated in *State Farm Fire & Cas. Co. v. Radcliff*, 987 N.E.2d 121, 127 (Ind. Ct. App. 2013). In *Radcliff*, a jury returned a verdict in favor of a contractor for defamation in response to an insurer's report of potential fraud by the con-

tractor to law enforcement. At the center of the controversy in *Radcliff* was a large hailstorm, which caused millions of dollars in property damage and generated thousands of claims for the insurer.[31] In response to the hailstorm, an independent contractor created an LLC with the purpose of repairing homes damaged by the storm.[32] The contractor also advertised to the community that he would "fight" the insurer.[33] After the insurer began to suspect wrongdoing on behalf of the contractor, including allegations that the contractor was causing damage to homes himself and having the homeowner make a claim on their policy, the insurer began to investigate the contractor.[34] Members of the insurer's SIU notified the National Insurance Crime Bureau ("NICB") of its investigation, and turned over a portion of its investigative file and the investigation of the claim to the NICB.[35] Subsequently, NICB turned its investigation over to local law enforcement. At that time the insurer's SIU became involved in the matter again and were asked to review the probable-cause affidavit against the contractor for accuracy.[36] While the SIU employees did provide NICB with some information from the claim file, they did not provide the entire claim file—some of which contained exculpatory evidence in favor of the contractor.[37]

The insurer sued the contractor and the LLC for insurance fraud, which suit was met by a counterclaim from the contractor and LLC for defamation based upon the SIU's communications with the NICB and local law enforcement described above.[38] The trial court jury returned a verdict in favor of the contractor on the defamation issue, and the Court of Appeals of Indiana upheld the verdict and affirmed the trial court's denial of judgment as a matter of law in favor of the insurer. The insurer argued that its SIU's statements were protected by privileges applicable to communications with law enforcement, and the court recognized the existence of such privileges. However, and detrimental to the insurer's argument, the court held that statements may lose their privilege protections when "(1) the communicator was primarily motivated by ill will in making the statement; (2) there was excessive publication of the defamatory statements; or (3) the statement was made without belief or grounds for belief in its truth."[39] The court found sufficient evidence to support that the insurer's employees were "primarily motivated by ill will" when they made the statements.[40]

The insurer also argued that it was entitled to statutory immunity for its involvement with the law enforcement investigation, however, and as outlined above, the court declined to afford those protections as it found that there was sufficient evidence to show that the insurer did not act in good faith.[41] Specifically, the court discussed the insurer's withholding of evidence from NICB and local law enforcement, and emphasized "that of the thousands of pages sent to the NICB, [the insurer] chose not to send the very pages that showed hail damage—and not vandalism—to the policyholders' homes."[42] The court found that the insurer had acted with "actual malice," as the evidence clearly showed that the employees knew there was evidence showing hail damage to some of the policyholders' homes and that independent contractors found hail damage instead of vandalism.[43] By only reporting to NICB that the contractor had vandalized homes with the intent to bill the insurer for work performed under the claim, the court concluded that the contractor and his company proved, by clear and convincing evidence, that the insurers' employees made defamatory statements "with knowledge that they were false or with reckless disregard of whether they were false."[44] This finding upheld a multi-million-dollar verdict in favor of the contractor.

While conjecture is not always helpful, it is clear to see that this entire situation could have been avoided if the insurer's employees had ceased to involve themselves in the investigation of NICB and local law enforcement as soon as they made their statutorily required report of suspected wrongdoing. The line between cooperation and coercion had been crossed, and the litigation between the insurer and contractor caused an expensive and embarrassing result for the insurer. While reporting to law enforcement is required, insurers should instruct their employees to take care to make sure that all reporting is made in good faith, and that involvement with law enforcement should cease, or proceed with the utmost caution and candor, as soon as the report is made.

The determination of whether work product is protected and of whether cooperation with law enforcement may be deemed collusion are delicate questions and are only resolved on a case-by-case basis. Accordingly, an insurer with any doubt as to these facets of the law should consult an attorney before advising employees on an appropriate course of action.

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1 13A Couch on Insurance § 196:1 (3d. ed.) (updated through Dec. 2019).
2 Edward J. Schrenk, Jonathon B. Palmquist, *Fraud and Its Effects on the Insurance Industry*, 64 Defense Counsel Journal 23, 27 (Jan. 1997).
3 *Chambers v. Allstate Ins. Co.*, 206 F.R.D. 579 (S.D. W. Va. 2002).
4 *See Wingo Holdings, LLC v. Northfield Ins. Co.*, No. 05-80587, 2006 WL 8433647 (S.D. Fla. Apr. 27, 2006) (citing *Chambers v. Allstate Ins. Co.*, 206 F.R.D. 579, 584 (S.D. W. Va. 2002).
5 *Stampley v. State Farm Fire & Cas. Co.*, 23 Fed. Appx. 467 (6th Cir. 2001) (citing *Binks Mfg. Co. v. Nat'l Preso Indus., Inc.*, 709 F.2d 1109, 1120 (7th Cir. 1983)).
6 *Carver v. Allstate Ins. Co.*, 94 F.R.D. 131 (S.D. Ga. 1982) (internal quotations omitted).
7 *See Westhemeco Ltd. v. New Hampshire Ins. Co.*, 82 F.R.D. 702, 708 (S.D.N.Y. 1979).
8 *Id.*; *See, e.g.*, *Wingo Holdings, LLC v. Northfield Ins. Co.*, 2006 WL 8433647 at *12 (S.D. Fla. Apr. 27, 2006).

9 *Wingo Holdings*, 2006 WL 8433647 at * 13.
10 *Id.* at *11.
11 *Id.* at *10.
12 *Id.* at *13.
13 *Marshall v. Safeco Ins. Co. of Indiana*, CV 112-113, 2013 WL 12180600 (S.D. Ga. May 14, 2013).
14 *Id.* at *5.
15 *Id.*
16 *Chambers v. Allstate Ins. Co.*, 206 F.R.D. 579 (S.D. W. Va. 2002) ("As a general rule, the voluntary disclosure of work product or an attorney-client communication constitutes a waiver of the immunity and privilege as to all other communications on the same subject.").
17 *Chambers*, 206 F.R.D. 579.
18 *Id.*, 206 F.R.D. at 589.
19 *Id.*; *see also In Re Doe*, 662 F.2d 1073, 1081 (4th Cir. 1981) ("Disclosure to a person with an interest common to that of the attorney or the client normally is not inconsistent with an intent to invoke the work product doctrine's protection and would not amount to such a waiver.").
20 *Chambers*, 206 F.R.D. at 585; *see also Airheart v. Chicago and North Western Transp. Co.*, 128 F.R.D. 669, 671–72 (D.S.D. 1989); *Pete Rinaldi's Fast Foods v. Great Am. Ins. Cos.*, 123 F.R.D. 198, 202 (M.D.N.C. 1988).
21 W. Va. Code § 33-41-5; § 33-41-6(a).
22 W. Va. Code § 33-41-6(b).
23 W. Va. Code § 15A-10-6.
24 *Id.*
25 *See infra*, fn. 35–53.
26 "A civil conspiracy is a combination of two or more persons by concerted action to accomplish an unlawful purpose or to accomplish some purpose, not in itself unlawful, by unlawful means." *Dunn v. Rockwell*, 225 W. Va. 43, 689 S.E.2d 255 (2009).
27 To prove negligence, a plaintiff must show that the defendant owed a duty, that the duty was negligently breached, and that this breach proximately caused plaintiff's damages. *Wheeling Park Commission v. Dattoli*, 237 W. Va. 275, 280, 787 S.E.2d 546, 551 (2016) (citations omitted). *See also Naumov v. Progressive Ins. Agency, Inc.*, 2008 WL 5263703 (W.D. Pa. Dec. 17, 2008) (denying motion to dismiss claim for negligence because of insurer's failure to adequately investigate vehicle damage and insurer's false or reckless report of suspected insurance fraud to the criminal authorities).
28 The elements for malicious prosecution in West Virginia are as follows: "(1) that the prosecution was set on foot and conducted to its termination, resulting in plaintiff's discharge; (2) that it was caused or procured by defendant; (3) that it was without probable cause; and (4) that it was malicious." *Goodwin v. City of Shepherdstown*, 241 W. Va. 416, 825 S.E.2d 363 (2019) (quoting Syl. Pt. 1, *Radochio v. Katzen*, 92 W. Va. 340, 114 S.E. 746 (1922).
29 *See Amatrone v. State Farm Fire and Cas. Co.*, 2018 WL 772078 (D. Nev. Feb. 7, 2018).
30 Benjamin Love, Components of an Effective Examination Under Oath, 23 No. 13 Ins. Litig. Rep. 393 (Sept. 1, 2001); *see also Amica Mut. Ins. Co. v. Schettler*, 768 P.2d 950 (Utah Ct. App. 1989) (finding that allegations made by insured regarding insurer's participation in insurance fraud prosecution were insufficient to state a claim for abuse of civil process where "insurer, service and agency did not institute criminal proceedings, did not exert pressure to prolong or maintain action, and did not indicate that criminal process was being used to force insured to reimburse insurer for money he received as a result of 'stolen' automobile claim.").
31 *State Farm Fire & Cas. Co. v. Radcliff*, 987 N.E.2d 121, 127 (Ind. Ct. App. 2013).
32 *Id.*
33 *Id.*
34 *Id.*
35 *Id.*
36 *Id.* (The affidavit prepared by local law enforcement was defamatory as the statements therein reflected the incomplete information given by the SIU to the NICB).
37 *Id.*
38 *Id.*, 987 N.E.2d at 137.
39 *Id.* (citing *Williams*, 914 N.E.2d at 763–64).
40 *Id.* at 141.
41 *Id.* at 143.
42 *Id.*
43 *Id.* at 149.
44 *Id.* at 151.

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