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The Bad Faith Sentinel

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

To Further Judicial Economy, Eastern District of Kentucky Bifurcates Bad Faith Claim From Coverage Claim

Hardy Oil Co. v. Nationwide Agribusiness Ins. Co., No. 11-75-JBC, 2011 WL 6056599 (E.D. Ky. Dec. 6, 2011)

Eastern District of Kentucky bifurcates bad faith claim and stays discovery to further judicial economy and to eliminate unnecessary discovery.

Hardy Oil Company ("Hardy") purchased insurance policies through Wells Fargo Insurance-Indiana ("Wells Fargo"), including coverage for its motor fuel operations from Nationwide Agribusiness Insurance Company ("Nationwide"). Nationwide denied Hardy's claim for coverage for losses sustained by a spill of diesel fuel at a site owned by Hardy. Hardy filed suit against Nationwide and Wells Fargo and asserted that the Nationwide policy covered damages from the spill, Nationwide's denial was a breach of contract and bad faith, and if the spill was not covered by the Nationwide policy, then Wells Fargo negligently breached its duty to provide insurance brokerage services to Hardy.

Nationwide and Wells Fargo moved to bifurcate the trial and stay discovery on the bad faith and negligence claims until the coverage claim could be decided. The Eastern District of Kentucky found that bifurcation would further judicial economy because the bad faith and negligence claims were dependant on the outcome of the breach of contract claim. To prevail on a bad faith claim in Kentucky, an insured must prove that the insurer is obligated to pay under the terms of the policy. Moreover, bifurcation would avoid prejudice to the parties by allowing the parties to engage in limited discovery for the coverage claim, thereby eliminating unnecessary discovery. The Court bifurcated the claims and stayed discovery on the bad faith and negligence claims pending resolution of the coverage claim.

Fifth Circuit Finds That Insurer Satisfied Its Continuing Duty To Investigate A Claim

Thompson v. Zurich American Ins. Co., No. 10-51013, 2011 WL 6016454 (5th Cir. Dec. 2, 2011)

In Texas, an insurer has a duty to conduct a reasonable investigation and has a continuing duty to investigate a claim to avoid liability for bad faith denial or delay of benefits.

On November 3, 2007, Dennis Thompson, a welder for Zachry Construction, slipped at work. After the company doctor ordered x-rays, which did not show damage, he diagnosed Thompson with a sprained knee and ankle. Thereafter, Thompson continued to have pain and his primary care physician, Dr. David Drury, recommended an MRI. The MRI revealed that Thompson had a torn meniscus and he was referred to Dr. John Waldrop, an orthopedic surgeon.

Zurich American Insurance Company ("Zurich") was the worker's compensation carrier for Zachry Construction. Zurich hired Specialty Risk Services, L.L.C. ("SRS") to investigate Thompson's claim that he was disabled and unable to work and that the meniscus tear was related to his compensable injury. SRS hired Dr. Alan Strizak, an orthopedic specialist, to perform a records and peer review. Dr. Strizak concluded that the meniscus tear was likely an injury that pre-dated Thompson's work accident. On March 14, 2008, Zurich denied Thompson's claims.

Thompson filed an administrative claim with the Texas Department of Insurance, Workers' Compensation Division (the "WCD"), which appointed Dr. Derry Crosby to examine Thompson. Dr. Crosby's written evaluation disputed Dr. Strizak's finding that the meniscus tear was pre-existing. It noted, however, that there was evidence of a pre-existing degenerative condition in Thompson's knee. The WCD ruled that Thompson's meniscus tear was compensable and that he was disabled as a result. Zurich promptly paid Thompson's benefits and declined to pursue an administrative appeal. On February 20, 2009, Thompson had surgery on his knee. Several months later, Thompson filed suit against Zurich and alleged common law claims for breach of the duty of good faith and fair dealing for failure to conduct a reasonable investigation and that Zurich had no reasonable basis for denying or delaying benefits. The District Court granted Zurich summary judgment on all grounds, and Thompson appealed.

The issue on appeal was whether Zurich complied with the duty of good faith and fair dealing in handling Thompson's claim. To avoid liability for denying or delaying a claim in Texas, an insurer must establish a bona fide controversy with a reasonable basis for the denial or delay, even if it is ultimately determined to be erroneous. An insurer has a duty to conduct a reasonable investigation of the claim and may rely upon experts, as long as such reliance is reasonable. An objective standard is used to determine whether a reasonable insurer under similar circumstances would have denied or delayed benefits. In Texas, a physician's opinion may be a reasonable basis for an insurer to deny or delay benefits, but it is not absolute. Thompson argued that Dr. Strizak's opinion was biased in favor of Zurich based on several factors.

Noting the contrary opinions of Dr. Drury and Dr. Waldrop, Thompson claimed that Zurich unreasonably relied on Dr. Strizak's opinion. Conflicting expert opinions alone, however, do not establish that the insurer acted unreasonably in relying on its own expert. A party alleging bad faith must also submit direct or circumstantial evidence showing that the opinion of the insurer's expert was questionable and that the insurer knew or should have known that the opinion was questionable. In Texas, an insurer's reliance on an expert's opinion is evaluated based upon knowledge at the time of the dispute. The record showed that Dr. Waldrop did not see Thompson until after the benefit dispute was resolved and Dr. Drury never conveyed his opinion to Zurich. The Fifth Circuit found that although the contrary opinions of the other experts may support the conclusion that Dr. Strizak's opinion was incorrect, it did not establish bad faith on the part of the insurer.

Thompson also claimed that Dr. Strizak's opinion was not supported by Thompson's medical records because Thompson's medical records did not show prior treatment for knee injuries. To show bad

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faith, an insured must show that an omission in the expert's investigation is of such magnitude as to affirmatively cast doubt on the insurer's basis for denial. The Fifth Circuit found that although there was no prior treatment for knee injuries in Thompson's medical records, that Dr. Strizak's opinion was substantiated by medical analysis on the effects of certain degenerative conditions and therefore did not establish bad faith.

Thompson then argued that Dr. Strizak was biased because he was paid by Zurich, he worked extensively for insurance companies, and SRS could not name any other doctors that it used. To show bad faith, an insured must show more than the fact that the insurer hired someone who primarily works for insurance companies. There was nothing in the record to show that Dr. Strizak gave opinions predominately in favor of insurers or that Zurich had knowledge of such a predisposition. The Fifth Circuit found that it would be impractical to require insurers to hire a new or different doctor for every medical review or be faced with judicial review of its decision to rely upon an expert. Accordingly, the Fifth Circuit did not find that Thompson raised an issue of material fact as to Zurich's bad faith in relying on Dr. Strizak's opinion.

In addition to having a reasonable basis for denial or delay of benefits, insurers in Texas have a duty to continuously investigate a claim. The duty to continuously investigate is not unlimited and is dependant on the circumstances of the dispute. The inquiry begins by determining whether and when liability became reasonably clear and ends with the insurer's actions thereafter. An insurer cannot escape liability by failing to investigate a claim so that it can assert that liability was never reasonably clear. The insured must show that there is a material issue of fact about whether the insurer denied coverage despite an indication that coverage had become "reasonably clear" or that the insurer acted unreasonably in failing to investigate. Three months elapsed between the time Zurich denied Thompson's claim and the report issued by Dr. Crosby that contradicted Dr. Strizak's conclusions. After the report was issued, Zurich participated in the WCD's administrative proceedings. Zurich denied coverage only until the WCD resolved the dispute and then promptly paid Thompson's claim without appeal. Insurers do not have the "duty to leave no stone unturned" when undergoing the administrative process. Based on the record, the Fifth Circuit affirmed the District Court's grant of summary judgment in favor of Zurich on the bad faith claims.

Due To Ambiguous State Law, Eastern District of Kentucky Remands Bad Faith Suit Against Insurance Adjuster

Collins v. Montpelier U.S. Ins. Co., No. 11-166-ART, 2011 WL 6150583 (E.D. Ky. Dec. 12, 2011)

The Eastern District of Kentucky concludes that Kentucky law is ambiguous on the issue of whether an insurance adjuster can be liable for bad faith.

On February 4, 2011, a fire burned down the business of John and Sandra Collins. The Collinses, who were insured by Montpelier, filed a claim to recoup their losses, and Montpelier hired GAB Robins and Dan Thornbury to investigate and adjust the claim. After Thornbury visited the property, Montpelier denied their claim. Montpelier also filed a declaratory judgment action seeking a declaration that it did not owe the Collinses for their losses. The Collinses then sued Montpelier, GAB, Thornbury and Jo Lynn Clemons, a Montpelier adjuster, in Kentucky state court. The Collinses alleged that Montpelier, Thornbury, GAB and Clemons

denied their claim in violation of Kentucky's Unfair Claims Settlement Practices Act, Consumer Protection Act and Unfair Trade Practices Act. Montpelier filed a notice of removal, asserting federal diversity jurisdiction. In the notice, Montpelier acknowledged that the Collinses and Thornbury were both Kentucky citizens, but contended that Thornbury's citizenship should be ignored for diversity purposes because the plaintiffs fraudulently joined him in the action. Specifically, Montpelier argued that Kentucky law did not allow the Collinses to assert bad-faith claims against an insurance adjuster like Thornbury.

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In 2000, the Kentucky Supreme Court held that the state's Unfair Claims Settlement Practices Act applied only to "persons or entities engaged in the business of insurance." *Davidson v. Am. Freightways, Inc.*, 25 S.W.3d 94 (Ky. 2000). The Eastern District of Kentucky, in examining Montpelier's argument in support of federal jurisdiction, determined that it was not clear whether an insurance adjuster is engaged in the business of insurance. Dicta in *Davidson*, which noted that Kentucky's insurance statutes were not designed to regulate "persons who are neither insured nor engaged in the business of entering into contracts of insurance," implied that adjusters, who do not enter into insurance contracts, cannot be sued for acting in bad faith. On the other hand, however, *Davidson* also held that the Unfair Claims Act applied "only to those persons or entities (**and their agents**) who are engaged. . . in the business of entering into contracts of insurance," implying

that insurance adjusters, who are surely the agents of companies that enter into insurance contracts, can be held liable for bad faith claims. Kentucky trial courts have reached inconsistent conclusions on how to apply *Davidson* to claims adjusters sued for bad faith under the Unfair Claims Act and the Kentucky appellate courts have not directly addressed the question. Because a federal court is not permitted to find a fraudulent joinder "unless it is clear that there can be no recovery" against the in-state defendant, the district court held that Montpelier must prove that the Collinses have no reasonable basis for recovering against Thornbury. Although the Collinses' bad faith claim might not survive a motion to dismiss, they at least had a reasonable basis for recovery given the ambiguity in Kentucky law and the district court thus remanded the case to state court.

Washington Court Holds Insurer Acted in Bad Faith By Invoking Inapplicable Exclusion Even Though It Had Other Grounds To Deny Coverage

Ledcor Indus. (USA), Inc. v. Virginia Surety Co., Inc., No. C09-1807RSM, 2011 WL 6140957 (W.D. Wa. Dec. 9, 2011)

The Western District of Washington held that an insured's bad faith claim succeeds regardless of whether the insurer, who invoked inapplicable coverage exclusion, was ultimately correct in determining coverage did not exist.

Ledcor, a general contractor, was hired to build a mixed-use real estate project in West Seattle—commonly referred to as the Adelaide Project—by West Seattle Property, the owner and developer of the property. Ledcor purchased an insurance policy from Virginia Surety relating to the Adelaide Project covering the period of December 1, 2003 through December 1, 2004. In August 2005, following the completion of the Adelaide Project, the homeowners associations for both the townhomes and condominiums ("the HOAs") advised Ledcor of various defects in the building, and Ledcor in turn notified Virginia Surety of the potential claims. Virginia Surety responded by requesting documents and information from Ledcor, including a list of the alleged construction defects, which Ledcor provided shortly thereafter. Ledcor's counsel also sent an email to Virginia Surety in which he stated that a disagreement existed as to the date that Ledcor achieved "substantial comple-

tion" of the Adelaide Project and that "if it were possible to establish the date it would fall between August 2003 and November 2003."

Virginia Surety denied coverage on February 21, 2006, taking the position that its duty to defend Ledcor applied only with respect to a "suit" for damages, and that its duty to indemnify applied only with respect to damages Ledcor became legally obligated to pay. Since no suit had yet been filed by either of the HOAs and because Ledcor had not yet become legally obligated to pay any damages, Virginia Surety took the position that there was not yet any duty to defend or indemnify. Virginia Surety, relying on two exclusions, also concluded that, even in the event a suit had been filed, there was no potential coverage for the loss. Virginia Surety first relied upon the policy's "Progressive Loss Exclusion"—a provision that generally

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excluded coverage for damages that occurred prior to commencement of the Policy—taking the position that based on Ledcor’s statements, the Adelaide Project had been substantially completed 10 days prior to commencement of the Policy. Second, Virginia Surety relied upon the Policy’s “Fungus Exclusion”—a provision that generally excluded coverage for damage caused by mold or fungus—taking the position that the losses claimed by the HOAs consisted of “water intrusion including mold on ceilings.”

The denial letter invited Ledcor to submit additional information, but there were no subsequent conversations between Ledcor and Virginia Surety until July 24, 2007, when Ledcor notified the insurer that the townhomes HOA had filed a lawsuit alleging defects in the building. Ledcor sent Virginia Surety the relevant pleadings and retendered its claim for coverage. Virginia Surety never responded to the second tender. Six months later, the condominiums HOA filed a similar lawsuit and Ledcor once again retendered its claim for coverage.

Ledcor filed suit against Virginia Surety, claiming that the insurer “misinterpreted and misrepresented” the policy. In its summary judgment motion Ledcor pointed out that during his deposition, the claims handler assigned to Ledcor’s claim testified that mold or fungus “would have been” referenced in the list of construction defects issued by the HOAs, even though the list provided by the HOAs merely referenced water stains and other water damage and did not include any reference to mold or fungus. Ledcor also asserted that Virginia Surety knew that certain “punch list” work was still ongoing

at the Adelaide Project as late as April 2004—several months into the term of the policy and that a reasonable investigation would have revealed the ongoing nature of the work.

The district court agreed that Virginia Surety’s invocation of the Fungus Exclusion rose to the level of bad faith, but that genuine issues of material fact remained as to whether it was bad faith for Virginia Surety to rely on the Progressive Loss Exclusion. The Court concluded that “reasonable minds could not differ” that Virginia had no basis for invoking the Fungus Exclusion since the HOAs never complained about the presence of mold or fungus. Virginia Surety was not entitled to deny coverage simply because it may have suspected that mold or fungus damage existed based upon the HOAs’ allegations of water intrusion. The Court was not persuaded by Virginia Surety’s attempt to characterize its invocation of the Fungus Exclusion as a mere reservation of rights since that denial letter explicitly stated that the exclusion “clearly operates to bar coverage for all the damage being alleged.” It was also not sufficient that the Progressive Loss Exclusion—and not the Fungus Exclusion—was the “primary basis” for the denial. Even if the finder of fact were to determine that the Progressive Loss Exclusion barred coverage, “an insured may maintain an action against its insurer for bad faith investigation of the insured’s claim and violation of the CPA *regardless of whether the insurer was ultimately correct in determining coverage did not exist.*” Because Virginia Surety invoked the Fungus Exclusion without justification, the Court found that it had acted in bad faith.

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