

EXTRA! EXTRA!

A Bulletin Dedicated to Recent Developments in the Law of Extracontractual Liability and Claims Handling

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OREGON COURT OF APPEALS AFFIRMS JURY VERDICT FOR BAD FAITH ARISING OUT OF USE OF COST-CONTAINMENT SOFTWARE

In *Strawn v. Farmers Ins. Co. of Oregon, et al.*, 228 Or. App. 454, 2009 WL 1409471 (Or. App. May 20, 2009), the defendant insurer included provisions in its motor vehicle policies that entitled its insureds to personal injury protection (“PIP”) benefits for “reasonable and necessary” medical expenses resulting from the use, occupancy, or maintenance of an insured vehicle in accordance with Oregon Revised Statute Section 742.524(1)(a).

Before 1998, the insurer processed requests for PIP benefits by having claim handlers review each medical bill to determine whether the bill was reasonable. In 1997, the insurer decided to change this process as part of an effort to recover losses and regenerate its surplus after the 1994 Northridge, California earthquake. As part of its “Bring Back a Billion” campaign, the insurer instructed its Portland, Oregon claim handling office to reduce the payment of PIP benefits to realize “PIP dollar savings.” In this effort, the Oregon PIP claims manager contracted with Medical Management Online (“MMO”), a bill review vendor. MMO, in turn, licensed a “cost containment software program” from Medata, a company that manages a database of roughly 100 million medical expenses. The software sorts those medical expenses by Current Procedural Terminology (CPT) codes, geographic region, and price. CPT codes, which are created by the American Medical Association, are used by medical providers to bill insurers. Geographic regions in the database are defined according to “PSRO” areas, which were socio-demographic regions established by the federal government in 1980 for workers’ compensation purposes.

The software allowed the insurer to determine whether a bill from a medical provider was more expensive than a given

percentage of the range of charges in other bills for the same CPT code in the provider’s designated geographic area. The insurer was able to select any percentile that it wished, and MMO then evaluated the bills that it received from the client to determine whether the bills exceeded that percentile. If a bill exceeded the pre-selected percentile, MMO generated an Explanation of Benefits (EOB) form that reduced payment with reference to a “reason code RC40” that explained “[t]his procedure was reduced because the charges exceeded an amount that would appear reasonable when the charges are compared to the charges of other providers within the same geographic area.”

Beginning in January 1998, the insurer implemented the new PIP claim handling process and selected the 80th percentile as the cutoff point for “reasonable” expenses - that is, any bills that exceeded the 80th percentile in the MMO database would be deemed to exceed the “reasonable” charge and would be “reduced” to that 80th percentile. Although the insurer contended that the EOB was only a “recommendation,” the court noted that “recommendations” were, as a practical matter, the final determination of reasonableness since the claim handlers were rewarded for following the recommendations and downgraded if they did not.

In a year and a half, the insurer reduced more than 60,000 individual bills by a total of approximately \$750,000, with ninety percent of the reductions being \$25 or less and twenty five percent of the reductions being \$3 or less. Although the insurer offered medical providers an opportunity to justify the charges that exceeded the established percentile, it was generally not cost-effective for the medical providers to pursue those avenues, so the insureds became responsible for those unpaid amounts.

The plaintiff class filed suit, asserting claims for breach of contract, breach of the implied covenant of good faith and fair dealing, fraud, and declaratory relief alleging that the insurer’s review process set an arbitrarily low percentage that resulted in the denial of claims for reasonable medical expenses, thereby increasing the insurer’s profits at the expense of PIP claimants and medical providers.

Ultimately, a jury found in favor of plaintiffs on all counts and awarded compensatory damages and prejudgment interest reduced by the trial court to just under \$1 million, \$8 million in punitive damages on the fraud claim, and \$2.6 million in attorney fees. The insurer appealed.

The Oregon Court of Appeals rejected seven of the eight assignments of error

See *Oregon* on page 4

DECISION WORTH NOTING...



The California Court of Appeal for the Second District recently held that because an underlying lawsuit for copyright infringement, breach of implied contract, and breach of confidence did not give rise to coverage, the insureds could not maintain an action for bad faith against their liability insurer. In *Bedford Falls Co. v. Fireman’s Fund Ins. Co.*, 2009 WL 1845230 (Cal. App. June 29, 2009), the insureds, a film and television production company and two of its partners, were issued “producers errors and omissions” liability policies from the insurer on an annual basis. The insureds were sued in federal district court for alleged intellectual property violations in connection with the motion picture *The Last Samurai*. The insurer denied a duty to defend or indemnify, based on a “potential claim” that had been made against the insureds during a prior policy period. The policies each provided that there was no coverage for a claim made or suit, action or proceeding commenced against the insured or of which the insured received notice, either prior to or subsequent to the term of the policy.

The insureds then filed suit against the insurer, asserting breach of contract, bad faith, and seeking declaratory relief. The trial court granted the insurer’s motion to dismiss, holding that the underlying lawsuit did not give rise to coverage. The appellate court, in affirming the dismissal in its entirety, addressed the question of whether the bad faith claim could survive dismissal even if there was no coverage under the policies. The insureds argued that their allegations the insurer failed to investigate properly, among other bad faith acts, were sufficient to support a bad faith claim even absent coverage. The court disagreed, holding that when benefits are due to an insured, delayed payment, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable, and numerous other tactics may breach the implied covenant because it frustrates the insured’s primary right to receive the benefits of his contract. Absent that primary right, however, the auxiliary implied covenant has nothing upon which to act as a supplement, and should not be endowed with an existence independent of its contractual underpinnings.

PROPERTY INSURER'S AGREEMENT TO PERFORM SUBSEQUENT ASSESSMENTS, WHICH RESULTED IN ADDITIONAL AMOUNTS PAID, WAS NOT EVIDENCE OF BAD FAITH AS TO ITS INITIAL ASSESSMENT

In *Spicewood Summit Office Condo. Assoc., Inc. v. Am. First Lloyd's Ins. Co.*, 2009 WL 1657568 (Tex. App. June 12, 2009) (Slip Op.), a hailstorm damaged five commercial buildings owned by the insured. After receiving notice of the damage, the property insurer performed its initial assessment of the loss. The insured also obtained an independent estimate for the repair of the damage, which was in excess of \$392,000. The property insurer later hired a roof consultant to re-inspect the property making payments for "minor additional roof repairs." Approximately a year after the loss, the insurer re-inspected the building in response to another request by the insured, resulting in a supplemental payment. Almost two years after the loss, the insured requested another inspection of the property, resulting in two additional inspections and another supplemental payment by the insurer.

The insured, not satisfied with the amounts paid by the insurer, filed suit for breach of contract, penalties under Chapter 542 (b) of the Texas Insurance Code, and attorney's fees. The insured also made extra-contractual claims for breach of the duty of good faith and fair dealing under common-law, Texas Insurance Code Chapter 541, and the Deceptive Trade Practices Consumer Protection Act. The insurer moved for summary judgment, arguing that the insured's contractual claims were precluded by the policy's "contractual limitations period" and extra-contractual damages claims were barred because there was a bona fide dispute regarding the extent of damage and valuation of loss. The trial court granted the insurer's motions, and the insured appealed.

With respect to the claim for extra-contractual damages, the insured alleged that the insurer's "wrongful withholding of benefits" and "act of denying payment of benefits" constituted a breach of the common law duty of good faith and fair dealing, violation of Texas Insurance Code Chapter 541, and violation of the Texas Deceptive Trade Practices Consumer Protection Act. The court noted that under Texas law "an insurer breaches its duty of good faith and fair dealing by denying or delaying a claim when the insurer's liability has become reasonably clear." Further,

"the focus is not on whether the insured's claim was valid, but on the reasonableness of the insurer's conduct in rejecting the claim." The court noted that the inquiry is normally a fact issue, but "absent legally sufficient evidence of bad faith," the insured's claims are subject to summary judgment. The court explained that under Texas law, "evidence establishing only a 'bona fide coverage dispute,' without more, does not rise to the level of bad faith."

Although the insured submitted three reports prepared by inspectors hired by the insurance company to assess the damage to the property, the insured did not produce any reports or testimony from any other expert as to the reasonableness or unreasonableness of the insurer's loss assessments. The court found that "there [was] no evidence that the reports of [the insurer's] inspectors were not objectively prepared, or that [the insurer's] reliance on each of those reports in making payments to [the insured] was unreasonable, or any other evidence from which a fact finder could infer that [the insurer] acted without a reasonable basis or that liability in excess of the reports damage assessments was reasonably clear."

The court also rejected the insured's arguments that the insurer's agreement to inspect the property several times and make payments several times, by itself,

was some evidence of bad faith. To the contrary, the court noted, "if anything, an insurer agreeing to perform a reassessment demonstrates good faith ... to find otherwise might encourage insurers to stand by their initial assessments for fear that their willingness to consider new evidence and issue supplemental payments would indicate their initial assessments were made in bad faith." Additionally, the court found that there was no evidence of delay in the insurer's response to the insured's demands, any fundamental differences between the multiple assessments, or any refusal by the insurer to make additional payments in accordance with the increased assessment of damage. The court further found that the insurer's issuance of multiple payments over time rather than one full payment at the outset was "no evidence" that the total amount paid was insufficient. Similarly, the court found that the fact the insured requested multiple assessments constituted "no evidence that the final assessment made was unreasonable."

Accordingly, the court affirmed the trial court's entry of summary judgment in favor of the insurer.



Prepared by Marcos G. Cancio, an associate in our Chicago office.

DECISION WORTH NOTING...

In *CF Industries, Inc. v. Turner Industries, Inc.*, 2009 WL 1655542 (La. App. June 12, 2009), the Louisiana Court of Appeal for the First Circuit held that a claim for bad faith was not subject to dismissal even though the court had earlier ruled that fact issues precluded summary judgment on the coverage issues. In a prior ruling, the First Circuit held that the trial court's granting of summary judgment in favor of the would-be insured as to whether it qualified as an additional insured was in error, as fact issues relating to the contractual relationship between the named insured and the purported additional insured precluded summary judgment. The would-be insured, CFI, later amended its petition to include a claim for bad faith, on which the insurer moved for summary judgment.

The district court granted the insurer's motion for summary judgment, holding that because fact issues precluded summary judgment on the coverage issues, a reasonable coverage dispute existed since the inception of litigation. The court held that such a legitimate coverage dispute could not support a claim for bad faith. The First Circuit reversed, holding that its prior ruling did not preclude a fact-finder, after hearing the evidence and making its credibility determinations, from finding that the insurer contravened Louisiana's statutory requirements regarding good faith. The court did not suggest the insurer had acted in bad faith, but rather concluded that its prior opinion was not determinative of the issue of good or bad faith, which is a question of fact. The court explained: "[I]t does not necessarily follow that the existence of a question of fact that precludes summary judgment would preclude a fact-finder from finding that [the insurer] acted in bad faith should it find insurance coverage in favor of CFI."

advanced by the insurer, and affirmed the jury's finding of bad faith. However, the court vacated the \$8 million punitive damages award. With regard to the punitive damages, the court held that \$8 million in punitive damages violated the insurer's due process rights on the facts of the case and suggested that "a punitive damages award that is four times plaintiffs' actual or potential harm is all that due process will bear" based on its conclusion that the insurer's actions were of "moderate reprehensibility." In pertinent part, the court noted that the success of the insurer's scheme was predicated, in part, on the theory that the

reductions were too small to be worth litigating. The court also noted that a reasonable jury could have understood the facts and available inferences in this case to demonstrate a willful pattern of deceit in wanton disregard of the injury, and that the evidence established a pattern of misrepresentation designed to increase its profits at the expense of its insureds.



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