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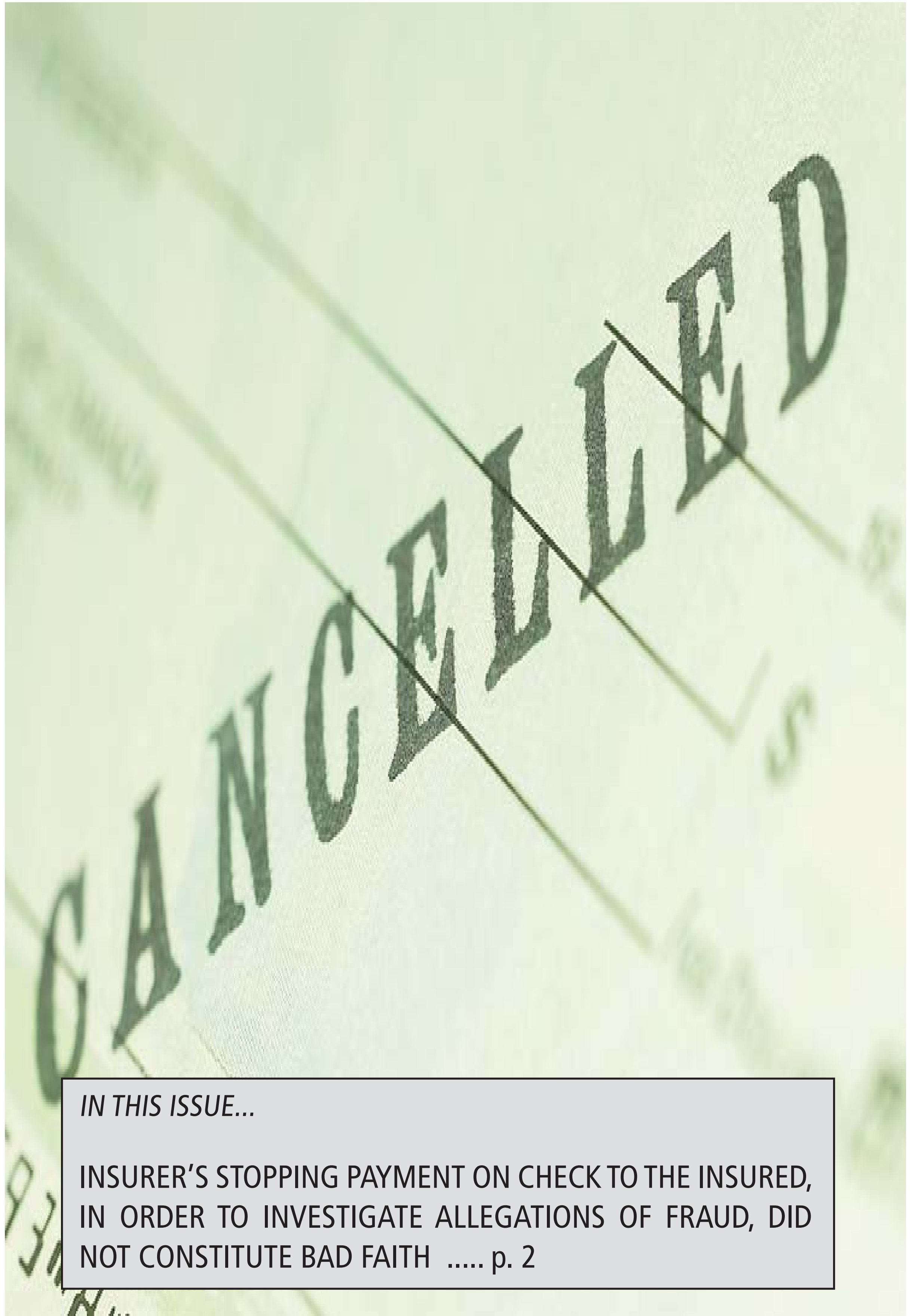
EXTRA! EXTRA!

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



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INSURER'S STOPPING PAYMENT ON CHECK TO THE INSURED, IN ORDER TO INVESTIGATE ALLEGATIONS OF FRAUD, DID NOT CONSTITUTE BAD FAITH

In *AG Equipment Co. v. AIG Life Ins. Co., Inc., et al*., 2009 WL 166806 (N.D. Okla. January 21, 2009), AG Equipment Company ("AG") provided its employees with medical insurance through a self-funded Medical Benefits Plan. AG was directly responsible for paying the first $40,000 of healthcare costs incurred by covered employees but, under the stop-loss Policy, AG could seek payment of "eligible expenses" from AIG of excess amounts falling within the Policy and up to the Policy limits of $1 million per employee. AIG used a third-party claims administrator, Mercer, to process claims under AG's policy.

In 2001, AG hired Suzanne Ash Kurtz, who was employed by AG until 2007. AG asserted that Kurtz was hired as AG's in-house counsel. She earned $2,500 per month or $30,000 per year. Kurtz was the ex-wife of AG's CEO, Grady Ash, and she was a licensed attorney in the state of Oklahoma. In late 2003, Kurtz became seriously ill and was diagnosed with MLS. She required several surgeries and hospital stays, and her medical expenses amounted to several hundred thousand dollars during the course of her treatment. AG paid the bills pursuant to the Plan, and AG requested reimbursement from AIG for the amounts covered by the Policy.

On April 24, 2007, Mercer received a telephone call from a janitor for AG, Mark Heidenreiter. Mr. Heidenreiter claimed that he found a folder of emails spanning several years in Ash's wastebasket and the emails suggested that Ash had colluded with Kurtz to defraud AIG. Specifically, he claimed that Ash put his ex-wife on the payroll for the purpose of providing her health benefits, but Kurtz did not actually work for AG. Heidenreiter claimed that he kept the documents because he believed the emails might be evidence that would need to be turned over to authorities.

Earlier on April 24, 2007, AIG had sent a check to AG in the amount of $467,775.89 as payment for expenses submitted by AG for medical treatment received by Kurtz. AIG immediately stopped payment on the check and initiated an investigation into the allegations that Kurtz was not actually working for AG.

AIG filed a motion for summary judgment on AG's claims of breach of contract and breach of the implied covenant of good faith and fair dealing, as well as on AIG's counterclaims.

The Court recognized that an insurer does not subject itself to a claim of bad faith merely by disputing coverage. An insurer does not breach the duty of good faith by refusing to pay a claim or by litigating a dispute with its insured if there is a legitimate dispute as to coverage or the amount of the claim, and the insurer's position is reasonable and legitimate. The decisive question was whether the insurer had a good faith belief, at the time its performance was requested, that it had justifiable reason for withholding payment under the policy.

The Court found that AIG did not act in bad faith by denying AG's claim for reimbursement of Kurtz's medical expenses, because a legitimate coverage dispute existed based upon the information available to AIG. AIG received information from an AG employee, that Kurtz may not be a covered employee under the Plan, and it had earlier the same day sent a substantial payment to AG to reimburse AG for Kurtz's medical costs. Although AG repeatedly claimed that Kurtz worked at least 30 hours per week, much of this evidence was in the form of unsupported statements by company employees and vague payroll records that did not reflect the number of hours that Kurtz worked. AG admitted that it did not keep track of Kurtz's hours and this created the issue of Kurtz's eligibility for coverage under the Plan.

The Court found that although a jury could conclude that AIG had an obligation to pay the disputed claim, the undisputed facts clearly showed that AIG conducted a reasonable investigation into the disputed claim and had a legitimate basis to dispute coverage. The Court was not required to accept AG's interpretation of the underlying facts and the evidence was not as clear as AG suggested. In the course of its investigation, AIG found evidence raising legitimate issues concerning the existence of insurance coverage, such as the number of hours worked by Kurtz and emails suggesting that AG employed Kurtz for the sole purpose of providing her with insurance benefits. While there is nothing inherently improper about accepting employment to acquire insurance, the emails and other evidence gathered by AIG created a reasonable basis to believe that Kurtz was not a covered employee. AG's failure to fully cooperate with AIG's investigation delayed the resolution of AG's claim, and AIG's alleged failure to issue an expeditious payment or denial of the claim was not evidence of bad faith. Therefore, the Court found that AIG was entitled to summary judgment on AG's bad faith claim.

Prepared by Kathy Karaboyas Malamis, an Associate in our Chicago office.

UNITED STATES DISTRICT COURT HOLDS THAT ARBITRATION PROVISION ENCOMPASSED BAD FAITH CLAIM, AND THE FEDERAL ARBITRATION ACT SUPERCEDED ANY CONTRARY STATE LAW

In *BCS Ins. Co. v. Independence Blue Cross*, 2009 WL 102978 (N.D.Ill. Jan. 15, 2009), the United States District Court for the Northern District of Illinois recently held that where an insured agrees to arbitrate "any controversy arising out of or relating to this Policy," this language encompasses any question that might arise, including the insured's bad faith claim, despite any contrary state law.

In *BCS*, BCS Insurance Company ("BCS") issued Independence Blue Cross ("IBC") a Directors and Officers Liability Insurance Policy. During the period of coverage, a third party sued IBC for alleged improper negotiation and performance of contracts. The lawsuit eventually settled. Afterwards, IBC filed a claim with BCS seeking indemnity for its incurred defense expenses. BCS subsequently denied coverage of IBC's claim.

IBC expressed to BCS its intent to submit the coverage dispute for arbitration, but informed BCS that it would file the bad faith claim in Pennsylvania state court. Consequently, BCS filed the instant petition to compel arbitration of IBC's bad faith claim against it, as provided for in the policy's arbitration provision. The policy's arbitration provision specifically provided, in relevant part, that "[a]ny controversy arising out of or relating to this Policy or the breach thereof shall be settled by binding arbitration..."

Claiming that Pennsylvania law applies to the dispute, IBC asserted that the court should not compel arbitration because Pennsylvania state court is the only forum available to resolve the bad faith dispute. IBC cited *Nealy v. State Farm Mut. Auto. Ins. Co.*, 695 A.2d 790 (Pa.Super.Ct. 1997), where the court held that Pennsylvania courts had original jurisdiction in which to hear Pennsylvania statutory bad faith claims. The court noted that the Federal Arbitration Act prevents state law from undermining parties' contractual agreement to arbitrate and that it supersedes any state law that lodges primary jurisdiction in another forum. As a result, the court reasoned that because the language "any controversy arising out of or relating to this Policy" contained in the arbitration provision contemplates any question that might arise, the court found that the provision was broad enough to encompass IBC's bad faith claim. Accordingly, the court held that IBC failed to overcome the strong presumption of arbitrability and concluded that the bad faith claim must be resolved in arbitration.

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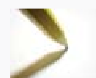
DECISION WORTH NOTING... 

A United States Court of Appeals held, on February 3, that an insurer's repeated requests for information from an individual who was incarcerated did not constitute bad faith. In *Hall v. Liberty Mut. Fire Ins. Co.*, 2009 WL 235640 (11th Cir. February 3, 2009), the insured was incarcerated when his home was damaged in a fire. Following the fire, the insured promptly filed a claim with his homeowners insurer, and was interviewed from jail by a special investigator for the insurer. According to the insured, the special investigator advised that no proof of loss was necessary, as the initial insurance adjuster had already examined the house and its contents.

Nonetheless, the insurer requested, in writing, a proof of loss form from the insured on at least four occasions. The insurer also sent at least seven written requests asking the insured's attorney to provide dates on which the insurer could obtain relevant documents and conduct an examination under oath ("EUO"). Ultimately, the insurer unilaterally scheduled a meeting, for the purposes of obtaining documents and conducting EUOs with individuals claiming losses under the policy. Apparently, while the insured's attorney did attend the meeting, he did not provide any of the requested information, and did not submit a proof of loss form. Due to his incarceration, the insured did not attend the meeting.

The insured later filed suit against the insurer in Georgia state court, seeking contractual damages, bad faith damages, and attorney's fees. Following the removal of the action to federal district court, the insurer moved for summary judgment. The court granted the motion, ruling that the insured was not entitled to contractual damages because he did not comply with the prerequisites to suit, as set forth in the insurance agreement. The court also ruled that the insured was not entitled to bad faith damages, as his failure to cooperate with the insurer precluded such recovery.

On appeal, the Court of Appeals affirmed. The court rejected the insured's argument that the insurer's repeated requests for information and for EUOs, despite knowing that the insured was unavailable due to incarceration, amounted to bad faith. The court pointed to the insurer's contractual right to conduct EUOs and procure documents, and found the insurer to have been patient and reasonable.

DECISION WORTH NOTING...

The United States District Court for the Western District of Oklahoma recently held that the actions of an umpire, hired to conduct an appraisal of the value of a damaged vehicle, could not be attributed to the insurer. In *Regional Air v. Canal Ins. Co.*, 2009 WL 152739 (W.D. Okla. January 22, 2009), the insured was unhappy with his auto insurer's initial estimate as to the value of his damaged vehicle. The insured filed suit in Oklahoma state court. The insurer moved to dismiss the suit, arguing that the insured had failed to submit a formal proof of loss, and had also failed to pursue the appraisal process as set forth in the policy. The court directed the parties to complete an appraisal within 60 days, and the plaintiff dismissed the suit.

Following the appraisal process, the insured filed suit in federal district court. The insured challenged the use of the appraisal process, sought to set aside the award, and also claimed that the insurer had acted in bad faith. The court found that, before the insured would be entitled to have the umpire's award set aside, it must prove by clear and convincing evidence that the award was entered by fraud, gross mistake, or misconduct. The court held that questions of fact remained on that issue.

The court went on to hold that the insured could not establish a viable bad faith claim. Citing to Oklahoma law, the court held that an insurer does not act in bad faith in litigating a dispute with its insured if there is a "legitimate dispute" as to coverage or the amount of the claim, and the insurer's position is "reasonable and legitimate." Rather, to prove a breach of the duty of good faith and fair dealing, the insured must show by a preponderance of the evidence that the insurer failed to treat the insured fairly or that it tried to make the insured "surrender his policy or disadvantageously settle a nonexistent dispute."

Here, the court held, the evidence demonstrated nothing more than a legitimate dispute about the value of the truck. Moreover, the court held that the conduct of the umpire, which allegedly constituted bad faith, could not be attributed to the insurer. The umpire was an independent entity who acted on behalf of neither party. Accordingly, the bad faith claim was dismissed.

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