Saul Ewing LLP

INSURANCE PRACTICE GROUP

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The Bad Faith Sentinel

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

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Tenth Circuit concludes that complaints of several underlying suits must be examined together when determining whether insurer has duty to defend

Apartment Investment and Management Company (AIMCO) v. Nutmeg Insurance Company, No. 08-1150, 2010 WL 348032 (10th Cir. Feb. 2, 2010)

AIMCO, a self-managed real estate trust that provided property management services, brought an action against Nutmeg, its professional liability insurer, for breach of the duty to defend it in several underlying suits. The suits all stemmed from allegedly fraudulent actions of a broker who procured insurance policies for AIMCO's managed properties and arranged financing for those policies.

An essential part of AIMCO's business was risk management, which entailed the selection and procurement of necessary insurance coverage for each managed property. In connection with its efforts to provide property and risk management services, AIMCO retained an independent contractor to create and manage its insurance program. Under the contractor's direction, AIMCO retained and worked with several brokers and firms in placing property and general liability insurance. One of these brokers allegedly used AIMCO's program as part of a Ponzi scheme by adding unaffiliated companies to the policies and then retaining their premiums, as well as by using these companies to fraudulently obtain additional premium financing.

Within a year of AIMCO's discovery of the scheme, it was sued as a defendant or counterclaim defendant by seven different entities in seven different lawsuits. Several of the suits alleged either AIMCO's direct involvement with the scheme or liability for the actions of its independent contractor. Upon receipt of these suits, AIMCO contacted Nutmeg to provide it with a defense under its professional liability policies. Nutmeg declined to defend the suits based on its position that none of the complaints alleged "wrongful acts" as covered by its policies. AIMCO subsequently brought suit in Colorado state court claiming Nutmeg breached its duty to defend and Nutmeg removed the case.

The district court examined each complaint separately and limited its analysis to comparing the allegations of each individual complaint with the insurance policies. The district court concluded that two of the seven complaints did not allege any covered conduct and that the other five were

excluded from coverage under the policy's insurance broker exclusion. Upon finding no duty to defend, the district court dismissed AIMCO's remaining claims, including claims for indemnification and bad faith breach of an insurance contract.

Ordinarily, in suits brought to determine whether or not an insurer has a duty to defend, the "complaint rule" limits the court's consideration to solely the policy and the complaint. The purpose of the complaint rule, as stated by the Colorado Supreme Court, is to "protect the insured's legitimate expectation of a defense" and to prevent an insurer or an insured, while litigating the duty to defend in a declaratory judgment action, from compromising the insured's defense in the underlying suit.

After examining the complaint rule, the Tenth Circuit concluded that, in certain circumstances, a court may consider evidence outside the complaint in making its determination on the duty to defend. The court explained that this exception to the complaint rule, which would require an insurer to consider facts of which it is aware in parallel complaints that tend to show a duty to defend, would not undercut an insured's legitimate expectation of a defense. Such an exception would likewise not thwart the second purpose of the complaint rule; it would not be necessary for an insured to establish facts through discovery as they would already be known to the insurer, thus there would be no prejudice. Additionally, even if an insured was forced to litigate whether these additional facts were known to the insurer, the insured would not have to establish these facts were true, but would instead simply have to show the insurer was aware of the alleged facts outside the complaint that potentially or arguably place a claim within the policy's coverage.

After determining that the exception exists, the court applied the exception to the AIMCO case and concluded, after examining the complaints together, that there was sufficient information to provide Nutmeg with reasonable notice that the suits might fall within coverage of the policy and thus reversed the district court's decision.

Insurer did not act in bad faith by relying on a contractual limitation to coverage

Nordi v. Keystone Health Plan West, Inc., No. 1476 WDA 2008, 2010 WL 204103 (Pa. Super. Jan. 22, 2010)

Nordi purchased an "Individual HMO Subscriber Agreement" from Keystone, an HMO subsidiary of Highmark, Inc. After she was injured in a car accident, Nordi requested and received approval from Keystone for 20 outpatient physical therapy visits starting on March 22, 2002 and ending May 21, 2002. On May 23, 2002, Nordi requested additional therapy sessions to continue her progress toward recovery, but Keystone denied her request on the ground that she had exhausted her coverage. Keystone based its decision on the "Schedule of Copayments and Limitations" section of the policy, which limited coverage to 60 days from initiation of treatment. Nordi consequently discontinued her therapy, allegedly leading to a delay in her recovery. In February 2004, Nordi filed a complaint against Keystone alleging breach of contract and bad faith denial of benefits, arguing that the policy language cited by Keystone required the insurer to pay for 60 therapy visits, regardless of the timeframe in which they occur. The trial court granted Keystone's motion for summary judgment on the basis that the plain meaning of the disputed contract language required Keystone to provide therapy sessions over a 60-day period beginning with the first therapy session, not to provide 60 sessions.

Nordi appealed the trial court's decision, arguing that the coverage language was ambiguous, and reasserted her bad faith arguments. The Pennsylvania Superior Court upheld the trial court's decision, holding that the plain and common sense meaning of the disputed contract language obligated Keystone to pay for therapy services rendered within 60 days of the first visit. The court concluded, despite Nordi's argument that anecdotal evidence indicated that many insureds were confused by the 60-day provision, "[j]ust because some people have difficulty understanding insurance policy language does not mean that the language is ambiguous."

The Superior Court also specifically addressed Nordi's bad faith argument by first indicating that the Pennsylvania HMO Act insulates Keystone from laws like Pennsylvania's bad faith statute, 42 Pa. C.S.A. 8371. The Court secondarily noted that Keystone could not be liable for bad faith handling of Nordi's claim as it had relied on an applicable exclusion for coverage.

Ohio court requires prima facie showing of waiver of attorney-client privilege in order for bad faith plaintiff to obtain claims file materials

Galion Community Hospital v. Hartford Life and Accident Insurance Company, No. 1:08 CV 1635, 2010 259126 (N.D. Ohio Jan. 29, 1010)

Galion and Hartford entered into a Stop Loss Insurance Agreement that provided for individual stop loss coverage and a Rider for Advance Reimbursement. In December 2007, Medical Benefits Administrators, the third-party administrator retained by Galion and approved by Hartford to process claims for benefits under the Stop Loss Agreement, submitted more than $600,000 in stop loss claims and advance reimbursement claims for payment, claims that Galion maintains were properly and timely submitted in accordance with the terms of the agreement. Hartford denied these stop loss and advance reimbursement claims. Galion filed a Complaint against Hartford attempting to bring six causes of action relating to the denial of its claims, including a claim for bad faith.

In December 2009, Galion filed a Motion to Compel Discovery or, alternatively, for *In Camera* Review of Documents Identified on Hartford's Privilege Log seeking production of claim file materials containing attorney-client communications. In response, Hartford filed a Motion for a Protective Order or, in the alternative, to Bifurcate Plaintiff's Bad Faith Claim and Stay Discovery. Galion argued that Hartford was not entitled to withhold the claim file materials from discovery under Ohio precedent. The Ohio Supreme Court, in *Boone v. Vanliner Insurance Co.*, 744 N.E.2d 154 (2001), allowed an insured to discover claim file materials containing attorney-client communications where the action alleged bad faith denial of coverage and the documents, created prior to denial, involved coverage. Hartford argued that the Ohio legislature limited the Supreme Court's decision by statutorily requiring a plaintiff to make a prima facie showing that the attorney-client privilege should be waived. The court agreed with Hartford's interpretation of the privilege and concluded that Galion failed to make a prima facie showing that the attorney-client privilege should be waived in this case.

Eleventh Circuit holds insured cannot recover bad faith damages that were not reasonably foreseeable

Heritage Corporation of South Florida v. National Union Fire Insurance Company of Pittsburgh, PA, No. 08-14824, 2010 WL 227578 (11th Cir. Jan. 22, 2010)

Heritage submitted claims to National Union for losses of over $3,000,000 from employee fraud. National Union refused to pay. Heritage sued National Union to recover damages and after a jury trial, Heritage was awarded $53,310. Heritage then brought another suit against National Union alleging that the insurer failed to settle the claims in good faith in violation of Florida statute. The district court granted summary judgment for National Union because all evidence indicated that National Union could not have

settled Heritage's claims for $55,310. Heritage consistently claimed millions of dollars in damages and during a deposition, Heritage's president testified that he did not think he would have accepted less than $3,800,000 to settle the case. Based on these facts, the trial court ruled there was no evidence of a reasonable possibility that National Union could have settled the claim for $55,310 and National Union's denial of Heritage's significantly higher demand of more than $3,000,000 therefore was not bad faith.

The Eleventh Circuit upheld the district court's decision. The appellate court, in addition to agreeing with the district court's assessment of the insurer's likely inability to settle, held that the damages Heritage sought were not reasonably foreseeable. In Florida, the only damages recoverable in a bad faith action are those damages that are a reasonably foreseeable result of a specified violation by the insurer. Heritage provided no evidence demonstrating that its losses exceeding $5,000,000 (the amount it alleged as damages) were a reasonably foreseeable result of National Union's failure to settle a claim worth $55,310. Heritage's own expert testified that National Union's failure to pay the $55,310 did not cause the $4,500,000 in losses he estimated that Heritage suffered.

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