



BAD FAITH LAW REPORT

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Preparing for Adjuster Depositions in Bad Faith Cases: The Plaintiff's Objectives

By Michael Sean Quinn and John D. Moyer*

The plaintiff's fundamental objective in every bad faith case is to show that the insurance company has not only breached the insurance contract but also behaved badly. Seldom can she prove that an insurance company has refused to pay a claim simply out of malice, perversity, pique, anger, or some sort of corporate will to self-injury. More often the insurance adjusters were enraged, irascible, obdurate, block-headed, or (more likely) inattentive. Thus, the main theme in a bad faith case is more likely to be irrationality than malice.

Irrationality, of course, takes many forms. Its weakest form is the kind of unreason associated with the law of negligence. In most jurisdictions, mere negligence does not constitute bad faith. Typically, there must be a denial that is not even debatable. Nevertheless, negligence can be a start. Evidence of adjuster negligence substantially reduces the probability of an insurer obtaining a summary judgment. Often, policyholders can use expert testimony from sympathetic experts to nudge negligence over some vague line into the area of bad faith. The more aggregate negligence there is, whether in separate acts or a single whopper, the better off the policyholder. Foul-ups can often be recast, at least before trial, as obduracy (at least) or (perhaps even) conspiracy. The more foul-ups, the better. The bigger an error, the worse the insurer looks. Of course, to err is human, and there are imperfections in the handling of many claims. The plaintiff's goal is to find all of the actual or arguable imperfections and present them to the jury in the most damning light possible. The defendant's goal is to explain away errors that

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are only apparent and to minimize the significance and culpability of any that cannot be explained. Both tasks require development of evidence.

In this article, we explore the challenges of conceiving, discovering, developing, and defending a bad faith case. In the next issue, we will build on that foundation by looking at deposition questions that a plaintiff may pose to an adjuster and how defense counsel can prepare the adjuster to respond to them.

The present article is largely written from the point of view of the policyholder and his lawyer. The reason is quite simple. In any bad faith case, the insurance company is almost always on the defensive. To defeat the policyholder's claims, the insurer must anticipate the case the policyholder is likely to present. Such anticipation requires thinking through the case from a policyholder's point of view and then recasting the case in the light most favorable to the insurance company. Defense counsel must prepare witnesses, before they are deposed, to assist in presenting the case in such a light. The deposition testimony shapes the case for trial.

Fundamentals

Bad faith cases provide policyholder lawyers with enormous opportunities for creative discovery. The lawyer representing the insurer has an obligation to respond with ingenuity. In anticipating what the defense lawyer might do, the plaintiff's lawyer should keep in mind the following "fundamentals":

1. Organizational chaos causes irrational decision-making.
2. Bureaucratic orderliness is a necessary condition for rationality in organizations.
3. The more disorderly the context in which claims decisions are made, the more likely it is that a claims decision is irrational.
4. One of the keys to every bad faith case is the order in which things happened. Another is the reason they happened.
5. Yet another of the keys to bad faith cases is the length of time in which things did not happen.

6. Still another key is what did not happen.
7. The last key is the why.
8. The essence of every bad faith case is to be found in the chronology of the adjustment.
9. Business ethics apply to claims handling.
10. The more deviation there is from accepted canons of business ethics in the handling of a claims file, or in a claims department, the more likely it is that there has been bad faith in handling the file.

We are not suggesting that any of these principles is actually true, especially the first three and the sixth. We are only suggesting that they are so widely believed that if facts can be developed that fit within their framework, summary judgment against the policyholder becomes less likely, and success at trial becomes more likely.

For the purposes of simplicity, we assume that all coverage issues have been resolved and that the insurer breached the insurance contract, either by failing to pay what was due or by delaying payment for so long that the policyholder suffered as a result. Next, we assume that the insured or her law firm has sufficient economic means for pursuing discovery and that the stakes justify it. For those purposes, we do not distinguish between first-party and third-party liability claims. Although the legal theories are different, the objective of showing insurer error is the same.

What Makes a Bad Faith Case Dangerous?

The experienced plaintiff's lawyer remembers that the idea of associating a duty of good faith and fair dealing with contractual obligations has been kicking around since the second world war. It was widely discussed through the early 1950s by legal realists such as Karl Llewellyn.¹ It was included in the Uniform Commercial Code, which has almost nothing to do with insurance but is extremely influential in contract law.² The duty of good faith in contract performance was generalized in the *Restatement (Second) of Contracts* and has taken the world of insurance by storm.³ Many lawyers believe that

¹ STEVEN J. BURTON AND ERIC G. ANDERSEN, *CONTRACTUAL GOOD FAITH: FORMATION, PERFORMANCE, BREACH, ENFORCEMENT* (1995). Chapter 2 provides a history of good faith performance at common law and outline of the theory. See Ziporah B. Wiseman, *The Limits of Vision: Karl Llewellyn and the Merchant Rules*, 100 R.L. Rev. 465 (1987). See generally William L. Twining, *KARL LLEWELLYN AND THE REALIST MOVEMENT* at 322 *et seq.* (1973).

² E. Allan Farnsworth, *Good Faith Performance and Commercial Reasonableness Under the Uniform Commercial Code*, 30 U. CHI.L.REV. 666 (1963); Robert S. Summers, "Good Faith" in *General Contract Law and the Sales Provisions of the Uniform Commercial Code*, 54 VA L.REV. 1995 (1968).

³ W. DAVID LAWSON, *BINDING PROMISES: THE LATE 20TH-CENTURY REFORMATION OF CONTRACT LAW* 104–32.

courts are in a period of retrenchment regarding these duties in the insurance area and regarding awards of substantial tort damages for breaching them. But if an insurance bad faith case is carefully and properly presented, apparently bad facts may overcome any retrenchment in the law.

Some of the themes policyholders generally try to develop are to be found in the jurisprudence of contractual good faith developed by lawyers and scholars reflecting upon the thrust of the UCC and upon the theory of the *Restatement*.⁴ Here are some of the important questions policyholder lawyers ask themselves and then pursue in discovery:

1. Did the insurer seek to evade the spirit of the deal? Was the insurance company faithful to the agreed common purpose of the parties to the insurance contract?

2. Did the insurer seek to evade the reasonable and justified expectations of the insured given the market, commercial history, customs in the industry, and the language of the policy?⁵

3. Was there any lack of diligence on the part of the insurance adjusters in pursuing the claim? Did they slack off?

4. Did the insurer make all the disclosures a thoughtful and helpful person would have made under the circumstances?

5. Did the insurer play upon any power differentials in its favor?

6. Did the insurer fail to cooperate with the policyholder in any respect?

7. Did the insurance company deliberately do only what was absolutely required? Did it willfully provide only substantial performance?

8. Was the insurer generous in exercising whatever discretion it had in performing under the contract?

9. Did the adjuster look for coverage or try to circumvent or ignore traces of coverage?

10. Was any conduct of the insurer unfair? Unreasonable? Indecent? Unconscionable?

There is an enormous amount of information to be found in answers to these questions.

We have assumed that the insurer breached the contract itself. But Question 1 seeks broader information. Was there a mere technical violation or was there an actual attempt to circumvent the deal? In a bad faith case, this can make a huge difference.

⁴ Steven J. Burton, *More on Good Faith Performance of a Contract: A Reply to Professor Summers*, 69 IOWA L. REV. 497 (1984).

⁵ Symposium, *Insurance and the Doctrine of Reasonable Expectations*, 5 CONN. INS. L.J. 1 474 (1988–1989) (ten articles on the subject by leading insurance scholars).

Many jurisdictions hold that a reasonable expectation of the insured (Question 2) may support an action against an insurance company.⁶ Other jurisdictions have not, and some have even repudiated it. The point is not what is admissible at trial or what will carry the day of the appeal. The point is to develop discovery. If an insurer is trying to evade what everybody thinks is appropriate under an insurance contract, the insurer probably will have done something quite specific that is unlawful.

Question 3 really has to do with the chronology. It will be almost immediately obvious whether the adjuster paid attention to the claim or let it slide. One of the principal functions of policyholder lawyers is to keep the ball in the insurance company's court. Insurance companies frequently try to get the ball in the insured's court and keep it there. As long as the insured is supposed to be doing something, the insurer has a reason to wait.

Question 4 asks whether an insurer tried to be helpful. Insurers like to picture themselves as obligated to perform under a contract. From a black-letter law standpoint, this may be true. But juries (and everyone else) expect insurers to try to be helpful and prompt.

Insurers are almost always more powerful than are their insureds. The insurers have the resources; they design the policy; they have the time; they have the expertise. Question 5 looks into this topic.

The difference in power inclines jurors to be hard on insurers when they do not cooperate with policyholders. That is why Question 6 is extremely important.

Question 7 inquires about whether the insurer adopted a minimalist approach to performance. If it did, the chances are that it did something unlawful. Even if it did not do anything unlawful in this context, the chances are that the jury will react negatively to this information, properly presented. As a result, if there is something else that the insurer did that is substandard, the insurer will find itself in trouble. Insurers have substantial discretion in handling claims. This is true of necessity. In fact, focused insurers can pull ahead of their competitors by exercising discretion generously to their insureds. This is a business reality. Everyone knows it. The plaintiff's lawyer should exploit it.

The opposite of generosity is for the adjusters to ignore coverage. If they did, they (in effect) leaned on the insured. This perception will make things hard for them with the jury.

Not all of these questions will apply to every case. Indeed, they will not all apply to many cases. But, when experienced policyholder lawyers design discovery with these questions in mind, the quality of the discovery will be high. If a lawyer for the insurer keeps them in mind when thinking about how to

defend against bad faith allegations, insurer responses will improve.

Finding and Analyzing the Documents

In considering, outlining, and formulating deposition themes and questions, as well as objections and (more importantly) responses, a number of points should be kept in mind. Of course, not all of these ideas apply to every case.

The Claim File

The experienced plaintiff's lawyer knows not to try to develop a bad faith case without having the claim file. Not long ago, we saw an elderly expert witness, who has nearly fifty years experience in the insurance business but who now mostly testifies for policyholders, brandish a rather small sheaf of papers in front of the jury, describe it as a "too thin" claim file, and suggest on this basis that the insurer was guilty of bad faith. The issue before the court was a simple one having to do with misrepresentation by the insured to the insurer. Of course there was a thin file. Moreover, the facts of the case were quite simple and largely undisputed. Nevertheless, this witness's performance was quite effective, underscoring the centrality of the claim file in any bad faith case.

The plaintiff's lawyer should insist upon obtaining the complete claim file. Informal letter requests (and follow-ups) are often the place the plaintiff's lawyer starts if there has been incomplete production. The complete file includes all pertinent matters to be found in computer systems, including reserves, payments, whatever else is found in what some companies call the "Financial Section," and data compilations. If the insurance company holds anything back and claims it to be privileged, the plaintiff's lawyer should insist upon a privilege log and take the claim of privilege to the court for adjudication. The insurer's computerized information-processing system is often considered the envelope in which the claim file is kept. There is frequently a computerized diary system, for example. Often, there is a "come up" log suggesting when the adjuster is to examine a file. The plaintiff's lawyer should get that log and compare it to the claim file. Communiqués between adjustment departments and underwriting departments are discoverable, and they should be pursued. Sometimes, the plaintiff's lawyer can get reinsurance documents in discovery, sometimes not.

A supervisor may have his own separate file. If no such file is produced in the first round of document discovery, the plaintiff's lawyer should determine whether there ever has been one. She should determine whether there were ever any handwritten notes in the supervisor's separate file, and, if they are missing, what happened to them. If no one seems to know where they are, then the plaintiff's lawyer may ask the jury to infer from the unexplained disappearance that it was mysterious and therefore nefarious. The inference is shaky, but it does raise doubts. Circumstantial evidence is evidence. Circumstances that fit a pattern constitute some evidence. On the other hand, if

⁶ See *id.*

the supervising claims person says that he never took any notes, and this fact is believed, then the plaintiff's lawyer may argue that the claims department was sloppy. Virtually any expert on adjustment will say that note taking is important and that its absence suggests inattention.

Historically, memoranda from adjusters to supervisors or from supervisors to adjusters, and various diverse reports provided a road map for studying the handling of a loss. In many cases, there is less of this sort of material now than there was in the past. Adjusters have less time than they use to, because they have more files. In addition, they formerly dictated reports and memoranda. In those days, there was a steno-pool to type them up. Now, adjusters are expected to key their own reports into a word processor. This is a daunting task for those who do not type well.

The plaintiff's lawyer should study the claim file carefully. She should prepare a detailed chronology. She should look for references to what might be absent. Naturally, she should seek production of those documents.

Studying the claim file requires that a lawyer know what various symbols mean. Frequently, claim files use a kind of shorthand. Some components of that shorthand are standardized abbreviations. Some abbreviations are standardized across the industry. Some are standard only within a company. It is a good idea to get material on company abbreviations. This sort of material is almost always available in some form or other. Different people put information into claim files. The experienced plaintiff's lawyer will obtain material identifying each such person.

Policy numbers frequently have a specific meaning. Claim numbers often have a precise significance. Policy numbers identify the type of policy, the location of sale, the location of the insured, the member company which is the insurer. Sometimes these numbers can provide clues to help find mistakes. The experienced lawyer will inquire about all this. Claim numbers may also be important. These numbers may indicate whether the insurer regards the claim as a large one or a small one. It may disclose who the real claims manager is and where the decision-making claims office is. Changes in either of these numbers may contain revealing information. An experienced plaintiff's lawyer knows to ask for the raw data, so that he will know how these numbers might have changed.

Sometimes it is required that the claims department report to a reinsurer or to the underwriting department. The plaintiff's lawyer should try to get these reports. An insurer may make all sorts of admissions in a report to a reinsurer that it denies making in litigation with a policyholder. A claims person may ask a question of the underwriting department that indicates that language is vague or difficult to understand, when the insurer is contending that the contract is so clear that any sixth grader could understand it.

The plaintiff's lawyer should see what is in the file in the way of profiles of evidence. If there have been recorded statements or depositions, the plaintiff's lawyer should try to determine whether that material has ever been in the claim file. If it has not been in the file, the plaintiff's lawyer should ask why not. If it is only summarized in the file, the plaintiff's lawyer should try to determine whether the summaries are accurate and complete. If that sort of material was in the file, the plaintiff's lawyer will try to determine what role, if any, it played in the denial of the insured's claim, why it was not referred to in internal reports, or, alternatively, why it was referred to wrongly in internal reports, and so forth. There will almost always be some problems of this sort. No complex adjustment is ever perfect. The plaintiff's lawyer's goal will be to maximize the zone of imperfection.

The plaintiff's lawyer should keep accurate and complete records of what the insurance company initially refuses or neglects to produce and accurate records of what is produced voluntarily, though late and after some argument, or only in response to a court order. The pattern of documents are "voluntarily" produced late or in response to a court order can be revealing. The fact that an insurance company tries not to produce some records at all is sometimes used as part of proving the bad faith case-in-chief. Policyholder lawyers often consider deposing people on production refusals and delays.

Some evaluation of the evidence will come from an expert witness. The goal is to produce an expert opinion, supported by descriptive narrative, to the effect that when an insurer refuses to produce documents of a sort, which this one initially refused to produce, the insurance company is often trying to hide something. This tactic is expensive, of course, and the testimony may not be admitted. (Many courts rule that this sort of conduct is not a proper subject of expert testimony, but still, the experienced plaintiff's lawyer frequently thinks it is worth some testimony.) If the testimony is admitted, it is extraordinarily dangerous to the insurance company. Indeed, the credible threat of such testimony may have an impact on the settlement value of the case.

Manuals, Training and Supervision

If there is an adjustment manual, an experienced plaintiff's lawyer sees to it that she gets it. Some insurance companies deny that such documents exist, but they frequently do. If a manual does not exist, the plaintiff's lawyer should ask why not and try to find out when, if ever, there has been an adjustment manual. Almost always, if an insurance company does not currently have an adjustment manual, it will have had one in the past. The plaintiff's lawyer should try to find out who had copies of it and what they remember about it. In particular, she should try to determine why it was withdrawn from use. The plaintiff's lawyer will ask her expert witness if it is appropriate for there not to be a policy manual. If the expert says there should be one, that there usually is one, or that having one is customary, such facts should be included in the expert's

opinion. The thorough plaintiff's lawyer sometimes searches cases, brief banks, news clippings (for example, from the trade press), the trade and law review literature, deposition and opinion data banks, and the internet for traces of an adjustment manual.

Often, claims manuals include procedures for how claim files are to be set up. If the material produced in a given case does not include file set-up procedures, it is often specifically and insistently sought by the experienced plaintiff's lawyer. Written set-up procedures invariably exist. If an existing file is substantially out of kilter with the set-up procedure, then something is wrong: the claims context has become disorderly.

Almost all insurance companies, and a great many adjustment departments, have "Mission Statements." The effective plaintiff's lawyer discovers them. Every mission statement contains broad, glowing, inspirational—indeed, idealistic—language, which is also vague and ambiguous. Comparing that language to the performance of the insurance company in a given case can be quite damning.

Some website prose is every bit as helpful as propositions in formal "Mission Statements." Even an inexperienced the plaintiff's lawyer will go to a company's website.⁷

Responsible claims people admit that training is important. How could they do otherwise? In depositions, the plaintiff's lawyer will find out how much training the line adjuster has received in, say, the last five years. If some arcane portion of the coverage was at stake in the coverage dispute, the plaintiff's lawyer should inquire about all training the adjuster has received on that topic at any time. Frequently insurance companies keep training materials. The deposition of the head of training may therefore be taken. The plaintiff's lawyer may seek the mission statement of the training department, what the insurer's philosophy of training is, and whether the insurer has used external training agencies. She may subject them to discovery.

Training records are frequently kept in the personnel file of the adjuster. This is one reason why the plaintiff's lawyer frequently seeks the personnel file, and why she asks for a list of all the documents therein, should the insurance company refuse to produce it. (One of the kinds of training documents that are found in personnel files are old tests, which adjusters have taken at the end of training courses. Is it fair to criticize an adjuster in the year 2000 for a test he got a 75 on in 1982? Most juries recognize that this is unfair. But then again, perhaps the adjuster should be prepared on this point, short of actually seeing the old test.)

The plaintiff's lawyer should study the pattern of supervision received by the line adjuster. She will find out how many

cases he has. This is very likely to be derivable from information in the insurer's computer system, if the adjuster does not actually know it. If the insurer says it is not, the plaintiff's lawyer will take depositions from the information technology department to determine what can be done. Beforehand, the plaintiff's lawyer will get a great deal of information about the insurer's computer system and the software it uses. Of course, often this information is obtained through interrogatories and requests for production. Policyholders often wish to review computer usage manuals. Occasionally, they are even permitted to extract information from the system.

In this context, the plaintiff's lawyer often finds out how many adjusters the senior claims person supervises. It may very well be eight to ten, which is probably too many. (Interestingly, this number has risen from three to four a few years back to its present number.) Policyholder counsel often try to figure out how many face-to-face meetings there were between the adjuster and her supervisor, how many e-mails there were, how many telephone conversations there were, how many file audits there were, and so forth.

If an insurance company denies having any such information available, the chances are that the full truth is not being told. Insurance companies are statistical engines, and they can frequently lay their hands on all sorts of statistics. Insurance company computers are designed to do this sort of thing. The plaintiff's lawyer should be prepared to attempt to contradict through depositions insurance company assertions regarding the non-existence of information.

Reserving

Reserves are frequently of interest. If the plaintiff's lawyer can prove that the insurance company under-reserved the claim, when a reasonable claims handler would have reserved the claim at a higher level, the plaintiff's lawyer can invite the jury to draw the inference that the insurance company performed a defective investigation or engaged in self-deception, which will tend to support an overall inference of bad faith. This is a topic rich with argumentative possibilities because the term "reserve" is ambiguous, although it expresses an important concept.

The law and sound business and accounting principles require insurers to account for "liabilities associated with the future performance of services that *may* be required under the insurance contract."⁸ Reserves are generally divided into two broad categories: loss reserves and expense reserves. Loss reserves are amounts that *may* have to be paid out for claims.

⁸ DAVID H. MARSHALL, WAYNE W. MCMANUS, PAUL M. KAZENSKI & KENNETH N. SCHOLAS, JR., ACCOUNTING AND FINANCE FOR INSURANCE PROFESSIONALS (1997) (the textbook for CPCU #8).

⁷ More will be said about websites in the next essay.

Loss reserves are often tied to an insurer's predictions and expectations.⁹ This is how insurers think of them. Obviously, the predictions and expectations should be as reasonable as possible. If loss reserves are tied to predictions of actual payments, then in first-party cases, when loss reserves are tied to reasonable estimate of what an insurance company will actually have to pay, the insurance company is entitled to consider not only the amount of the insured's loss but also the probability that coverage may not exist. If an insured has suffered a \$1 million loss, but coverage is only a 50-50 proposition, then the loss reserve should be \$500,000. The situation would be more complicated in a third-party case. Suppose the insured faces possible liability of \$1 million, and there is a significant evidentiary problem in the plaintiff's case so that the probability of a plaintiff's victory is no greater than 50 percent. Further suppose that coverage is again a 50-50 proposition. The loss reserves should be \$250,000. Notice again that when loss reserves are tied to predictions or expectations of actual payment, probability of coverage is relevant matter.

Adjusters are frequently taught, however, that reserves constitute their best estimate of what the insurer will have to pay, if there is coverage. Obviously, this concept of reserves differs from the more actuarial notion, which includes some references to the existence of coverage. Many insurance company executives do not want adjusters to think in terms of discounting possible total payments by the improbability of coverage. They fear that taking this approach may lead to damaging testimony, and they are right. The alternative is not much better, but it is hard for the plaintiff's lawyer to ferret it all out.

In summary, there are two separate approaches to reserving. One might be called the "probabilistic" approach. This approach looks at what an insurance company will probably have to pay and includes reference to coverage. The other approach might be called the "potentiality" approach. This approach asks what the insurance company *may* have to pay if coverage exists.

⁹ THOMAS E. GREEN, GLOSSARY OF INSURANCE TERMS 153 (1994). Loss reserves are the "estimated liability for unpaid insurance claims or losses that have occurred from a given evaluation date." In the aggregate, a loss reserve number "describes a loss reserve as it would appear in an insurer's financial statement. As to individual claims, the loss reserve is the estimate of what will ultimately be paid out in that case." See HARVEY RUBIN, DICTIONARY OF INSURANCE TERMS 240 (1991) (loss reserves constitute "provision for known claims due but not paid, known claims not yet due, and provision for incurred but not reported (IBNR) claims"); MICHAEL C. THOMSETT, INSURANCE DICTIONARY 121 (1989) (Loss reserves are "reserves established to estimate the pending losses to be paid. These losses include a provision for Incurred But Not Reported (IBNR) losses, existing in known claims that have not yet been paid to policyholders, claims acknowledged but not due until a future date, or losses reported in the end of one period but not paid until the next. The reserve can also include a contingency for contingent losses that will not be manifested for many years, but that the company expects to have to pay.").

Some state statutes arguably require the latter approach. Consider article 21.39 of the Texas Insurance Code, a typical statute. It provides: "Every insurer shall maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of statement, whether reported or unreported, which are unpaid as of such date and for which such insurer *may* be liable[.]" The statute goes on to order the Texas Insurance Commissioner to adopt formulas for establishing reserves recommended by the National Association of Insurance Commissioners. These are very complicated formulae, and they will be lost on most jurors. The key to this statute is the word "may." If the word "may" is associated with what is possible, then the concept of the loss reserve should not be connected to what the insurance company reasonably expects it *will* have to pay. It should be connected to what the insurance company reasonably thinks it *might* have to pay under a worst case scenario.¹⁰

The plaintiff's lawyer may well try to persuade a jury that it should take the word "may" literally and thereby suggest that the claim in question was substantially undervalued by the insurance company. The plaintiff's lawyer does not care that the insurance company systematically undervalues claims, if her conception of loss reserves is adopted. Indeed, this is not something she wishes to explore at all. She wants to suggest her case is unusual. The plaintiff will try to get the adjuster to concede that it was quite possible that the insurance company would have to pay more than was included in the reserve.

The plaintiff's lawyer will then try to demonstrate that the insurance company failed to pay in part because of the low reserve. It is not at all uncommon for adjusters to decline to increase offers because of the level at which a reserve has been set. This is true in both first-party and third-party claims. This tendency among claims handlers is one of the reasons why insurance companies do not want adjusters to discount reserve estimates by the improbabilities arising from noncoverage. There is simply too great a tendency to reserve in anticipation of bartering or negotiating. This is especially true in liability

¹⁰ Curiously, the difference between *expectation* and *potential* is reflected through the definitions to be found in sources already quoted. The Green GLOSSARY (at 222) also defines the term "reserve" as "[a]n amount representing actual or *potential* liabilities tapped by an insurer to cover debts to a policyholder." Obviously, the word "potential" is broader than that which is "predicted" or that which is "expected." You can have all sorts of potential liabilities which you do not expect. The Thomsett dictionary (at 181) contains a similar definition of the term "reserve." That term is defined as "a liability established for the purpose of paying future claims. The present value of the amount established, as a reserve is estimated to be equal to the present value of all future claims." Notice that the amount of the reserve must be equal to "all future claims." It is not "all future claims which must be paid" or "all future claims for which there is coverage." This may very well be a number substantially larger than all future claims which are paid, or which are legally required to be paid, or which a reasonable adjuster would reasonably believe be legally required to be paid.

situations. Obviously, in first-party situations, whether coverage is an issue, it is immediately on the table, and it is something that stays on the table.

Third-party claims involve another complication. If an insurer believes that there is no coverage, there may be two adjusters involved in the case. There will be unquestionably be a claims person to deal with the defense of the insured. There may also be another one involved to deal with claims problems. The plaintiff's lawyer will want to know who set the reserve. He will want to know how the two claims people interacted with each other, and this inquiry creates an interesting problem. If they interacted closely, it will look collusive, and the jury may infer that the insurance company feathered its own nest. If the claims handlers did not communicate at all, it may appear that both operated in the dark, and that too is a problem.

The defense lawyer should make sure that she has all of the pertinent definitions of the word "reserve" her client utilizes. Her witnesses should know these definitions, and they should be prepared to explain why reserves were set the way they were. Witnesses may need to be alerted to the ambiguity inherent in the notion of loss reserves. If the claims witness is sophisticated and articulate, perhaps he should be schooled in the NAIC reserve-setting formulae.

Many insurers instruct their lawyers not to divulge reserve numbers in discovery. Some courts go along with this practice. We question whether this approach is sound. Reserve numbers seem relevant, in the broad sense of discovery and maybe even in the narrower sense of admissibility. On the other hand, the concept is undeniably confusing.

Communications with Underwriting, Agents, or Brokers

If there are substantial controversies about coverage, the plaintiff's lawyer should try to find out whether the claims representative contacted the underwriting department and or the broker to resolve them. If there were contacts with the underwriting department, the plaintiff's lawyer should take depositions from the relevant underwriters. If there were contacts with the brokers, the plaintiff's lawyer should depose the brokers. In either case, the plaintiff's lawyer should get the underwriting file and the broker's file. Material from these files should be studied carefully, in chronological order, and correlated with the claim file. This is particularly significant if the claim department took positions at variance with those of the underwriting department. The plaintiff's lawyer should try to get relevant portions of underwriting manuals, guidelines, instructional material, topical memoranda, and the like.

Currently, for example there is substantial controversy over whether mold is a pollutant. Many brokers and underwriters inflexibly believe that it is not, while many adjusters believe that it is. The plaintiff's lawyer should argue that unresolved internal controversies, like ambiguous policy language, should

be resolved in favor of the insured. The policyholder should find out how much controversy there was inside the adjustment department as to the denial of the plaintiff's claim. The plaintiff's lawyer is always interested to know what the adjuster himself thinks personally—to find out if she has any doubts.

Handling of Other Claims

In novel areas of inquiry and dispute—such as whether mold is a pollutant—the policyholder should find out, if possible, what the insurance company has done in the past. Frequently, insurers will pay small claims for large or insistent insureds, even though they are doubtful. Sometimes, claims are not just doubtful, they are invalid. This fact can be used by the plaintiff's lawyer in the service of a bad faith case, even if all of the unwarranted claim payment was passed back to the insured through retroactive premiums and deductibles. This last observation involves a misleading implication. Under the adversary system and the requirement that lawyers pursue their client's interests zealously, this fact is irrelevant to the plaintiff's lawyer. Defense counsel must neutralize it.

Organization and Compensation

Many insurance companies now organize their claims departments as profit centers. Conceptually, claims departments are treated as separate companies selling claims services to the insurance company. Where this scheme is employed, it is a good idea to try to find out what the terms of the "deal" are. Juries tend to believe that the claims department is judged not only on whether it keeps claims' expenses down but also whatever it keeps down both the individualized and aggregate amounts of claims payments.

Policyholders may suspect that adjuster bonuses are set on the basis of the extent to which they can reduce claims payments. To be sure, bonuses are determined by outstanding performance, and outstanding performance is inconsistent with over-paying claims by much very often. Unfortunately, the line between systematically under-paying claims and paying the right amount efficiently is a very difficult one to draw. This is never true in respectable insurance companies, even though it is sometimes true in less reputable ones. It is extremely difficult for juries to draw the distinction.

There is currently a very substantial turnover in claims departments. At one time, adjusters stayed for years in the same department and in the same positions. Such people were thoroughly experienced. This is frequently no longer true. Often, adjusters are willing to talk about this fact if it is approached gently. The more turnover there is, the more disorderly the claims department looks. High turnover ratios diminish morale. Juries have difficulty imagining that diminished morale would not reduce the quality of adjuster decision-making.

Low morale is also a kind of disorder. Anxiety about job security contributes to a lack of focus. The plaintiff's lawyer should investigate any history of downsizing over the previous

two or three years and assume that downsizing may have diminished morale and therefore performance. (Evidence of downsizing can sometimes be found in the insurance press.) This is not an area where direct questions work. It is, however, easily established by experts on business performance psychology for the purposes of summary judgment, and jurors probably will draw the same inference if needed at trial.

Almost invariably, an expert witness hired by insurers can help policyholders establish standards of sound adjustment. First, standards of sound adjustment are objective. Virtually everyone agrees upon them. Second, standards of sound adjustment have been reduced to mantra-like slogans. (Consider the slogan, "The insurer must look for coverage.") Third, problems in good faith adjustment are not usually to be found in disagreement about the applicable standards of sound performance. Disagreements are to be found in the application of these standards. One good strategy for the policyholder lawyer is to secure agreement on fundamentals, develop his case that the insurer violated its own principles (as expressed by its expert), and then blend principle and factual scenario in closing argument.

In addition, experts on business management and human resources can be helpful in establishing such propositions as "Disorder leads to poor decisions." Usually, insurers have personnel departments and they have psychologists in them. If the plaintiff's lawyer can figure out a reason to take the deposition of such people, he should certainly try.

Personal Weaknesses

The abuse of alcohol or drugs diminishes the quality of claims handling, just as it reduces the quality of doctoring or of lawyering.¹¹ Fuzziness, a sense of being short-circuited, out-and-out hangovers, shame, retrospective blackout worries ("I wonder what I said this time?" "Who was that fellow?"), and guilt all degrade claims handling. There is seldom harm in asking an adjuster directly about her alcohol and drug use. If the plaintiff's lawyer gets an indication of abuse, that is all to the good; if the plaintiff's lawyer gets a denial, everyone knows that the adjuster either means what she says or the opposite. When the plaintiff's lawyer elects to pursue this line of questioning, it should come toward the end of the deposition because it is very likely to anger the witness, and there had better be external indications. Videotaped depositions have sometimes been helpful here. The plaintiff's lawyer may also probe

¹¹ The recent confessional literature on this is extremely helpful. All sorts of litigators can study this with profit. BERT PLUYMEN, *THE THINKING PERSON'S GUIDE TO SOBRIETY* (1999) (by a lawyer from Austin, Texas); PETE HAMMILL, *A DRINKING LIFE* (1994); CAROLINE KNAPP, *DRINKING: A LOVE STORY* (1997); DANI SHAPIRO, *SLOW MOTION* (1998); SUSAN CHEEVER [daughter of John Cheever], *NOTE FOUND IN A BOTTLE: MY LIFE AS A DRINKER* (1999). Is it bad faith to let a known alcoholic handle files? Fire all drunks?

whether the adjuster had personal or emotional problems that might have impacted her job performance.¹²

Like many progressive and humane firms, insurance companies usually have offices specializing in assisting personnel with personal difficulties of the sort discussed here. (Sometimes, these are called "Personal Assistance Offices".) Employers like to believe that the records of these offices are privileged, and the courts, by and large, would like to help them. Nevertheless, such records are seldom privileged. The Personal Assistance Offices are almost never staffed by physicians. The plaintiff's lawyer may seek records from this office in written discovery. If he receives an objection that is not followed by an assertion that no such records exist, he may infer that they do exist and go after them. (For obvious reasons, many lawyers are queasy about doing this, and one of the nuances of defending a bad faith case is to know how to manipulate this sense of decency.)

Sometimes, when adjusters are "disciplined" for fouling up, they are "sentenced" to undertake various activities under the auspices of the Personal Assistance Department. Sometimes, the plaintiff's lawyer can lay his hands on these records. If they exist the plaintiff's lawyer had better know about them.

No plaintiff's lawyer has any such qualms about going after personnel records and performance evaluations. These are almost always valuable to the plaintiff's lawyer. If the adjuster

¹² Knowledge of symptoms, can help the practicing lawyer. One very good source about depression in general is LEWIS WOLPERT, *MALIGNANT SADNESS: THE ANATOMY OF DEPRESSION* (1999). Another recent source which includes the study of depression is PETER C. WHYBROW, *A MOOD APART, DEPRESSION, MANIA, AND OTHER AFFLICTIONS OF THE SELF* (1997). See also DAVID A. KARP, *SPEAKING OF SADNESS: DEPRESSION, DISCONNECTION AND THE MEANINGS OF ILLNESS* (1996); MARTHA MANNING, *UNDERCURRENTS: A LIFE BENEATH THE SURFACE* (1994) (depression in a professional woman). Elizabeth Wurtzel describes depression as the slow, silent, invisible growth of malignancy:

Over the years, the data will accumulate in your heart and mind, a computer program for total negativity will build into your system, making life feel more and more unbearable. But you won't notice it coming on, thinking that it is somehow normal, thinking about getting older . . . , and then one day you realize that your entire life is just awful, not worth living, a horror and a black blot on the white terrain of human existence. One morning you wake up afraid you are going to live. . . . Depression . . . involves a complete absence: absence of affect, absence of feeling, absence of response, absence of interest. The pain you feel in the course of a major clinical depression is an attempt on nature's part . . . to fill up the empty space. But for all intents and purposes, the deeply depressed are just the walking, waking dead.

ELIZABETH WURTZEL, *PROZAC NATION* (1994). No wonder the depressed adjuster has trouble getting things done in a timely fashion or thinking clearly about transactions.

Is it bad faith for an insurer to keep a profoundly depressed adjuster handling files? Humane bad faith?

has made mistakes and personnel records show that she has an erratic history, then the insurance company is guilty of poor oversight. That fact may contribute to liability. If, on the other hand, the adjuster has made mistakes but has received glowing evaluations year after year, that too may suggest poor supervision or dishonesty. An insurance company that lies to itself will lie to its policyholders, or so the plaintiff's lawyer should say to the jury.

Advertising

Lawyers representing policyholders frequently try to use advertising slogans and copy in cross-examining adjusters. Sometimes they save this for trial. Sometimes they do it in depositions. It can be very effective. Some compulsive policyholder lawyers keep libraries of advertising. Even the inexperienced the plaintiff's lawyer should utilize the company's website. Because the material is, by definition, public, it can often be obtained outside the discovery process.

Advice of Counsel

Often, in bad faith cases, the insurer elects to utilize an advice-of-counsel defense. This requires waiving the attorney-client privilege between the carrier and its lawyer. When this happens, all correspondence between the carrier and the lawyer in a given case must be produced, as well as the lawyer's entire file. Policyholder lawyers love this, even though, in the end, advice of counsel may provide a complete defense. Getting the whole file may require some demands and motions. Now things become even more fun. Has the lawyer advising the insurer on coverage accurately represented the evidence in the case he is handling? Was it accurately and comprehensively portrayed to the plaintiff's lawyer in the first place? Has the lawyer correctly appreciated the significance of the evidence she reports? Did the adjuster study the lawyer's reports carefully? What recommendations did the adjuster make on the basis of the lawyer's reports? Were they sensible? Were they followed?

It is extremely difficult to determine whether an adjuster has even read, much less understood, reports from lawyers. Adjusters sometimes get rid of cases by sending them to lawyers, so they can work on other cases. Frequently, adjusters do not study material from lawyers carefully but rely on the lawyers. The adjusters say to themselves, "Isn't that what lawyers are for?"

It is difficult for the plaintiff's lawyer to force an adjuster to admit that he did not pay much attention to a case. Sometimes, this is done indirectly. For example, if an insurance company has discharged a law firm, or if the lawyer that handled the given case has left a law firm, the lawyer might be willing to say that it did not appear to him that the adjuster paid any attention. This kind of luck does not happen very often, but the plaintiff's lawyer knows it is worth looking into. Good luck does not make itself. Lawyers will be far more willing to criticize adjusters if they do not regard them as clients. In the first-

party situation, of course, the insurer is the lawyer's client. In the third-party situation many lawyers like to believe that the insurance company is not a client. Thus, in third-party bad faith litigation, some inquiry about the lawyer's views on this matter early in the deposition, before it is clear where the plaintiff's lawyer is going, might be in order.

Implications for Defense Counsel

The defense lawyer must anticipate what the adjuster will be asked at his deposition. Preparing adjusters, supervisors, and underwriters for their depositions may be the most important work that a lawyer representing an insurer in a bad faith case can do.

The defense lawyer must study the plaintiff's pleadings, discovery requests, motions, and depositions to try to figure out where the plaintiff is going. Sometimes this is obvious, sometimes not. In addition, the lawyer for the insurer should secure all of the kinds of documents discussed in this essay, even if the insured does not ask for them. The lawyer for the insurer may or may not want to show them to the prospective witnesses, but she should surely be familiar with them and should prepare the witness to answer in conformity with their themes, even if she does not actually show them to the witness.

Of course, the defense lawyer must have at least as detailed a chronology as the plaintiff's lawyer should have. The raw material for defending a bad faith case is almost always on the surface of the chronology. If a case is difficult, one has to look deeper.

The best way to prepare an insurer and witnesses is at length. Adjusters do not always cotton to this approach, and their supervisors almost never do. After all, it is extremely expensive. In addition, it may well be uncomfortable.

Deposition preparation should take several phases. First, the witness should read the entire claim file. Second, the witness and the defense lawyer should go over the file and solidify their knowledge. Third, they should look for problems, methods for explaining away the problems, methods for explaining why the apparent problems are not really problems. If necessary, there should be explanations as how the problems were resolved in good—if not the best—faith. Fourth, the lawyer and the adjuster should discuss the exact standards and criteria employed in the relevant jurisdiction for determining whether an insurer committed bad faith. Fifth, they should discuss the general principles underlying bad faith that have been set forth in this article. Sixth, the applicability of general principles of business ethics to this particular adjustment should be explored. Finally, the witness should be exposed to sample questions and question patterns. Two or three different lawyers should be enlisted, if the case has enough money in it. These examinations should be videotaped and reviewed.

Titillating Teaser

In our next essay, we will consider how some deposition questions illustrating the points made in this essay might go. It is time for a teaser. Consider the following sequence of questions to an adjuster.

Q: Is the Kafka Insurance Company for which you work invariably honest in its dealings with insureds?

A: Yes.

Q: Is the Kafka Insurance Company consistently reasonable in handling claims?

A: Yes, in my experience.

Q: Have you ever made a serious error in adjusting a claim?

A: No.

Q: Have you ever been spiteful in dealing with an insured?

A: No.

Q: Are insureds ever difficult to deal with?

A: Sometimes, but not really. We are well trained to deal with insureds in distress.

For a variety of reasons, each one of these answers is suspect. In a way, the plaintiff's lawyer does not really care what the answer is. Many of the answers just recorded are simply incredible. Jurors will not believe them. Some of them may well be contradicted by policyholder himself or the policyholder's representative. If they are contradicted by the policyholders representative, the adjuster will appear to be insensitive and arrogant.

On the other hand, if the adjuster gives the opposite answers to the ones recorded above, those answers are potentially damaging to the insurance company and possibly worthy of exploration. Then again, sometimes not. The next article will build on this one by considering what sorts of questions might usefully be asked, and how adjuster witnesses might be prepared to deal with such questions.

Wrongful Denial or Delay of Benefits Is Essential to Bad Faith Action: No Action Lies Against Insurer That Pays and Sues to Recover

By Robert D. Phillips, Jr.*

In a case of first impression, a California appellate court has held that an insured may not bring a bad faith claim against its insurer for initiating litigation against the insured unless the insured contends that the insurer acted unreasonably in connection with the underlying claim.¹ This article points out some of the important implications for insurance practitioners. A larger article is planned for the future, placing this decision in the context of California jurisprudence on the litigation privilege.

Old Republic Ins. Co. v. FSR Brokerage, Inc.

FSR was a real estate brokerage corporation with errors and omissions indemnity policies from Old Republic. The policies had a \$100,000 deductible and provided that Old Republic would indemnify "the Insured" for covered losses in excess of the deductible. The policies defined "Insured" to include FSR, as well as any partner, officer, director, or employee of FSR. The policies also provided coverage to "the Insured . . . for losses arising from the acts, errors or omissions of independent contractors in the performance of real estate services for which the Insured is legally liable," and "for the liability of the Insured to indemnify independent contractors for loss where such liability arises out of the rendering or failure to render real estate services by such independent contractors."²

During the Old Republic policy period, a lawsuit was filed against FSR and one of its sales agents, Larry Cannizzaro, arising from a real estate transaction handled by Cannizzaro. Old Republic paid \$250,000 to settle the lawsuit. Shortly thereafter, a second lawsuit was filed based on the same property transaction. Old Republic paid \$15,000 to settle the second action. The law firm that had represented Cannizzaro then filed a lawsuit against Cannizzaro for nonpayment of attorneys' fees

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¹ *Old Republic Ins. Co. v. FSR Brokerage, Inc.*, 95 Cal. Rptr. 2d 583 (Ct. App. 2000)

² *Id.* at 586.

incurred during the initial lawsuit. Old Republic paid \$71,369.20 to settle the third lawsuit.

Cannizzaro next filed a lawsuit against Old Republic and FSR alleging breach of contract, bad faith, and other claims. Old Republic filed a cross-complaint against Cannizzaro and FSR seeking subrogation, indemnity, and declaratory relief. In the cross-complaint, Old Republic alleged that it had funded settlements or paid legal fees in the three actions involving Cannizzaro to protect FSR, and that it was entitled to recover these sums from Cannizzaro and FSR.

Old Republic's cross-complaint alleged claims of fraud, breach of contract, and bad faith against FSR based on allegations that FSR had intentionally failed to disclose Cannizzaro's true status as an independent contractor and had submitted false invoices to Old Republic regarding the defense expenses incurred. Old Republic alleged that, during the litigation of the three lawsuits filed against FSR and Cannizzaro, Old Republic had questioned FSR regarding the status of Cannizzaro as an employee or independent contractor for the purpose of determining whether coverage existed. Old Republic contended that FSR had intentionally and knowingly failed to disclose Cannizzaro's status as an independent contractor in order to ensure that Old Republic would pay the defense and settlement costs. FSR responded by filing a cross-complaint against Old Republic for breach of contract and bad faith. The bad faith claim was based on the theory that Old Republic's assertion of a fraud claim against FSR was an act of bad faith.

Old Republic obtained a summary judgment award as to Cannizzaro's complaint because the trial court found that Cannizzaro was neither an insured nor a third-party beneficiary under the Old Republic policies.³ A bifurcated trial then took place on Old Republic's and FSR's cross-complaints. Old Republic's reimbursement claims were resolved at a bench trial, and a jury trial took place on FSR's bad faith claim. The court ruled against Old Republic on the reimbursement claim, finding that it had not adequately reserved its rights to seek recovery of its payments. Regarding FSR's bad faith claim, the jury found that Old Republic had acted in bad faith but not with malice, oppression, or fraud. Old Republic appealed.

The Decision

The California Court of Appeal, Second District, first concluded that the trial court had improperly denied Old Republic a jury trial on the factual issue whether it had waived its right to reimbursement. Undisputed evidence established that the reservation had been properly made, and testimony conflicted on whether the reservation was later waived. The trial court was directed to conduct further proceedings on the issue.

Old Republic argued that FSR's bad faith claim was barred by the absolute privilege in California Civil Code Section 47,

creating a privilege for any publications or broadcasts made in a judicial proceeding. This was a critical issue because FSR had based its bad faith claim solely on Old Republic's cross-complaint alleging fraud by FSR. FSR made no allegations of improper claims handling, investigation, or payment.

The basis of the bad faith tort is that an insured seeks peace of mind and economic protection when purchasing insurance and that an insurer's breach of the covenant can frustrate the core purpose of insurance and leave the insured exposed to a catastrophe it has paid to avoid.⁴ So, "tort recovery for breaches of the implied covenant protects the insured's interests in securing an insurance policy."⁵ As a result, "the scope of the implied covenant is tied to the express terms of the policy. When policy benefits were *never* due to the insured, California courts have generally held that the insured may not assert a bad faith claim."⁶

"In some circumstances the implied covenant continues to protect the insured's interests in the policy after litigation has begun between the insured and the insurer, despite the absolute litigation privilege found in Civil Code section 47."⁷ But "[n]o case has addressed the scope of the implied covenant when, as here, an insurer sues its insured after properly paying all benefits due under the policy."⁸ Here, FSR's theory of bad faith arose solely on the allegations in Old Republic's cross-complaint against FSR, so it fell within the protection of the litigation privilege.⁹

When the claim has been fully and promptly paid,

the insured cannot contend that it has been denied the security against losses and third party liability that it purchased under the express terms of the policy, and the only uncertainty the insured faces is whether the insurer is entitled to recover some or all of the policy proceeds in a judicial proceeding. Absent recovery for bad faith, the insured is nonetheless protected from abusive litigation by the cost of litigation against the insured, and by the availability of an action for malicious prosecution and other remedies consistent with the absolute privilege under Civil Code section 47.¹⁰

Those torts were not alleged, so FSR's bad faith claim failed as a matter of law.

Implications

The FSR decision is significant on at least two levels. First, FSR encourages insurers to pay the policy benefits so as to resolve the insured's immediate concerns while expressly reserving the right to litigate whether the insured acted improv-

³ *Id.* at 587.

⁴ *See id.* at 596.

⁵ *Id.* at 596.

⁶ *Id.* at 596.

⁷ *Id.* at 597 (citations omitted, emphasis original).

⁸ *Id.* at 597.

⁹ *See id.* at 598.

¹⁰ 95 Cal. Rptr. 2d 583, 599.

erly in pursuing the claim for policy benefits. Most California insurers have generally taken this cautious approach, but there is now more reason than ever to do so on a claim that raises doubts about the reliability of information submitted by the insured. Of course, this requires care to reserve rights.

FSR is important in a broader sense because of its reiteration of the basic principle that a bad faith claim must be premised upon an unreasonable denial or delay of benefits. California plaintiffs' lawyers frequently seek to assert "bad faith" damages in cases where benefits have been timely paid because they have some other objection to the insurer's conduct. *FSR*'s insistence that unreasonable claims handling is an absolute prerequisite to a bad faith claim makes such claims more difficult to pursue.

Claim Handling Corner

If the insured's attorney wants fees for recovery of the subrogation amount, look at whether (and to what extent) the attorney's services actually benefited the subrogee insurer. *Wensman v. Farmers Ins. Co.*

If the insurer does not participate in settlement discussions, it may not be able to object that a settlement was made without its consent. *Kitchnefsky v. National Rent-A-Fence, Inc.*

On uninsured and underinsured motorist claims, do not treat the insured as an adversary. *Newport v. USAA.*

Do not delay payment by raising unreasonable questions and expect to avoid bad faith by paying the claim later. *McGee v. State Farm Fire & Cas. Co.*

Bobbing and weaving to avoid paying a meritorious claim can get an insurer in big trouble. *Commercial Union Ins. Co., v. Seven Provinces Ins. Co.*

Competing claims for policy benefits can be resolved by submitting them to a court. *Phoenix Home Life Mut. Ins. Co. v. Brown.*

If the evidence against benefits liability is contradictory or doubtful, check it out. *Bohorquez v. Metropolitan Property & Casualty Ins. Co.*

Even when you get advice from counsel, examine counsel's rationale to make sure it can stand up to hostile scrutiny. *Scherz v. South Carolina Ins. Co.*

Recent Cases

Third-Party Cases

Insurer May Bring Malpractice Action Against Attorney Hired To Defend Insured

Paradigm Ins. Co. v. Langerman Law Offices, P.A., 2 P.3d 663 (Ariz. Ct. App. 1999), review granted (Ariz. 2000)

Paradigm Insurance Co. hired The Langerman Law Offices to defend its insured doctors. According to Paradigm, the Langerman firm agreed not to accept cases adverse to Paradigm's insureds. The Langerman firm then began representing one of Paradigm's insured doctors in a medical malpractice action. After the Langerman firm had performed some legal work in the matter, Paradigm concluded that the Langerman firm violated the alleged agreement not to take cases against Paradigm insureds. Paradigm fired the Langerman firm, retained new counsel to defend its insured, and refused to pay the attorneys' fees billed by the Langerman firm.

The Langerman firm sued Paradigm to collect its attorneys' fees, and Paradigm counterclaimed for breach of contract, malpractice, breach of fiduciary duty, and breach of ethical obligations. The trial court granted summary judgment in favor of the Langerman firm on its claim for attorneys' fees. The trial court also rejected Paradigm's malpractice claim based on the court's conclusion that, absent an express agreement, an attorney hired by an insurance company to defend an insured has no attorney-client relationship with the insurer.

While affirming the trial court's award of attorneys' fees to the Langerman firm, the Arizona Court of Appeals, Division One, reversed the judgment in favor of the law firm on the malpractice claim. The court identified the majority rule in other jurisdictions as holding that, in the absence of a conflict, the attorney has two clients, the insurer and the insured. A minority limits the attorney's duties only to the insured.

The court adopted the majority rule, which it found had three advantages. "First, to hold that an insurer cannot maintain a malpractice action against an attorney it hired to represent its insured would immunize that attorney's malpractice. . . . Second, our ethical rules do not absolutely prohibit an attorney from representing more than one client in a single matter. Third, as long as the interests of the insured and the insurer overlap, one attorney representing both makes economic and practical sense." On the facts before it, the court found "no evidence of any conflict between Paradigm and its insured. [so] a dual attorney-client relationship existed, and