BAD FAITH

NATIONAL UPDATE FROM THE COURTS

CONNECTICUT

Is It Over Yet? The Fallout from Superstorm Sandy Continues for Connecticut Insurers

On October 29, 2012, Superstorm Sandy slammed into the coast of Connecticut. Shortly after Sandy subsided, it was estimated that the storm caused at least $360 million in damage and resulted in countless claims for insurers. Closing in on a year and a half later, insurers may find some relief under the limitation provision in the Standard Form Property & Casualty Policy.

Conn. Gen. Stat. § 38a-307 provides that property & casualty policies cannot include a provision limiting the time to bring suit on the policy to a period of less than eighteen months after loss.[1] While an insurer is allowed to increase an insured's time to bring suit under a policy, this statutorily mandated floor effectively bars most claims once the period expires.[2] For damage from Superstorm Sandy, this eighteen month period is set to expire shortly.

It is worth noting that although this limitation bars most claims, certain bad faith claims are not subject to this provision and will remain viable. Connecticut law recognizes four causes of action for bad faith. Two of these arise from the policy (breach of contract and breach of the implied covenant of good faith and fair dealing). These causes of action should be barred once the standard eighteen month limitation period expires. However, Connecticut law also recognizes two statutory bad faith causes of action under CUTPA (§§ 42-110a-110q) and CUIPA (§§ 38a-815-823). These statutory claims survive all time limitations within the policy. *See Lees v. Middlesex Ins. Co.*, 219 Conn. 644, 647 (1991). While the statutory bad faith claims under CUTPA and CUIPA survive policy time limitations, an insured who attempts to bring suit on these causes of action is faced with numerous hurdles, the greatest of which is the insured must prove that an act of bad faith was committed or performed with such frequency that it amounted to a general business practice. *See McCulloch v. Hartford Life & Acc. Ins. Co.*, 363 F. Supp. 2d 169, 182 (D. Conn. 2005).

[1] There is proposed legislation to extend the time period to 2 years. *See* An Act Concerning Changes to the Property and Casualty Insurance Statute, 2014 Connecticut House Bill No. 5502 (2014).

[2] Although not binding in Connecticut, the Court of Appeals of New York, in *Executive Plaza, LLC v. Peerless Ins. Co.*, 2014 WL 551251 (Feb. 13, 2014), recently held that such contractual limitations are unenforceable as a matter of public policy. Other jurisdictions have found that the limitation period may be equitably tolled until the insurer actually denies a claim (provided the claim was made prior to the expiration of the limitation period). *See Schnell v. State Farm Fire & Cas. Co.*, 2014 WL 1089752 (W.D. Wash. Mar. 18, 2014).

In Other News:

Despite the residency requirement of a homeowner's policy, one Connecticut court recently found that an insured qualified for coverage even though she had adopted a "transient lifestyle" because the insured property was her "permanent home." *See McCants v. State Farm Fire & Cas. Co.*, 2014 WL 1089752 (Conn. Super. Ct. Jan. 24, 2014).

MASSACHUSETTS

Bad Faith Claim Fails When Insurer Pays Insurance Proceeds Greater than Reference Panel's Value Determination of Damages

In *30 Magaziner Realty, LLC v. Peerless Ins. Co.*, No. 12-01149-F (Mass. Super. Ct. Feb. 13, 2014), Sloane & Walsh LLP represented Peerless Insurance Co. (Peerless) and won summary judgment on claims for breach of contract, violation of the implied covenant of good faith and fair dealing, statutory bad faith, and negligence asserted by the insureds, 30 Magaziner Realty, LLC (30 Magaziner) and others.

The lawsuit arose out of the collapse of the roof of 30 Magaziner's textile warehouse due to an accumulation of snow. Within days of the collapse, 30 Magaziner submitted a claim to its insurer, Peerless. Peerless paid 30 Magaziner $904,766.10 for the "Actual Cash Value" on the claim. Unhappy with the amount received, 30 Magaziner submitted a demand for reference pursuant to its policy. The Reference Panel conducted a hearing and determined that 30 Magaziner was entitled to less than the amount Peerless had previously paid. The panel awarded only $865,701.74 for the "Actual Cash Value" of its claim. Still unhappy with that amount, 30 Magaziner brought suit against Peerless.

On cross-motions for summary judgment, the Superior Court granted Peerless's motion and ordered judgment in its favor on all claims. The court explained that pursuant to the statutorily mandated Standard Fire Policy, an insurer is only required to insure property to the extent of its actual cash value (although 30 Magaziner's policy contained language allowing for recovery of "Replacement Cost" it could not meet the requirements under the policy). Furthermore, the court explained that as a matter of law, reference panels are empowered to determine the amount of loss (they may not, however, determine questions of coverage). More importantly, the court highlighted that a reference panel's value determinations are final and unappealable. The court held that Peerless did not breach the policy or prevent 30 Magaziner from receiving the benefits of the policy because (1) only one valuation method ("Actual Cash Value") was applicable; (2) the Reference Panel's determination of that value was final and binding; and (3) the Reference Panel's valuation was

Public Adjusters Beware

The U.S. District Court for the District of Massachusetts recently denied a public adjuster's motion to dismiss a negligence claim asserted against it by an insured client. The client alleged that the adjuster failed to warn the insured about the time limitation by which suit must be brought on the insured's policy. The court explained that it could not dismiss the claim because the adjuster had a fiduciary duty to act in furtherance of the insured's interest and the adjuster had the ability to point out unambiguous policy language (such as the time limitation), especially when this ability was promoted on the adjuster's website. *See Oden v. U.S. Adjusters, Inc.*, 2014 WL 900722 (D. Mass. Mar. 7, 2014).

lower than the amount Peerless had already paid out.

INDIANA

Insurer Not Bound by Settlement Agreement But It May Still Have Acted in Bad Faith

In *Klepper v. Ace Am. Ins. Co.*, 2013 WL 6333532 (Ind. Ct. App. Dec. 5, 2013), the plaintiffs (property owners) brought suit against Pernod (the insured) and its liability insurers (XL Insurance America (XL) and ACE American Insurance, Inc. (ACE)) for property damages resulting from the insured's manufacturing processes.

The liability policy issued by Ace included a "legally obligated to pay provision," providing that ACE would "pay those sums that the insured becomes legally obligated to pay as damages because of . . . 'property damage' to which this insurance applies," and a "voluntary payment" provision, providing that "[n]o insured will, except at the insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent."

During settlement negotiations, XL and the insured asked ACE to contribute $1 million toward the settlement agreement. ACE refused and offered $250,000. Nevertheless, during mediation, the plaintiffs, XL and the insured reached a settlement agreement. Meanwhile, ACE left the mediation before it was finished. The settlement provided that the insured and XL would contribute $1.2 million and $1 million respectively, while ACE would provide $3 million. The insured also assigned all of its claims against ACE to the plaintiffs. After the court approved the settlement, the plaintiffs filed a complaint seeking a declaration that the $3 million be paid by ACE under the insurance policy and asserted claims of bad faith against ACE. The trial court entered an order that the insured had breached its obligation under the "voluntary payment" clause and therefore, it could not collect the $3 million from ACE. However, the court declined to enter final judgment on the entire complaint.

Affirming the order, the Court of Appeals of Indiana held that ACE could rely on the "voluntary payment" provision in the policy to avoid liability for the settlement. The court explained that it was not convinced that ACE's actions (agreeing to only contribute $250,000 when asked to contribute $1 million) amounted to an abandonment of the insured. Accordingly, because the insured breached the policy by agreeing to a settlement without ACE's consent, and Ace did not breach it, ACE was relieved of paying the $3 million obligation under the settlement.

The court, however, refused to enter final judgment on the bad faith claims against ACE. It explained that there are two distinct theories of recovery on an insurance policy. Although the plaintiffs had no recognizable contractual-based theory of recovery against ACE, the court held that ACE may still be liable to the insured under a bad faith tort. Recognizing that the insurer's duty to deal in good faith includes an obligation to refrain from "(1) making an unfounded refusal to pay policy proceeds; (2) causing an unfounded delay in making payment;

(3) deceiving the insured; and (4) exercising any unfair advantage to pressure an insured into a settlement of his claim," the court believed that it was premature to enter final judgment on all of the plaintiffs' claims.

COLORADO

Jury Finds $0 in Damages for Insurer's Delay in Payment, Yet Court Upholds Award of $150,000 + Attorney's Fees for Bad Faith Claim Where Identity of Insured is Fairly Debatable

In *Hansen v. Am. Fam. Mut. Ins. Co.*, 2013 WL 6673066 (Colo. App. Dec. 19, 2013), the Colorado Court of Appeals affirmed the trial court's award of two times the policy limit for coverage, despite the insured not being awarded any damages for a delay in payment. The insured originally filed for UIM benefits under her parents' auto policy after being injured in an automobile accident. After multiple attempts to obtain verification from the insured whether she was living with her parents at the time of the accident (a necessary condition for coverage), the insurer denied coverage. After suit was filed, the insurer learned that the insured had owned the vehicle at the time of the accident. In response, the insurer retroactively reformed the policy (in effect consenting to coverage) and settled the claim at mediation for the maximum policy benefit—$75,000. Nevertheless, the insured maintained her claims for bad faith, and this aspect of the case went to trial. At trial, a jury determined that the insurer had acted in bad faith, however, the insured's resulting monetary damages were $0. Subsequently, the insured successfully submitted a post-trial motion to amend the jury's verdict, and the trial judge awarded the insured $150,000 (two times the covered benefit of $75,000), plus attorney's fees and costs, pursuant to Colo. Stat. §§ 10-3-1115 and 10-3-1116.

On appeal, the court affirmed the post-trial award. It explained that where it is fairly debatable if the insured is covered under the policy, the question of whether the insurer denied the claim without reasonable basis under § 10-3-1115 is a question for the jury; thus, the court could not overturn the jury's verdict. Additionally, the court explained that pursuant to the express language of §§ 10-3-1115 and 10-3-116, the claimant is entitled to two times the covered benefit if the insurer is found to have unreasonably delayed or denied payment of a covered benefit. In the case before it, the court reasoned that because the insured and insurer settled the claim for the maximum policy benefit of $75,000, the parties in-effect defined the covered benefit to be doubled pursuant to Colorado statutory law. The court additionally noted that pursuant to the same statutes, the court properly granted attorney's fees and costs to the insured.

TEXAS

In the Absence of an Obligation to Provide Coverage, an Insurer Cannot be Liable for Bad Faith in Failing to Timely Investigate a Claim

In *Lexington Ins. Co. v. JAW The Pointe, LLC*, 2013 WL 3968445 (Tex. App. Aug. 1, 2013), the Texas Appellate Court precluded a policyholder from arguing that an insurance company acted in bad faith by failing to timely investigate a claim when the insurer properly denied coverage under the policy. However, the court reiterated that, despite a proper denial of coverage, a bad faith claim is still viable when the insurer's conduct is extreme.

The underlying plaintiff in the dispute, JAW The Pointe, LLC (the insured), owned an apartment complex located next to the seawall in Galveston, Texas. The defendant, Lexington Insurance Co. (the insurer), provided a commercial policy covering the insured's property. A little over a year into the policy, Hurricane Ike crashed into the shoreline of Galveston, causing severe damage to the insured's property—$3.5 million from flood damage and $1.278 million from wind damage. City officials informed the insured that it had determined that the insured's property was "substantially damaged," and pursuant to city ordinance, the insured needed to demolish and rebuild to comply with current code requirements. In response, the insured submitted a claim for the amount of wind-caused damage, which the insurer paid. However, prior to the insured filing a claim for flood-caused damage, the insurer informed the insured that it determined that the policy did not afford coverage for these damages. As a result, the insured filed suit against the insurer claiming breach of the insurance contract and bad faith.

On appeal, the Texas court concluded that the policy did not provide coverage for the insured's loss. The court explained that when construing an insurance policy, it must give effect to all provisions within the policy so that none are rendered meaningless. Reading the provisions together, the court reasoned that the policy only provided coverage if the loss was a covered cause of loss, despite the added Ordinance and Demolition and Increased Cost of Construction (DICC) endorsements. Highlighting the anti-concurrent causation clause in the exclusion section, the court further reasoned that any loss caused, at least in part, by flood was not a covered loss under the Ordinance and DICC endorsements. In this instance, there was no evidence to support a claim that any of the damages were a result of something other than, at least in part, floodwaters (and significantly, the insurer had already paid out a claim for damages caused by wind). Furthermore, regarding the DICC endorsement, there was no evidence to suggest that there was any additional loss sustained in demolition and rebuilding caused by enforcement of an ordinance based on anything other than damage from floodwaters.

In concluding that the policy did not provide coverage for the insured's loss, the court rejected the insured's arguments that it still could maintain a bad faith claim. The court explained that, generally,

Texas does not recognize bad faith claims where an insurer properly denies a claim to which coverage does not exist. However, the court noted that the Texas Supreme Court has left open the possibility that if the insurer's conduct is extreme and produces damages unrelated to and independent of the claim, an insured may maintain a bad faith claim, despite an insurer's proper denial of a claim and correct coverage determination. In this instance, the court reasoned that the insured failed to assert or show any extreme conduct on the part of the insurer. Furthermore, the court explained that the insured's argument that bad faith can arise out of a timely investigation of a claim has never been recognized in Texas. Accordingly, the Court held that the insured had no viable bad faith claim and entered judgment for the insurer.

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