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Bad Faith in the Reinsurance Arena— Beyond the Utmost Good Faith: Breach of the Implied Duty of Good Faith and Fair Dealing in Contract

By John D. LaBarbera and Benjamin A. Blume

The relationship between cedents and reinsurers has become discordant in recent years. What has traditionally operated as a harmonious relationship, even in the face of disagreements, has seemingly devolved, raising tensions between the parties to the reinsurance contract and raising the specter of claims of bad faith premised on the reinsurer's handling of the cedent's billing.

Until recently, there has been very little guidance from the courts with respect to claims of bad faith or unfair dealing brought by cedents against reinsurers, with most treatises or court opinions focusing on the doctrine of *uberrima fides*. In *BJC Health Systems v. Columbia Casualty Company*, 478 F.3d 908 (8th Cir. 2007), the United States Court of Appeals for the Eighth Circuit provided a glimpse into the type of conduct that may constitute "bad faith" in the reinsurance arena. In that case, the court held that a cedent may pursue a claim for bad faith against its reinsurer premised not on the breach of the customary "utmost good faith" found in the reinsurance contract, but rather on the breach of the implied covenant of good faith and fair dealing found in all contracts. 478 F.3d at 914.

This article will discuss the distinction between the concepts of *uberrima fides* and the covenant of good faith in contract law in general. Part I will briefly trace the historical development and treatment of the doctrine of "utmost good faith." We will then analyze the application of the doctrine in the reinsurance arena including a discussion of whether the doctrine creates any fiduciary obligations among the parties to the contract. Part IV will discuss the decision in *BJC Systems* and how that case may provide a workable framework for addressing the application of bad faith in the handling of reinsurance claims in the future.

I. The Evolution of the Doctrine of "Utmost Good Faith"

While all contracts contain an implicit promise to deal in good faith, *N.Y.U. v. Continental Ins. Co.*, 87 N.Y.2d 308, 318 (N.Y. 1995), insurance contracts have traditionally been described as that of *uberrima fides* or "utmost good faith." *Compagnie de Reassurance*
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d’Ile de France v. New England Reinsurance Corp., 944 F. Supp. 986, 992 (D. Mass. 1996). Historically, the doctrine was premised on the practical fact that the insured was in a much better position to know about its risks than the insurer and should thus be obligated to divulge that information to the insurer. *Id.* at 993. The doctrine itself made the most sense early in the evolution of modern insurance, in the area of marine insurance, because it was practically impossible for an insurer to inspect the insured boat thousands of miles away from the insurer. *Id.*

As direct insurance became more common and direct insurers more sophisticated, courts shifted away from applying the doctrine of “utmost good faith” as between insureds and insurers. *Id.* Courts have found that application of the doctrine in the direct insurance market made less sense for fire, life, or health insurance where it is relatively easy for an insurer to inspect the insured risk. *Id.* Some courts have ventured to state that in the direct insurance market “the sole remaining substantial vestige of the doctrine is in maritime insurance law.” *Albany Ins. Co. v. Anh Thi Kieu*, 927 F.2d 882, 888 (5th Cir. 1991).

Utmost good faith has been treated differently in the reinsurance context, however. *Compagnie*, 944 F. Supp. at 993. Reinsurance is an insurance policy purchased by an insurance company, called the cedent insurer, from another insurance company, called the reinsurer, for some portion of the risk it underwrites. *Stonewall Ins. Co. v. Argonaut Ins. Co.*, 75 F. Supp. 2d 893, 895 (N.D. Ill. 1999). The cedent buys reinsurance to guard against potentially bankrupting catastrophic losses, to lower the legal amount of capital reserves it must keep on hand, and to allow for a more diversified portfolio of policies.

There are two basic types of reinsurance: facultative and treaty. *Id.* at 1550. Under a facultative reinsurance contract, the cedent pays for the reinsurer to take on all or part of the risk from a single policy. *Id.* The reinsurer controls which risks it wishes to reinsure, maintaining the ability to deny any risk it chooses. *Id.* Under a reinsurance treaty policy, an overarching document governs a continuous relationship between the reinsurer

and cedent. *Id.* The reinsurer is obligated to assume for a certain category of risks and does not have the discretion to refuse any particular risk within the named category. *Id.*

The application of the doctrine of *uberrima fide* in this context is logical for two reasons: First, the cedent insurer is in a much better position to know about the risk it underwrote. *Compagnie*, 944 F. Supp. at 993. The cedent insurer has claims handling personnel and they inspect and deal directly with the insured risk. Second, for reinsurance to work and continue to be available, reinsurers must be able to charge their cedents less than what the cedent sold the policy for. *Id.* at 994. For reinsurers to charge less, they must save money administratively by not handling the claims and doing the actuarial work. *Id.* If cedents did not share their information with their reinsurers, reinsurers would have to duplicate their administrative work and could not offer reinsurance policies. *Id.* The entire system depends on information being shared in an honest way.

Historically this was not a problem. Most reinsurance arrangements were long-term profitable relationships where neither party wanted to risk ruining the relationship over any one claim. Recently however, inflation, insurer insolvencies, and huge environmental liability damage awards on old policies, have changed the landscape of reinsurance.

Most recently, the doctrine of *uberrima fide* has been employed by reinsurers to rescind reinsurance contracts, if the cedent acted with “bad faith,” where a reinsurer suffered prejudice from a failure on the part of the cedent to disclose material facts. *Compagnie*, 944 F. Supp. at 994. It is well accepted that the cedent bears the burden of providing the reinsurer with all essential material facts concerning the risks known to the cedent but practically unknowable by the reinsurer. *Christiana Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268, 278 (2d Cir. 1992). In this context, materiality has been found where knowledge of the facts would likely influence an underwriter’s decision about premium pricing or acceptance of the risk. *George Nichols III v. Am. Risk Mgmt.*, 89 Civ. 2999 (JSM), 2002 U.S. Dist. LEXIS 22221 *4-5 (S.D.N.Y. Nov. 14, 2002). It is also well known that the

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reinsurer has no duty to inquire, *Allendale Mutual Ins. Co. v. Excess Ins. Co. Ltd.*, 992 F. Supp. 278, 282 (S.D.N.Y. 1998), and no specific intent to deceive is required; even innocent failures to disclose breach the duty of utmost good faith. *Nichols III*, 2002 U.S. Dist. LEXIS at *5.

This bad faith or prejudice approach for determining a breach of the duty of utmost good faith has been adopted by several courts. See, *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049, 1068-70 (2d Cir. 1993); *North River Ins. Co. v. CIGNA Reinsurance Co.*, 52 F.3d 1194, 1212 (3rd Cir. 1995); *Compagnie De Reassurance D'Ile De Fr. v. New Eng. Reinsurance Corp.*, 57 F.3d 56, 72 (1st Cir. 1995); *Allendale*. For example, in the *Allendale*, the United States District Court for the Southern District of New York held that a cedent violated its duty of utmost good faith, thereby rescinding the reinsurance contract. *Allendale Mutual Ins. Co. v. Excess Ins. Co. Ltd.*, 992 F. Supp. 278, 282 (S.D.N.Y. 1998). The reinsurer agreed to reinsure a policy for fire protection on a warehouse so long as the insured complied with all of the reinsurer's safety recommendations, including adding sprinklers and another water supply. 992 F. Supp. at 281. Six months went by and another reinsurance policy was issued, this time without the safety recommendations. *Id.* The cedent never informed the reinsurer that the insured did not comply with the safety recommendations. *Id.* Two weeks later the warehouse burned down. *Id.* The cedent was found to have breached its duty of utmost good faith because it never told the reinsurer that the safety recommendations were not followed. *Id.* at 286.

II. Fiduciary Duties and Utmost Good Faith

While case law typically refers to the duty of utmost good faith, not a fiduciary duty, some courts have found a similarity in meanings. *Compagnie*, 944 F. Supp. at 995-996. "It is hard to see any principled distinction between the two standards for the purposes of fraudulent concealment analysis." *Id.* A fiduciary is one who has "duties involving good faith, trust, special confidence, and candor towards another." Black's Law Dictionary

625 (6th Ed. 1990). There is not a fiduciary relationship simply because one party trusted another. *Compagnie*, 944 F. Supp. at 995. "[A] fiduciary relationship may be presumed from the very relationship of the parties...or may be found to exist in a particular situation where confidence is reposed on one side and there is a resulting superiority and influence on the other side." *Mutuelle Generale Francaise Vie v. Life Assurance Co.*, 688 F. Supp. 386, 398 (N.D. Ill. 1988). "The purpose of imposing such an obligation is to protect the dominated party from abuse by the dominating party." *Int'l Surplus Lines Ins. Co. v. Fireman's Fund Ins. Co.*, No. 88 C 320, 1989 U.S. Dist. LEXIS 15626 *8 (N.D. Ill. Dec. 29, 1989).

The duty of utmost good faith and a fiduciary duty both come into play when one party to a contract is vulnerable to the other party for one of two reasons. *Compagnie*, 944 F. Supp. at 996. First, vulnerability may be inherent because of a disparity in knowledge, such as an attorney-client, trustee-beneficiary, *Mutuelle*, 688 F. Supp. at 398, or doctor-patient relationship. *Compagnie*, 944 F. Supp. at 996. Second, vulnerability may arise because of an agreement where one party agrees to trust the other, regardless of the relative knowledge of each party. *Id.* Two common examples would be creditors of a bankrupt estate who trust the bankruptcy trustee or a shareholder who trusts the corporate director. *Id.* Neither the creditor nor the shareholder inherently have less knowledge about the subject than the bankruptcy trustee or the corporate director. *Id.*

Since reinsurance involves two sophisticated entities bargaining at arms' length, there will rarely be inherent vulnerability like there is in the doctor-patient relationship. For a fiduciary relationship to exist, a reinsurer must therefore show the second kind of vulnerability- an agreement to enter into a transaction that leaves them at the mercy of their cedent's honesty and forthrightness. As discussed below, courts have not found a fiduciary relationship in the context of facultative reinsurance, but have found the existence of a fiduciary relationship in treaty reinsurance.

III. Facultative vs. Treaty Reinsurance: Differing Duties

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There have been many cases finding no fiduciary duty owed by the cedent insurer to its reinsurer in the context of facultative reinsurance certificates. Illinois has repeatedly refused to recognize a fiduciary relationship between a direct insurer and the insured, and as such has refused to recognize a fiduciary relationship between an insurer and its reinsurer. *Int'l Surplus Lines Ins. Co. v. Fireman's Fund Ins. Co.*, No. 88 C 320, 1989 U.S. Dist. LEXIS 15626 *1, *3 & *9 (N.D. Ill. Dec. 29, 1989); *Overby v. Ill. Farmers Ins. Co.*, 170 Ill. App. 3d 594 (Ill. App. Ct. 1988); *Robacki v. Allstate Ins. Co.* 127 Ill. App. 3d 294 (Ill. App. Ct. 1984). Since both parties are sophisticated entities with no clear dominion by the cedent insurer, some courts are reluctant to find a fiduciary relationship between a cedent insurer and reinsurer. *Int'l Surplus*, 1989 U.S. Dist. LEXIS 15626 at *12 (holding that the court could not "conceive of a commercial relationship less likely to constitute a fiduciary relationship.").

For example, in *PXRE Reinsurance Co. v. Lumbermens's Mut. Cas. Co.*, No. 03 C 5155, 2004 U.S. Dist. LEXIS 9343 at *11 (N.D. Ill. May 24, 2004), the reinsurer was given the opportunity to investigate and reject the risks that it was asked to reinsure. The court found the opportunity to review the cedent's work prior to accepting the risk "highly relevant." *Id.* at *10. The court refused to change the written language of the contract to conform with the doctrine of *uberrima fide*, a doctrine it called a default rule. *Id.* at *7-8.

Conversely, with treaty reinsurance, the reinsurer typically has no opportunity to duplicate the cedent's administrative work. In *PXRE*, 2004 U.S. Dist. LEXIS at *10, the court distinguished *Mutuelle*, 688 F. Supp. at 398, which found a fiduciary duty from the cedent insurer to the reinsurer because under the contract, the reinsurer could place the "highest faith" in the cedent insurer and because it was a treaty reinsurance, rather than facultative. Unlike facultative reinsurers who are free to reject any risks they choose and thus have an incentive to investigate individual risks, treaty reinsurers are in a naturally vulnerable position. *Compagnie*, 944 F. Supp. at 996. The cedent insurer has discretion to cede any risk it chooses under the treaty to the reinsurer and the reinsurer cannot refuse those risks. *Id.* The reinsurer must rely on the good faith of

its cedent insurer in passing on the risks. *Id.* Even though both insurance companies to a treaty reinsurance policy are sophisticated, the very nature of a treaty reinsurance policy puts the cedent insurer in a dominant position. *Id.* at 997.

While some courts will find the duty of utmost good faith running from the cedent to at least a treaty reinsurer, the duty has not been treated as a bilateral duty by the courts, thus far. Three courts have addressed whether a reinsurer owes a fiduciary duty to its cedent insurer and all three have answered negatively. *Stonewall Ins. Co. v. Argonaut Ins. Co.*, 75 F. Supp. 2d 893, 910-11 (N.D. Ill. 1999); *Employers Reinsurance Corp. v. Mass. Mut. Life Ins. Co.*, No. 06-0188-CV-W-FJG, 2007 U.S. Dist. LEXIS 24161 at *11 (W.D. Mo. Apr. 2, 2007); *North River Ins. Co. v. Columbia Cas. Co.*, No. 90 Civ. 2518 (MJL), 1995 U.S. Dist. LEXIS 7956 at *5 (S.D.N.Y. May 31, 1995). These cases used the same reasoning as cases finding no such duty from a cedent to its facultative reinsurer. *Id.* They looked to the equality in sophistication and bargaining power between the reinsurer and cedent insurer, and the lack of a fiduciary relationship between an insurer and its insured, while ignoring the financial reason reinsurance is possible. *Id.* Based on the reasoning of these decisions, it is unlikely that a breach of the duty of utmost good faith on the part of a reinsurer will support a claim for bad faith by a cedent.

IV. Bad Faith as the Breach of the Implied Duty of Good Faith and Fair Dealing

If the doctrine of *uberrima fide* does not give rise to a cedent's claim of bad faith against a reinsurer, can a mere breach of the implied duty of good faith and fair dealing, found in all contracts, form the basis of such a claim? In *BJC Health Systems v. Columbia Casualty Company*, 478 F.3d 908 (8th Cir. 2007), the court held that the breach of the common duty of good, faith found in all contracts, can support a claim for bad faith against a reinsurer. In that case, BJC Health System, a network of hospitals, was the sole shareholder of ATG Assurance Company Ltd., a captive insurance company that provided insurance for BJC. BJC entered into a three-year contract where

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Columbia agreed to provide reinsurance to ATG for a fixed yearly premium. Columbia agreed to reinsure ATG for individual claims that exceeded \$ 1 million or \$ 3 million, depending on the hospital, and aggregate claims over \$ 22 million. One clause, “the incurred loss condition,” provided that continued coverage would be conditioned upon an incurred loss ratio of less than 75% for three years of reinsurance. *Id.* at 911.

On September 22, 2000, only days before the end of the current policy year, Columbia informed BJC that it had determined that BJC had exceeded the aggregate incurred loss ratio. Columbia also stated that the incurred loss ratio had been exceeded on an individual claim, the “Baby C” claim, as well. BJC had set a claim reserve below \$3 million on the “Baby C” claim, but Columbia assessed a reserve of \$5 million, a sum which would lead to an incurred loss ratio well in excess of the 75% set forth in the contract. Columbia informed BJC that it would not continue with the third year of the program unless the premium was increased to \$ 3.1 million and the aggregate retention level was increased to \$ 31.1 million. *Id.*

Columbia extended the policy so that BJC could obtain replacement reinsurance, which BJC acquired from Zurich. There were differences, however, between the policy offered by Zurich and the policy that BJC had with Columbia. For example, while Columbia’s coverage commenced at an aggregate loss of \$22 million, Zurich only offered coverage starting at an aggregate loss of \$25 million. This \$3 million gap in coverage meant that BJC faced an additional \$ 3 million in potential liability that it would not be facing had Columbia continued with the third year of the program. Although Zurich declined to provide reinsurance starting at \$22 million, it stated that if it did offer coverage commencing at that level, the premium for the additional \$ 3 million in coverage would be \$ 1.2 million. *Id.*

BJC filed suit, alleging breach of contract, and sought compensatory damages for the cost of the Zurich replacement policy, as well as compensation for the additional risk exposure BJC had to assume with the Zurich replacement policy. BJC claimed that this

latter amount was \$ 1.2 million -- the price Zurich would have charged for meeting the \$ 3 million coverage gap. BJC also sought punitive damages, which were based on Columbia’s allegedly fraudulent conduct. *Id.* at 912.

The dispute between the cedent and reinsurer revolved primarily around the actuarial work Columbia presented to BJC to justify Columbia’s determination that the incurred loss ratio had exceeded 75%. On October 10, 2000, the parties met in Chicago to discuss their differences. At this meeting, Columbia distributed an actuarial analysis that concluded that the incurred loss ratio had been exceeded. That report was time-stamped at 10:23 that morning. This analysis contained errors that were not present in an earlier version of the report that had been printed at 8:33 that morning, but which had not been distributed. The errors in the distributed version contributed to a higher incurred loss ratio. On October 19, in response to unrelated concerns voiced by BJC, Columbia distributed a third version of the report that addressed BJC’s concerns but also corrected the incorrect figures from the second version.

This third version of the actuarial report, however, contained a new error: one of the figures was about \$ 2.4 million too high, an error which, as described below, may have resulted in the calculation of an incurred loss ratio in excess of 75%. *Id.* Both parties agreed that determining the loss ratio involves some discretion. The true dispute between the parties involved how Columbia calculated the loss ratio. *Id.* at 912. Columbia kept one actuarial report to itself and produced two other reports to BJC, both of which contained errors in Columbia’s favor. *Id.* at 912.

During the course of litigation, BJC reviewed all three versions of the actuarial report and offered testimony that Columbia did not provide any explanation regarding the manner in which it converted accident year data to report year data. An accident year to report year conversion was necessary because, while BJC’s loss data was compiled on an accident year basis, the reinsurance policy was priced on a report year basis. BJC’s witness remarked that this conversion was “the critical final step” in the analysis and that it was “unreasonable” to make this conversion without an explanation

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as to how it was performed. He also noted that without knowing how Columbia had made the transition from accident year to report year figures, it was difficult to estimate the impact that the new error in the third version of the actuarial report might have had. He did, however, attempt to calculate the effect and estimated that if this error was corrected the incurred loss ratio would fall below 75%. *Id.*

BJC also offered testimony that Columbia unreasonably selected the same average experience ratio -- an important figure -- in all three versions of the actuarial analysis, despite the fact that the underlying data in these versions was different. The witness stated that the average experience ratio had a significant effect on the accident year figures, but could not state exactly how it might affect the report year data, because Columbia did not explain the accident year to report year conversion. *Id.*

Columbia's actuaries either did not know or could not remember how the accident year to report year conversion was done and Columbia was unable to produce the computer models it used to conduct its 1999 and 2000 actuarial analyses of the BJC account. There was also evidence that Columbia's actuaries recommended a premium of nearly \$ 13.5 million for the third policy year, a substantial increase that could only be justified by a dramatic change in BJC's losses or a by significant change in the assumptions Columbia used in assessing the BJC account. Columbia's actuaries did not know whether BJC had experienced a serious change in losses between 1998 and 2000 and did not know whether there was a significant change in Columbia's methodologies. BJC presented testimony that there were no significant changes in its losses. *Id.* at 912-13.

BJC also presented testimony pertaining to the Baby C claim. Its director of claims and litigation testified that there was no reason why a reserve above BJC's \$3 million self-insured retention had to be set and that Columbia's reserve of \$5 million was neither proper nor reasonable. The witness outlined various considerations that she said would tend to lessen BJC's potential losses on the claim. She also stated that Columbia had never expressed

concerns about BJC's reserving practices. BJC also presented testimony that after a claims audit in August 2000 the "general consensus" was that "things were fine." *Id.*

In granting a judgment as a matter of law against BJC, the trial court concluded that, under the contract, Columbia had the right to determine incurred loss and that BJC had offered no evidence that Columbia's incurred loss determination was made in bad faith. *Id.* at 913. On appeal, BJC argued that the incurred loss condition is a condition subsequent. BJC contended that because the incurred loss condition is a condition subsequent, Columbia bore the burden of presenting evidence pertaining to incurred loss. *Id.*

The appellate court agreed with BJC, holding that the language of the reinsurance contract suggested that the incurred loss condition is a condition subsequent. *Id.* The court noted that "[w]hen the contractual provision in question reposes discretion in the defendant, however, the plaintiff must show that this discretion was exercised in bad faith." *Id.* at 914. The court reasoned that "[a]ny latitude Columbia might have had under the contract, however, was constrained by the covenant of good faith and fair dealing that Missouri law finds implicit in every contract." *Id.*

The court noted that in order to establish a violation of the covenant of good faith and fair dealing, it is not enough for a plaintiff to show that a party invested with discretion made an erroneous decision. *Id.* Instead, the plaintiff must show that the party exercised its discretion in such a manner as to evade the spirit of the transaction or so as to deny [the other party] the expected benefit of the contract. *Id.* The covenant of good faith and fair dealing does not establish a "general reasonableness requirement." Rather, unreasonableness can serve only as "evidence of subjective intent to undermine fulfillment of the contract." *Id.*

To establish a colorable claim of bad faith the court held that "BJC was required to do more than offer evidence that Columbia's incurred loss determination was flawed or unreasonable." *Id.* Instead, the court held that BJC had to present evidence that Columbia's determination of incurred loss was directed

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toward evading the spirit of the contract or denying BJC the benefit of its bargain. In this case, the benefit for which BJC bargained was three years of reinsurance coverage guaranteed at a fixed premium. Accordingly, it would have been bad faith, for example, for Columbia to have selected a particular method for calculating incurred loss or to have made other judgments in the process of determining incurred loss that were specifically designed to trigger a contractual provision enabling Columbia to avoid its third-year obligation. *Id.* at 914-15.

Of interest, the court held that mere acts of self interest would not constitute bad faith. The court held that while financial self-interest will not excuse a party from performing its contractual obligations in good faith, the implied duty of good faith and fair dealing does not extend so far as to undermine a party's general right to act on its own interests in a way that may incidentally lessen the other party's anticipated fruits from the contract. *Id.* at 915.

For example, the court explained that it would not necessarily constitute bad faith for Columbia to employ a risk-averse method of calculating incurred loss that might have the "incidental" consequence of triggering the incurred loss condition. The court stated, however, that a certain measure of caution, then, would be consistent with the bargain struck by the parties and not constitute an act of bad faith, even if it incidentally resulted in the calculation of a higher incurred loss ratio. It would not, however, be permissible for Columbia to exercise its discretion in a manner designed to "scuttle the deal," however much in Columbia's best financial interest it might have been to reduce its profile in the area of medical malpractice insurance and to shed clients in that line. *Id.*

The court concluded that sufficient evidence existed to suggest that a jury could conclude Columbia acted in bad faith. Columbia asserted that the incurred loss ratio exceeded 75% based on the position that both aggregate claims and a single claim, the "Baby C claim," had been breached. BJC's evidence of bad faith as it pertained to the aggregate claims centered primarily on the actuarial analysis conducted by Columbia.

Considered as a whole, the court concluded that the evidence permits an inference that the purpose of the analysis was to reach a desired and predetermined conclusion. *Id.* The court also noted that there was testimony that Columbia unreasonably selected the same average experience ratio in all three versions of the actuarial analysis despite the fact that the underlying numbers were changing.

The court found that the evidence could indicate that the actual data were not as important to Columbia as arriving at a particular conclusion. In addition, the court noted that Columbia appeared largely incapable of explaining how it made a crucial transition between accident year and report year data and was unable to produce certain records. *Id.* at 915.

Columbia also argued that BJC could not establish bad faith because BJC's witnesses expressed only a professional disagreement with Columbia's incurred loss determination and because none of the witnesses testified that the incurred loss figure assessed by Columbia was unreasonable. The court found this argument unavailing. *Id.* at 916. The court found that there was testimony that the manner in which Columbia calculated incurred loss was unreasonable and evidence that the calculation was made in a manner designed to trigger the incurred loss provision, thus denying BJC the third year for which it had bargained. The court further characterized Columbia's conduct as "pre-textual." *Id.* The court noted that although the figure might at first glance appear reasonable to a neutral observer if considered out of context (*i.e.*, without reference, for example, to the manner in which it was calculated), a jury could still determine that Columbia had acted in bad faith. Based on these considerations, the court determined that the trial court erred in granting Columbia's motion for judgment as a matter of law.

The *BJC Health Systems* decision is instructive not only in what the court delineated as conduct on the part of the reinsurer that may evidence bad faith but also in what type of conduct on the part of the reinsurer is not. Bad faith is conduct directed toward evading the spirit of the contract or denying the cedent the benefit of its bargain. Such conduct is

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evidenced where the reinsurer acts merely to obtain a specific result that denies the cedent from the benefit of the reinsurance contract. As the court in *BJC Health Systems* noted, it would have been bad faith, for example, for the reinsurer to have made other judgments in the process of determining incurred loss that were specifically designed to trigger a contractual provision enabling it to avoid its third-year obligation.

Bad faith, however, is not mere self interest on the part of the reinsurer without regard to the cedent. As the court noted, while financial self-interest will not excuse a party from performing its contractual obligations in good faith, the implied duty of good faith and fair dealing does not extend so far as to undermine a party's general right to act on its own interests in a way that may incidentally lessen the other party's anticipated fruits from the contract. It would not necessarily constitute bad faith, for instance, for Columbia to employ a risk-averse method of calculating incurred loss that might have the "incidental" consequence of triggering the incurred loss condition. The court stated however that a certain measure

of caution exercised by the reinsurer would be consistent with the bargain struck by the parties and not constitute an act of bad faith, even if it incidentally resulted in the calculation of a higher incurred loss ratio.

Conclusion

The breach of the implied duty of good faith and fair dealing found in all contracts may give rise to a claim for bad faith on the part of a cedent against its reinsurer. While the implied duty of good faith is not as ingrained as the doctrine of *uberrima fide* in the case law, the implied duty of good faith is existent in all reinsurance contracts. As the disputes between cedents and reinsurers grow more aggressive over time, it is likely that an increase in claims related to the breach of the implied duty of good faith and fair dealing on the part of reinsurers will increase. The United States Court of Appeals for the Eighth Circuit's decision in *BJC Health Systems v. Columbia Casualty Company*, 478 F.3d 908 (8th Cir. 2007), provides a glimpse into the type of conduct that may constitute "bad faith" in the reinsurance arena.

Illinois Appellate Court Rules That Insurer Not Required To Refund Portion Of Premiums Attributable To Tax Later Found Unconstitutional

Gore v. Ind. Ins. Co., No. 1-06-3325, 2007 Ill. App. LEXIS 978 (Sept. 5, 2007)

An insurance company was not required by the implied duty of good faith and fair dealing or public policy to refund portions of premiums attributable to passing on a tax later found unconstitutional. *Gore v. Ind. Ins. Co.* Plaintiff Gore purchased insurance from two out-of-state property insurers from 1993 to 1998. A law requiring out-of-state insurers to pay a 2% tax for the privilege of doing business in Illinois was held unconstitutional in

1997. The court recognized that the implied duty of good faith includes how discretion is exercised, but found that businesses are allowed to pass on the costs of taxes to their customers and did not see how an unconstitutional tax could support a breach of contract claim. Gore could not show a violation of the public policy of "preventing excessive rates" because insurers are allowed to include taxes in their calculations on what to charge.

Oklahoma Federal Court Rules Insurer That Can Be Liable For Bad Faith Even Where It Has No Liability For Breach Of Contract

In *Owens v. Resource Life Ins. Co.*, the federal district court held that an insurer is not insulated from liability for bad faith merely because it did not breach its contractual duties to its insured. In so holding, the court noted that under Tenth Circuit and Oklahoma Supreme Court precedent, “breach of contract and bad faith claims are separate bases for recovery, even though ‘indemnity for loss’ is the centerpiece for both types of claims.” See *id.* (citing *Roemer v. State Farm Fire & Cas. Co.*, 2007 U.S. Dist. LEXIS 10854 at *5 (N.D. Okla. Feb. 14, 2007) (unpublished decision)).

The plaintiff filed suit against Resource Life Insurance Company alleging breach of contract and of the implied covenant of good faith and fair dealing, based on a denial of death benefits under a life insurance policy issued to her deceased husband. Resource claimed that the plaintiff’s husband made a misrepresentation on the application for the policy in his answer to a question as to whether he had received care, diagnosis or treatment of cancer, within 12 months of the date of the application. Although it appeared that Mr. Owens checked both the “yes” and “no” boxes next to the question, Resource interpreted Mr. Owens’ answer as “no,” and issued the policy.

After Mr. Owens’ death, the plaintiff submitted a claim to Resource, listing the cause of Mr. Owens’ death as “carcinoma of the lung.” Plaintiff told a Resource employee who had contacted her that her husband had been diagnosed with cancer in the year prior to completing the application, although it was in remission. Resource rescinded the policy on the basis that the application contained a material misrepresentation. However, resource later discovered that there were several copies of Mr. Owens’ application, some of which arguably showed that Mr. Owens checked the “yes” box and struck a line through the “no” box. Based on this discovery, Resource reversed its decision

to rescind the policy and made payments to plaintiff.

Despite Resource’s reversal of its decision, Mrs. Owens filed suit alleging breach of contract and bad faith. The court granted Resource’s motion for summary judgment on the breach of contract claim, holding that although Resource initially denied the existence of a valid contract, it reversed its decision and paid Mrs. Owens the contract amount. Nonetheless, the court denied Resource’s motion with respect to the claim for breach of the covenant of good faith and fair dealing.

Resource first argued that there was no bad faith because there was no viable breach of contract claim. The court rejected this argument, stating that a fundamental premise of Oklahoma law is that a claim for bad faith and a claim for breach of contract are separate and independent bases for recovery, citing, *Taylor v. State Farm Fire and Casualty Company*, 1999 OK 44, 981 P.2d 1253 (Okla. 1999). The court reasoned that Resource did not pay the claim until nearly a year after it was filed and, during that time, plaintiff had a viable claim for breach of contract and Resource engaged in conduct that could arguably be described as bad faith. The court held that under these circumstances, plaintiff had a legal basis to proceed with her claim for bad faith even though the Court had granted Resource summary judgment on the breach of contract claim.

Resource also argued that the facts showed that a legitimate coverage dispute existed and plaintiff could not factually prevail on her claim for bad faith. The court pointed out that Resource violated its own general procedures by not investigating Mr. Owens’ ambiguous responses in the application immediately. Therefore, there was no legitimate coverage dispute, and Resource’s motion for summary judgment on Mrs. Owens’ bad faith claim was denied.

Owens v. Resource Life Ins. Co., 2007 U.S. Dist. LEXIS 65734, *28 (N.D. Okla. September 5, 2007)

Minnesota Court Of Appeals Holds That Minnesota Law Does Not Recognize A Tort Of Bad Faith Breach Of Contract

St. Paul Fire and Marine Ins. Co. v. API, Inc., 2007 Minn. App. LEXIS 123, *11-*12 (September 11, 2007)

In *St. Paul Fire and Marine Ins. Co. v. API, Inc.*, a Minnesota appellate court held that an insurer and its insured do not have a fiduciary relationship outside of the duty to settle within policy limits and that Minnesota does not recognize a tort of bad faith breach of contract. The court also upheld the trial court's decision that *pro rata* time-on-the-risk allocation of coverage was appropriate in the circumstances of that case.

API was sued in a number of asbestos-related personal injury lawsuits. API tendered the defense of these suits to various insurers, including General Accident Insurance Company. API was unable to produce copies of the policies issued by General Accident. As a result, General Accident declined to defend. After another of API's insurers brought a declaratory judgment suit against API, API brought a third-party action against several insurers, including OneBeacon Insurance Company (as a successor to General Accident), seeking a declaration of the insurers' duty to defend and to pay all sums API had become obligated to pay as damages. OneBeacon denied having any evidence demonstrating insurance coverage for API and denied that API was entitled to defense or indemnification under any contract of insurance with General Accident.

At trial, the jury found that API had proven the existence and essential terms and conditions and limits of General Accident policies in effect from 1958 to 1966. The jury found that General Accident breached its contracts by failing to defend or indemnify, resulting in "direct" damages in excess of \$27,000,000. The jury also found that General Accident had acted in bad faith and breached its fiduciary duty, for which API was entitled to \$10,000,000 and \$15,000,000, respectively. The jury further found that General Accident falsely represented a material fact to API, but that API did not rely on the false

representation.

On appeal, OneBeacon first argued that the jury instructions were erroneous because Minnesota does not recognize a claim of bad faith or breach of fiduciary duty under the facts of the case. The trial court instructed the jury that an "insurer and its policyholder hold a fiduciary relationship and the insurer owes its policyholder a fiduciary duty...[A]n insurer acts in bad faith when it breaches its fiduciary duty." The appellate court first noted that special circumstances must exist in a relationship between parties for creation of a fiduciary relationship. The court further stated that ordinary business relationships may involve reliance on trust and a duty of good faith, yet not fall within the class of fiduciary relationships. The court concluded that at its inception, the insurer-insured relationship is not fiduciary.

Minnesota has carved out an exception when an insurer is obligated to assume and assumes the defense of the insured. Where there is no dispute as to coverage, a defending insurer owes the insured a fiduciary duty to settle claims in good faith. The court held that the trial court was in error when it did not limit the fiduciary duty to the situation where the insurer represents the insured for settlement purposes. The insurer-insured relationship was not *per se* fiduciary.

The appellate court next addressed the trial court's award of extracontractual damages. The court stated that to establish extracontractual damages in a breach of contract action, the insured must do more than allege a malicious or bad faith motive in breaching the contract. The insured must prove the elements of an independent tort. The court stated that the "traditional rule" in Minnesota is that a bad faith breach of contract does not convert to a tort. In this case, API did not establish all of the elements of intentional or negligent misrepresentation. As the insured could not establish the elements of an independent

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tort, it was not entitled to extracontractual damages.

API argued that the trial court erroneously applied a *pro rata* time-on-the-risk allocation of coverage. The trial court applied the holding in *Domtar, Inc. v. Niagara Fire Ins. Co.*, 536 N.W.2d 724, 733-34 (Minn. 1997), which held that *pro rata* time-on-the-risk is the proper allocation “in those difficult cases in which...damage is both continuous and so intermingled as to be practically indivisible.” *See id.* at *20. API requested the court to limit the allocation period to years of available

coverage based on *Wooddale Builders, Inc. v. Maryland Cas. Co.*, 722 N.W.2d 283 (Minn. 2006). API argued that multiple discrete and identifiable events made General Accident liable for the damage that occurred during the policy period. The court cited expert evidence at trial which showed that the inhalation of the asbestos fibers could not be divided into discrete events. The court affirmed the trial court’s exercise of discretion in its determination on *pro rata* allocation, but remanded for a determination on the total period over which liability was allocated.

Oklahoma Federal Court Refuses To Apply The Follow The Settlement Doctrine In The Absence Of An Express Provision In The Reinsurance Agreement

State of Oklahoma v. Employers Reins. Corp., 2007 U.S. Dist. LEXIS 68069 (W.D. Okla. September 13, 2007)

In *State of Oklahoma v. Employers Reins. Corp.*, the court held that punitive damages paid by the cedent are a “loss” under a reinsurance agreement where the insured is vicariously liable for another party’s actions. The court also refused to apply the “follow the settlements” doctrine in the absence of an express provision in the reinsurance agreement.

Hospital Casualty Company (“HCC”) issued primary and excess general liability policies covering two nursing homes. HCC reinsured the excess policies through ERC. The State of Oklahoma, acting as receiver for HCC in liquidation, brought an action against ERC, contending that ERC breached the reinsurance agreements by failing to reimburse/indemnify HCC for monies it paid in settlement of claims asserted against the two nursing homes. In addition to seeking damages, the State requested a declaration that ERC had certain obligations under the reinsurance agreements, including the duty to reimburse HCC for various payments it had made. At issue were two sets of claims against HCC’s insureds: the “Mulberry claim” and the “hepatitis claims.”

In the “Mulberry claim,” the jury returned a verdict for the underlying plaintiffs

and concluded that the plaintiffs had established the necessary basis for an award of punitive damages. Prior to the determination of the amount of punitive damages, HCC settled the Mulberry claim and made a demand on ERC under the reinsurance agreement. The settlement amount included estimated punitive damages, although it does not appear that there was any allocation of any specific amount.

HCC sought indemnity for the settlement amount in excess of \$1 million. ERC denied the claim, arguing that there was no “loss” within the meaning of the reinsurance agreement, because neither the amounts attributable to punitive damages nor those attributable to plaintiff’s statutory expenses qualified as a “loss.” Absent those items, the amounts paid by HCC were fully absorbed by the (non-reinsured) primary policy. The court stated that Oklahoma law does not ordinarily permit an insured to shift its potential liability for punitive damages to others (*i.e.*, an insurance company) via liability insurance, except where the insured’s liability for punitive damages is based on its vicarious liability for the acts of another. Noting that the plaintiff’s claims included both direct and vicarious

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claims against the insured nursing home, and based on the jury's verdict, the court held that ERC was obligated to reimburse HCC for the amounts paid under the excess policy because the payments qualified as amounts "paid by the Reinsured in settlement of claims" within the meaning of the reinsurance agreement.

In the "hepatitis claims," HCC reached an agreement with its insured and ERC to a "3/5 split" risk allocation in settlement of the underlying case. However, HCC later sought to re-allocate the risk, claiming that the parties in fact reached a "4/4 split," which changed the allocation across policy years. The State argued that the "follow the settlements" doctrine, which is conceptually similar to the broader "follow the fortunes" doctrine, required ERC to follow HCC's interpretation of the allocation. The State

also argued that "follow the fortunes" is an implied term in every reinsurance contract, whether expressly included or not, and that it applies to post-settlement allocations. ERC argued that the doctrine did not apply because there was no express provision in the reinsurance certificates.

Although the court acknowledged that there was case law supporting both positions, it held that because an express "follow the fortunes" provision was not included in the reinsurance agreement, the doctrine was inapplicable. The court concluded that the doctrine did not extend to situations where a cedent sought to explicitly allocate the risk between policy years and then later re-allocate the risk on a different basis. Consequently, the court held that ERC was not bound by the terms of the "3/5 split" risk allocation.

Ninth Circuit Vacates Punitive Damages Award Against Disability Insurer Based On Trial Court's Failure To Provide Limiting Instruction Precluding Punishment For Wrongful Conduct Against Nonparties

Merrick v. Paul Revere Life Insurance Co., et al., 2007 U.S.App. LEXIS 20959 (9th Cir. Aug. 31, 2007)

The United States Court of Appeals for the Ninth Circuit vacated a jury's \$10 million punitive damages award against two insurers because the District Court failed to instruct the jury that it could not punish the defendants for conduct that harmed only nonparties. The case was remanded for a new trial on punitive damages.

Merrick sought coverage from the defendant Paul Revere Life Insurance Company ("Paul Revere") under an "own occupation" disability policy. The policy entitled him to benefits in the event that he was not able to perform his job duties because of sickness or injury. Initially, Paul Revere paid benefits under the policy based on plaintiff's doctor's diagnosis of Chronic Fatigue Syndrome. After plaintiff unsuccessfully tried to return to work, Paul Revere offered a compromise settlement and then later denied coverage based on an Independent Medical Examination and an intensive review of the claim file regarding

Merrick's illness. Merrick subsequently filed suit against Paul Revere and its parent corporation, Unum Provident, alleging breach of contract and of the duty of good faith and fair dealing.

At trial, Stephen Prater, an insurance industry expert, testified that Merrick's claim was denied as part of a scheme by the insurer to 'scrub' the company's liability for "expensive and noncancellable" disability policies. Prater also testified that following the merger between the two insurers, Paul Revere adopted Unum Provident's "best practices" model which allegedly included aggressive and unethical handling of claims, including pressuring claimants to accept settlements for a fraction of the total benefits, relying on biased Independent Medical Examiners who would support claim denials, and holding "round table" meetings with lawyers, doctors and claim handlers designed to "triage" the most expensive claims.

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The jury awarded Merrick \$1,147,355 in unpaid benefits and \$500,000 for mental and emotional distress. In addition the jury imposed punitive damages upon Paul Revere in the amount of \$2,000,000 and \$8,000,000 against Unum Provident.

On appeal, the insurers argued that the jurors should have been provided with an instruction that they may not punish the insurers for conduct or practices that did not affect Plaintiff, even if the jury believed that such conduct or practices were wrongful or deserving of punishment. According to the insurers, the court's failure to include this instruction violated their Due Process right against unconstitutionally excessive punitive damages in accordance with the United States Supreme Court's decision in *Phillips Morris USA v. Williams*, 127 S.Ct. 1057, 1063 (2007).

The Ninth Circuit agreed, finding that under *Williams*, the "Due Process Clause forbids a State to use punitive damages awards to punish a defendant for injury that is inflicted upon nonparties." While a plaintiff may offer evidence of harm to other victims to show the reprehensibility of a defendant's conduct, a jury cannot use a punitive damages verdict to punish a defendant directly on account of harm it allegedly caused to nonparties.

Because the evidence at trial presented a "significant risk" to defendants that the jury considered defendants' conduct with respect to nonparties in awarding the punitive damages, the district court erred in failing to provide a limiting instruction in accordance with *Williams*. The Ninth Circuit therefore vacated the \$10 million punitive damages award and remanded the case for a new trial on punitive damages.

A Kansas Federal District Court Judge Denied Summary Judgment on Allocation of Loss Because A Fact Issue Existed With Respect to Whether Claims Against the Insured Constituted a Single or Multiple Occurrences

Ace Property & Casualty Ins. Co. v. Superior Boiler Works, Inc., 2007 U.S. Dist. LEXIS 63499 (D.Ct. Kan. 2007)

A federal district court judge declined to rule that Kansas law required application of *pro rata* time on the risk allocation, finding that the plaintiff insurers had failed to establish whether numerous asbestos bodily injury claims against their insured constituted a single or multiple occurrences.

The court disagreed with plaintiffs' argument that application of *Atchison, Topeka & Santa Fe Ry. Co. v. Stonewall Ins. Co.*, 275 Kan. 698, 750, 71 P.3d 1097, 1132 (2003) should automatically result in a *pro rata* method of allocation. In that case, the Kansas Supreme Court applied a *pro-rata* time on the risk allocation for defense and indemnity costs arising out of noise induced hearing loss claims caused by excessive noise in the workplace. Under the terms of the contract at issue in *Atchison*, the Supreme Court found that the sums the insurer is obligated to pay must be on account of property damage arising out of

an occurrence during the policy period. Because the claims in *Atchison* involved a single, continuous occurrence resulting in an unallocable loss implicating successive policy periods, the Supreme Court applied a *pro rata* time on the risk allocation. In this case, plaintiff insurers' argued that there was no need to decide the number of occurrences issue because summary judgment was warranted under the *Atchison* decision.

The District Court disagreed. Without discussing what facts would give rise to a single or multiple occurrence ruling, the District Court concluded that a single occurrence was central to the Kansas Supreme Court's holding in *Atchison*. *In addition*, because plaintiffs in this case had failed to present any evidence establishing a single occurrence with respect to the underlying claims, it was unclear whether a single or multiple occurrence ruling was warranted.

In reaching its conclusion, the district court noted that the *Atchison* court adopted the reasoning of the Illinois appellate court in *Missouri Pacific R.R. Co. v. International Ins. Co.*, 288 Ill.App.3d 69, 679 N.E.2d 801 (2nd Dist. 1997) in finding a single occurrence. However, the court noted a divergent result was reached under the facts present in the Illinois Supreme Court case of *Zurich Ins. Co. v. Raymark*

Indust., Inc., 118 Ill2d 23, 514 N.E.2d 150 (1987), which declined to order a *pro rata* allocation. Because there was a genuine issue of material fact as to whether the underlying claims constituted a single occurrence, the district court could not determine the proper method of allocation and summary judgment was not appropriate.

About SmithAmundsen

SmithAmundsen LLC is a law firm that provides services to clients on a wide range of legal and business issues. Our goal is to become our clients' primary source for legal services and business advice. The Insurance Services Group at SmithAmundsen offers experienced attorneys that have a comprehensive understanding of the business environment in which insurers operate. We represent insurers and reinsurers in the property and casualty, life and health, excess and surplus lines fields. Our attorneys have extensive experience representing the interests of insurers in all aspects of their business, including claims counseling, litigation, dispute resolution, reinsurance and policy drafting. A number of our attorneys have held positions in insurance companies, which provides us with a unique perspective on our clients' concerns. We maintain a perspective beyond the individual case and look for solutions consistent with the long term interests of the company. Whether the issue involves policy coverage, avoidance of bad faith, representation in arbitration or litigation, reinsurance disputes or drafting policy language, we have the expertise to provide reliable and cost effective solutions.

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