

**LITIGATION AGAINST THE
INSURANCE CARRIER:
THE PLAINTIFF'S PERSPECTIVE**

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Contents

- I.** Introduction
- II.** The *Georgetown* Trilogy
- III.** Trial Tactics and Arguments
 - a.** Duty and Pleadings
 - b.** Negotiations and Demand Letters
 - c.** Tactics
 - d.** Punitive Damages
 - e.** Arguments
 - f.** Attorney's Fees
 - g.** Farmers' "Pooling" Agreement
 - h.** The *Goddard* Odyssey
- IV.** Sample Jury Instructions

I. INTRODUCTION

This paper is written to provide guidance for plaintiff's counsel in their handling of the underlying claim and subsequent bad faith case. Even though I refer throughout this paper to "bad faith," this is a misnomer, because the correct standard is ordinary care only. *Maine Bonding v. Centennial Insurance Company*, 298 Or 514, 518 – 519 (1985). The courts have explicitly stated the subjective connotations of good faith or bad faith are not the criteria in assessing whether a carrier has exercised reasonable care. See however, ORS 746.230 (1)(f) which by its terms requires insurance companies to attempt, in ". . . good faith, to promptly and equitably settle claims in which liability has become reasonably clear." (Emphasis added.)

It is important to understand that Oregon only recognizes third-party "bad faith," meaning circumstances wherein the insured has, by terms of their insurance contract, given away the right to defend, negotiate and legally represent themselves. This typically occurs in automobile cases wherein an insured tenders a complaint filed against him or her to his carrier for a defense.

Contrast this with first party actions by a policyholder, such as in life or health, when the policyholder makes a claim directly against their own insurance company. The important distinction is that in third party cases, when the insurance carrier undertakes to "defend," it agrees to provide legal representation and to stand in the shoes of the party that has been sued. The insured relinquishes control over the defense of the asserted claim; thereby placing its monetary liability in the hands of the insurer.

II. THE *GEORGETOWN* TRILOGY

There are approximately 15 Oregon appellate decisions defining the law in this area. With the completion of the *Georgetown* trilogy in 1992, many of the long-standing issues in this area were finally addressed. The bottom line is that bad faith is now acknowledged to sound in tort. The primary consequence is that emotional injuries and punitive damages are legally possible.

A cryptic history of *Georgetown* is in order. *Georgetown Realty v. The Home Ins. Co.*, 102 Or App 611 (1990), *Georgetown I*, the first Court of Appeals decision in this matter, involved a third party excess claim wherein a jury had awarded the plaintiff damages in excess of the insurance policy limits Georgetown Realty had purchased from the Home Insurance Company. After entry of judgment, Georgetown Realty sued its insurance carrier, alleging that the carrier had breached its duties to Georgetown in the defense of the underlying claim; thereby causing it to become indebted in the amount of the judgment, minus its policy limits with The Home Ins. Co. In the later bad faith trial, the jury found in the plaintiff's favor on both a contract and a tort theory. The general damages were \$32,500 in a breach of contract claim, \$35,000 for the tort claim, with an additional \$1,500,000 for punitive damages on the tort allegations.

In *Georgetown I*, the Court of Appeals reversed the tort theory, holding that because the cause of action was founded on the underlying insurance contract, the plaintiff's remedy was therefore in contract only. The verdict for emotional and punitive damages was reversed.

The Supreme Court initially denied review, thereby affirming the Court of Appeals decision in *Georgetown I*. In *Georgetown II*, 313 Or 97 (1992), the Supreme Court reversed the

Court of Appeals and reinstated the underlying tort cause of action. In summary, the Court ruled, at page 106, that:

“The lesson to be drawn from this court’s cases discussing the choice between contract and tort remedies is this: When the relationship involved is between contracting parties, and the gravamen of the complaint is that one party caused damage to the other negligently performing its obligations under the contract, even though the relationship between the parties arises out of the contract, the injured party may bring a claim for negligence if the other party is subject to a standard of care independent of the terms of the contract.”

Further, at 110-111,

“When a liability insurer undertakes to ‘defend,’ it agrees to provide legal representation and to stand in the shoes of the party that has been sued. The insured relinquishes control over the defense of the claim asserted. Its potential monetary liability is in the hands of the insurer. That kind of relationship carries with it a standard of care that exists independent of the contract and with our reference to the specific terms of the contract . . . therefore, plaintiff’s excess claim can be brought as a claim for negligence.”

The Supreme Court then remanded to the Court of Appeals for resolution of issues concerning punitive damage and attorney fees, thus spawning *Georgetown III*.

Georgetown III is found at 113 Or App 641 (1992). Probably the most important aspect of this final *Georgetown* decision is the favorable language found at page 644 concerning the matter of punitive damages in bad faith claims:

“Two of defendant’s assignments are directed against the court’s submission of the punitive damage claim to the jury. Defendant contends that the evidence showed, at worst, that it was negligent in not settling. The trial court disagreed, explaining that it could be inferred from the evidence that defendant chose to expose their insured to a very substantial claim, and they evidently knew they were not going to pay the claim, although they had not warned their insured that they were not going to pay it. They did that for the purpose of protecting a much smaller amount of their own money.

Under these circumstances from all of the evidence that was offered, I’m satisfied that if punitive damages are permissible in Oregon that this is an appropriate case to submit to the jury.”

The Supreme Court approved the term of negligence as an appropriate denomination of the tort claim, but commented at 313 Or 97, 110 footnote 7 that it could also be properly labeled a “breach of a fiduciary duty.” As a practice matter, I recommend that the case caption label the cause of action as “Negligence - Breach of Fiduciary Duty” with a similar allegation set forth in the body of the complaint. This supports a later jury instruction advising that the insurance carrier is in a fiduciary relationship with its insured, and a further explanation of what a fiduciary relationship is. See Jury Instruction No 2.

III. TRIAL TACTICS AND ARGUMENTS

From the plaintiff’s perspective, the trial of a third party claim presents a number of unique features. The following is an inventory of suggestions, practice tips and cautions. I have lumped these suggestions topically into comments concerning analysis of the carrier’s duty and how to plead it, followed by negotiations with attendant demand letters, general tactics including punitive damages, attorneys fees and finally, generic arguments.

III-a. DUTY AND PLEADINGS

A. Every insurance company has multiple primary responsibilities to its insured, under both ORS 746.230 and the policy they sold. These include at least the following:

1. To investigate both the facts and applicable law;
2. To evaluate the claim;
3. To negotiate with the plaintiff (as if there were no policy limits);
4. To fully communicate with their insured; and,
5. To competently defend the claim if necessary.

Georgetown II at 313 Or 97 at page 101, footnote 2, has a comprehensive listing of the traditional allegations of fault.

B. Any analysis of the insurance carrier’s duty starts with a careful reading of ORS

746.230. Two cases underscore the importance of the statutes even though they may not create a private right of action. Read *Bollam v. Fireman's Fund Insurance Company*, 76 Or App 267, 270 (1985) and *Goddard v. Farmers Insurance Company*, 173 Or App 633, 638 (2001).

A violation of any of the following provisions does not create a private right of action, i.e., a statutory tort. *Employers Fire Ins. v. Love It Ice Cream*, 64 Or App 784 (1983). The statute is however, some evidence the jury can consider in assessing whether the defendant's conduct was reasonable. *Hagen v. Gemstate Manufacturing, Inc.*, 328 Or 535, 538-540 (1990).

746.230 Unfair claim settlement practices. (1) No insurer or other person shall commit or perform any of the following unfair claim settlement practices:

- (a) Misrepresenting facts or policy provisions in settling claims;
- (b) Failing to acknowledge and act promptly upon communications relating to claims;
- (c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;
- (d) Refusing to pay claims without conducting a reasonable investigation based on all available information;
- (e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;
- (f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;
- (g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;
- (h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;
- (i) Attempting to settle claims based on an application altered without notice to or consent of the applicant;
- (j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;
- (k) Delaying investigation or payment of claims by requiring a claimant or the physician of the claimant to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

- (l) Failing to promptly settle claims under one coverage of a policy where liability has become reasonably clear in order to influence settlements under other coverages of the policy; or
- (m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim.

C. Affirmatively plead any statutory allegations (ORS 746.230) you maybe relying on.

This anticipates and responds to any later defense “notice” arguments that they are surprised because you didn’t plead the statutes. No matter what you do, expect the defense to later contend that you should have done just the opposite, i.e., if you do plead the statutes then you are pleading law, if you don’t, then they were never on notice. Err on the side of caution. Plead the statutes, and then let the defense move to strike them as pleadings of law. It really does not matter whether ORS 746.230 is in the pleadings or not; you just want to make sure that you have done everything the particular judge thinks is necessary to assure that your experts can discuss the statutes and that the jury will later be properly instructed concerning them.

D. The Insurance Commissioner’s office has also generated numerous administrative regulations that control the conduct of the insurance industry. They are topically indexed so they are easy to access and research. For example, see OAR 836-080-0215 which requires that an insurance carrier maintain its files sufficiently that they can later be reconstructed. This affirmative legal duty is in addition to any “weaker and less satisfactory” instruction you may be entitled to if documents have been altered, lost or destroyed by either the carrier or the counsel they selected and hired to defend their insured.

E. Every company has extensive internal policies and procedures regarding how the company should do business. These make wonderful enlargements for the jury to prove the defendant’s negligence; i.e., they didn’t follow their own rules.

F. Carriers can generally settle when they “deem it appropriate” under their policy. In some professional policies the policyholder’s consent is necessary, but this is not true for most general casualty policies. This is powerful proof demonstrating the fiduciary nature of the relationship and the disparity of power between a defendant policyholder and the carrier.

G. Review the insurance agent’s entire file. The defendant insured has probably bought insurance from the Holy Grail Insurance Company for years, faithfully paying his premiums with hardly a claim. Do not start your proof at trial with the accident and a submitted proof of loss. Hopefully, you can begin years earlier with a policyholder who never wrote a bad check for their premiums and bought a reasonable level of protection from the carrier’s friendly agent. Remember: try your case, not the carrier’s case.

H. The *Fazzolari* concept of “special relationships” 303 Or 1 (1987) at page 17, has special application to bad faith claims because, by contract, the insured has contracted away their right to defend themselves. This means that the very corporate entity that seeks to profit by saying less is in conflict with its insured when there is exposure for a judgment over the insurance policy limits.

The importance of that special relationship is discussed at *Georgetown III*, 113 Or App at page 645, “Negligence may be the standard of liability, but the relationship of the parties clearly involves fiduciary standards.”

I. An Insurance carrier must evaluate the claim acting as if it were liable for the entire judgment that might eventually be entered against the insured. *Kuzmanich v. United Fire and Casualty*, 242 Or 529 (1966). *Eastham v. Oregon Auto Insurance Co.*, 273 Or 600 at 607 (1975).

“With respect to settlement and trial, an insurance company must, in the exercise of good faith, act as if there were not policy limits applicable to the claim, and as if the rest of loss was entirely its own.”

J. Many tactical problems can be solved by the seldom-used technique of alternative pleadings. See ORCP 16 ©) and *Goddard v. Farmers* at p.640, footnote 5. An example is if the plaintiff would not have accepted a policy limits offer because of a prior misrepresentation by a representative of the insurance company. Consider asserting the alternative allegations in the reply rather than the complaint.

K. If the defense raises allegations of comparative fault against their policyholder, cautiously consider moving to strike them. In *Stumpf v. Continental Casualty Company*, 102 Or App 302, 308-310 (1990), the court ruled that any duties the policyholder owed to the company were derived solely from the contract of the insurer. These duties are generally limited to notifying the carrier of any claim, appearing at court hearings and cooperating. I am guarded in filing Rule 21 motions to strike because tort or general negligence concepts requiring “reasonableness” may be a little more expansive than the duties imposed by the insurance contract. If the insured has violated any of the contractual provisions, it may be a bar to recovery in a contract action, but is merely an allegation of comparative fault in a related tort action.

Radcliffe v. Franklin National Insurance Company, 208 Or 1, 22 (1956), suggested that if the carriers expect something from an insured, they should say so in the policies they sell.

L. In *Warren v. Farmers Ins. Co. of Oregon*, 115 Or App. 319, 325, P2d, (1992), the court ruled that when an insurance company incorrectly fails to undertake a defense, claiming a lack of coverage, the plaintiff’s subsequent remedy is in contract only. If the defense is not undertaken, the tort duty to exercise reasonable care does not arise. See also *Strader v. Grange*

Mutual Insurance Company, 179 Or App 329, 332 – 335, P2d, (2002).

At page 326, the Court of Appeals effectively invited the Supreme Court to overrule *Farris* saying:

“In all fairness, it is difficult to see why the insurer should be in a better position by refusing to defend, and thereby breaching the insurance contract, than it would have been had it undertaken the defense, but done so negligently. We fail to see any principled distinction between the conflict of interest that exists when an insurer makes a decision whether to defend, and the conflict that exists when, having undertaken the defense, a settlement opportunity arises that would cost the insurer its policy limits but would result in no personal liability for the insured. Were we writing on a clean slate, we might reach a different result.”

The Oregon Supreme Court denied plaintiff’s petition for review.

III-b. NEGOTIATIONS AND DEMAND LETTERS

M. It is invigorating to be an advocate, however, as the attorney in the successful underlying case, you will probably be a historical-fact witness in the subsequent “bad faith” case; therefore, when you finally do attend the big party, the later “bad faith” case, it should be as a witness and not a lawyer.

N. Your offers of settlement, meaning your demand letters, must on their face show the verdict was not only foreseeable - it was predictable. When writing the demand letters in the underlying case, do not permit the carrier to later be able to say “If only we had more information, or time or . . .” A well-constructed demand letter will anticipate, and thereby preempt every after the fact excuse. The insurance company knew because “I told them so” is what your letters effectively shout. You will be able to prove to the jury that you did so by referencing your well-crafted settlement demand letters. It is not hindsight, it was foresight, and here is the proof!

The carrier answers, “We tried to be thorough, but we did not have enough information, cooperation, time or what have you . . .” Give them anything and everything they want. Bend over backwards. Treat them better than the way you want and expect to be treated. Why? First, because it is obviously fair, and second, because it is in the interests of both your client and the defendant. When the carrier chooses to “go for broke” and declines an obviously reasonable offer, the carrier may then become responsible for the entire amount of the judgment, because they caused it. The reasonableness of both your letters and conduct anticipates and preempts the inevitable insurance company arguments that some plaintiff’s lawyer was just trying to “set them up.” Anticipate every generic defense. Write the carrier multiple letters. Each demand letter, carefully explaining the obvious, should be sent by certified mail, with copies to every person or entity potentially involved.

Confirm all important telephone conversations to the adjusters and defense counsel with notes to the file and letters. Your correspondence will document the history of the negotiations and thereby enhance your credibility with the jury when you testify years later concerning who said what, and when.

O. Typical defense requests in the underlying case include extensions of time or requests for “IME” depositions of the parties or witnesses. Cheerfully give it all to them. Some of these requests for the depositions of “other” witnesses are a ruse in an attempt to buy more time beyond your demand limits by dreaming up some last minute detail that needs to be explored.

There are no hard and fast rules declaring exactly what is reasonable or unreasonable in this area. The key question will always be whether the insurance company’s conduct in the handling of the case was reasonable - under all the facts. The ultimate answer to this question, in no small measure, will be a reflection of whether you, as plaintiff’s counsel in the underlying

case, were reasonable in any restrictions you placed upon the offers you extended. If you denied an insurance company's demands, then you had better be sure their request was patently unreasonable. The conduct of plaintiff's counsel implicitly sets a standard of care concerning fairness. I welcome unreasonable requests that I can further comply with. I consider this just another opportunity to prove how reasonable I am, and will continue to be. If the carrier does eventually pay the policy limits - then both your client and the defendant win. If the insurance company does not pay, and you have been imminently reasonable in your demands and conduct, then once again both your client and the defendant win. Because of their own negligence, meaning by failing to have accepted your reasonable offer, the insurance company has now bought coverage for all the plaintiff's damages, and possibly exposed itself to punitive damages.

P. You still need to be able to credibly explain why you turned down the company's tardy offer of the policy limits, particularly if it is only a few days late. When five o'clock p.m. passes on the specific date you have given the company to accept your offer, and they have not responded, begin preparing aggressively for trial the very next morning. This proves you mean business and are a lawyer of your word. It also supports the equitable or quantum merit arguments (based on the work you have invested in the file after the offer has lapsed) that justifies your rejection of any subsequent offers.

Remember that when the offer is date and time specific, once that time has passed, the offer expires by its very terms, so there is nothing for the carrier to later thereafter accept. Make sure your demand letter specifically declares that the offer is withdrawn once that acceptance date has passed, that time is of the essence, and that the matter will then proceed to trial and judgment. Your demand letter, and subsequent testimony, should persuasively explain the dire medical and financial straits of your client, and why a prompt settlement is so important. If

you were willing to cut your fee if the matter could have been settled promptly then this should be confirmed in writing.

Spend hours carefully crafting every word in your demand letters to the carrier. Assume the demand letters issued over your signature will be Exhibits 1, 2 and 3, in the subsequent bad faith trial. Further, assume you will be the first witness called to testify! You will be both deposed and cross-examined before a jury on the accuracy of every word you use and every representation you make. Put some careful time and thought into drafting your correspondence. Avoid hyperboles and overstatements. Examples might include marginally accurate recitals such as “this is the worst case of . . . that I have ever seen.” Ask yourself if any portion of the letter is less than an objective view of the facts. Be prepared to back up what you say. If something is questionable, consider rephrasing it. Acknowledge that “there may be two different ways of viewing a certain matter, but the clear weight of evidence favors the plaintiff, and that a jury will also probably see it this way.”

Q. It is important that the defendant hire his or her own excess attorney who, in response to your offer to the insurance company to settle, writes a separate letter demanding that the carrier settle this case.

R. When the plaintiff alleges in the bad faith case that the insurance company failed to negotiate reasonably in the underlying claim, then arguably all of the parties prior settlement conduct become admissible as proof in the bad faith case. Remember under *Goddard* 173 Or App 633, 640-641 (2001), the duty to negotiate extends throughout the pendency of any appeal. Remember that rules of appellate procedure now mandate that both sides consider a settlement conference.

Be wary. Anything occurring during a mediation or settlement conference may be admissible, not in the original case, ORE 408, but as relevant evidence by either side in the later bad faith case, to prove whether the carrier negotiated reasonably in the underlying case. I recommend you not file the bad faith case until all appeal rights are exhausted in the underlying case to avoid overlapping. Before you write a letter to the insurance carrier saying you are not willing to attend a settlement conference, first ask yourself, “Is this a letter I want to later have to defend in front of a jury - especially when I am the one alleging that it is the other side who refused to negotiate in good faith? Remember, as a later witness you must successfully defend every letter you write (as a future trial exhibit), and everything you have said to both the opposing adjuster and defense attorney, under oath, in the later bad faith trial.

III-c. TACTICS

S. Are there any “smoking guns” in the claims files? Do not settle a “bad faith” claim without first thoroughly reviewing all of the claims files. This includes the local, regional and home office files. If there is nothing for the insurance company to be worried about, then the carrier should not mind showing you the proof.

T. Be careful when drafting the assignment. It must not extinguish the assignor’s ultimate responsibility in the underlying case. ORS 17.100 provides:

“Assignment of cause of action against insurer. A defendant in a tort action against whom a judgment has been rendered may assign any cause of action that defendant has against the defendant’s insurer as a result of the judgment to the plaintiff in whose favor the judgment has been entered. That assignment and any release or covenant given for the assignment shall not extinguish the cause of action against the insurer unless the assignment specifically so provides.”

U. *North Pacific Insurance Company v. Wilson Distributing*, 138 Or App 166 (1995) prevents an insurance company from filing a declaratory judgment action to resolve coverage

prior to the trial of the underlying case when the “dec action” discovery might be to the policy holder’s disadvantage in the pending underlying case.

V. Distinguish between verdict range and reasonable settlement value. A critical examination of the insurance claims evaluations in the underlying case will reveal that they were always within policy limits. I am sure there are a thousand good reasons why this always happens, but it does amaze me. The insurance company’s analysis seems to begin at zero dollars and magically peak out comfortably just below the policy limits. No one from the insurance industry would ever agree with the foregoing statement, but it seems to be the *modus operandi*. Once the reserves are set, the carrier then begins to work backwards trying to save a dollar.

W. Is there the possibility that the insured may be liable for a type of damages not covered by the terms of the policy? How about punitive damages not covered by the insurance policy? This means the insurance company is truly “rolling the dice” with their insured’s future. Note at the bottom of page 643 in footnote 1 in *Georgetown III*, the comment is made in passing that the insurance company took the position that not all of the damages sought in the underlying action were covered by the policy, even if they came within its monetary limits. Under a tort theory, the insurance company should be responsible for the entire amount of the judgment, irrespective of whether the carrier had a duty to indemnify for all portions. Whenever punitive damages are a possibility, and there is no coverage for them, the insured is automatically at risk for a judgment “in excess” of his insurance policy limits, irrespective of the amount. Punitive damages are also, in general, not dischargeable in bankruptcy. This means they follow the insured to the grave. This is the stuff that fiduciary duties are made of.

X. Because Oregon has apparently adopted the “judgment” rule, the amount of the damages in a bad faith contract action are set as a matter of law at the amount of the judgment

entered in the underlying case, with statutory interest added since its entry. There is nothing for the jury to decide factually concerning the measure of contract damages once a certified copy of the underlying judgment comes into evidence. See *Stumpf v. Continental Casualty Company*, 102 Or App 302, 312-313 (1990).

Y. In the Goddard case, we asked for no emotional damages for the policyholder John Munson. This was a tactical decision. We felt Mrs. Goddard was an excellent witness, and it was John Munson who had killed her son, and was later convicted of criminally negligent homicide. He also had, by his own admission, lied when providing prior statements to Farmers concerning whether he had Mrs. Foley's permission to be driving her car when he had been drinking alcohol. Proof at trial was that Munson's blood alcohol content at the time of the collision was approximately .23 percent. He obviously was not a sympathetic client, yet because Mrs. Goddard was standing before the jury based on an assignment from Munson of any claim he may have had against Farmers, we needed to minimize Munson's prominence during the trial. The only general damages proof we placed in evidence was the judgment in the underlying wrongful death case. The jury found Munson 20 percent at fault under Farmers' allegation of comparative fault. Any comparative fault does not reduce the amount of punitives the jury may award, which was the real issue in the bad faith trial.

Z. Carefully review the reserves the company set on the case as some evidence of "bad faith." Anytime a company has the file's reserves set substantially in excess of its offers is some evidence of bad faith. See *Kabatoff v. Safeco Ins. Co.*, 627 F 2d 207 9th Cir. (1980).

AA. Most every insurance company has written internal cost containment guidelines that assigned defense counsel are expected to follow. These may include such matters as not ordering depositions typed up until 60 days before trial, or not routinely filing Rule 21 motions

because they are viewed to be inefficient and non-productive or limiting depositions to only the witness perceived to be important. Whatever the wisdom of these practices, they can make the carrier look pretty bad when reviewed, and the insured later claims his insurance company did not put on an adequate defense for him. They were trying to “pinch pennies” and save a buck rather than permitting the assigned lawyer to “zealously” represent him. DR 7-101. Plaintiff’s counsel should file a Request for Production concerning such documents.

BB. Subpoena the assigned defense counsel’s total annual billings with this particular carrier for past years. This is relevant to prove the bias, interest and motive of the assigned defense lawyer(s) when you later argue that the lawyers the insurance company selected and paid for put the interests of the carrier ahead of the policy holder they were assigned to defend; the real client who they owed their undivided loyalty to.

CC. Look carefully for any evidence of conflicts of interest between the carrier and its policyholder when conducting discovery. Some conflicts are structurally inherent in the nature of the relationship when the policyholder is exposed for more protection than they bought. Juries are very sensitive to a policyholder’s vulnerabilities. It is your job to ferret out such proof, and then effectively argue it.

DD. Expert witnesses are crucial. Find high quality attorneys experienced in the handling of insurance defense matters. One of plaintiff counsel's biggest hurdles is in locating experts who have represented insurance companies and are willing to crossover and testify against an insurance carrier, and thereby bite the (insurance industry’s) hand that feeds them.

EE. Be mindful of the collateral source rule. ORS 18.580. File a motion in limine to exclude any evidence that the plaintiff in the underlying case received money from any other source. The defendant may try to reduce the plaintiff’s judgment to impact the multiplier if there

are punitive damages and a due process question is raised. *Parrott .v Carr Chevrolet, Inc.* 331 Or 537, 562 (2001).

FF. *Georgetown II* has resolved most of the previously unanswered questions in Oregon concerning bad faith law. One important area left involves *Stumpf v. Continental Casualty Co.*, 102 App 302, 794 P2d 1228 (1990), and the scope of pre-trial discovery - assuming defense counsel is the insurance company's agent. Plaintiff's counsel will want to argue that this (implication of) agency relationship “opens the door” rendering everything in the company and assigned defense counsel’s files admissible, and therefore discoverable. Meanwhile, the defense will argue that the defense counsel is the agent of the insured, and not that of the company. Once you get an assignment from the defendant, get a release that you then tender to the carrier. This should provide access to all the insurance company files, including those of the assigned defense counsel.

GG. Make the defendants file an appeal bond with an A or A+ rated insurance company during the pendency of any appeal. As of the writing of this paper, Farmers rating has dropped to C+. An appeal bond filed by Farmers or one of their many subsidiaries is insufficient assurance of later payment for an appeal that could extend for many years.

III-d. PUNITIVE DAMAGES

HH. Three prior Oregon cases discussing awards of punitive damages in “bad faith” claims contain helpful language. In *Groce v. Fidelity General Insurance Co.*, 252 Or 296, at 303-304 (1969) the court stated:

“Long before the cases were filed, the agents of the defendant knew that the damage claims were not the kind that would, if tried, would be likely to result in verdicts within the insurance limits. Notwithstanding the high probability of

verdicts far in excess of policy limits, there is no evidence that the Defendant ever consulted the insured or considered any interest he might have had in avoiding judgments in excess of his insurance coverage. On the contrary, affirmative evidence showed that the Defendant, at least through the mouth of its adjuster, reflected an arrogant disdain for the right of its bankrupt insured, and was willing to use the insured's insolvency as additional leverage in an attempt to settle the claims for less than the meager limits of the policy. The adjuster, who had learned from his own investigation that the insured was intoxicated at the time of the accident and who knew there was virtually no defense on the issue of fault, wrote to his supervisor, 'In this adjuster's experience, he has never paid a policy limit to date, and does not intend to start with the subject claim.'" (Emphasis added)

See also *Farris v. United States Fidelity and Guaranty Co.*, 284 Or 453 at 455 (1978), a pre-*Georgetown* case that did not allow tort claims, and therefore punitives. The insurance company's file apparently showed that the claims manager wrote, "Let's bluff it out - we can always buy out at a later date." (Emphasis added.) See Justice Lent's language in his dissent in *Farris* at page 481, arguing that punitive damages should have been allowed in this case because the conduct to be deterred was that of liability insurer refusing in bad faith to defend its insured by "bluffing it out." See also the favorable language in *Georgetown III*, 113 Or App 641 at 644 (1992).

II. In the *Williams v. Philip Morris, Inc.*, 182 Or App 44 at 52 (2002), the defendant made (mis)representations to the general consuming public concerning the safety of their cigarettes. It isn't much different when an insurance company like Farmers markets itself saying they are "Fast, Fair and Friendly" or that "America Can Depend on Farmers" and your proof is to the contrary.

III-e. ARGUMENTS

JJ. It is generally easy to have a plaintiff whom the jury can relate to when suing on an assignment taken from the original defendant in the underlying case. Yes, it is true their original wrongdoing caused someone else serious injury, but that is exactly the reason they purchased

insurance. Because the insurance company chose to “go for broke,” he or she is now strapped with a large judgment they cannot afford to pay.

KK. Jurors understand that an institution makes a profit by taking in more money than it pays out; therefore, the less it pays out the more profit it will make. The motivation any insurance company has to compromise its duties to its insured is obvious. Insurance companies traditionally “loose” money when you compare the total dollars paid out, compared with the premium dollars they take in. Their profits are in the “time value” of money and the investment they make when holding onto the collected premiums before they ultimately pay them out.

LL. Argue that the insurance company is asking this jury to second guess the first jury’s verdict rendered in the underlying case. Able defense counsel can always generate an explanation for why the jury “Went crazy with the big numbers,” thereby rendering the first verdict a big surprise. Respond that this argument slurs the integrity of the entire jury system, and is a slap in the face of the citizen jurors who take the time to serve on the second “bad faith” case.

MM. In a sense, many bad faith defense arguments are that the insured simply did not buy enough insurance. After all, if their insured was going to have a really big accident, then he certainly should have had the foresight to also go out and buy a really big policy!

NN. Argue that even when an insurance company pays the policy limits, they may arguably lose a little, but if they do not and they are wrong, then the insured loses everything.

OO. The defendants always argue that the underlying verdict was a fluke, and that what is really going on is hindsight. Respond that the verdict was affirmed by not only the trial judge when he or she denied all defense post-trial motions, but also that the appellate judges of this state agreed in affirming the underlying judgment when the defense appealed the matter to them.

This includes both the Court of Appeals when they affirmed the underlying judgment, again when they denied the petition for rehearing, and finally the Supreme Court when they denied the defendant's petition for review - thereby saying they agreed with the Court of Appeals. The insurance company has tried to tell the trial judge and appellate courts of this state that the first jury's verdict was a fluke. Apparently, because no one has yet agreed with them, they are once again back on their knees with the same tired arguments.

III-f. ATTORNEY'S FEES

PP. Conventional wisdom is that the plaintiff should plead conjunctive theories of liability, i.e., contract and tort. This is because ORS 742.061 permits an award of attorney's fees. This is what was done in the *Georgetown* case. Both theories went to the jury with a special verdict form. As a plaintiff's lawyer, I want a simple verdict form; the fewer questions the better. Ask yourself how important the attorney's fee issue is to you, including any appeals, and then plead accordingly. See *Goddard v. Farmers Ins. Co.*, 177 Or App 621 (2001).

QQ. Keep detailed time records because they will be important proof in the later attorney's fee hearing on the contract claim. Expect any attorney's fees to be awarded at an hourly rate, as opposed to a contingency fee. This is a matter of judicial discretion. See *Stumpf* at 102 Or App 302, 313-314 (1990) where a contingency fee award was approved.

III-g. FARMERS' "POOLING" AGREEMENT

RR. Farmers of Oregon Inc. is a paper entity that owns no physical assets and has no employees. Under a "subscription agreement," Farmers of Oregon contracts the evaluation, negotiation and settlement of all policies it sells to Farmers Exchange. Eighty percent of Farmers of Oregon's stock is owned by Farmers' Exchange and twenty percent by Truck Insurance Exchange, another one of Farmers' companies. Under the terms of the pooling

agreement, note that Farmers of Oregon only pays 4.28 percent of any judgment entered against it. In the *Goddard* case, the defense tried to exclude the pooling agreement as being insurance, thereby violating ORE 411. The policy agreement is not insurance, it is proof of what the defendant is.

The pooling agreement is also admissible on the issue of punitive damages to show the amount necessary to punish both the defendant, and others similarly situated. This is the first time this pooling agreement has been received into evidence against a Farmers insurance company in a trial.

III-h. THE *GODDARD ODYSSEY*

SS. The latest bad faith decision issued by the Oregon courts came out of our office. *Goddard v. Farmers Ins. Co.*, 173 Or App 633 (2001). The fifteen-year case history merits some discussion. I have attached a separate section labeled as IV including instructions that were used in the *Goddard* case. The underlying case was a wrongful death claim resulting in a January 1990 judgment for \$863,274.

On October 27 1987, John Munson turned his vehicle directly in front of Marc Goddard's oncoming pickup truck, killing Goddard. The defendant Munson was convicted of criminally negligent homicide. Civil Liability was therefore obvious. The decedent Goddard was a 19 year old with a checkered past who was entering college. Munson was potentially covered by two \$100,000 Farmers policies. The first policy was his own, the second Farmers policy was written to his friend Foley, who loaned Munson the pickup truck he was driving the night of the collision. In June 1988, the wrongful death action was filed. Farmers defended Munson in the civil wrongful death claim under a reservation of rights. Munson had no assets beyond the policies. In December 1988 Farmers filed a declaratory judgment action (hereinafter referred to

as “dec action”), in an attempt to determine the coverage, if any, under the two Farmers policies. Remember this was pre-*North Pacific Ins. Co v. Wilson’s Distributing* 138 Or App 166 (1995). In the dec actions, Farmer’s contested under Foley’s policy whether Munson was driving Foley’s pickup with her “permission,” and under Munson’s policy argued there was no coverage because he had the “regular and frequent” use of Foley’s truck. The Goddard estate argued in the dec actions that both policies applied, and further that the two policies “stacked” to provide \$200,000 in total coverage. Trial in the underlying wrongful death claim occurred in late January 1990. The jury returned a plaintiff’s verdict for \$863,274. After entry of the wrongful death judgment, the plaintiff obtained an assignment (ORS 17.100) from Munson of any rights he had against Farmers. The bad faith claim was filed in May of 1990. The Court of Appeals affirmed the judgment in the underlying wrongful death claim. 108 Or App 342 (1991). Farmers obtained a judicial stay of the bad faith claim pending final resolution of the dec action, arguing that if there was no coverage under either policy, then as a matter of law, there could be no bad faith claim. The dec actions were tried three times, in 1991, (reversed - 127 Or App 413 (1994)), 1995, (reversed - 145 Or App 512 (1996)), and 1998; ultimately resulting in a finding that Munson had been driving Foley’s pickup truck with her permission and therefore there was coverage under her Farmers policy, however, there was no coverage for Munson under his own policy because he had the “regular and frequent use” of Foley’s pickup at the time of the collision. Once coverage was finally found under the Munson policy, the judicial stay was lifted in the bad faith claim. Prior to trial, court granted the defendant’s motion for summary judgment, concluding that, even if Farmers had offered the \$100,000 it was finally determined they owed, there was no evidence that the plaintiff would ever have accepted it. Therefore, even if Farmers had never offered the \$100,000, there could be no bad faith because the element of “causation” was

missing. The Court of Appeals reversed this ruling. 173 Or App 633 (2001). In a later Court of Appeals decision, they also ruled there would be no attorney's fees because the plaintiff's claim had proceeded only in tort, and not on the contract. *Goddard v. Farmers Ins. Co.*, 177 Or App 621 (2001). In April 2002, a Multnomah County jury awarded the plaintiff \$20,700,000 in punitive damages. The trial court denied all post-trial defense motions. The matter is now on appeal.

From this tortured history the 2001 *Goddard* decision has clarified the prominence of ORS 746.230 as a basis for liability, and that an insurance carrier's duty to their insured extends not just through trial and entry of judgment, but also throughout the period of any appeal. This duty, of course, includes the responsibility to negotiate. Language at 173 Or App 641 reads ". . . a liability insurer owes an 'even greater duty' to its insured following entry of judgment."

A question that remains unanswered is, once an excess judgment is entered in the underlying case, what is the carrier's exact duty during the pendency of any appeal? Is it, as the defense claims, to only tender the policy limits, or as the plaintiff argues, to act "reasonably" and pay more than the policy because those are the known damages that have resulted from the carrier's earlier breach of its duty? This issue is raised by way of defense rule 21 motions to force the plaintiff to plead "causation," i.e., that they would have settled for policy limits if they would have been offered during the pendency of the appeal. The problem with this is by this time the plaintiff has already tendered many prior offers to settle for the policy limits. Now that the judgment in excess of the policy has occurred, the plaintiff understandably requests that they pay the full judgment that resulted from the carrier's prior negligence. In *Goddard*, 173 Or App 64 1, the plaintiff argues that the carrier's duty is always to act "reasonably," and given the

carrier's prior breach of its duty to settle, the company has now "bought" the entire amount of the underlying judgment, *Goddard v. Farmers*, 173, Or App 633, 642, 22 P3d 1224:

"Following entry of judgment in excess of its policy limits an insurer must continue to give equal consideration to the interests of its insured. The insurer must act as if it alone was liable for the amount of the entire judgment, and the reasonableness of the insurer's actions after judgment should be viewed in this context."

The exciting evolution of the common law continues . . .

IV. SAMPLE JURY INSTRUCTIONS

Request that the jury receive written instructions under ORCP 59B. Prepare a separate set of instructions for each juror. Also, request that the jury be charged prior to closing arguments. ORCP 58 B [8]. When the law is favorable, why not take advantage of it? Preparing a separate set of written instructions for each juror takes a little more work, but it's worth it. The following instructions are taken from the *Goddard* case. I have set forth the proposed instruction, then its authority, and finally have included a comment section where I discuss the tactics and arguments supporting the instruction.

PLAINTIFF'S JURY INSTRUCTION NO. 1

John Munson previously assigned all of his rights, including the right to file this lawsuit against Farmers Insurance Company, to Margie A. Goddard, as the personal representative of the Estate of Marc E. Goddard. This is legally proper and thereby gives Margie Goddard, as the personal representative of the Estate of Marc E. Goddard, the right to bring this lawsuit against Farmers Insurance Company.

AUTHORITY:

ORS 17.100

Comment: Jurors have trouble understanding who the “real” plaintiff is. This instruction answers their question and legitimizes the assignment.

PLAINTIFF'S JURY INSTRUCTION NO. 2
Duties of a Fiduciary

Under Oregon law, an insurer, that is an insurance company, is in a fiduciary relationship to its insured. A fiduciary is one who is in a position of trust and confidence with another, usually called a principal, while acting for and on behalf of the other.

A fiduciary is legally bound in equity and good conscience to act in good faith and for the best interests of the principal. A fiduciary's loyalty must be to its principal.

Any conduct that is intended to place a fiduciary's own interests or the interests of any other party ahead of the best interests of the fiduciary's principal is a breach of the fiduciary's duty.

AUTHORITY:

Georgetown Realty v. The Home Ins. Co., 313 Or 97, 110, footnote 7 (1992)

Comment: While the cause of action is in negligence, this favorable language characterizing the relationship as fiduciary goes a long way toward preempting any comparative fault allegations.

PLAINTIFF'S JURY INSTRUCTION NO. 3

I instruct you that it is the law of the State of Oregon that no insurer or other person shall commit or perform any of the following unfair claim settlement practices.

- (a) Misrepresenting facts in settling claims;
- (b) Failing to acknowledge and act promptly upon communications relating to claims;
- © Refusing to pay claims without conducting a reasonable investigation based on all available information;
- (d) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted; and
- (e) Not attempting in good faith, to promptly and equitably settle claims in which liability has become reasonably clear.

AUTHORITY:

ORS 746.230 (1) (a), (b), (d), (e), (g) (underlining added)

Comment: This is at the heart of the plaintiff's case. Ponder the importance of the underlined words and begin your liability analysis here. Your pleadings, argument and instructions can be centered around this law.

PLAINTIFF'S JURY INSTRUCTION NO. 4

Oregon has various laws concerning the conduct and practices of insurance companies. You may consider whether the defendant, or any of their agents, violated one or more of these insurance laws in determining whether the defendant or their agents were negligent.

AUTHORITY:

Axen v. American Home Products Corp., 158 Or App 292, 305-307 (1999)

Hagan v. Gemstate Manufacturing, Inc., 328 Or 535, 538-540 (1999)

Volt Services Group v. Adecco Employment Services, 178 Or App 121, 129 – 131 (2001)

PLAINTIFF'S JURY INSTRUCTION NO. 5

In conducting the defense of a claim against their insured, an insurance company must use such care as would have been used by an ordinary, prudent insurance company with no policy limits applicable to the claim against their insured. The defendant insurance company was negligent in failing to settle if an opportunity to settle existed, if in choosing not to settle it was taking an unreasonable risk. A risk is deemed unreasonable if it involved chances of unfavorable results out of reasonable proportion to the chances of favorable results.

AUTHORITY:

Maine Bonding v. Centennial Insurance Company, 298 Or 514, 518-519 (1984)

Comment: This is the “gold standard” statement of an insurance company’s duty.

PLAINTIFF'S JURY INSTRUCTION NO. 6

An insurance company's duty to defend is independent of, and not limited by, its duty to pay and indemnify. The duty to defend requires that the insurance company exercise reasonable care to protect its insured's interests, in addition to its own. This obligation requires that the insurance company negotiate with a view to settling the case within policy limits.

AUTHORITY:

Maine Bonding v. Centennial Insurance Company, 298 Or 514, 519 (1985)

Spray v. Continental Casualty Co., 86 Or App 156, 161 (1987)

Comment: The last sentence declares that the carrier has an affirmative duty to its policyholder to settle the case if possible. This is an ongoing duty, thus the carrier cannot sit on an offer made earlier if events have changed, such as the trial has gone badly. See *Spray* at Page 161, footnote No. 4.

PLAINTIFF'S JURY INSTRUCTION NO. 7

An insurance company may be negligent in unduly delaying making an offer, or counteroffer, to settle.

AUTHORITY:

Maine Bonding v. Centennial Insurance Company, 298 Or 514, 524-525 (1984)

“A liability insurer is not necessarily free from excess liability because the claimant made no offer to settle within the policy limits. Due care may require an insurer to institute settlement negotiations. The insurer’s conduct in conducting settlement negotiations ‘must be considered with reference to the context in which the failure or delay occurs.’”

Comment: Another instruction that emphasizes the duty of the carrier to affirmatively attempt to settle the case.

PLAINTIFF'S JURY INSTRUCTION NO. 8

If you find that Farmers’ negligence resulted in the judgment of February 5, 1990, against their insured John Munson for \$863,274, then Farmers must act as if it alone were liable for the amount of the entire judgment. The reasonableness of the insurer’s actions after the entry of any judgment should be viewed in this context.

AUTHORITY:

Goddard v. Farmers Ins. Co., 173 Or App 633, 641 (2001)

Comment: The carrier has a duty to negotiate after the entry of the judgment and during the pendency of any appeals.

PLAINTIFF'S JURY INSTRUCTION NO. 9

If the defendant insurance company failed to exercise the care of an ordinary prudent insurer with no policy limits applicable to the claim, it may be liable for the excess judgment entered against the insured, regardless of the amount of the policy limits, the amount of the excess judgment, or whether the policy provided coverage for punitive damages.

AUTHORITY:

Spray v. Continental Casualty Company, 86 Or App 156, 162 (1987)

Kriz v. Government Employee Ins. Co., 42 Or App 339, 349 (1979)

Georgetown Realty v. The Home Ins. Co., 313 Or App 641, 643, footnote 1 (1992)

Comment: Under a tort theory, there are no contractual limitations. If the case could have, and should have been settled, then it is no subsequent defense that some aspects of the resulting judgment included matters that were excluded by the policy.

PLAINTIFF'S JURY INSTRUCTION NO. 10

I further instruct you that the Marc E. Goddard estate may be excused from failing to accept an otherwise reasonable offer by Farmers, if the defendant through its agents, misrepresented facts or policy provisions to the estate's lawyers, and those lawyers then reasonably relied on Farmers representations in declining such offers by Farmers.

AUTHORITY:

Goddard v. Farmers Ins. Co., 173 Or App 633, 641 (2001)

Comment: ORS 746.230 (1-a) declares that no insurer may misrepresent either facts or policy provisions. This is a good place to consider alternative pleadings under ORCP 16-C. The plaintiff would have accepted a timely offer of policy limits, and alternatively, if he or she would not have, it was because of misrepresentations made by the insurance carrier's representatives. See *Goddard at 640*, footnote No. 5.

PLAINTIFF'S JURY INSTRUCTION NO. 11 Constructive Knowledge

I instruct you that the knowledge of an agent is legally imputed to its principal.

Comment: This standard instruction is useful when the ultimate decision maker at the regional or home office did not know everything the adjusters in the field knew at the branch office.

PLAINTIFF'S JURY INSTRUCTION NO. 12

I instruct you that at all times James Sellers, MaryKay Hendrickson, Randy Voth, Dave Strand, Doug Heatherington, Dick Younge, Don McClure, Martin French, Frank Soldano, Stan Benion and Edward Austin Morris were employees of the Farmers Insurance Exchange.

MaryAnn Selzer and Don DeWolfe, signatories to the Farmers Insurance Company of Oregon policies issued to John Munson and Helen Foley, were employees of Farmers Group, Inc.

Farmers Group, Inc, Farmers Insurance Exchange, and the defendant Farmers Insurance Company of Oregon are all separate legal entities.

Farmers Insurance Group is not a legal entity. It is a federally registered service mark.

Comment: Many insurance companies are not ordinary corporate creatures. Farmers Insurance Company of Oregon has no employees or physical assets. It is party to a pooling agreement of wholly owned Farmers Companies that all reinsure each other. They all contract with the Farmers Insurance Group for the investigation, evaluation and negotiation of all their claims. The agents within the geographical confines of the state say Farmers Insurance Company of Oregon sell policies with limits of \$100,000, yet the adjusters in the Portland Regional office have only \$50,000 in authority. Thus, the settlement of larger claims, and the filing of all declaratory judgment actions, all must be referred on to Farmers' home office in Los Angeles.

PLAINTIFF'S JURY INSTRUCTION NO. 13

An insurance company may be civilly liable for the actions of its agents, including the attorneys it selects to represent its insureds.

AUTHORITY:

Stumpf v. Continental Casualty Co., 102 Or App 302, 308 (1990).

Comment: This should be used when the assigned defense attorney arguably places the interest of the carrier ahead of the insured, the “real client.” Most defense counsel have long standing relationships with carriers, and earn substantial sums from carriers over the years. These numbers should be both discoverable and admissible to impeach the attorneys’ bias, interest and motive.

PLAINTIFF'S JURY INSTRUCTION NO. 14

The duties of both the defendant insurance company and the lawyers they select to protect the interests of their insureds are not reduced or altered by the fact that their insured may have retained their own counsel.

AUTHORITY:

Cathay Motorway, 582 F Supp 650, 659 (1984)

Comment: Use when the insured has hired his or her own excess attorney, and the carrier tries to deflect their contractual responsibilities onto the excess attorney.

PLAINTIFF'S JURY INSTRUCTION NO. 15

If you find the defendant reasonably relied on good faith evaluations of the attorneys it selects, then you may consider such relevance as evidence of defendant’s exercise of due care.

If, however, you find the defendant attempted to affect the opinions or services of such attorneys, or chose to ignore their recommendation, then you may also consider such evidence as a lack of due care towards its insured.

AUTHORITY:

Stumpf v. Continental Casualty Company, 102 Or App 302, 308 at footnote No. 8 (1990)

Bohemia Inc. v. Home Insurance Company, 725 F. 2d 506, 511 (1984).

Comment: Request this when there is evidence the carrier failed to follow the advice of its own lawyer.

PLAINTIFF'S JURY INSTRUCTION NO. 16
UCJI No. 75.02 – MODIFIED PUNITIVE DAMAGES

If you decide to award punitive damages, you may properly consider the following items in fixing the amount:

- (a) The likelihood that serious harm would arise from the defendant's misconduct;
- (b) The degree of the defendant's awareness of that likelihood;
- (c) The profitability or potential profitability of the defendant's misconduct;
- (d) The defendant's motive;
- (e) The duration of the misconduct and any concealment of it;
- (f) The attitude and character of the defendant's conduct upon discovery of the misconduct;
- (g) The number and position of employees involved in causing or covering up the misconduct;
- (h) The sum of money that would be required to discourage the defendant and others similarly situated, from engaging in such conduct in the future; and
- (I) The income, assets and financial condition of the defendant Farmers Insurance Company of Oregon.

AUTHORITY:

State ex rel Young v. Crookham 290 Or 61, 618 P2d 1268 (1980)

“The finder of fact must determine what punitive damages, if any, to award based on the proper premise of deterring future similar misconduct by the defendant or others. To this end, a number of factors may be relevant, including the seriousness of the hazard to the public, the attitude and conduct of the wrongdoer upon learning of the hazard, the number and position of employees involved in causing or covering up the misconduct, the duration of the misconduct and/or its cover-up, the financial condition of the wrongdoer, and prior and potential punishment from similarly situated plaintiffs or other sources.”

Comment: Depending on your facts, the *Crookham* decision presents language that may provide better material for a punitive damages instruction than the standard UCJI No. 7502.

Addendum:
Eastwood v. American Family Mutual Insurance Company

INTRODUCTION

While preparing for a “bad faith” trial recently against American Family, Bill Barton was kind enough to share his original article relating to litigation against insurance carriers, and also reviewed records and met with me on several occasions to help reduce a factually complicated case into understandable trial themes. The case settled during the third day of trial, and Bill asked me to write an addendum to his original article which included the lessons I learned from my case with the hope that it might be useful to someone else at a later date. I can’t thank Bill enough for all of the time and effort he spent assisting me and I am glad to pay it forward in any way possible. I am also thankful to Mark Bocci who spent a great deal of time providing his own valuable insight and guidance. Thank you both for sharing so generously your time and insight.

FACTS

Ivey Eastwood was 17 years old when she purchased an insurance policy with American Family with liability limits of \$100,000. Approximately 3 weeks later, on July 9, 2003, Ivey was driving to work and was stopped at an intersection waiting for traffic to clear so she could turn left. As she began to turn left, she struck a car approaching from her right which, in turn, struck Braudilio Vivero, a pedestrian who was waiting nearby for a bus. Mr. Vivero’s leg was eventually amputated as the result of the impact. The car which Ms. Eastwood struck was insured by Country Companies with liability limits of \$50,000.

Mr. Vivero retained Charles Robinowitz to represent him. On April 5, 2004, Mr. Robinowitz sent demand letters to both Country Companies and American Family with a 20-day time limit. Country Companies contacted Mr. Robinowitz within three days of receiving the policy limit demand and offered the limits conditioned upon Mr. Robinowitz providing medical documentation of the injury. American Family did not respond to the policy limits demand. Country Companies paid its limits of \$50,000 in exchange for a full release.

On May 13, 2004, Mr. Robinowitz filed a lawsuit against Ivey Eastwood for \$5 Million. After receiving notice of the lawsuit, American Family offered its policy limits. Mr. Robinowitz refused to accept the limits, claiming that American Family was negligent in failing to respond to the policy limits demand in a timely manner. Mr. Robinowitz expressed an interest in receiving settlement offers in excess of the policy limits, but American Family refused. American Family claimed that it was not negligent in failing to respond to the limits demand and also argued that Mr. Robinowitz’ client was not prejudiced by the delay. Smith Freed & Eberhard was retained by American Family to defend Mr. Robinowitz’ lawsuit.

Starla Goff, from Smith Freed advised Ms. Eastwood regarding her excess exposure and I was asked to represent Ms. Eastwood personally with hopes of preventing an excess judgment. I sent repeated letters to American Family requesting that it either settle the claim in excess of the policy limits or otherwise agree to satisfy any judgment which might be entered against Ivey Eastwood. American Family refused to offer more than the \$100,000 limits.

I explored the possibility of assigning Ms. Eastwood's extra-contractual claim to Mr. Robinowitz but was unsuccessful. American Family's policy contained an "anti-assignment clause" preventing the assignment of the extra-contractual claim without American Family's express written authority. Another complicating factor was Mr. Robinowitz' concern that he possess an enforceable judgment against Ivey Eastwood personally, or else American Family would claim that the assignment of her claim was fraudulent and unenforceable. As a solution, Mr. Robinowitz proposed that Ms. Eastwood stipulate to a judgment against her personally in the amount of \$3.1 Million which he agreed not to execute upon until after the bad faith claim was resolved. Understandably, Ms. Eastwood would not stipulate to an enforceable judgment of \$3.1 Million, and the case went to trial resulting in a \$1 Million verdict.

Judgment was entered and American Family again refused to offer more than the policy limits of \$100,000. Ms. Eastwood began making payments of \$25 a month in return for an agreement not to execute upon the judgment pending the outcome of her claim against American Family. She then filed suit against American Family for breach of contract in addition to negligence and punitive damages. American Family removed the case to federal court because the adjuster was not named personally and American Family is an out-of-state corporation.

After several months of discovery and depositions, American Family filed a motion for summary judgment based upon the theory that Mr. Robinowitz' demand letter was not an unconditional offer to settle which American Family could have accepted because the demand letter did not state that a release would be given in return for payment of the policy limits, nor did the demand letter address how the liens would be paid. American Family also contended that because Mr. Robinowitz conditioned acceptance of the policy limits upon American Family providing a certified copy of the declaration page, as well as a statement of the policy holder identifying any additional potential defendants, the policy limits offer was conditional and non-binding. American Family further contended that their claims adjuster orally offered the policy limits by telephone several months before the policy limits demand was received even though there was no documentation supporting the offer. Judge Haggerty denied American Family's motion for summary judgment and the case went to trial in October 2007. Prior to trial, American Family satisfied the underlying judgment against Ms. Eastwood in efforts to diminish her economic damages but still contested liability at trial. Prior to trial of the underlying case, Ms. Eastwood began seeking counseling due to the stress of the lawsuit in addition to the unexpected death of her father during the litigation. The case settled the third day of trial for a confidential amount.

LESSONS LEARNED

1. "BAD FAITH"

As indicated in Bill's materials, the term "bad faith" is a misnomer for extra-contractual claims in Oregon. The standard in Oregon is whether the insurer acted as a reasonably prudent insurer under the circumstances then and there existing, not whether its subjective intent demonstrated "bad faith" or an intent to injure the policy holder. Defense lawyers like to inject subjective intent into their defense because it raises the bar in terms of the plaintiff's proof. It is important to make certain that the jury understands from the beginning that the claim is based upon negligence, rather than "bad faith." This will help to preempt any attempt by the defense to

confuse the jurors at a later time by arguing that there was no subjective evidence of “bad faith” or intent on behalf of the insurer to injure its policy holder. When corresponding with insurers regarding extra-contractual claims, I suggest avoiding the use of the words “bad faith” and instead characterize the insurer’s actions in terms of negligence. Keep in mind that all of your correspondence may end up as an exhibit at trial and you do not want defense counsel utilizing your own correspondence against you.

2. DEMAND LETTERS

One of the main defenses by American Family was its criticism of Charles Robinowitz’ demand letter. American Family claimed that the demand imposed a “unilateral” 20-day demand and did not address whether a release would be provided in return for payment of the policy or liens satisfied. American Family also argued that the letter was not an unconditional offer to settle because it was “conditioned” upon American Family providing a certified copy of their insured’s declaration page, as well as a statement from the insured regarding other potential defendants.

The reality is that language of Mr. Robinowitz demand letter mirrored 99% of the demand letters I have written or reviewed. The letter even went so far as to invite American Family to contact Mr. Robinowitz if there were any questions or concerns with the policy limits demand. Having watched the defense attempt to thoroughly confuse the jury with technical and obscure defenses related to the contents of the demand letter, I suggest making demand letters as concise and as complete as possible. I suggest stating in the demand letter that the policy holder will be released in return for payment of the policy limits and that the liens will be satisfied by the plaintiff. As indicated in Bill’s materials, I think it is wise to comply with all of the carrier’s requests in response to the demand, even the ridiculous, to remove any defense it may raise at a later date that you did not comply with requests for additional information. As Mr. Robinowitz did in his letter, it is effective to invite the carrier to contact you with any questions or concerns or if they need additional time or materials to appropriately respond to your demand.

Keep in mind that the demand letter will likely become an exhibit at trial. I suggest that you keep the tone of the letter professional and accommodating. You want to demonstrate to the jury that you did everything possible to educate the insurer that it was reasonable to pay the limits in order to protect their insured from an excess judgment.

3. CLEARLY DOCUMENT YOUR FILE

It seems self-evident, but send letters confirming the details of all your discussions with claims adjusters, especially discussions related to settlement offers and demands. Also document your own file regarding phone calls with adjusters. The adjuster for American Family claimed that he tendered the limits in a conversation with one of Mr. Robinowitz’ legal assistants several months before a demand was even made. The legal assistant was very detailed in her note taking which was extremely helpful in disproving the adjuster’s claim. A follow-up letter confirming her understanding of the conversation would have been more effective so that no claim could be made at a later date that there was an “understanding” or agreement which never occurred.

When corresponding with carriers, do not assume that anything is “understood.” Keep in mind that a jury of non-lawyers will be faced with deciding whether sufficient information was provided to the carrier so as to trigger an obligation to offer policy limits. Even though lawyers and adjusters are accustomed to the patterns of practice common in our industry and understand that a release will be given in return for payment of policy limits, a creative defense lawyer can create a lot of confusion in the minds of jurors based simply upon what is not documented. Anticipate the potential defenses and address them in your correspondence with the carrier. This is especially true with demands as well as requests for consent to assign extra-contractual claims.

4. CLIENT CARE

Understandably, exposure to excess judgments is extremely stressful for policy holders. Encourage your client to seek counseling if an excess claim is pending against them should they encounter difficulty with coping with the stress. Also, encourage them to seek financial advice regarding the worst potential outcomes, including bankruptcy, so that they understand all potential implications involving the excess claim, both good and bad. In the event of an excess judgment, try to reach an agreement with the judgment creditor on a payment plan while you pursue the extra-contractual claim in the event it has not been assigned. This will help to relieve the pressure on your client and will also show the jury that the carrier’s actions have deeply impacted your client.

5. KEEP IT SIMPLE

As lawyers, we deal with issues of potential excess exposure claims on a routine basis and the claims and settlement process is second nature. For jurors, the rules and regulations relating to insurance and excess liability is confusing and must be made as simple as possible. At Bill’s suggestion, I read Rick Friedman’s and Patrick Malone’s book *Rules of the Road* and found it invaluable. I created my own lists of rules of the road (attached). I used the rules during the depositions of all of their claims people and attorneys. I also used the rules as the foundation for each of my expert witnesses’ testimony. Particularly in the insurance context, it is easy to craft rules with which no reasonable witness can argue. It was helpful for the jury. I also created a flow chart documenting how the claims process should work and what happens when it doesn’t work properly.

In my case, I had the unique prospective of two different insurance carriers being involved in the case. County Companies received a policy limits demand and settled the case. American Family did not. I created two different timelines; one for Country Companies which was very short, and the other for American Family that went on for pages. After the 20-day demand period expired from Mr. Robinowitz’ policy limits letter, I was able to tell the jury that everything after that date should never have happened. Keep in mind that you are usually talking about a lawsuit within a lawsuit which can get very confusing. I created a board with the names of all of the parties involved in both lawsuits and tried to keep it in front of the jury so that they could refer back to the board frequently to understand everyone’s role in the underlying case and extra-contractual claim.

I crafted the list of “rules” from statutory and case law as well as the insurance policy itself. I also used American Family’s claims handling manuals and the standards of care within the community. I utilized the list of rules in my opening to explain the obligations of a reasonable insurer and how American Family breached those obligations. I plan on using a similar list in every case I try.

6. STATE V. FEDERAL COURT

American Family removed my case to federal court because I did not name the adjuster personally. This is a mistake I will not make twice. I firmly believe that you are better off in state court with personal injury claims, particularly when damages are based upon emotional distress and punitives. The requirement for a unanimous verdict in federal court increases the likelihood of a mistrial, or worse yet, a defense verdict. This is not to mention the added expense and the amount of work product that is disclosed during the course of discovery in federal court which allows the carrier to strengthen their defenses prior to trial.

7. CONSIDER BOTH BREACH OF CONTRACT AND TORT THEORIES

As noted by Bill in his materials, extra-contractual claims create causes of action based upon breach of contract and tort theories. As part of the breach of contract claim, the policy holder is able to seek attorney fees which greatly increases pressure on the carrier.

THEMES

1. INSURANCE IS A PROMISE TO PROTECT

An important concept for the jury to understand is the nature of the relationship between the policy holder and the insurer. People purchase insurance for protection. They pay good money for protection and, in return, trust their insurance carrier to live up to its promise to protect. The fiduciary duty created as a result of that trust is a compelling yet confusing theme for jurors. They must understand that as a policy holder, once you pay your money for protection, you no longer have any control over the insurer’s actions. Most auto insurer policies require you to jump through a number of hoops in order to comply with the policy yet you have no control as to what the carrier does to protect you. Unlike medical malpractice policies where a doctor’s consent is usually required, you have no input as a policy holder with an automobile insurer. This lack of control creates the fiduciary duty and insurers must keep policy holders apprised of offers to settle and must consider the policy holder’s interest equal to their own. When developing evidence for trial, explore in detail everything the insurance carrier did to advise the policy holder of the underlying claim and any offers to settle. Look for actions by the insurer which demonstrate that it considered its own interests above the policy holder’s. Bill prefers the term “policy holder” to “insured.” I agree. “Policy holder” in my mind creates the image a person holding a promise to protect from the carrier

2. TIME VALUE OF MONEY

The time value of money is another valuable theme at trial. The longer the insurer holds onto its money, the more money it makes. In a strange way, bad and unethical claims handling practices which result in a refusal to pay are good business for insurance carriers. It is important that jurors grasp this concept and I suggest using a defense lawyer or an insurance expert to explain it. Keep in mind that insurance carriers are in business and businesses exist to make profits, but not at the expense of their policy holders.

3. THE FINANCIAL IMPACT OF AN EXCESS JUDGMENT ON THE POLICY HOLDER

A policy holder's damage claim is comprised of the value of the judgment against them; attorney's fees; the financial impact the judgment may have in the future; the emotional pain and suffering caused by the excess judgment and potential punitive damages. Rational minds agree that an excess judgment is stressful but it is important to bring to life the practical impact of an excess judgment on the daily life of the policy holder. In order to demonstrate the practical impact upon Ivey Eastwood, I hired a credit expert who was prepared to explain to the jury exactly how an excess judgment affects credit ratings as well as the potential impact upon job applications.

Defense counsel in the *Eastwood* case argued that Ivey Eastwood could declare bankruptcy to discharge the excess judgment. While many jurors might find this argument distasteful, keep in mind that there are a number of potential jurors who have declared bankruptcy themselves and do not consider it a "big deal." It is important to have your client address this issue in terms of their own personal beliefs as to whether bankruptcy is a morally acceptable option. My credit expert was prepared to explain the long term effects of bankruptcy to dispel the belief that bankruptcy, even if it were a morally acceptable option, is a very "big deal."

Encourage your clients to seek counseling when they experience stress from an excess judgment so that you can document what they endured. Ivey Eastwood began seeing a counselor before the judgment was entered against her and continued to see a counselor throughout the pendency of her extra-contractual claim. I also asked a psychologist to perform an independent medical evaluation to further document and substantiate her emotional injury. You cannot assume that the jurors will automatically identify with your client's plight unless it is well documented and consistent.

4. PERSONAL AND CORPORATE RESPONSIBILITY

Ivey Eastwood was 17 years old when she purchased her own car and her own insurance. Rather than purchasing the minimum liability limits, she spent extra money for \$100,000 worth of coverage when she had nothing to lose. She did so to be a good and responsible citizen. When the jury awarded Mr. Vivero the \$1 Million judgment against her, she hugged Mr. Vivero in tears and offered to drive him to work. She even offered to buy him groceries when she could afford to do so because she had nothing else to offer. She began making payments to Mr. Vivero out of her own pocket of \$25 - \$50 a month. All of Ivey's actions demonstrated her strong sense

of personal responsibility and were in stark contrast to the actions of American Family which offered nothing more than excuses for failing to respond to the policy limits demand in a timely manner. Had American Family conducted its business the way Ivey Eastwood conducted her life, the case would have settled before the expiration of the policy limits demand period. Personal responsibility is a great theme to anchor to the breach of contract and breach of fiduciary duty claims. The policy holder dutifully pays premiums with the expectation that they are going to get what is promised. If the policy holder was late with a premium payment, the insurer would cancel the policy. It is ironic that the insurer defines the nature of their relationship with the policy holder by the very terms of its contract, yet when the policy holder abides by every term of the contract and pays premiums in a timely manner, the insurer offers nothing but excuses for why it was reasonable in breaching the contract.

5. INSURERS' STATUTORY AND CONTRACTUAL DUTIES

The primary sources of the duties owed to the policy holder by the insurer come from the contract itself, the Unfair Claims Settlement Practices Act (ORS 746.230), the common law and the insurer's own guidelines and claims manuals. The insurer's guidelines and claims manuals are valuable sources of information regarding internal requirements when processing claims and can be used to form the insurer's own standard of care. Claims guidelines frequently mirror the requirements of the Oregon Revised Statutes and duties established under Oregon common law. An effective tool for cross examination is to create a list of violations by the insurer based simply upon the insurer's own claims manual.

A concept which should not be overlooked is the insurer's duty to settle a claim even without having received a policy limits demand. The Unfair Claims Settlement Practices Act, ORS 746.230(1)(f), requires insurers to promptly and equitably settle claims in which liability has become reasonably clear. American Family's claim that it attempted to settle the underlying claim prior to receiving a policy limits demand backfired because it had to admit that in order to make a policy limits offer, it must have recognized that it was a policy limits case yet American Family had no documentation of an attempt or even an intent to settle the claim before their policy holder was sued. This is a direct violation of the statutory duty to settle.

Rules of the Road – Insurance Claims

1. Because the insurance company controls the handling and settlement of a claim, the insurance carrier is in a fiduciary relationship with their insured and must act accordingly.
2. As a fiduciary, the insurance company is in a position of trust and confidence and cannot place its own interests ahead of the insured when investigating, evaluating or settling a claim as if there were no limits.
3. The insurance company must use reasonable care and perform diligent, prompt and thorough claims investigation and evaluation;
4. The insurance company must settle claims within their insured's policy limits when given the opportunity to do so;
5. The insurance company is obligated to make inquiries to determine if settlement within policy limits is possible;
6. The insurance company must respond promptly and in a timely manner to written and verbal communications on a claim;
7. The insurance company should make conditional offers to settle within policy limits if additional documentation or information is necessary;
8. The insurance company should advise the insured of all settlement offers and policy limits demands prior to expiration of the demand;
9. An insurance company should thoroughly document all communications and actions on a claims file – if it's not in the file, it didn't happen;
10. An insurance company should confirm all offers to settle in writing;

11. An insurance company must respond to policy limits demands in the time set forth in the demand;
12. If an insurance company does not have sufficient information to evaluate a claim in order to respond to a policy limits demand or a conditional offer, it must contact the claimant's attorney and ask for additional time and information within the period of the demand;
13. The insurer must take no action to prejudice the insured;
14. An insurance company cannot misrepresent important facts to their insured;
15. The insurance company's fiduciary duty extends beyond entry of judgment and it must continue to consider its insured's interests equal to its own;
16. If an insurance company fails to appropriately respond to a settlement demand in a timely manner, the insurance company must protect their insured against an excess judgment.