2020 CLM Focus Conference
December 3, 2020
Virtual Conference

"THE EXTRA-CONTRACTUAL YEAR IN REVIEW: ROUNDTABLE TWO"

Presenters and participants will review the most significant caselaw, administrative, and regulatory extra-contractual decisions from across the country in 2019 to engage participants and attendees in a compelling discussion of industry best practices and claim handling procedures in respect to the same.

The roundtable will dissect the current state of extra-contractual law and litigation by exploring its economic costs and financial impact on insurers and policyholders, examining fresh ideas and dynamic defenses to EC claims and litigation, and achieving collaborative organizational implementation of the same to maximize successful outcomes and results. The roundtable will also address the impact of Covid-19 on claims handling and associated EC concerns.

IMPORTANCE OF AN ANNUAL REVIEW OF EXTRA-CONTRACTUAL CASELAW DECISIONS

Doing the same thing over and over is not going to achieve a different outcome. Reviewing the latest cases from across the country allows carriers to adapt to ever changing standards, explore better options, step out of our comfort zones, and try doing things better.

We should endeavor to rethink extra-contractual law and litigation by exploring its economic costs and financial impact on insurers and policyholders, examining fresh ideas and dynamic defenses to EC claims and litigation, and achieving collaborative organizational implementation of the same to maximize successful outcomes and results.

RECONSIDERING PREVAILING PRACTICES

When a claim is received, the insurer attempts to determine which claims are valid. The insurer has a duty to its policyholders to pay valid claims. But the insurer has an equal duty to its policyholders to deny invalid claims. These two duties are different sides of the same coin and are equal in their importance to the ability of the insurer to fulfill the promises made by the insurer to the honest policy owners.

What is the difference for an insurer between acting in good faith and acting in bad faith? A review of the current case law establishes that the many attempts to define when an insurer has acted in bad faith offer little consistency and that there is no universally accepted definition of the term.

The term "bad faith" generally applies to something worse than simply being negligent. It is generally tortious conduct combined with a bad intent and most scholars agree that bad faith requires a showing of more than that the insurer did something wrong. An accusation that an insurer acted in bad faith requires more than a showing that the insurer did not act in good faith.[1]

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[1] There is no bad faith if the insurer did not act "unreasonably" or without proper cause. In some states this defense is handled through eliminating the elements of the insurer's claim. See, Adams v. Auto Owners Ins. Co., 655 So.2d 969, 971 (Ala. 1995), and Pickett v. Lloyd's (A Syndicate of Underwriting Members), 621 A.2d 445, 450 (N.J. 1993).

In other jurisdictions, a bad faith claim can be defeated by showing there was a "genuine dispute" or the claim was "fairly debatable." See, Chateau Chamberay Homeowners Association v. Associated. International Ins. Co., 90 Cal.App.4th 335, 346 (2001); Griffin Dewatering Corp. v. Northern Ins. Co. of N.Y., 176 Cal.App.4th 172, 209 (2009); Lunsford v. American Guarantee & Liability Ins. Co., 18 F.3d 653 (9th Cir. 1994) (applying California law); and, Travelers Ins. Co. v. Savio, 706 P.2d 1258, 1275 (Colo. 1985).

Even if there is no state law, this defense should be raised because it is common sense. If there was no legal precedent on the coverage issue and the reason the insurer took the position it did was sound, the insurer's position cannot have been unreasonable.