

Litigating the Bad Faith Claim in North Carolina

This Article addresses litigating “bad faith” insurance claims in North Carolina. The first section addresses the substance of these claims, and the second section addresses the procedural issues for prosecuting and defending such claims.

THE NATURE OF THE CLAIMS

Where the insurer fails (or refuses) to pay pursuant to its policy provisions (whether a first- or third-party claim), the insurer may be sued for actual damages for breach of contract, usually being the amount owed under the policy. In the case of a failure to defend, it includes the cost of defense.

There are, however, situations where the insurer may be liable for amounts beyond mere compensatory damages. These are sometimes referred to as extra-contractual damages. The two claims recognized by North Carolina law upon which an insurer may be held liable for these damages are for violations of Chapter 75 (i.e. unfair and deceptive acts) and for “bad faith.”

A. Unfair and Deceptive Acts

One form of extra-contractual liability arises from acts in violation of Chapter 75. G.S. § 75-1.1(a) provides, “Unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are declared unlawful.” This statute is significant for two reasons. First, it may provide a remedy where one does not exist under other theories (e.g. negligence or contract). Second, a person violating this statute must pay treble damages. G.S. § 75-16.

The first issue is therefore whether the insurer’s conduct constitutes an “unfair or deceptive” act or practice. The most recent pronouncement on Chapter 75 claims against insurance companies from our Supreme Court is Gray v. North Carolina Ins. Underwriting Ass'n, 352 N.C. 61, 68 (2000). Gray set forth many central principles to these claims. Gray (“In enacting N.C.G.S. §§ 75-1.1 and 75-16, the legislature intended to effect a private cause of action for consumers.” “[A] plaintiff must show: (1) an unfair or deceptive act or practice, (2) in or affecting commerce, and (3) which proximately caused injury to plaintiffs. [A] practice is deceptive if it has the tendency to deceive.

This Court has also observed that “[a] practice is unfair when it offends established public policy as well as when the practice is immoral, unethical, oppressive, unscrupulous, or substantially injurious to consumers.” . . . Moreover, where a party engages in conduct manifesting an inequitable assertion of power or position, such conduct constitutes an unfair act or practice.”).

Gray addressed the interplay of Chapter 58 (regulation of insurance) and Chapter 75 (unfair practices). A violation of Chapter 58 supports a violation of Chapter 75, and the insured need not show a general business practice of such conduct. Gray, 352 N.C. at 71.

Thus, an insured may establish a violation of Chapter 75 by conduct which is unfair or deceptive without regard to whether it violates Chapter 58, and may also establish unfair or deceptive conduct by showing a violation of Chapter 58.

Chapter 58 enumerates several practices which are unfair. It states, in relevant part, “The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:”

(1) Misrepresentations and False Advertising of Policy Contracts. -- Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or . . . or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

. . .

(11) Unfair Claim Settlement Practices. -- Committing or performing with such frequency as to indicate a general business practice of any of the following: Provided, however, that no violation of this subsection shall of itself create any cause of action in favor of any person other than the Commissioner:

- a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

- e. Failing to affirm or deny coverage of claims within a reasonable time after proof-of-loss statements have been completed;
- f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;
- g. Compelling [the] insured to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insured;
- h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled;
- i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;
- j. Making claims payments to insureds or beneficiaries not accompanied by [a] statement setting forth the coverage under which the payments are being made;
- k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- l. Delaying the investigation or payment of claims by requiring an insured claimant, or the physician, of [or] either, to submit a preliminary claim report and then requiring the subsequent submission of formal proof-of-loss forms, both of which submissions contain substantially the same information;
- m. Failing to promptly settle claims where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and
- n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

G.S. § 58-63-15.

For cases finding the evidence (or pleadings or forecast of evidence) sufficient to state a claim under chapter 75, see Gray v. North Carolina Ins. Underwriting Ass'n, 352 N.C. 61, 65 (2000) (insured sustained wind damage, which was covered by policy, and insurer rejected opinion of first adjuster to pay claim, and fired that adjuster and retained another adjuster, then offered a settlement figure (lower than that suggested by first adjuster) which was rejected, and issued advance payment to insured and another person claiming interest in property, and jury found that insurer violated one or more provisions of Chapter 58 (duty to settle, communicate with insured, make reasonable offers)); Pearce

v. American Defender Life Ins. Co., 316 N.C. 461, 468 (1986) (where insured inquired as to whether rider would cover his death while flying a plane, and insurer's agent incorrectly said that it would, there was evidence that insurer violated Chapter 58 prohibition against "[m]aking, issuing, circulating, or causing to be made, issued, or circulated, any . . . statement misrepresenting the terms of any policy issued . . . or the benefits or advantages promised thereby"); Country Club of Johnston County, Inc. v. United States Fid. & Guar. Co., 150 N.C. App. 231, 246-247 (2002) (jury determined that USF&G "prematurely and improperly" determined it would deny the Club's claim (arising from sale of alcohol) prior to conducting a "meaningful investigation," USF&G "misrepresented" to the Club that it would investigate the claim, USF&G "unfairly" and "improperly" sent a reservation of rights letter based on Exclusion C without having "an adequate or documented basis to reverse Mr. Funk's position to not reserve rights as to Exclusion C documented on 11/19/91," and that USF&G solicited an opinion letter from counsel only after having made its decision regarding coverage, USF&G's "conduct arguably violates" various provisions of Chapter 58); Vazquez v. Allstate Ins. Co., 137 N.C. App. 741, 742-743 (2000) (jury found defendant liable for wrongful death and awarded \$104,003.00, insurer then stipulated that claimant was entitled to payment under UIM policy, and jury then concluded that the defendant had refused to settle the plaintiff's claim in bad faith, that insurer failed to adjust the plaintiff's loss fairly, follow its own standards, act reasonably in communications, conduct a reasonable investigation and to effect a fair settlement in good faith); Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 10 (1996) (where plaintiff, victim of auto accident, obtained judgment against tort-feasor, in excess of two liability policies and implicating his UIM coverage, and dispute arose among insurers as to duties to pay pre-judgment and post-judgment interest, and UIM carrier refused to pay full amount of judgment in excess of liability payments (based on alleged offset for MedPay, which had been decided contrary to UIM carrier), plaintiff established violations of Chapter 58 pertaining to communicating promptly with insured, attempting in good faith to effectuate prompt, fair and equitable settlements, unreasonable offers, failing to explain the basis for denial); Miller v.

Nationwide Mut. Ins. Co., 112 N.C. App. 295, 302 (1993) (Plaintiff relies specifically on G.S. § 58-63-15(11) (f, h, m and n) ; where plaintiff alleges \$98,000 in medical expenses arising out of the injuries sustained in the auto accident, with documentation proving permanent and disabling injuries, and underlying carrier paid \$50,000, and plaintiff had \$150,00 additional in UIM coverage, and additional \$100,000 in coverage was disputed, and plaintiff alleged that insurer had an across-the-board policy of denying such claims (stacking), Plaintiff alleged that insurer acted without reason and attempted to coerce plaintiff etc.); ABT Building Products Corp. v. National Union Fire Ins. Co. Of Pittsburgh, 472 F.3d 99 (4th Cir. 2006) (where umbrella insurer recognized from insured's expert's report and its own underwriting analysis that its policy would be triggered in underlying litigation against insured, insurer's liability was reasonably clear, and insurer had duty to attempt good faith settlement with its insured under Chapter 58; insurer's closing its file rather than responding to insured's settlement demand for coverage after it became reasonably clear that its policy provided coverage violated Chapter 58 and Chapter 75).

For cases finding the evidence insufficient, see Erler v. Aon Risks Servs., Inc., 141 N.C. App. 312 (2000) (policy writer's employee told insured that the lower floor, a "walkout," was classified separately from a basement and eligible for contents coverage, insured's building flooded, and the flood policy denied claim because the lower floor was a basement; defendants stood to gain very little from their misleading conduct which was limited to this plaintiff; actions cannot be characterized as immoral etc.; effect of defendants' actions in the marketplace would be negligible; no unfair advantage was to be gained from defendants' actions since the flood insurance sought by plaintiffs was not available among competing insurers); Hooper v. Liberty Mut. Ins. Co., 84 N.C. App. 549 (1987) (dismissal was proper where insurer merely re-evaluated workers compensation claim and determined that it was not responsible for the claimant's underlying arthritic condition, insurer merely attempted to settle claim, and insurer left open \$2000 offer); Marshburn v. Associated Indem. Corp., 84 N.C. App. 365 (1987) (where insured's home was struck by lightning, insured settled claim for \$643.65 as full payment, then more than

three years later insured noticed cracks along mortar joints and through some bricks, and re-submitted claim, and adjuster inspected plaintiffs' premises and retained engineer, and adjuster requested that insured dig trench to concrete footing to expose the alleged lightning damage, insured protested but complied, resulting in insured having to drain trench following rain, and adjuster then notified insured that claim was denied on basis of expert's conclusion that damage was due to water intrusion, and insured retained engineer who opined that the lightning had cracked concrete footing, and adjuster then denied claim based on cause of damage and also on expiration of time period for filing claims, "the record does not reveal the existence of any facts which would create any genuine issue that the manner in which defendant conducted its investigation, or its subsequent denial of plaintiffs' claim, was unethical, oppressive or deceptive in any way"); Douglas v. Pennamco, Inc., 75 N.C. App. 644, 646 (1985) (where disability insurer required proof of disability each month benefits were applied for, as the policy permitted, insurer was not "unfair in requiring an insured whose injury is of uncertain duration and subject to improvement to show that he is still disabled before paying him further disability benefits," and even though insured claimed that his home was foreclosed upon and that he lost all equity therein because the insurer failed to pay timely benefits under his disability policy, insured failed to support Chapter 75 claim); Whitney v. Blue Cross & Blue Shield of N.C., (N.C. App. 2007) (health insurance benefits for anorexia; "we are unpersuaded that the gravamen of plaintiff's claim - that the carrier failed to pay monies owed under the contract - also constitutes a claim under Chapter 75"; unpublished 2007 WL 2034071); Carter v. West American Ins. Co., 661 S.E.2d 264 (N.C. App. 2008) (where insurer took 18 months to pay for the dwelling and 3 years to pay for the personal property, but the claim was disputed, and the insured refused the first check, claims for unfair and deceptive acts was also properly dismissed); Nelson v. Hartford Underwriters Ins. Co., 177 N.C. App. 595, 630 S.E.2d 221 (2006) (engineer's report which concluded that an oversized air conditioning system caused mold in house satisfied HO insurer's obligation to conduct a reasonable investigation, even though the report did not discover the water leaks or identify the type of mold); Westchester Fire Ins.

Co. v. Johnson, 221 F.Supp.2d 637 (M.D.N.C. 2002) (insurer's request for second examination insured under oath was not violation of Chapter 75 where information requested was not substantially the same as in first examination).

The manner of trebling damages is somewhat unclear. The leading authority on this is Gray. Gray seems to hold that the only amount which is trebled is the damages resulting from the breach of contract, and that the contract damages are not to be trebled. In Gray, the jury found that the insured was entitled to \$256,000 under the policy. It also found \$117,000 in damages flowing from this breach. "The trial court then trebled the jury award of \$117,000 to \$351,000 pursuant to N.C.G.S. § 75-16. Accordingly, the trial court correctly trebled only the damages found by the jury in Issue Six -- those proximately caused by the violation of N.C.G.S. § 75-1.1." Gray, 352 N.C. at 75. The trial court awarded the insured \$256,000 plus \$351,000, for a total of \$607,000. Although the opinions from the Supreme Court and Court of Appeals are not entirely clear, it appears that this computation was affirmed.

Another case would suggest that the insured cannot recover the contract damages and treble damages for the other damage. Vazquez v. Allstate Ins. Co., 137 N.C. App. 741, 745 (2000) (jury awarded \$104,000 for wrongful death, then \$29,160 for the acts constituting unfair and deceptive trade practices and for the defendant's bad faith refusal to settle, trial court required insured to choose between (1) \$50,000 (limits), (2) \$29,000 (bad faith), (3) treble damages (\$29,160.00 x 3 = \$87,480.00)). It would seem that where the insurer's wrongful conduct is non-payment of the benefit, that the benefit should be trebled. High Country Arts & Craft Guild v. Hartford Fire Ins. Co., 126 F.3d 629, 631 (1997) (affirming judgment where jury awarded \$246,809 to insured in compensatory damages and \$148,085.42 in punitive damages, and insured elected an award of treble damages and attorneys fees under Chapter 75). See also Johnson v. Colonial Life & Acc. Ins. Co., 173 N.C.App. 365, 371-372, 618 S.E.2d 867, 872 (2005) ("the court will not allow a defendant to divide the breach of contract action and the conduct which aggravated the breach when in substance there is but one continuous transaction amounting to unfair and deceptive trade practices"; not an insurance dispute). It is

possible to reconcile Gray with this result because in Gray the jury did not specifically find that the non-payment of the insurance proceeds was an unfair act.

Where the insured alleges a deceptive act, he must establish that he relied on the deceptive act to his detriment in order to maintain a Chapter 75 claim. Pearce v. American Defender Life Ins. Co., 316 N.C. 461, 472 (1986) (“The evidence is sufficient to support a finding that Lt. Pearce relied to his detriment upon the statements in defendant's letter.”). The insured must likewise show prejudice resulting from the unfair conduct. Carter v. West American Ins. Co., 661 S.E.2d 264 (N.C. App. 2008) (even though the insurer put a notation on a check to the insured stating that the payment was full and final (“reflects total recoverable under these coverages”), the insured rejected this check and was not harmed; even though the adjuster told the insured to pretend that she was not represented, so that they could talk directly, insured was not harmed).

A person who is not a party to the insurance contract does not have a Chapter 75 claim against the insurer. Wilson v. Wilson, 121 N.C. App. 662, 665 (1996) (“a private right of action under N.C.G.S. § 58-63.15 and N.C.G.S. § 75-1.1 may not be asserted by a third-party claimant against the insurer of an adverse party.”). After the claimant obtains a judgment against the insured, however, the claimant may have a Chapter 75 claim against the insurer. Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 16 (1996) (“Therefore, the instant plaintiff [who has obtained a judgment against insured] is in contractual privity with State Farm and U.S. Liability [liability carriers], and for this reason alone, is not bound by the third-party restrictions set forth in Wilson.”).

A claim under chapter 75 is subject to a four year statute of limitations. The statute generally runs from the date of the violation, at which time the plaintiff can file the claim. Page v. Lexington Ins. Co., 177 N.C.App. 246, 251, 628 S.E.2d 427, 430 (2006) (“plaintiffs' UDTP claim was separate and distinct from plaintiffs' claims on the underlying insurance policy, and the UDTP claim is therefore governed by the four-year statute of limitations applicable to such claims.”); Hammond v. Wray (N.C. App. 2008; unpublished; 2008 WL 2582400) (claims for bad faith accrued when she was denied UIM coverage, and not the date of the MVA; claim for fraud has ten-year statute of limitations;

claim for breach of fiduciary duty accrued when insured allegedly discovered that policy did not provide coverage).

B. Bad Faith

The second avenue for extra-contractual damage is for “tortious,” or “bad faith,” breach of contract, giving rise to punitive damages. The seminal case on this issue in North Carolina is Newton, which stated:

The general rule in most jurisdictions is that punitive damages are not allowed even though the breach be wilful, malicious or oppressive. Nevertheless, where there is an identifiable tort even though the tort also constitutes, or accompanies, a breach of contract, the tort itself may give rise to a claim for punitive damages.

...

While the distinction between malicious or oppressive breach of contract, for which punitive damages are generally not allowed, and tortious conduct which also constitutes, or accompanies, a breach of contract is one occasionally difficult of observance in practice, it is nevertheless fundamental to any consideration of the question of punitive damages in contract cases

...

The aggravated conduct which supports an award for punitive damages when an identifiable tort is alleged may be established by allegations of behavior extrinsic to the tort itself, as in slander cases. Or it may be established by allegations sufficient to allege a tort where that tort, by its very nature, encompasses any of the elements of aggravation. Such a tort is fraud, since fraud is, itself, one of the elements of aggravation which will permit punitive damages to be awarded.

Newton v. Standard Fire Ins. Co., 291 N.C. 105, 111 (1976).

The Court held that the evidence was insufficient in that case, but further stated:

Insurer's knowledge that plaintiff was in a precarious financial position in view of his loss does not in itself show bad faith on the part of the insurer in refusing to pay the claim, or for that matter, that the refusal was unjustified. Had plaintiff claimed that after due investigation by defendant it was determined that the claim was valid and defendant nevertheless refused to pay or that defendant refused to make any investigation at all, and that defendant's refusals were in bad faith with an intent to cause further damage to plaintiff, a different question would be presented.

We are slow to impose upon an insurer liabilities beyond those called for

in the insurance contract. To create exposure to such risks except for the most extreme circumstances would, we are certain, be detrimental to the consuming public whose insurance premiums would surely be increased to cover them.

On the other hand, because of the great disparity of financial resources which generally exists between insurer and insured and the fact that insurance companies, like common carriers and utilities, are regulated and clearly affected with a public interest, we recognize the wisdom of a rule which would deter refusals on the part of insurers to pay valid claims when the refusals are both unjustified and in bad faith.

Newton, 291 N.C. at 116.

Where the claim is denied based on a reasonable interpretation of the policy, the insurer does not commit bad faith. Our courts have stated:

The claim was clearly the basis of an honest disagreement between the parties and that plaintiffs' claim of tortious breach and punitive damages were required to be dismissed. . . . Necessarily, there can be no claim for punitive damages if there has been no tort committed. It appears that defendant here promptly and consistently denied plaintiffs' insurance claim based on an interpretation that is neither strained nor fanciful, regardless of whether it is correct. Further, while defendant's agents may have provided plaintiffs with inaccurate advice, they did so apparently in good faith, with the desire to be helpful and perform their duties, not with the intent to injure plaintiffs or with a disregard for plaintiffs' unfortunate predicament.

Olive v. Great American Ins. Co., 76 N.C. App. 180, 189 (1985).

Regarding the denial of a claim for health benefits, it has been said:

In order for the Plaintiff to recover on her claim for punitive damages under North Carolina law, she would have to produce evidence that the Defendant had determined that the claim was valid and that the Defendant nevertheless refused to pay and that such refusal was in bad faith with intent to cause further damage to Plaintiff. There is nothing in this evidence to warrant a finding by this Court that the Defendant's denial of Plaintiff's claim was in bad faith with intent to cause further damage to this Plaintiff.

Michael v. Metropolitan Life Ins. Co., 631 F. Supp. 451, 453 (W.D.N.C. 1986) (judgment for insurer upon findings of fact, where insurer denied coverage for new fertility

treatment, with 20% success rate). This language was actually erroneous based on prior cases.¹

Some state cases have utilized this language, stating that, “In order to recover punitive damages for the tort of an insurance company's bad faith refusal to settle, the plaintiff must prove (1) a refusal to pay after recognition of a valid claim, (2) bad faith, and (3) aggravating or outrageous conduct.” Lovell v. Nationwide Mut. Ins. Co., 108 N.C.App. 416, 420, 424 S.E.2d 181, 184 (1993).

A claim for punitive damages against an insurance company presumably now must comply with Chapter 1D, enacted in 1995. G.S. § 1D-10 (“This Chapter applies to every claim for punitive damages, regardless of whether the claim for relief is based on a statutory or a common-law right of action or based in equity. In an action subject to this Chapter, in whole or in part, the provisions of this Chapter prevail over any other law to the contrary.”). Nevertheless, many cases, in the context of insurance and otherwise, continue to address claims for punitive damages without citation to Chapter 1D, but rather with reference to the language of older cases addressing punitive damages under common law. E.g. Cash v. State Farm Mut. Auto. Ins. Co., 137 N.C.App. 192, 201, 528 S.E.2d 372, 378 (2000) (“We hold that plaintiff has failed to state facts indicating that State Farm's settlement with claimants rose to the level of aggravation”; claim for punitive damages dismissed); Blis Day Spa, LLC v. Hartford Ins. Group, 427 F.Supp.2d 621, 631 (W.D.N.C. 2006) (To prevail on a claim of bad faith in the insurance context, a complainant must establish that there was: 1) a refusal to pay after recognition of a valid claim; 2) “bad faith”; and 3) “aggravating or outrageous conduct.”); Schaffner v. USAA Cas. Ins. Co., 2005 WL 1949877, 4 (unpublished; N.C.App. 2005) (“To establish that an insurer acted in bad faith, the insured must prove, in addition to the tortious act (here, plaintiff argues a refusal to settle), some element of aggravation indicating an insurer's

¹ Michael relied on Newton for this proposition, but Newton said only, “Had plaintiff claimed that after due investigation by defendant it was determined that the claim was valid and defendant nevertheless refused to pay or that defendant refused to make any investigation at all, and that defendant's refusals were in bad faith with an intent to cause further damage to plaintiff, a different question would be presented.” Newton v. Standard Fire Ins. Co., 291 N.C. 105, 115-116, 229 S.E.2d 297, 303 (1976).

actions were “wilful, wanton and in conscious disregard of [its] duty to pay plaintiff's insurance claim.”). In other areas our courts continue to use the language of older cases predating Chapter 1D.²

Under Chapter 1D, such a claim requires fraud, malice, or willful or wanton conduct. G.S. § 1D-15(a). Willful or wanton means “conscious and intentional disregard of and indifference to the rights and safety of others, which the defendant knows or should know is reasonably likely to result in injury, damage, or other harm. ‘Willful or wanton conduct’ means more than gross negligence.” G.S. § 1D-5(7). Punitives may not be awarded based on vicarious liability. G.S. § 1D-15(c). Punitive damages are now limited by Chapter 1D, to the greater of \$250,000 or three times the actual damages. G.S. § 1D-25.

The following cases have found the evidence of bad faith to be sufficient: Lovell v. Nationwide Mut. Ins. Co., 108 N.C. App. 416, 420 (1993) (affirming \$225,000 punitive award against insurer where passenger was killed in auto accident, insurer issued \$250,000 liability policy covering driver (driving passenger), and \$2,000 in medpay, and insurer used adjuster who aggressively attempted to resolve all claims with passenger's family, and insurer did not pay for funeral expenses for ten months, negotiations ensued, adjuster said he "just plumb forgot" about medpay claim for funeral expenses, evidence “tends to establish that defendant intended to ‘wear down’ the Lovells to influence settlement of the liability claim,” agent contacted plaintiff husband five times before the funeral to urge them to meet as soon as possible, and even insinuated that the policy could be voided if they did not immediately comply, and adjuster told them their daughter wasn't worth very much, that his daughter was not asleep at the time of the accident and that she had "burned up," insurer denied that Rusty Lewis was the driver of

² Bartlett Milling Co., L.P. v. Walnut Grove Auction and Realty Co., Inc., 665 S.E.2d 478, 487 (N.C.App. 2008) (action by judgment creditor against creditors; plaintiff did not have claim for punitives; “In order for a plaintiff to collect punitive damages there must be some additional element of asocial behavior which goes beyond the facts necessary to create a simple case of tort.”); Austin v. Bald II, L.L.C., 658 S.E.2d 1, 6 (N.C.App.,2008) (action for spite fence; court citing Newton; “The aggravated conduct which supports an award for punitive damages when an identifiable tort is alleged may be established by allegations of behavior extrinsic to the tort itself ... [o]r it may be established by allegations sufficient to allege a tort where that tort, by its very nature, encompasses any of the elements of aggravation”).

the car, although decedent's body was found seat-belted on the passenger side, and Lovells had to hire reconstruction expert on this issue before defendant admitted liability, and in response to Mr. Lovell's inquiry concerning nonpayment of the medpay claim, defendant's agent responded "[y]ou're the one who got a lawyer," evincing an intent to delay prompt settlement of the suit and hostility to the fact that plaintiff had retained a lawyer); Dailey v. Integon General Ins. Corp., 75 N.C. App. 387, 395 (1985) (plaintiff was insured under fire insurance policy, and sued defendant-insurer for benefits and punitive damages for denying claim and other bad faith conduct, and jury awarded \$105,000, the policy limits, for fire damage done to the house, \$37,000 for fire damage done to the contents, and \$15,000 for living expenses, \$20,000 for wrongful conduct of adjuster in maliciously and untruthfully notifying various neighbors and acquaintances of plaintiff that Integon had determined that plaintiff burned his house or caused it to be burned for insurance purposes, and awarded \$100,000 for defendant's wrongful failure to settle the claim in good faith, judgment is affirmed; fire marshall determined fire was deliberately set, but investigation eliminated plaintiff as a suspect; insurer had returned multiple proof of loss forms with the notation "rejected" across the top, and delayed in responding, and two estimators testified that repairs would exceed the policy limits of \$105,000, and insurer's estimate from a carpenter, not a general contractor, was for \$48,286.63 without tearing any portion of it down, and insurer contended "among other things, that shoes over a year old had no value at all," and insurer offered to settle entire claim for \$69,607.85, and insurer hired adjuster who told witness that he "determined this was a contract burning of the house and that it was done for insurance purposes" and that he "knew that the house had been burned . . . for insurance purposes," and offered witness \$10,000 fee and immunity from prosecution if he would sign a statement and testify that he was hired by insured to set fire to the house; "The evidence produced at trial is clearly sufficient, we think, to support the jury's finding that with accompanying aggravation of a very high degree, indeed, defendant tortiously refused in bad faith to settle plaintiff's claim. Defendant's argument that plaintiff failed to prove the existence of a "separate identifiable tort" is based on a misreading of the law."; "after arbitrarily rejecting

plaintiff's well documented claim defendant took no steps at all to check plaintiff's estimated construction costs for several months and then selected an unqualified builder to do the checking, and then waited another month before making a settlement offer for the real property loss that had no reasonable basis and an offer to settle the contents loss that disregarded the actual utility and value of the destroyed items.”; insurer “requir[ed] him to go to the inconvenience and expense of obtaining qualified, expert estimates defendant had no intention of considering; inordinately delaying both the settlement and plaintiff's return to his usual comforts and amenities of life; and then offering about half the amount owed in anticipation that plaintiff would have neither the will nor the resources to refuse it.”; affirming jury's finding that adjuster was insurer's agent); Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 18-19 (1996), supra, (bad faith claim against NW (UIM) carrier survives SJ because insurer refused to pay interest allegedly without cause and allegedly failed to attempt in good faith to settle; “the judgment based on plaintiff's first cause of action . . . attests to the aggravating conduct of Nationwide.”); Robinson v. North Carolina Farm Bureau Ins. Co., 86 N.C. App. 44 (1987) (fire loss; where insurer denied that the building was damaged in excess of \$100,000.00, offering instead to pay plaintiff \$88,451.00, and umpire set loss at \$170,000, and insurer then paid the \$100,000.00 building loss, which was seven months after the fire, five months after the plaintiff's initial submission of its proof of loss claims, and insured had obtained estimates for \$170,000 and \$111,000; “we are not establishing a rule that an insurance company is liable for punitive damages in every case wherein the value of the damages is disputed and the claimant ultimately wins in the independent appraisal process”); Payne v. North Carolina Farm Bureau Mut. Ins. Co., 67 N.C. App. 692, 695 (1984) (plaintiff sustained theft loss, adjuster said that insurer discouraged the payment of any such claims for benefits pursuant to such theft coverage and alleged numerous excuses as to why insurer refused to compensate insured, with insurer raising new requirements and objections); Smith v. Nationwide Mut. Fire Ins. Co., 96 N.C. App. 215, 219 (1989) (insured alleges “bad faith” and 5-month passage of time between when the adjuster from defendant company first observed the damages to plaintiff's mobile

home and when a claim check was issued; the extended period of negotiations with little progress toward reaching a resolution; and the substantial disparity between both of plaintiff's estimates and the estimate relied upon by defendant); Von Hagel v. Blue Cross & Blue Shield, 91 N.C. App. 58, 62-63 (1988) (insured alleged that insurer breached its duty to act in good faith in refusing without reason to pay for private duty nurses and all doctor bills, refusing to adequately investigate plaintiff's claim and refusing to negotiate and settle plaintiff's claim, and plaintiff specifically alleged that despite the opinions of two of decedent's treating physicians regarding the necessity of nursing care, defendant refused to investigate the claim or consult a qualified physician for evaluation before denying the claim and that such refusal was in bad faith, and Plaintiff further alleged that defendant refused to pay for private duty nursing care after it had previously approved that expense and communicated that approval to plaintiff).

In the following case, the court determined that the evidence was insufficient to support a verdict for punitive damages: Hornby v. Pennsylvania Nat'l Mut. Casualty Ins. Co., 77 N.C. App. 475 (1985) (where insurer's agent was negligent in efforts to procure insurance and negligently delayed acting on application for insurance, but did not do so intentionally or wantonly, there was no bad faith); McMillan v. State Farm Fire & Casualty Co., 93 N.C. App. 748, 752 (1989) (where insured sustained fire loss, and insurer sought appraisal and paid appraiser's award, and plaintiff asserts that defendants failed to conduct a reasonable investigation before demanding appraisal, and that their settlement offer was unreasonably low, and insured characterizes defendants' action in initiating the appraisal process when he had been without the use of his home for approximately two months as unreasonable, given their duty to relieve the financial distress of their insured, "these examples of purportedly unreasonable actions do not rise to the level of aggravated conduct" required); Olive v. Great American Ins. Co., 76 N.C. App. 180, 189 (1985) (following fire loss agent visited the property and said he "wasn't sure" whether the loss was covered, apparently due to ambiguity in which structures were covered, and after checking with the Company, informed plaintiffs that their claim would be denied, and Plaintiffs thereafter had several discussions with agents during which a

settlement figure of \$55,834.00 was proposed, subject to approval by insurer's office in Cincinnati, and approval was denied, and insured-wife injured her back escaping from the fire and her recovery was slowed by the unusual living conditions, and she had to use vacation time to pursue settlement of claim, "Plaintiffs' argument that this is evidence of bad faith appears to be premised almost entirely on their contentions that defendant has not interpreted the policy correctly," and coverage issue was for the jury, "the claim was clearly the basis of an honest disagreement between the parties"); Shields v. Nationwide Mut. Fire Ins. Co., 50 N.C. App. 355 (1981) (fire loss; where insured alleged that insurer initially formed an intent to deny plaintiff's claim, and that insurer required plaintiff to follow all requirements of the policy including forcing him to undergo a deposition and to undergo an \$11,000 expense for an appraiser, to harass and intimidate insured to accept less than the full benefits, and insurer offered evidence that insured made misrepresentations (as to value of the premises, the fact that he had not sought to obtain other insurance on the premises prior to the issuance of the defendant's policy, the amount of repairs and improvements to be made on the property, the amount of repairs or improvements made at the time of the fire, the amount expended for repair and improvements, his involvement in or procurement of the fire which occurred on the property on or about July 6, 1976, the fact that he had never been refused insurance coverage etc.), and officials determined that the fire was "probably the work of an arsonist," but insured was not specifically implicated, but suspicious factors were present (straw on premises), claim was not denied until some 19 months after the fire and insurer's investigation continued during that time).

As a general matter, a non-party to the liability contract cannot maintain an action for bad faith. "In order to state a claim for punitive damages, a plaintiff must have a valid cause of action against the defendant in which at least nominal damages may be awarded were the plaintiff to recover. Because of our disposition of plaintiff's claim against defendant Nationwide, Ms. Wilson has no cause of action against Nationwide. Thus, we hold that her claim for punitive damages was properly dismissed." Wilson v. Wilson, 121 N.C. App. 662, 668 (1996). It is not clear whether a bad faith claim may be

maintained by a non-insured for the insurer's conduct following a judgment. See Murray v. Nationwide Mut. Ins. Co., 123 N.C. App. 1, 15 (1996) (holding that Wilson's reasoning does not preclude Chapter 75 claim by non-insured who obtains judgment against insurer).

A claim for bad faith has a three year statute of limitations, apparently running from the date of loss. Page v. Lexington Ins. Co., 177 N.C.App. 246, 251, 628 S.E.2d 427, 430 (2006) ("plaintiffs' claims for breach of contract, breach of fiduciary duty, and bad faith arose on 21 February 2001 [date of loss], and plaintiffs did not file their complaint until 28 July 2004. Plaintiffs' claims for these causes of action were thus barred by the three-year statute of limitations applicable to these claims.").

PROCEDURAL ISSUES -- LITIGATING THE CLAIM

There is no set formula for litigating a "bad faith" lawsuit. As the term "bad faith" is used in this topic, it refers to a lawsuit against an insurance company which seeks more than compensatory damages within the limits and terms of the insurance policy; rather, this article addresses those lawsuits against an insurance company to recover amounts beyond what is contractually required (extra-contractual liability), based on an allegation that the insurance company acted in "bad faith," or in violation of Chapter 75.

Every bad faith coverage dispute of course entails its own particular facts, and particular set of strengths and weaknesses. Each such case may require a vastly different strategy at trial, either from the insured's or from the insurer's perspective. This Article merely addresses several general issues and themes when litigating bad faith lawsuits.

1. Pre-Suit Considerations – Paper the File!

Both the insurer and the insured should attempt to resolve this dispute voluntarily through settlement, prior to filing suit. This will typically entail several letters, telephone calls, and possibly e-mails between the insured and the insurer.

The insured generally wants to provide the insurer with every opportunity to resolve the case short of litigation. If the insured's bad faith lawsuit is primarily based on a denial of coverage, then the insured at trial wants to be able to show to the jury that the

plaintiff-insured was reasonable in seeking coverage, and that the defendant-insurer was unreasonable in denying coverage. By contrast, the need for such evidence is far less if the alleged “bad faith” has already occurred, such as a failure to settle a third-party claim within policy limits which has resulted in an excess verdict.

The insurer likewise wants to show that its actions in attempting to resolve the claim were reasonable.

The coverage and bad faith lawsuit is dissimilar to the typical tort action (e.g. dog bite, motor vehicle accident, slip and fall) in terms of the ability to create evidence for trial. In these more common cases, the conduct at issue has occurred before the attorney has a chance to communicate with the other side. The attorney can at most attempt to prove the prior conduct that is relevant to the issue for the jury (e.g. the defendant’s negligence). By contrast, in a coverage dispute, the attorney has several weeks or months, or even years to “paper the file” to establish its position and to probe the other side’s position. Moreover, these communications may be admissible and highly relevant in the bad faith lawsuit. An insurer’s denial is essentially a continuous act, and therefore the parties have a rare opportunity to actually shape the trial, even prior to actual litigation.

The insurer may want to invite the insured to notify it of reasons that coverage is afforded. This may help to negate a subsequent claim of bad faith. Bennett v. Stonebridge Life Ins. Co., (W.D.N.C. 2007) (life insurer did not commit bad faith or commit unfair or deceptive acts in denying life insurance claim under accidental death policy where there was evidence that cause of death was heart attack, which resulted in insured’s driving into utility pole; insurer also took reasonable steps in investigating the claim; “The Defendant also provided the Plaintiff an opportunity, of which she failed to take advantage, to give reasons why its decision should be changed.”; unpublished; 2007 WL 2572339).

The insured and insurer should also be mindful of the “tenor” of such correspondence, because they may become evidence at trial and presented to the jury.

In order to recover attorney's fees under Chapter 75, the insured must show an "unwarranted refusal by the [insurer] to resolve the issue fully." These documents will may help to support a claim for the recovery of attorney's fees, or may help the insurer to show its good faith.

The insurer of course does not generally control the commencement of a bad faith lawsuit, but the insurer should nevertheless begin "making the record" to be able to establish its good faith and reasonableness at trial. The insurer should present a cogent and courteous description of its position on coverage, and should express being open-minded to receive new information and arguments.

Prior to filing suit, the insured's attorney should also review the policy to ascertain whether there are any conditions precedent to a lawsuit. Such conditions are not very common in North Carolina coverage disputes, but some policies require the insured to send a particular type of notice prior to suit, or may require the insured to submit to arbitration (binding or non-binding), or to an appraisal process. Prior to filing suit, the insured's attorney may want to write to the insurer and ask it to notify him whether he must comply with any additional conditions prior to filing suit. (Many policies have a "no action against us" provision, but this generally prohibits only a suit by a person who has settled with the insured, and then seeks to enforce the judgment against the insurer.)

When counsel for the insured or for the insurer becomes heavily engaged in discussions regarding coverage with the other side, there is some potential that the attorney may later become a witness, and may therefore have to disqualify himself. This may have ramifications for the insured and for the insurer. If a party desires that its attorney not become a testifying witness at trial (or deposition), then any substantive communications by the attorney should be made in writing, and oral communications (in person or telephone) should be summarized in a follow-up letter. If the communications are documented, then the attorney may be able to simply rely on the writings to establish the communication with the other side's attorney or representative; the writings should "speak for themselves" such that no further explanation regarding the conversation is

needed. This is not, however, a foolproof method to avoid having the attorney disqualified.

This disqualification issue has been litigated in other states. Often, the insurer will attempt to have the insured's attorney disqualified from participating (except as a witness) in the bad faith lawsuit. These attempts are usually unsuccessful. Zurich Ins. Co. v. Knotts, 52 S.W.3d 555, 560 (Ky. 2001) ("the showing of prejudice needed to disqualify opposing counsel must be more stringent than when the attorney is testifying on behalf of his own client, because adverse parties may attempt to call opposing lawyers as witnesses simply to disqualify them"); Smithson v. U.S. Fidelity & Guar. Co., 186 W.Va. 195, 201, 411 S.E.2d 850, 856 (W.Va. 1991) ("we conclude that when an attorney is sought to be disqualified from representing his client because an opposing party desires to call the attorney as a witness, the motion for disqualification should not be granted unless the following factors can be met: First, it must be shown that the attorney will give evidence material to the determination of the issues being litigated; second, the evidence cannot be obtained elsewhere; and, third, the testimony is prejudicial or may be potentially prejudicial to the testifying attorney's client."). See also Ohio Cas. Ins. Co. v. Firemen's Ins. Co. of Washington, D.C., (E.D.N.C. 2008) (attorney which represented insured in underlying action can represent excess carrier in coverage suit by excess carrier against primary carrier which allegedly failed to settle in bad faith; "[The excess insurer's] good faith conduct is not the relevant legal issue. The question, rather, is whether [the primary insurer] acted in good faith. The subjective views and evaluations of [the excess insurer's] agents do not shed light on the question of [the primary insurer's] good faith."; unpublished; 2008 WL 441840). The party is generally able to block a deposition of its own attorney. N.F.A. Corp. v. Riverview Narrow Fabrics, Inc., 117 F.R.D. 83, 84 (M.D.N.C. 1987) ("In general, protective orders totally prohibiting a deposition should be rarely granted absent extraordinary circumstances. A request to take the deposition of a party's attorney, however, constitutes a circumstance justifying departure from the normal rule.").

2. Figuring Out Whom to Sue and Where to Sue

In a bad faith lawsuit, the insured will obviously sue the insurer who issued the relevant policy, and who allegedly committed the acts of bad faith. Identifying the proper defendant is sometimes difficult in a coverage action because often there are related insurers with similar names. The failure to name the correct company can obviously be fatal, especially if the statute of limitations is about to expire. The procedural rules in state court in North Carolina are fairly strict regarding the duty of the plaintiff to name the proper defendant, and the plaintiff is generally not allowed to substitute another legal entity at a later date, without having to so amend the pleadings within the statute of limitations. Franklin v. Winn Dixie Raleigh, Inc., 117 N.C.App. 28, 40, 450 S.E.2d 24, 32 (1994) (original complaint against “Winn-Dixie Stores, Inc.” was insufficient to sue “Winn Dixie Raleigh, Inc.”).

In addition to suing the insurer, the insured sometimes sues the individual adjuster or adjusting company as a defendant. There is no clear authority in North Carolina as to whether a suit against the adjuster based on bad faith is viable. The basic contractual or coverage dispute would generally not be against the agent, because the agent was not a party to the insurance contract, and further because his or her actions are committed on behalf of a disclosed principal. A claim for bad faith is, however, somewhat akin to a tort action, in which an employee may be sued for his or her own torts.

North Carolina has recently held that the insured cannot sue an independent adjuster for bad faith, because he lacks privity. Koch v. Bell, Lewis & Associates, Inc., 176 N.C. App. 736, 738, 627 S.E.2d 636, 638 (2006) (“This case presents a question of first impression for this Court: whether under North Carolina law an independent insurance adjuster (Bell Lewis and Travis) owes a legal duty to claimants (plaintiffs) who are not the insured (Quality) of the insurance company (Southern and Southern Pilot).”; finding no duty). Many cases from other states are in accord. Havard v. Kemper Nat. Ins. Companies, 945 F.Supp. 953, 957 (S.D.Miss.1995) (“The evidence shows that Meadows merely adjusted the Havards' claim in the ordinary course of business, that he disagreed with repair estimates submitted by the plaintiffs, and that he furnished an appraisal estimate to Kemper at its request. The complaint fails to allege that the

insurance adjuster engaged in any independent conduct which rose to the level of gross negligence, malice, or reckless disregard for the rights of the plaintiffs. Further, the affidavit of John Meadows asserting that the insurance adjuster did not engage in separate egregious conduct is uncontested, and plaintiffs have put forth no evidence on this issue of which they have the burden of proof.”); Griffin v. Ware, 457 So.2d 936, 940 (Miss.1984) (“adjusters employed by an insurer, who were not parties to the agreement for insurance, are not subject to an implied duty of good faith and fair dealing to the insured.”); Wathor v. Mutual Assur. Adm'rs, Inc., 87 P.3d 559, 560 (Okla. 2004) (third party administrator who denied health benefits has no tort duty of good faith and fair dealing toward insured).

Even though the thrust of the cases is that the individual adjuster has no (personal) duty of good faith to the insured, the plaintiff may still want to sue these persons, especially under the framework of Chapter 1D. In order to recover punitive damages under Chapter 1D, the insured cannot rely simply on the misconduct of a rogue adjuster. G.S. § 1D-15(c) (“Punitive damages shall not be awarded against a person solely on the basis of vicarious liability for the acts or omissions of another. Punitive damages may be awarded against a person only if that person participated in the conduct constituting the aggravating factor giving rise to the punitive damages, or if, in the case of a corporation, the officers, directors, or managers of the corporation participated in or condoned the conduct constituting the aggravating factor giving rise to punitive damages. Rather, the insured must prove that the insurer’s management participated in some manner in the wrongful conduct of the adjuster.”). (By contrast, a claim for treble damages under Chapter 75 apparently does not require this degree of control by management.) It is therefore somewhat unclear whether the conduct of a rogue adjuster, who still acts in his scope of employment, may give rise to a claim for punitive damages against him personally.

This article primarily addresses a bad faith claim against the insurer for a wrongful denial of benefits, or other improper conduct by the insurer while adjusting the claim. There may, however, be bad faith suits pertaining to the creation of the insurance

policy. Davidson v. Knauff Ins. Agency, Inc., 93 N.C. App. 20, 33 (1989) (offering underinsurance coverage which has no value, because of other underinsurance available is an "unfair trade practice which would at the least tend to deceive"). In such event, the insured may also want to sue the insurance agent, in addition to suing the insurer.

From the defense perspective, the insurer of course wants to scrutinize the complaint and summons to determine whether the insured has sued the correct party.

In addition, the insurer may want to file third-party actions for contribution or indemnity against other persons. In the context of a "bad faith" lawsuit, the extent to which the insurer has such a contribution or indemnification claim is unclear. One case held that an agent was entitled to contribution from the insurer, after settling a claim for negligence and breach of contract. Jefferson Pilot Fin. Ins. Co. v. Marsh USA, Inc., 582 S.E.2d 701, 705 (2003) (where agent settled claim by insured for negligence and breach of contract, arising from insurer's denial of coverage for embezzlement by insured's employee, under insurer's bond, agent was entitled to contribution from insurer, as they are joint-tortfeasors, even though jury found insurer was not negligent; agent is entitled to 50-50 contribution from insurer for amount of settlement). Where the insurer is held liable based on the conduct of its independent adjuster, then the insurer may have a contribution or indemnification claim against that adjuster. There is, however, very little authority for this point. The cases are somewhat mixed on this point, but indemnity is allowed in some circumstances. In re Cooper Mfg. Corp., 131 F.Supp.2d 1238 (N.D.Okla. 2001) (insurer who settled case based on refusal-to-settle pay sue its broker/agent for indemnity and contribution, where broker deprived insurer of no-tender affirmative defense); American Chambers Life Ins. Co. v. Power, 690 So.2d 683 (Fla. App. 1997) (insurer had indemnity claim against agent for contractual liability, but not bad faith liability); Fireman's Fund Ins. Co. v. Haslam, 29 Cal.App.4th 1347, 35 Cal.Rptr.2d 135 (1994) (insurer could recover indemnity from agent for extracontractual damages resulting from delayed payment, where agent's acts were legal cause of delay); Aetna Cas. and Sur. Co. v. Hartford Acc. & Indem. Co., 74 Md.App. 539, 554, 539 A.2d 239, 246 (1988) (insurer liable for bad faith may not recover from another insurer;

“equity will withhold subrogation from one who is guilty of a wrong in connection with the matter in controversy”).

If coverage is also being litigated (in addition to “bad faith”), then the insurer generally wants to include in the lawsuit any other persons who may potentially have a claim under its policy, arising from the same facts or claims already at issue in the lawsuit. The insurer therefore generally wants to include any other potential insureds, and any third-party beneficiary (such as a potential claimant against the insured). See, e.g., Hales v. North Carolina Ins. Guar. Ass'n, 337 N.C. 329, 332, 445 S.E.2d 590, 593 (1994) (even though one claimant previously lost DJ action to establish that policy was in effect, another claimant (his son) could file second suit to establish coverage, and was not bound by *res judicata*). For a case addressing the right of a claimant to intervene in a coverage action between its insurer and another insured, see National Union Fire Ins. Co. of Pittsburgh, Pa. v. Reichhold, Inc. (M.D.N.C. 2008) (holding that insurer and insured were capable of litigating the issue, the claimant was not a necessary party; unpublished; 2007 WL 2480320).

This section contemplates that the lawsuit was the result of the insured filing suit against the insurer for bad faith. In those cases where coverage has not been established, however, the insurer may want to “take the bull by the horns,” and pre-emptively file a lawsuit to establish coverage. A few cases have held that coverage actions are premature, Newton v. Ohio Cas. Ins. Co., 91 N.C. App. 421, 423, 371 S.E.2d 782, 784 (1988) (refusing to hear UM dispute because “the issue of liability has yet to be resolved”), but the majority of cases recognize that the insurer may seek a declaratory ruling where there is a bona fide coverage dispute. The insured may of course file a counterclaim seeking a declaration as to coverage, and may also allege her bad faith claim against the plaintiff-insurer. The advantage of this approach to the insurer is that it is more likely to receive its forum of choice, and further the insurer initially casts the issues in the manner in which it wants them to appear. Where the insurer files the coverage lawsuit, it may of course want to do so early in the dispute, especially if it appears that a settlement is unlikely.

North Carolina Farm Bureau Mut. Ins. Co. v. Warren, , 365 S.E.2d 216, 89 N.C.App. 148 (1988) (excess insurer cannot bring coverage action where there was primary policy and extent of injuries were not alleged)

In declaratory judgment proceeding wherein an insurer sought construction of insurance policy, counterclaim for damages allegedly resulting from wrongful conduct on part of insurer's agents was not properly pleadable. U. S. Fire Ins. Co. v. Parks, 1954, 80 S.E.2d 641, 239 N.C. 680.

Declaratory judgment proceeding wherein an insurer sought construction of an insurance policy and defendants counterclaimed for damages allegedly resulting from wrongful conduct on part of insurer's agents.

U. S. Fire Ins. Co. v. Parks 239 N.C. 680, 80 S.E.2d 641 (N.C.1954)

Provided actual controversy exists, liability of insurer under policy is proper subject of declaratory judgment. Newton v. Ohio Cas. Ins. Co., 1988, 371 S.E.2d 782, 91 N.C.App. 421.

Declaratory judgment action may be brought to determine whether coverage exists under insurance policy. Western World Ins. Co., Inc. v. Carrington, 1988, 369 S.E.2d 128, 90 N.C.App. 520.

Roofers' liability insurer was entitled to maintain declaratory judgment action to determine whether claim against roofers was within policy coverage. Iowa Mut. Ins. Co. v. Fred M. Simmons, Inc., 1962, 128 S.E.2d 19, 258 N.C. 69.

Venue can be as important in a coverage dispute as it can in any other contract dispute, or in a tort suit. The first venue consideration is whether the insured (or the insurer) wants to be in state or federal court.

A coverage dispute will not generally involve a federal question. (If the suit is barred by ERISA, then a federal question is presented. Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1212 (11th Cir. 1999) (“federal courts have subject-matter jurisdiction over state-law claims that have been superpreempted”); whether insurance

claims are barred by ERISA raises federal issue, and bad faith suits are barred); 29 U.S.C. § 1144(a) (group insurance policies issued as part of an employee benefit plan are subject to ERISA).)

Diversity jurisdiction exists only if there is “complete diversity” and the amount in controversy exceeds \$75,000. If any plaintiff and defendant are citizens of the same state, then diversity is non-existent. There is a specific provision regarding the citizenship of an insurer in a “direct action,”³ but this provision should rarely, if ever, be applicable to a bad faith suit, because such a suit is based on the conduct of the insurer, and not the insured.

The insurer may of course also remove a coverage dispute to federal court if the parties are diverse and the amount in controversy is greater than \$75,000. The only qualification would be that the defendant-insurer may not remove the case if it is a citizen of North Carolina.

Both sides must consider whether to be in federal or state court. In theory, the underlying substantive law of coverage and bad faith should be identical. The procedural and evidentiary rules will, however, differ in federal court. The nuances regarding the distinctions between State and Federal Rules of Evidence and Rules of Procedure are beyond the scope of this article. Both sides should, however, give some consideration to

³ 28 U.S.C.A. § 1332 (c)(1) (“a corporation shall be deemed to be a citizen of any State by which it has been incorporated and of the State where it has its principal place of business, except that in any direct action against the insurer of a policy or contract of liability insurance, whether incorporated or unincorporated, to which action the insured is not joined as a party-defendant, such insurer shall be deemed a citizen of the State of which the insured is a citizen, as well as of any State by which the insurer has been incorporated and of the State where it has its principal place of business”). *Boyd v. Baird* (W.D.N.C. 2008) (Plaintiff obtained a judgment against a tortfeasor, and then sued his UM insurer in federal court to recover the judgment; court rejected insurer’s argument that diversity jurisdiction did not exist based on 28 U.S.C. § 1332(c)(1), which states that in a “direct action” the insured’s residence, and not the insurer’s residence, controls).

the procedural and evidentiary distinctions. A subsequent section addresses the differences between the state and federal rules regarding the use of expert testimony.

If the suit is filed in State court, then of course each party generally prefers to have the action tried in its home or principal county. The action must be tried where one of the parties resides at the time of filing. An insurer “resides” in any county where it “maintains a place of business.” G.S. § 1-79(2). See, e.g., Travelers Indem. Co. v. Marshburn, 371 S.E.2d 310, 91 N.C. App. 271 (1988) (by complying with G.S. § 58-150, foreign insurer was domesticated and was to be treated as domestic corporation for venue purposes and could sue in county where it conducted business and maintained regional office; court applying residential venue statute at G.S. § 1-82).

The parties may of course also want to consider the convenience and availability of any potential trial witnesses.

As with any lawsuit, the venue may have a significant impact on the ultimate legal ruling from the Judge, and factual findings by the jury. In addition to considering convenience to themselves and to witnesses, the parties will therefore also want to consider which venue (judges and jurors), is more likely to favor their position.

It is difficult to draw any generalizations regarding counties which are pro-insured or pro-insurer. A “conservative” county should, however, generally be more favorable to the insurer. A county which has a reputation for large verdicts in personal injury suits would generally be a county that is more pro-insured.

In a smaller county or district, the parties may be able to predict which particular judge may ultimately preside over the dispositive motions (e.g. summary judgment and directed verdict), and over the evidentiary rulings. Counsel may also want to consider the frequency of hearing and trial dates, and other practical scheduling matters.

3. Draft Pleadings to Maximize Your Case

There is no set formula for a bad faith complaint. The complaint should of course comply with the Rules of Civil Procedure, which require only that the complaint set forth a short and simple statement of the claim for relief. This author recommends that the complaint be broad, both in terms of factual allegations and in terms of legal theories.

There are a few advantages to having a thorough factual complaint. The first is that it will assist the insured's attorney in thinking through the case globally. Some important legal or practical problems could surface in the process of drafting a thorough complaint. For example, as discussed in a previous section, upon reviewing the file in detail, you may realize that it would behoove the insured's case to send one additional demand letter, or to respond to any issues raised by the insurer, to which you have not already provided a response. The second reason to have a detailed complaint is to maximize your theories of recovery at trial. Although the Rules of Civil Procedure should theoretically be "liberal," and allow you to pursue any claim of which the defendant is on notice, as any trial attorney knows, it is better to be "safe than sorry" when pleading the plaintiff's case.

The third potential reason to draft a detailed complaint is to ensure that the insurer (and its attorney) are aware of the complete history of the claim, in a fairly concise manner. Often, the file will be transferred to a new adjuster after the bad faith lawsuit is filed, and the case may be given a greater level of scrutiny by others in the insurance company. The insured may therefore have a new "set of eyes" reviewing the case from the insurer's side. If your case has significant merit, your insured may be able to resolve the dispute with the insurer at an early stage in the bad faith lawsuit, which is generally preferable for all parties.

The legal theories should likewise be drafted broadly in a bad faith lawsuit. The insured will generally allege breach of contract, tortious or "bad faith" breach of contract, negligence and gross negligence in claims handling, and unfair or deceptive acts or practices (Chapter 75). For a case sufficiently alleging a claim for bad faith and Chapter 75, see Miller v. Nationwide Mut. Ins. Co., 112 N.C. App. 295, 302 (1993). For cases finding that these claims were insufficiently pled, see Beasley v. National Sav. Life Ins. Co., 75 N.C. App. 104, 107 (1985) (nonpayment of claim for health benefits, alleging that insurer violated its covenant of good faith and fair dealing to the plaintiff; "Not only has plaintiff herein failed to sufficiently allege a tortious act, he has failed to allege any accompanying 'element of aggravation' ."); Hoke v. Young, 89 N.C. App. 569, 571

(1988) (where insurer answered claimant's complaint by alleging claimant's intoxication at time of accident, claimant dismissed claim and refiled action and added insurer as party, claiming violation of Chapter 75 by alleging he had been intoxicated, claimant's allegations that the insurer's attorney relied on hearsay statements gathered by an accident investigator and did not sufficiently investigate the defense before raising it in the answer were insufficient).

Once again, although pleadings should theoretically be construed broadly, the insured wants to ensure that all of his claims and theories for relief are preserved for submission to the jury at trial. A superfluous allegation or theory plead in the complaint is generally harmless to the insured.

In some bad faith lawsuits, the fundamental "coverage" issue has already been decided, or is conceded. For example, where the automobile insurer acknowledges coverage of a third-party claim, but fails to settle the claim within coverage, resulting in an excess verdict against its insured, the insured need not establish coverage, but need simply establish that the insurer's failure to settle was in bad faith (or negligent). In many cases, however, the fundamental coverage issue remains disputed, and the insured must first establish his coverage, prior to establishing bad faith. (This does not mean that the insured must present his evidence or establish his case in any particular order, but rather only that if he loses his coverage action, then he probably has no bad faith action.) For example, a homeowner suing under a fire insurance policy essentially has, at a minimum, a "coverage" dispute with his insurer. (If they both agree on the existence of coverage and the amount of the loss, then there would be no dispute.) In such a case, the insured may simultaneously sue for breach of contract (i.e. coverage), and also sue for a "bad faith" denial of this coverage.

In general, where the insured desires to assert a bad faith action against her insurer, she should generally assert the coverage and "bad faith" claims in the same lawsuit, to avoid the doctrine of *res judicata* (which essentially means that a person must bring all claims arising out of the same incident).

There is, however, authority in North Carolina that the insured may first bring a coverage action, and if he prevails, then he may file a second action for bad faith. In one case, the North Carolina Court of Appeals held that the insured-country club could sue its insurer for a wrongful denial of coverage, in which the insured sought punitive damages, after the insured had already successfully litigated the coverage claim against the insurer. The Court held that the coverage action and the bad faith action were substantially dissimilar so as to preclude the application of *res judicata*. Country Club of Johnston County, Inc. v. U.S. Fidelity and Guar. Co., 135 N.C. App. 159, 165-166, 519 S.E.2d 540, 545 (1999) (“In short, the issue in the instant case is no longer one of coverage, but rather USF & G's liability for alleged bad faith, tortious breach of contract, unfair claim settlement practices, or unfair and deceptive trade acts or practices in its handling of the Club's claim and the resulting litigation. There is no possibility of any verdict inconsistent with previous judicial determinations.”).

It should be noted, however, that the insured may not be able to take this two-step approach in a claim for punitive damages. Under Chapter 1D, the same jury is supposed to hear the compensatory and punitive damages aspects of the case. Hence, if the insured first tries the contract case, he may not then be able to assert a second action for bad faith.

The insured should, however, have a solid basis for his bad faith or Chapter 75 allegations. The insurer may be awarded its attorney's fees if the Court determines that the allegations of a violation of Chapter 75 were frivolous. The Cincinnati Ins. Co. v. Dynamic Development Group, LLC, 336 F.Supp.2d 552 (2004) (insurance company not entitled to award of attorney fees where insured made good-faith arguments regarding validity of claim). Similarly, “The court shall award reasonable attorneys' fees, resulting from the defense against the punitive damages claim, against a claimant who files a claim for punitive damages that the claimant knows or should have known to be frivolous or malicious.” G.S. § 1D-45.

When drafting the answer, the insurer's counsel of course wants to ensure that the responses to the allegations are correct. More importantly, however, the insurer must be careful to include any “affirmative defenses” in its answer. It is often useful to remember

that the basic coverage dispute (without consideration of “bad faith”) is essentially a contract action. Therefore, all defenses to a contract action apply. The insurer therefore wants to consider defenses such as voiding the contract, or the statute of limitations.

In addition to the defenses which apply to the coverage dispute (if any), defense counsel should raise any defenses to the bad faith claim. It is not clear whether there is a true affirmative defense to a claim for bad faith. In addition, defense counsel may want to specifically recite any issues within Chapter 1D that may apply to the claim, such as the cap on punitive damages, the right to a bifurcated trial, and the absence of liability based upon *respondeat superior*. These matters are probably technically not “affirmative defenses” but there is no harm in raising these potential issues under Chapter 1D.

4. Use of Written Discovery and Depositions

In general, both the insured and the insurer should engage in written discovery (interrogatories and request for documents), and should use a request for admissions to establish facts which are probably not in controversy (such as the authenticity of medical or business or other records). The plaintiff (insured or insurer) should generally attach a complete copy of the policy (declarations and remainder of policy) to the complaint, and the terms of the policy will usually be admitted in the defendant’s answer.

If the insured fails to respond to a Request for Admission, the matter admitted may be sufficient to prevail as a matter of law. Brown v. Foremost Affiliated Ins. Services, Inc., 158 N.C.App. 727, 582 S.E.2d 335 (2003) (insureds admitted that homeowners insurer did not breach contract of insurance, or engage in bad faith or unfair and deceptive trade practices, when insureds did not respond to requests for admissions; some admissions were specific, and “Further, [insurer] requested that the Browns admit that their claims for bad faith and for unfair and deceptive trade practices were frivolous and groundless upon information known to them at the time of the filing of the complaint. Because these statements also are deemed admitted, we see no genuine issue of material fact with regard to these claims.”).

The parties should also use interrogatories to explore the coverage issues. Interrogatories can be useful for ascertaining the adversary's information and position, and forcing the other side to commit on a given issue, in a fairly cost-effective manner.

Both parties should consider the potential burden of discovery when moving forward with a bad faith action. A corporate insured and an insurer may have extensive documents relevant to the claim and damages which they may not want to disclose.

The insured will generally want to request the insurer's claims file. In a bad faith suit, many of the insurer's files which would otherwise be protected may be discoverable, In Evans v. United Servs. Auto. Ass'n, 142 N.C. App. 18, 33 (2001), an insured sued his insurer alleging a bad faith denial of coverage. The insured sought documents in discovery. "The documents that plaintiff seeks to discover may be organized into four categories: (A) entries in a 'claims diary'; (B) a report by outside investigator Ward-THG; (C) internal memoranda; and (D) internal policy manuals."

The lower court ordered that some documents remain privileged and held that others were subject to discovery. The appellate court affirmed, finding that the lower court acted within its discretion. It is therefore difficult to discern any bright line rules from this case. Nevertheless, there are a few critical holdings.

The court held that, "documents prepared before an insurance company denies a claim generally will not be afforded work product protection," and "an insurance company and its counsel may not avail themselves of the protection afforded by the attorney-client privilege if the attorney was not acting as a legal advisor when the communication was made." The court found no abuse of discretion in ordering the production of four internal memoranda generated by defendants' in-house counsel, regarding action being, or to be, taken on the claim.

The courts generally rule that the insurer's claims handling manual is subject to a protective order, and the use of the manual outside the litigation is prohibited. A recent case from a federal court in North Carolina required disclosure of the claims manual; a protective order was not addressed. Ohio Cas. Ins. Co. v. Firemen's Ins. Co., (E.D.N.C. 2008) (The primary insurer requested the excess insurer's claims manual; "A claims

manual is discoverable and relevant in cases involving allegations of bad faith or unfair trade practices.” “Because Plaintiff has alleged claims of bad faith and unfair trade practices, which involve reviewing a carrier's own procedures for claims investigations, the court concludes that the claims manual is discoverable and relevant to the current action.” Even if the excess insurer’s tort defense counsel did not rely on the claims manual (because it was not in existence), “it may have some relevance in to the current action.” “The excess insurer must disclose its manual on the condition that the primary carrier produce its manual.”; unpublished, 2008 WL 413849).

Another hotly contested issue is whether any written coverage opinions from the insurer’s legal counsel are discoverable. Cases from other jurisdictions are split as to the extent to which the insurer’s memoranda and mental impressions are discoverable. Lorenz v. Valley Forge Ins. Co., 815 F.2d 1095 (7th Cir. 1987) (applying Indiana privilege law and holding that insurer did not waive attorney-client privilege by denying insured's allegation that insurer had failed to make good faith settlement offer in litigation against insured); Holmgren v. State Farm Mut. Auto. Ins. Co., 976 F.2d 573, 576 (9th Cir. Mont. 1992) (although insurer’s adjuster's notes were work product, the notes were discoverable because mental impressions were at issue in the case and the need for the notes was compelling; handwritten memoranda drafted during the litigation of the tort action by adjuster with range of values for claim).

Where the insurer does not rely on the advice, then many courts hold that the advice is not discoverable. Aetna Cas. V. Pietrzak, 153 Cal. App. 3d 467, 475 (1984) (“Aetna is not saying that their conduct was reasonable *because their counsel opined so*, but rather that their conduct was reasonable because the *facts* indicated that no valid claim existed.”; “Aetna claims it acted as it did not because it was advised to do so, but because the advice was, in its view, correct.” “”Such a defense does not waive the attorney-client privilege.”). But see State Farm v. Lee, 13 P.3d 1169 (Ariz. 2000) (finding waiver even where insurer did not rely on advice).

Both sides want to consider whether to take a deposition early in the case, before discovery is complete, especially if they anticipate that their early depositions will produce favorable inconsistencies later (e.g. created by the documents produced later).

As in all cases, discovery should be conducted with a view toward a summary judgment motion. The insured or the insurer may of course want to avail themselves of summary judgment on all or part of the claim. In general, both sides should strive to eliminate any unfounded claims (or defenses) as quickly as possible, to simplify trial, and to simplify trial preparation. In many coverage disputes, the coverage dispute will already be decided, or will be moot. In other cases, the insured must litigate coverage, in addition to bad faith. In those cases in which coverage is disputed and litigated, both parties want to consider having that issue resolved in their favor at summary judgment.

Many cases suggest that coverage should generally be decided by the Court as a matter of law, and that summary judgment is especially appropriate for a case involving a dispute over the terms of an insurance policy. Wachovia Bank & Trust Co. v. Westchester Fire Ins. Co., 276 N.C. 348, 354, 172 S.E.2d 518, 522 (1970) (“The sole question before us is, What is the meaning of the language used in this policy of insurance? This is a question of law.”); Duke University v. St. Paul Fire & Marine Ins. Co., 96 N.C. App. 635, 637, 386 S.E.2d 762, 763 (“Since this issue is determined by interpreting the language of the policy, it is a question of law which may be resolved by summary judgment.”), disc. review denied, 326 N.C. 595, 393 S.E.2d 876 (1990); State Auto Prop. & Cas. Ins. Co. v. Travelers Indem. Co. of Am., 343 F.3d 249, 254 (4th Cir. 2003) (“Pursuant to North Carolina law, the interpretation of an insurance policy is a question of law that is appropriate for resolution on summary judgment.”). Other cases indicate that summary judgment is appropriate in coverage lawsuits where the facts are not in dispute. Unless a particular factual issue is in dispute, the Court will generally construe the insurance policy and will decide the coverage issue as a matter of law.

The matters submitted on the summary judgment motion must be competent evidence. A conclusory affidavit is insufficient. Blis Day Spa, LLC v. Hartford Ins. Group, 427 F.Supp.2d 621, 633 -634 (W.D.N.C. 2006) (“much of the information [in

affidavit] is mere conclusory statements of Heil's ultimate opinions, and does not “reveal a process of reasoning beginning with a firm foundation.” Such information is insufficient to create a genuine issue of material fact for summary judgment purposes.”; “the affidavit does not back up the general conclusions with any specific evidence that the instant dispute is the product of a “grossly inadequate investigation or a willful intent to deceive” or that Johnson's analysis “fall[s] well below the professional standards” required of a CPA, such that there is an “absence of ‘honest disagreement’ or innocent mistake in [the] matter.””). Accord Rogers v. Unitrim Auto and Home Ins. Co., 388 F.Supp.2d 638, 643 (W.D.N.C. 2005) (“Rather than submit a supporting opinion from Mr. Wilbur, their expert, or some other evidence sufficient to create an issue of material fact as to whether the policy exclusions apply, the Plaintiffs have elected to rely solely upon Mr. Rogers' revised opinion that the water leak occurred suddenly, and his similarly unsupported opinion that the leak did not result from a faulty pipe, precisely the “mere scintilla of evidence” that is insufficient to overcome a motion for summary judgment.”). The insured’s recorded statement may be used to defeat coverage. Rogers v. Unitrim Auto and Home Ins. Co., 388 F.Supp.2d 638, 642 (W.D.N.C. 2005) (“Notwithstanding the Plaintiffs' unsupported contentions to the contrary, an insured's tape-recorded statements to an insurance adjuster may be offered as evidence that an injury or alleged damage is not covered under the terms of the policy.”).

In general, discovery should be complete before the summary judgment motion is heard. At a minimum, the non-movant should have an opportunity to conduct discovery. One case, however, held that the motion could be heard with pending discovery requests. Stott v. Nationwide Mut. Ins. Co., 183 N.C.App. 46, 55-56, 643 S.E.2d 653, 659 - 660 (2007) (insured sued insurer for Chapter 75 claim for denying medpay claim, and sending claim to arbitration; insured filed motion to compel to obtain additional documents; trial court simultaneously denied motion to compel and allowed insurer’s motion for summary judgment; “Plaintiff failed to show further discovery would lead to the production of relevant evidence. No evidence exists in the record to suggest defendant did not comply with the trial court's order compelling defendant to answer

plaintiff's discovery request within thirty days after entry of the arbitration award. . . . Plaintiff has failed to show the trial court abused its discretion and its order was not the result of a reasoned decision.”).

If the insurer prevails on coverage, then generally the “bad faith” action based on the denial should likewise be resolved in favor of the insurer as a matter of law. The insured could then appeal from the adverse coverage ruling, and the potential bad faith claim would depend on whether this ruling is upheld on appeal. A claim for distinct damages arising from improper claims-handling may, however, proceed even if the insurer prevails on the coverage issue. Nelson v. Hartford Underwriters Ins. Co., 177 N.C. App. 595, 609, 630 S.E.2d 221, 231 (2006) (“Thus, even if an insurance company rightly denies an insured's claim, and therefore does not breach its contract, as here, the insurance company nevertheless must employ good business practices which are neither unfair nor deceptive.”).

If the insured prevails on the underlying coverage issue, then the road is paved for the insured to pursue his bad faith claim. Moreover, his case may be strengthened because he can argue to the jury that his position on coverage was vindicated, and the position of the insurer was rejected. (Under the substantive law of bad faith, of course, the mere fact that the insurer was wrong about coverage does not constitute bad faith.)

There are, however, many cases in which coverage cannot be decided as a matter of law, and summary judgment is inappropriate. Where, for example, the parties dispute whether a policy was timely renewed, a factual issue may be presented. Similarly, whether the “intentional acts” exclusion applies may present an issue of fact. And, of course, ascertaining the fair market value of property (such as in a fire loss) generally presents an issue of fact.

Even if the insurer loses the coverage dispute, it may still prevail as a matter of law on the bad faith claim. Where the insurer can prove, as a matter of law, that its basis for a denial was a reasoned, albeit erroneous, decision, then the insurer is entitled to summary judgment.

Where the insurer faces a “bad faith” lawsuit under Chapter 1D, and also a suit for unfair and deceptive acts under Chapter 75, the insurer may move for summary judgment on either of these claims. It is conceivable that conduct by an insurer may be actionable under one of these theories, but not the other.

The tactical and strategic considerations that apply to motions for summary judgment in any lawsuit also apply to a coverage lawsuit. The parties must establish the “record,” upon which the summary judgment motion will be decided. The insurance policy should be a part of the record. Depositions can be useful for establishing certain facts. Some facts may be explored effectively in a deposition, as opposed to an interrogatory. In general, a party may not contradict himself when opposing a summary judgment motion, and therefore the testimony in a deposition has a very significant impact at summary judgment. By contrast, it is generally recognized that at trial, a party or a witness may deviate from her deposition testimony, and such deviation affects only the weight, and not the admissibility, of the testimony. Papadopoulos v. State Capital Ins. Co., 644 S.E.2d 256, 260 (N.C. App. 2007) (“Furthermore, defendant's contention that the witness gave an inconsistent response in his prior deposition is simply beside the point. This goes to the witness's credibility, and while it would be appropriate for defendant to impeach the witness on cross-examination, it does not bear on the admissibility of the statement.”). For this reason, counsel for both sides must exercise judgment in asking questions at depositions, especially if it may have the effect of educating the other side.

5. Use of Experts

In a bad faith suit, as with any case, the use of experts can be critical to prosecuting or defending the action. The expert can help to put things in perspective, and can help to summarize complicated evidence. The first issue is of course whether such testimony is admissible.

The federal courts have continued to struggle with the Daubert decision regarding the admissibility of expert testimony, in which the United States Supreme Court, in essence, held that junk science is inadmissible. Daubert v. Merrell Dow Pharmaceuticals,

Inc., 509 U.S. 579, 113 S.Ct. 2786 (1993). In the Daubert decision, the Supreme Court set forth general guidelines to consider when deciding on the admissibility of expert testimony. Some federal courts then struggled with whether the Daubert holding affected the admissibility of non-scientific opinion testimony, which would include, for example, the testimony of an expert claims adjuster. The Supreme Court ultimately ruled that Daubert applies to non-scientific experts also.

The Federal Rule was subsequently amended to read:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.
Fed. R. Evid. 702.

The amendments largely codified the Daubert holding. In Federal Court, an insurance expert's opinion must meet the criteria for reliability within the Rule. The reliability of such opinions in an insurance context will not have a "scientific" methods. "Some types of expert testimony will be more objectively verifiable, and subject to the expectations of falsifiability, peer review, and publication, than others. Some types of expert testimony will not rely on anything like a scientific method, and so will have to be evaluated by reference to other standard principles attendant to the particular area of expertise." F. R. Evid. 702 Advisory Committee Notes.

Some federal courts have held that an insurance-expert's background and experience can qualify him or her as an expert. See, e.g., Shepherd v. Unumprovident Corp. 381 F.Supp.2d 608, 611 (E.D. Ky. 2005) ("The Court concludes that Fuller's extensive background and experience in the insurance industry qualify her to testify as an expert in this case, despite her lack of formal education in the field of insurance.").

Even if the insurance expert is qualified, his testimony may be inadmissible where it will not assist the trier of fact. Some cases hold that expert testimony regarding insurance practices and procedures may be inadmissible. Bergman v. USAA, 742 A.2d 1101 (Pa. Super. 1999) ("generally, it is within the capability of the fact finder, unaided

by expert testimony, to assess whether an insurer acted in bad faith or breached its duty of care”); Lone Star Steakhouse and Saloon, Inc. v. Liberty Mut. Ins. Group, 343 F.Supp.2d 989 (D. Kan. 2004) (where expert testimony pertained to whether underlying lawsuit involved occurrence or expected or intended injury, and whether insurer was inconsistent in its handling of claim, testimony would not assist trier of fact, because jury was qualified to make these determinations).

On the other hand, many courts allow this expert testimony where it assists the jury. Campbell v. State Farm Mut. Auto. Ins. Co., 65 P.3d 1134, 1160 (Utah 2001) (“The experts' familiarity with the insurance industry in general, and State Farm in particular, must have greatly aided the jury's understanding of the issues.”); Talmage v. Harris, 354 F.Supp.2d 860, 865 (W.D.Wis.,2005) (Wis law; “expert testimony is not required to establish what a reasonable insurer would have done under the circumstances, but it is permitted if the witness testifying is qualified and the testimony will help the trier of fact to understand the evidence or determine a fact in issue”)

In some contexts, expert testimony may be required to show bad faith. Weiss v. United Fire and Cas. Co., 197 Wis.2d 365, 382, 541 N.W.2d 753, 758 - 759 (Wis. 1995) (insured was not required to present expert testimony in this case, but “[where] an insurer's alleged breach of its good faith duty involves ‘unusually complex or esoteric’ matters beyond the ken of an average juror, the []court should ordinarily require an insured to introduce expert testimony to establish a prima facie case for bad faith”).

Where you are seeking to exclude the other side’s expert (on insurance matters), you should ask her the reasons that she is more qualified than jury to determine the reasonableness of the insurer’s conduct.

In North Carolina State Court, the Daubert decision has been specifically rejected. Howerton v. Arai Helmet, Ltd., 358 N.C. 440, 458, 597 S.E.2d 674, 686 (N.C. 2004) (the basic test is stated as follows: “(1) Is the expert's proffered method of proof sufficiently reliable as an area for expert testimony? (2) Is the witness testifying at trial qualified as an expert in that area of testimony? (3) Is the expert's testimony relevant?”; “application

of the North Carolina approach is decidedly less mechanistic and rigorous than the ‘exacting standards of reliability’ demanded by the federal approach”).

North Carolina does not have any cases specifically addressing whether testimony from an claims-handling expert is admissible, but with proper qualifications, such testimony is probably admissible. There are a couple of appellate case which may implicitly seem to approve of the use of expert testimony in these cases. See Country Club of Johnston County, Inc. v. United States Fidelity & Guar. Co., 150 N.C. App. 231, 236, 563 S.E.2d 269, 273 (2002) (affirming finding of Chapter 75 violation; in recitation of facts, noting that insured’s witness “testified as an insurance expert in the fields of underwriting and claims handling,” who testified that insurer failed to follow “acceptable claims practices”); Erler v. Aon Risks Servs., Inc., 141 N.C. App. 312, 317 (2000) (insurer may be liable for negligent misrepresentation of whether policy covered structure; noting that “an independent adjuster [] testified that he is certified by FEMA to make a determination of whether an area should be classified as a ‘basement.’ . . . [and] he believed the lower floor was a basement and that Cothren [agent who wrote policy] should have known it was a basement.”).

One recent case from North Carolina holds that the expert may be excluded by the trial court, depending on the exact nature of his testimony. In Burrell v. Sparkkles Reconstruction Co., 657 S.E.2d 712, 716 (N.C. App. 2008), the homeowner experienced a water leak and ultimately had a dispute with her HO carrier regarding the extent of damages (and covered losses). She claimed that the delay in treating the mold was an unfair and deceptive acts. The insured sought to establish the insurer’s negligence or bad faith with the use of an expert witness. The witness, Mr. Dinsmore, started his career in insurance in 1969 with State Farm, adjusting auto and HO claims, and he received a designation in insurance in 1972. He continued adjusting until 1978, at which time he became an agent with Prudential. In 1981 he became an independent general adjuster. In 1984 he became a regional property supervisor at Lumberman’s. From 1985-1993 he adjusted for USAA (auto and large loss). He attended law school from 1994-1997, after which he worked as an insurance consultant, starting with a Florida-based expert witness

company. He had extensive experience with water and mold claims. The trial court prohibited him from presenting any testimony to the jury regarding the manner in which the HO insurer handled the plaintiffs' claim. He would have testified that the insurer "had engaged in conduct that violated statutory law, particularly in the way they responded to and handled her claim" and that the insurer "violated insurance industry standards." His opinions were based on insurance industry education and training; and investigating, evaluating and settling claims, and communicating with insureds. The trial court ruled that these "opinions would invade the province of the Court in determining whether legal standards have or have not been met." It further held that the opinions were irrelevant, and were misleading. The appellate court held that the trial court did not abuse its discretion in excluding this testimony.

In a related vein, a federal court has rejected an expert's (engineer's) testimony regarding a coverage issue. In Breezewood of Wilmington Condominiums Homeowners' Ass'n, Inc. v. Amerisure Mut. Ins. Co., 2008 WL 859018 (E.D.N.C. 2008), the court found no coverage for the construction-related claims and also said, "The court ignores [expert Ron] Wright's testimony to the extent he opines that the damages incurred by Quality Built constitute 'property damage' under the insurance policies. An expert may not proffer opinions regarding the legal effect of an insurance contract."

Shea Homes, LLC v. Old Republic Nat. Title Ins. Co. (W.D.N.C. 2007) (both parties offered "expert" testimony as to the meaning of the policy provisions; court rejected the use of such opinions, "Because these experts offer solely legal conclusions regarding the effect of the parties' contract.").

It is therefore not clear in North Carolina whether expert testimony on claims-handling procedures is admissible. The insured and insurer will therefore want to give consideration to whether they want to admit or exclude testimony of an expert, when deciding whether to seek a ruling in Federal or State Court.

Many insurers seek to exclude such expert testimony, but a general strategic rule probably cannot be set forth. An expert can help to summarize what would otherwise be voluminous and complex testimony and exhibits. She can also offer the customs,

standards or norms in the claims-handling industry, which are probably beyond the personal experience of most jurors. From the insured's perspective, this testimony may be necessary, especially if the insurer's adjusters (and other claims personnel) contend that they complied with all formal and industry standards. From the insurer's perspective, if it has complied with the industry standards, then such an expert will probably be more persuasive than self-serving statements of its current (or former) employees.

6. Voir Dire: The First Essential Step in Winning the Case

Selecting jurors in a bad faith lawsuit is as unpredictable as selecting jurors in any case.

There may be a few generalizations regarding prospective jurors which tend to favor the insured and which tend to favor the insurer. Presumably, a blue collar juror will be more sympathetic toward the insured, and a "conservative" white collar worker will be more receptive to the position of the insurer. In reality, these stereotypes may be very unreliable. The white collar business person may have had his or her own struggles with an insurance company, either under a business policy, or under his or her homeowner's policy. Conversely, the blue collar worker may have had satisfactory results with his collision claims, and may have a positive attitude toward insurance companies.

The more reliable way of ascertaining a favorable or non-favorable juror is of course through particular questions. In a bad faith lawsuit, both sides want to thoroughly examine the jurors regarding their views on insurance companies generally, and on their particular experiences with insurance companies. In general, a juror who has been dissatisfied with his insurer is expected to be favorable to the insured. Conversely, a juror who has had positive experiences with his claims may be more favorable toward the insurer.

A juror who has worked in the insurance industry (e.g. as an adjuster or an agent) would typically be more pro-insurer, but of course if that person had negative experiences with the insurer, or if that person had experienced bad faith conduct herself, then they may favor the insured.

In most cases, the attorneys must generally steer clear of questions regarding insurance, but in a bad faith case, insurance is the central theme, and the majority of the voir dire questions should probably focus on insurance.

In addition to using voir dire to weed out an unfavorable juror, the attorneys should use this opportunity to begin to make their case. The defense lawyer may, for example, want to ask a family simplistic questions such as, “does any (prospective) juror believe that a large insurance company with millions of dollars should pay every claim which is submitted to the company?” The obvious answer to this question is “no,” but a question such as this can begin to help to enable the juror to see the case from the insurer’s perspective. The defense lawyer should probably also directly address the potential issue of bias against a large insurance company with large reserves. She may want to ask, for example, “is any juror going to be more likely to side with the insured simply because my client is a large insurance company?” Or she may want to ask, “is any juror going to have trouble being fair to my client, simply because it is an insurance company?” The jurors may of course not respond to these questions truthfully, but these questions can still be useful in attempting to make the jurors realize that they need to be fair to both sides and that they need to be careful of their biases.

There are not many cases specifically addressing the questions that may be asked of jurors in a bad faith case. One case held that the insurer could make the jurors aware of several personal aspects of the insureds during voir dire, such as that the insureds were members of a country club, traveled to Europe, and had supported Republican politicians. Owens v. Mississippi Farm Bureau Cas. Ins. Co. 910 So.2d 1065, 1077 (Miss. 2005) (action for bad faith; “we find the questions were reasonably calculated to learn information about jurors, and possible contacts, affiliations and beliefs which might bear on the decision to exercise peremptory strikes of jurors”). The trial judge has broad discretion in allowing voir dire. Sentry Indem. Co. v. Peoples, 856 F.2d 1479, 1480 (C.A.11 1988) (insured “contend[ed] that the district court erred in prohibiting certain voir dire questions concerning prospective jurors' connections with

insurance companies”; matters are within “broad discretion” of the court, and party failed to object).

7. How to Create an Order of Witnesses

Both parties may want to file motions in limine to exclude prejudicial evidence coming before the jury. The insured may want to exclude evidence which may cast them in a negative light, such as a significant history of other insurance claims. The insurer may want to exclude evidence of its handling of other claims.

The opening statement in a bad faith case is quite significant for both sides. A coverage case typically presents complex issues, including the interpretation of an insurance policy, the inner workings of an insurance company and its adjusters, and the potentially complicated history of the claim and the losses sustained by the insured. Presenting this evidence at trial may be somewhat cumbersome and confusing. The opening statement gives both sides a good opportunity to educate the jury as to the “big picture,” which should assist the jury in understanding the evidence presented later.

Following the opening statements, the plaintiff, and then the defendant, will of course present evidence relevant to the claims being tried. At this point, it should be noted that if the fundamental underlying issue of coverage has not been determined, then the defendant-insurer has the right under G.S. § 1D-30 to bifurcate the trial between compensatory (or contractual) and punitive damages. G.S. 1D-30 (“Upon the motion of a defendant, the issues of liability for compensatory damages and the amount of compensatory damages, if any, shall be tried separately from the issues of liability for punitive damages and the amount of punitive damages, if any. Evidence relating solely to punitive damages shall not be admissible until the trier of fact has determined that the defendant is liable for compensatory damages and has determined the amount of compensatory damages.”).

As a procedural matter, it is not clear when this right must be asserted by the insurer. Out of an abundance of caution, the insurer should at least raise this as a possible means of trying the case in its answer. Further, the insurer should place the court and the

insured on notice of its intent to seek a bifurcated trial as soon as possible, without jeopardizing the defense.

Although the defendant has the right to a bifurcated trial, the defendant-insurer may not necessarily want to exercise this right. The strategic advantage for the insurer in having a bifurcated trial is to exclude any evidence of bad faith or aggravated conduct on its part. The insurer may also be able to avoid some testimony from the insured which may engender sympathy for the insured. The case would thus be tried as a straightforward coverage action, and the events during the claim process would be generally inadmissible. (The claims process could of course be rendered relevant if, for example, the plaintiff raises a coverage issue of waiver or estoppel, based on the insurer's conduct in handling the claim. Similarly, if the insurer raises a defense which negates coverage, such as a failure to comply with a condition of the policy, such as submitting a proof of loss form or cooperating with the insurer, then the insured's and possibly the insurer's conduct following the insured's loss may become relevant and admissible.)

On the other hand, the insurer may want to introduce evidence of the insured's conduct in the claims process, if that conduct may look suspicious or unreasonable. In such a case, the insured's conduct could potentially assist the insurer to prevail on the fundamental coverage issue. (By analogy, some defendants are successful in a tort action on the liability issue based on a suspicious damages case by the plaintiff.)

Another potential drawback to a bifurcated trial for the defense is that if the insured prevails on coverage, and the jury is then presented with additional evidence and instructions regarding bad faith and punitive damages, it may feel more compelled to regard this as a legitimate claim, and to award more substantial damages than it would award if it were ruling on both issues simultaneously.

It should also be noted that even if the evidentiary portion of the case is bifurcated, the jury must be questioned regarding its ability to award punitive damages during the selection process, and therefore issues such as bad faith and punitive damages and possibly even the insurer's net worth and income may become areas of inquiry with the prospective jury.

The same jury hears both aspects of the case. “The same trier of fact that tried the issues relating to compensatory damages shall try the issues relating to punitive damages.” G.S. § 1D-30.

It is not clear how the trials of the coverage action, Chapter 75 action, and the bad faith action are to be coordinated. In one case, the case was actually trifurcated. The first issue was damages (bodily injury); the coverage at issue was UIM, and therefore this was tantamount to a coverage action (i.e. how much was the insured entitled to recover under the policy). The court then tried the Chapter 75 claim, and finally tried the claim for punitive damages. Vazquez v. Allstate Ins. Co., 137 N.C.App. 741, 742, 529 S.E.2d 480, 481 (2000) (“Phase I dealt with the wrongful death claim against Mr. Brevard. Phase II addressed plaintiff’s claim for unfair and deceptive trade practices. Finally, in Phase III, the jury considered plaintiff’s claim for punitive damages.”).

The plaintiff must decide her order of witnesses. This can also be a very important and tricky aspect of the case. Under a more traditional approach, the insured would probably first testify on her behalf, and would provide evidence regarding the issuance of the insurance policy, the nature of the risk insured (such as home or medical expenses), would testify about the claims process, and, to the extent permitted, the general impact of the insurer’s claims handling conduct on her life. She would normally also provide the basic evidence regarding damages.

The plaintiff may also want to call as a witness one or more employees of the defendant-insurer. Such testimony is probably necessary to establish the claims process used in the particular case. These persons would presumably be hostile witnesses, which would allow the insured’s counsel to ask leading questions. The insured could also present evidence via deposition testimony of these employees. If so, then the testimony is probably more persuasive if presented by video.

An aggressive move by the plaintiff-insured would be to call the defendant-insurer’s adjuster as her first witness. The plaintiff may be more like to catch the witness unprepared, or not yet accustomed to courtroom procedures, but if the witness presents

well, then the jury's first impression of the insurer may be favorable. The insurer should therefore ensure that its witnesses are ready to testify at the outset of trial.

The insured may also want to consider use of an expert witness, in the field of claims handling. The admissibility of such testimony is addressed in a previous section. It appears that such testimony is probably admissible, if the witness has a proper background, and if his testimony will assist the jury. As with any expert, the appearance and demeanor of the witness is as important as his or her substantive knowledge. The expert witness may be useful in summarizing or synthesizing lots of claims information.

In an action for "bad faith" seeking punitive damages, Chapter 1D sets forth the matters that may be considered. The statute states that the jury:

- (1) Shall consider the purposes of punitive damages set forth in G.S. 1D-1 [to punish a defendant for egregiously wrongful acts and to deter the defendant and others from committing similar wrongful acts]; and
- (2) May consider only that evidence that relates to the following:
 - a. The reprehensibility of the defendant's motives and conduct.
 - b. The likelihood, at the relevant time, of serious harm.
 - c. The degree of the defendant's awareness of the probable consequences of its conduct.
 - d. The duration of the defendant's conduct.
 - e. The actual damages suffered by the claimant.
 - f. Any concealment by the defendant of the facts or consequences of its conduct.
 - g. The existence and frequency of any similar past conduct by the defendant.
 - h. Whether the defendant profited from the conduct.
 - i. The defendant's ability to pay punitive damages, as evidenced by its revenues or net worth.

N.C.G.S.A. § 1D-35.

Although this list of types of evidence would seem to be intended to narrow the admissible evidence in a bad faith case, some of the categories are fairly broad and may allow admission of a wide array of evidence. It appears that other "past" improper conduct by the insurer is admissible. The insured may argue that a pattern of improper denial of claims demonstrates the insurer's bad faith in denying his particular claim, and justifies a higher award. The insurer, in response, may still argue that other claims are

irrelevant and confusing and prejudicial, and will exhaust the court's time and resources. Although North Carolina has no appellate law addressing this evidentiary issue, both sides have a fairly solid argument.

In a recent federal case, involving a claim for bad faith, the court held that evidence pertaining to similar denials of coverage by the insurer was discoverable. In this case, the insured sought coverage for claims against it for antitrust violations (e.g. price-fixing). The insurer refused to disclose evidence about three similar cases in which it denied coverage. The court held that the insurer had to disclose the information, and that the concerns about confidentiality of those other claims were addressed by a protective order. Parkdale America, LLC v. Travelers Cas. and Sur. Co. of America, Inc. (W.D.N.C. 2007) (the court also noted that much of the information sought (regarding antitrust allegations) would be public record; 2007 WL 4165247, unpublished). See also Boileau v. Seagrave, 2008 WL 4630528, 3 (N.C.App. 2008) (in action for alienation of affection, for punitive damages, trial court acted within discretion in excluding evidence of similar adulterous conduct by defendant 30 years earlier; "even if the evidence of Defendant's prior conduct contains sufficient similarities to the present conduct and, thus, is probative of Defendant's conduct in this case, the passage of approximately 30 years between Defendant's prior acts and the acts charged diminishes the probative value of the evidence and enhances the tendency to cause unfair prejudice and confusion of the issues.").

In a case from another jurisdiction, the insurer challenged the admission of the following categories of evidence: "1. Evidence relating to first-party property claims; 2. Unsubstantiated allegations in class action lawsuits; 3. Verdicts in first-party cases; 4. Evidence of the conduct of a non-party sister company; 5. Evidence that State Farm employed predictable experts; 6. Evidence that State Farm engaged in hard ball litigation tactics; 7. Evidence that State Farm strongly encouraged first-contact settlements; and 8. Evidence showing that State Farm discriminated on the basis of sex and race." The appellate court held that the evidence was properly admitted. Campbell v. State Farm Mut. Auto. Ins. Co., 65 P.3d 1134 (Utah 2001), rev'd other grounds, 538 U.S. 408,

(2003) (trial court did not abuse discretion in allowing this evidence, as it was pertinent to the plaintiff's theme of the case; affirming punitive damages award of \$145 million in action based on failure to settle within limits).

In addition to experts on claims-handling issues, the parties may of course want experts in other fields, such as fire cause-and-origin and valuation (and cost-of-repair). The expert must, of course, have suitable qualifications. In a related vein, any experts used by the insurer in denying the claim should have adequate qualification, and the absence of such qualification may be evidence of bad faith. In one case in North Carolina, the insurer was adjusting a fire loss, and hired a person to estimate the cost of rebuilding the structure. This person was not, however, a licensed general contractor. The Court held that the use of an essentially unqualified expert was evidence of bad faith. Dailey v. Integon General Ins. Corp., 75 N.C. App. 387, 396, 331 S.E.2d 148, 155 (1985) (“defendant had an unlicensed builder, whose lack of qualifications to do the work were not checked, to examine the house, and it was a month after that before defendant offered to settle the claim based on that builder's estimate, which was grossly inadequate”).

Where the insurer relied on an expert to deny the claim, the extent to which that insurer routinely employs that particular expert may be relevant. Most cases hold that in general, the repeated use of the same expert tends to undercut the insurer's ability to rely on that expert. One case holds, however, that the mere use of the same expert in numerous cases is not, of itself, bad faith. McManus v. State Farm Lloyds 2004 WL 2533558, *4 (N.D. Tex. 2004) (“the evidence that Perdue receives substantial revenues from State Farm is not sufficient to raise a genuine issue of material fact whether State Farm acted reasonably in denying McManus' claim. State Farm is entitled to judgment as a matter of law on McManus' bad faith claim.”).

The insurance claim may sometimes raise a pure coverage issue, as distinct from a factual issue. In such event, the adjuster may have sought the advice of legal counsel regarding the coverage issue presented. North Carolina does not have any cases addressing the significance of the insurer's reliance on the advice of independent counsel when denying a claim, but this is probably not an absolute defense, at least where the

advice is contrary to settled law. See generally Culp v. Stanford, 16 S.E. 761, 761 (N.C. 1893) (“It is doubtful, to say the least, if the advice of counsel could be a defense where the law in favor of the ward's right to the fund had been so clearly settled by the authorities.”). The cases from other jurisdictions generally hold that the reliance on the advice of independent counsel is evidence that the insurer acted in good faith. “An insurer may defend itself against allegations of bad faith and malice in claims handling with evidence the insurer relied on the advice of competent counsel. The defense of advice of counsel is offered to show the insurer had ‘proper cause’ for its actions even if the advice it received is ultimately unsound or erroneous.” State Farm Mut. Auto. Ins. Co. v. Superior Court, 228 Cal.App.3d 721, 725, 279 Cal.Rptr. 116, 117-18 (1991).

One case held that the insurer acted improperly in failing to seek a coverage opinion prior to denying coverage. Country Club of Johnston County, Inc. v. United States Fid. & Guar. Co., 150 N.C. App. 231, 246-247 (2002) (affirming treble damages under Chapter 75 where, inter alia, “USF&G solicited an opinion letter from counsel only after having made its decision regarding coverage”).

In one case, the court suggested that the insurer’s retention of counsel for a legal opinion, after the insurer had already decided to deny coverage, was actually evidence of bad faith. Country Club of Johnston County, Inc. v. United States Fidelity & Guar. Co., 150 N.C. App. 231, 236, 563 S.E.2d 269, 273 (2002) (affirming Chapter 75 violation where jury found “USF & G solicit[ed] an opinion letter from counsel after having already made a decision to deny coverage.”).

The insurer should also be aware that if it relies on the “defense” of “advice of counsel,” that all communications to and from the attorney are probably subject to discovery. North Carolina does not have much authority on this issue. See generally Evans v. United Services Auto. Ass'n, 142 N.C. App. 18, 32, 541 S.E.2d 782, 791 (2001) (“Here, it appears that the twenty-one diary entries found by the trial court to be protected by the attorney-client privilege were either requests to counsel for advice and opinions, or were counsel's reply to such requests. Upon careful review of the record, we find no

evidence that the trial court abused its discretion when it ordered the partial production and partial protection of the claims diary entries.”).

Most cases hold that where the insurer does not rely on the defense of advice-of-counsel, that the privilege is maintained. Ring v. Commercial Union Ins. Co. 159 F.R.D. 653, 658 (M.D.N.C. 1995) (“Thus, the Court finds that plaintiff has failed to make a sufficient showing of bad faith to obtain defendants' work product in their claims file, must less the opinion work product. It is noted that defendants have not relied on advice of counsel as a defense which might cause the Court to reconsider its position.”); Ohio Cas. Ins. Co. v. Firemen's Ins. Co. of Washington, D.C. (E.D.N.C. 2008) (2008 WL 413847, unpublished) (excess insurer sought to depose two of primary carrier’s employees; primary carrier filed motion to establish that communications from its tort counsel to insurer were protected (and could not be explored at depositions); primary carrier “has not impliedly waived the attorney-client privilege because it has not put the legal counsel of its lawyers at issue by suing Firemen's.”). But see State Farm v. Lee, 13 P.3d 1169 (Ariz. 2000) (finding a waiver even where the insurer did not rely on the advice). See also Nationwide Mut. Fire Ins. Co. v. Burlon 172 N.C.App. 595, 617 S.E.2d 40 (2005) (insurer’s defense attorney’s communications with insured regarding coverage was privileged, but insured waived privilege).

The plaintiff’s case is enhanced with the use of exhibits. Any insurance policy language which is helpful for the insured should be presented to the jury in a user-friendly matter; similarly, any letters between the insured and insurer, and any documents in the insurer’s file which help the insured should be presented in a user-friendly manner, such as an enlargement.

Following the plaintiff’s presentation of evidence, the insurer may move for a directed verdict, either on the underlying coverage issue, or on the sufficiency of evidence of bad faith or aggravated conduct.

Assuming that the motion for directed verdict is not allowed, then the insurer may want to present additional evidence on its behalf to combat the evidence of bad faith conduct. The insurer may want to call additional employees to testify regarding the

claims process and to establish its “good faith.” The insurer would presumably be limited to those categories of evidence in G.S. § 1D-35. Under a very strict reading of those categories, the insurer could possibly be prevented from presenting evidence that it has changed (and improved) its claim-handling process, that it was sanctioned by a state agency (e.g. Department of Insurance), or that other insurers engage in similar practices.

The insurer in a given case may also want to use an expert to testify that its procedures were reasonable and customary. The value of a defense expert is enhanced if the insured has an expert himself. The admissibility of this evidence is discussed previously.

Following the conclusion of the evidence, the insurer should of course renew its motions for a directed verdict.

Assuming the case proceeds to the jury, then both sides may want to submit very specific instructions for the jury. The Pattern Jury Instructions may not be sufficient to address all applicable aspects of bad faith law.

In addition, the insured may want to submit interrogatories to the jury on its claim for unfair and deceptive trade practices. The cases generally hold that the jury finds facts which are relevant to the claim under chapter 75. The judge then decides, as a matter of law, whether those factual findings support a conclusion that the insurer violated Chapter 75. United Laboratories, Inc. v. Kuykendall, 322 N.C. 643, 664, 370 S.E.2d 375, 389 (1988) (“under N.C.G.S. § 75-1.1, it is a question for the jury as to whether the defendants committed the alleged acts, and then it is a question of law for the court as to whether these proven facts constitute an unfair or deceptive trade practice”). See also Country Club of Johnston County, Inc. v. United States Fidelity & Guar. Co., 150 N.C.App. 231, 236, 563 S.E.2d 269, 273 (2002) (judge submitted special interrogatories to jury, and imposed treble damages based on findings).

Regarding closing arguments, there are no cases from North Carolina, and research has disclosed no cases from other jurisdictions, providing any specific guidance on proper closing arguments in a bad faith case. The attorneys generally have wide latitude in their arguments. The insured may not, however, ask the jurors to place

themselves in the position of the insured. Fox-Kirk v. Hannon, 142 N.C. App. 267, 279, 542 S.E.2d 346, 355 (2001) (“in personal injury cases, as in criminal cases, a closing argument in which the jury is asked to put itself in the position of the injured party is improper”).

Under the recent decision from the United States Supreme Court in Philip Morris USA v. Williams, 127 S.Ct. 1057, 1060 (2007), the insured’s attorney must be careful to not argue that the jury should punish the insurer for acts which the insurer committed against other claimants. Id. (“We are asked whether the Constitution's Due Process Clause permits a jury to base that award in part upon its desire to punish the defendant for harming persons who are not before the court (e.g., victims whom the parties do not represent). We hold that such an award would amount to a taking of ‘property’ from the defendant without due process.”). The insurer may apparently argue, however, that those other violations are otherwise relevant to the jury in arriving at its award for punitive damages.

The insured’s general theme in many of these cases is “David v. Goliath.” The insured wants to stress that the insurance company used its superior bargaining position to try to force the insured into submission. If the insured can show that the insurer was at least reckless in its claim handling process, and especially if the insurer had a pecuniary motive in denying the claim (as opposed to a legitimate coverage dispute), then the likelihood of a substantial punitive damages award is enhanced.

The insurer will generally argue that its claims personnel followed their procedures. The adjuster has a duty to the insurance company for whom she works. Where the insurer is a publicly held corporation, then the adjuster is also essentially working for the benefit of its shareholders. The insurer may be able to argue that it has a duty to those shareholders. Blake v. Aetna Life Ins. Co., 99 Cal.App.3d 901, 924, 160 Cal.Rptr. 528, 542 (1979) (“Therefore, in the absence of evidence showing that the death was not a suicide, Aetna acted reasonably in withholding payment and continuing to investigate while it yet remained willing to pay the claim upon discovery of persuasive facts that death was accidental. Aetna thereby satisfied both its obligation to the plaintiff

to act fairly and in good faith and its obligation to other policy holders and to stockholders not to dissipate its reserves through the payment of meritless claims.”). But see McCormick v. Sentinel Life Ins. Co., 153 Cal.App.3d 1030, 1043, 200 Cal.Rptr. 732, 739 (1984) (“We accordingly reject any implication in Austero or Blake there is an equivalent duty, either in a first party or third party case, owed to an insurer's stockholders which may be balanced against the duty owed to its insured.”). Further, an individual adjuster generally has little to gain by denying a particular claim.

The insurer can also attempt to argue that the State, and the insured, has a remedy with the appropriate regulatory body. The insured may, for example, file a complaint with the North Carolina Department of Insurance. This potential administrative remedy should generally help to blunt an award for punitive damages. The insurer should of course also argue that an incorrect coverage decision by the insurer does not warrant punitive damages. The insurer is essentially given some “elbow room” to make errors in its adjusting decisions. Although the insured may be entitled to compensatory damages, an award of punitive damages may have the undesired effect of causing the insurance company to pay too many claims, or to pay too much on particular claims.

Finally, in a claim for punitive damages the insured must “prove the existence of an aggravating factor [e.g. willful and wanton conduct] by clear and convincing evidence.” N.C.G.S.A. § 1D-15(b). The insurer can therefore argue that the evidence does not meet this elevated standard, and perhaps the jury will rule for the insurer if the issue of bad faith is a “close call,” but it is not clear how this evidentiary standard actually plays to the jury.

8. Post-Trial Procedures and Appeal of a Coverage Case

Following the jury’s verdict, either side may of course move for a new trial. The standard under Rule 59 is fairly broad. The trial court’s ruling on this issue is rarely overturned on appeal. The losing party therefore has little to lose by filing a motion for a new trial.

In addition, the insurer may file for a JNOV following an adverse verdict. The essentially gives the judge a second opportunity to review the evidence to determine

whether the insurer's conduct was justified, or based on a reasonable interpretation of the policy, or instead, whether the insured presented sufficient evidence of bad faith.

North Carolina is still struggling with the computation of damages in a Chapter 75 case, and with the doctrine of election of remedies. Because treble damages and punitive damages largely serve the same purpose, the plaintiff must choose between those recoveries. "When the same course of conduct supports claims for fraud and for an unfair or deceptive trade practice under Chapter 75, recovery can be had on either claim, but not on both." Wilder v. Hodges, 80 N.C.App. 333, 334, 342 S.E.2d 57, 58 (1986). G.S. § 1D-20 ("A claimant must elect, prior to judgment, between punitive damages and any other remedy pursuant to another statute that provides for multiple damages.").

Either party may of course also appeal from any adverse rulings. The insured will typically appeal from any rulings which dismiss its claims. The insured may also want to appeal from the exclusion of any evidence, such as the exclusion of other instances of improper handling of claims by the insurer. The insurer may also appeal from any adverse evidentiary rulings, and also of course from the denial of its motion for a directed verdict (or JNOV).

The appeal of a bad faith case is fundamentally no different from any other appeal. At present, our appellate courts are construing several appellate rules rather strictly, and counsel is therefore well-advised to strictly comply with the appellate rules, and to err on the side of caution when preparing the record and briefs. The appealing party must be careful to include all relevant exhibits and other matters on appeal. The failure to do so may result in the loss of the appeal. In one case, for example, the insurer which appealed from an adverse ruling, but did not include the insurance policy in the record, was held to have forfeited its appeal, because the appellate court could not review the lower decision. Steve Mason Enters. v. City of Gastonia, 2007 N.C. App. LEXIS 1290 (2007).