2010

Chad Jones v. Farmers Insurance Exchange : Reply Brief

Utah Supreme Court

IN THE UTAH SUPREME COURT

CHAD JONES, Plaintiff and Appellant vs. FARMERS INSURANCE EXCHANGE, dba FARMERS INSURANCE COMPANY, Defendant and Appellee	Case No. 20100951

APPEAL FROM A FINAL JUDGMENT
THIRD JUDICIAL DISTRICT COURT
THE HON. MARK S. KOURIS

REPLY BRIEF OF APPELLANT

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RESPONSE TO FARMERS' "STATEMENT OF FACTS"

In his opening brief, Jones set forth a Statement of Facts with citations to the record. In response, Farmers has not disputed that Jones' facts are supported by the record. Instead, Farmers offers a competing statement of facts, drawing all inferences in its own favor and largely omitting facts supportive of Jones' version of events.

Farmers correctly notes that, "Whether an insured's claim is fairly debatable under a given set of facts is a question of law. However, because the complexity and variety of the facts upon which the fairly debatable determination depends, the legal standard under which this determination is made conveys some discretion to trial judges." (Appellee's Brief at *v* (ellipses omitted)), *citing Billings v. Union Bankers Insurance Co.*, 918 P.2d 461, 464 (Utah 1996).

Throughout its brief, however, Farmers overlooks the fact that the "given set of facts" in this case – the "facts upon which the fairly debatable determination depends" – are disputed. Even while acknowledging that Jones' statement is supported by the record, Farmers appears to assume that a trial court (or this Court) is entitled to weigh competing statements and decide for itself the underlying facts. That is not the kind of "deference" granted by this Court in *Billings*. If the material underlying facts are undisputed, then the trial court is afforded "some deference" in determining the insurer's reasonableness under those undisputed facts. *See, e.g., Prince v. Bear River Mutual Ins.*, 2002 UT 68, 56 P.3d 524 (undisputed that insurer relied upon independent expert report).

Nothing in this Court's precedent indicates that, on bad faith claims, a trial court is now authorized to weigh evidence and make findings of underlying fact when resolving a

motion under U.R.Civ.P. 56. Yet that is essentially what Farmers asked the trial court to do – indeed, the memorandum supporting its motion for summary judgment began with this sentence: "This case is about credibility and common sense." (R. 399.) Assessments of "credibility" have, by their very nature, traditionally been left to the finder of fact. *Salt Lake City v. Hughes*, 2011 UT App 128, ¶ 5, 253 P.3d 1118 (*quoting Reed v. Reed*, 806 P.2d 1182, 1184 (Utah 1991)).

On appeal, Farmers essentially asks this Court to weigh evidence as well, repeatedly relying upon disputed facts and inferences drawn in its own favor and, in some instances, affirmatively misstating facts. Some examples follow:

Throughout the case, Farmers has emphasized that there is no mention in the records of a potential head or face injury until four years after the accident. (*See, e.g.,* Appellee's Brief at *vii-ix, xi, xvii,* 5-6.) However, the very medical records cited by Farmers in support of summary judgment included a report in the emergency room of a "head crack." (R. 437.) Mr. Jones noted this in his opening brief. In response, Farmers argues that "'head crack' is not a recognized term in medical parlance, and that the correct handwriting on the cited page of the emergency room records is 'complains of pain upper thoracic area 'heard crack.'" (Appellee's Brief at *vii.*)

There are two problems with Farmers' argument. First, the words were put in quotation marks by the person making the record, which usually reflects what a reporting party is saying, rather than a recognized medical term. Second, even under Farmers' reading, a report of "hearing a crack" would hardly aid Farmers' position, given that Mr.

Jones simultaneously reported pain in both the upper thoracic and cervical (neck) areas. (R. 437, 445.)

Typically, injury to the neck occurs when there are unusually strong forces on the body and head that create whiplash. Without a medical opinion, a layperson is not legally competent to deny benefits based only on a "common sense" feeling that such whiplash motion would never cause cracked teeth, as Farmers assumed here. *See, e.g.,* R. 317 (adjuster stating that insured "does not even mention a blow to the head, facial bruise, contusion or anything like it. Nor does [claimant] mention a bump or blow to the head or face during ER visit.").

There was no medical evidence at all to support Farmers' apparent position that teeth cannot be injured without a direct impact. In fact, Farmers' own expert during the arbitration countered Farmers' "common sense" claim: "Q. But you have told us that he doesn't have to strike his head to have injury [to his teeth]. A. That's right, so has Dr. Hughes." (R. 571-572.)[1]

In several paragraphs (*e.g.,* 5-13), Farmers notes that Mr. Jones did not complain of pain in his head or jaw area at the time of the accident. (Appellee's Brief at *viii-ix.*) That, of course, is irrelevant – the evidence is undisputed that teeth may crack without causing pain at the time, as Farmers would have learned had its adjuster asked someone with a medical or dental background. (R. 575.)

[1] Anyone who has ever stepped off a curb unexpectedly and had his or her teeth slam together is aware of this "common sense" principle, to borrow Farmers' vernacular.

In paragraphs 19-20, Farmers mentions a notation by dentist Hughes that Mr. Jones reported "that he was in an automobile accident 4 years ago and injured his mouth," and that Mr. Jones indicated that "he was aware that he had broken his tooth but was involved with several medical procedures that took precedence." Farmers then notes that Mr. Jones had not complained about his broken tooth to a doctor previously. (Appellee's Brief at *xi*.) Farmers does not appear to dispute, however, that a broken tooth would constitute an "injur[y]" to his mouth.

Paragraph 21 contains a misleadingly incomplete quotation. In that paragraph, Farmers states that, after deeming Dr. Hughes' initial report inadequate, "Farmers sent Dr. Hughes a letter stating that 'your report indicates that you saw Mr. Jones on 9/14/2005 nearly four years after this loss occurred which obviously leads us to question causation. The purpose of this letter is to get your professional opinion on the cause of Mr. Jones teeth damage . . . .'" (Ellipse in original.) Significantly, however, Farmers fails to include the entire quote, which actually read "to get your professional opinion on the cause of Mr. Jones teeth damage and to get the following questions answered." (Emphasis added.) Farmers then set forth the list of specific questions it wanted Dr. Hughes to answer. (R. 460.)

None of those questions asked whether cracked or broken teeth would automatically cause pain, whether patients sometimes do not seek immediate medical attention for a broken tooth, etc. – in other words, Farmers asked no questions about the very assumptions it later cited as allowing a "common sense" denial. Farmers admits that, as requested, Dr. Hughes did give his opinion as to causation, and that he reasserted,

despite Farmers' stated concerns, that the tooth injuries were caused by the accident. Farmers says that Dr. Hughes did not offer any additional explanation for his opinion, but of course Farmers had not asked him to. Nor did Farmers ask whether Dr. Hughes's opinion hinged upon an assumption of physical impact, or inform Dr. Hughes that it had unilaterally decided to disbelieve Mr. Jones' report of the injury.

In paragraphs 24-25, Farmers quotes the conclusions of its own adjuster as to what the adjuster would have expected with broken teeth. Farmers does not identify what qualifications, if any, the adjuster had for making these bald assumptions. Did she have a medical background? Had she handled a dozen cracked-teeth cases before? Farmers does not say.

In paragraph 27, Farmers suggests that Dr. Richard Elggren (an expert retained by Farmers two years later for the arbitration) rendered an opinion that the accident did not cause Jones' teeth damage. Farmers sets forth a quotation attributed to Dr. Elggren ("causation to the accident cannot be concluded . . . ."), and says that Dr. Elggren gave opinions regarding potential alternate causes, citing to R. 469.

Importantly, there is no such report from Dr. Elggren in the record. R. 469 is an "Arbitration Position" drafted by Farmers' *attorneys* on November 14, 2009. (R. 465-469.) The only evidence in the record of Dr. Elggren's testimony is at R. 568-572, a portion of Dr. Elggren's deposition in which he testified that: (1) if Jones had no other trauma than from the accident, it is logical to assume the teeth were cracked in the accident; (2) he did not know of any other trauma; (3) he agreed that teeth can be cracked without striking the head; and finally, (4) he deferred to Dr. Hughes's opinions. (R. 571-

72.) The arbitration panel confirmed this in its award, stating: "The defense had a records review done by Dr. Elggren and he deferred to the plaintiff's treating physician, Dr. Hughes regarding causation and damage." (R. 563.)[2]

In paragraphs 28-31, Farmers claims that an unsigned document e-mailed by one of the three arbitrators on December 17, 2009, was "an arbitration award," and that Farmers is entitled to rely on wording in that document which was removed from the final award issued four days later. (The unsigned document said, "The evidence does not preponderate that the plaintiff hit his jaw or damaged his teeth in the accident." (R. 471.) The December 21 document removed the words "or damaged his teeth.") Thus, for example, Farmers argues, "The fact that a three-member arbitration panel agreed with Farmers that the teeth damage was not caused by the accident only underscores the legitimacy of Farmers' position." (Appellee's Brief at 14.)[3]

Farmers acknowledges that a second document was sent out December 21, 2009, but claims the arbitrators "did not sign this version, either." (Appellee's Brief at *xv*, ¶ 32.) That is incorrect. The December 21, 2009, award was signed. (R. 562-563.)

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[2] In its Summary of Argument, Farmers reiterates that "Dentist Richard Elggren opined that the teeth damage could not have been caused by the accident due to the fact that Mr. Jones reported no mouth pain for four years after the accident." (Appellee's Brief at *xviii*.) Again, there is no support in the record for such representation except for Farmers' self-serving position statement.

[3] Farmers also rewords the December 21 document at times. For example, Farmers says that "the arbitrators in this case flatly rejected his contention that he hurt his jaw in the accident..." (Appellee's Brief at 13.) No, the arbitrators said he had not hit his jaw. As discussed above, it is Jones' position that a whiplash-related injury may occur without a physical blow to the head or face. Farmers does not acknowledge Jones' position on this point. *See id.* at 12 (claiming that "the premise behind Mr. Jones' teeth damage claim [is] the notion that he hit his jaw in the accident").

Construing reasonable inferences in Jones' favor, the arbitrators did not find that Jones' teeth were not damaged in the accident, as Farmers wishes.

In paragraph 35, Farmers says that Mr. Jones has raised new issues on appeal from those raised in his motion for partial summary judgment. (Appellee's Brief at *xv-xvi* ("In his motion, Mr. Jones did not argue (as he does now on appeal) that Farmers had committed bad faith by not adjusting his UIM claim in a timely manner, by treating him as a lay person, by 'lowballing him', or by allegedly forcing him into arbitration.").) While the arguments made by a plaintiff in his own motion for summary judgment would seem irrelevant to review of an order granting an opponent's motion, Jones made all of these accusations against Farmers as part of his claim. *See* R. 56-84; *see, e.g.,* re: lowballing—paragraphs 65, 72, 82(a), 82(b), 82(c); forced to arbitrate—paragraphs 73, 82(e); untimely investigation and adjusting—paragraphs 70-72). In factual statements contained in the summary judgment briefing, Jones addressed and raised the facts relating to these aspects of the claim. (R. 254-261; 582-592.) Finally, during the hearing, Jones' counsel repeatedly emphasized that Farmers failed to timely investigate and made a lowball offer that forced Jones into arbitration. (R. 686 pp. 5-14, 33.) The trial court's application of the "directed verdict" standard for bad faith claims rendered all such assertions immaterial.

ARGUMENT

Introduction

In his opening brief, Jones argued that the trial court's grant of summary judgment was premised upon two incorrect legal principles. First, the court erroneously believed that, unless an insured can obtain summary judgment as a matter of law on his contract claim, then his claim is inherently fairly debatable, and any bad faith claims must be dismissed. Relatedly, the court appeared to assume that an insurer is so immunized even if the insurer conducted an inadequate or untimely investigation, failed to treat the insured as a layperson, and/or "lowballed" the insured in settlement discussions.

Jones pointed out that this Court has not squarely addressed either of these issues of law. While the Court has reaffirmed that it is not bad faith to "fairly debate" a claim, it has never articulated a "directed verdict" standard for bad faith claims, nor held that an insurer is completely immunized even if it violated other *Beck* duties to an insured's detriment. Jones then argued that, once the trial court's erroneous assumptions are corrected and the correct legal standard applied, then an issue of fact exists in this case, compelling reversal of the summary judgment.

Although Farmers chides Jones for arguing the legal standards before applying them to the facts of the case "late in his brief" (Appellee's Brief at 4), the disposition of a motion for summary judgment would seem to flow in that order: What law applies, and then, under that law, do material issues of fact exist?

I. IT IS NOT THE LAW IN UTAH THAT AN INSURED CAN ONLY PURSUE A BAD FAITH CLAIM IF HE CAN PROVE ENTITLEMENT TO HIS UNDERLYING INSURANCE CLAIM AS A MATTER OF LAW.

Farmers does not dispute that it argued below, and the trial court accepted, that an insured cannot maintain a bad faith claim in Utah unless he can establish his entitlement on the underlying contract claim as a matter of law. Indeed, Farmers reiterates that position on appeal. *See* Appellee's Brief at 3 ("Put another way, if an insured cannot establish that it is entitled to summary judgment on the merits of his claim, that means the claim is fairly debatable.").

Farmers implies that this standard has already been adopted by the Court, but the cases cited simply reiterate the general principle that the burden is on an insured to prove that an insurer acted unreasonably. None of the cases mention the directed-verdict standard urged by Farmers, let alone adopt it.

Farmers does not address Jones' contention that bad faith claims are still governed by U.R.Civ.P. 56, which requires the absence of material issue of fact for summary judgment to be granted. Farmers does not address multiple Utah Court of Appeals cases recognizing that – when facts are in dispute – bad faith is a "fact-intensive inquiry, ordinarily left for the fact-finder." (Appellants' Brief at 22-23, citing *Pugh v. North American Warranty Services*, 2000 UT App 121, *et al.*) Nor does Farmers address, let alone challenge, cases in other jurisdictions rejecting a directed verdict standard – including the Rhode Island Supreme Court, which initially adopted such a standard before abandoning it as unworkable. (*Id.* at 20-22.)

Farmers' principle support for a directed-verdict standard on bad faith claims is a truncated quotation from Stephen S. Ashley, *Bad Faith Actions Liability & Damages*, § 5.04 at 5-17, 5-18 (2d Ed. 1997). The treatise does indeed make the statement quoted by Farmers – but then spends the rest of the section describing how that statement is no longer valid law. The quoted language originated in *National Savings Life Insurance Co. v. Dutton*, 419 So.2d 1357 (Ala. 1982), which, as the author proceeds to explain, has largely eroded over the years, culminating in *State Farm Fire & Casualty Co. v. Slade*, 747 So.2d 293 (Ala. 1999), in which the Alabama Supreme Court "effectively spells the end of the directed verdict rule in Alabama." Ashley, § 5.04.[4]

In short, Farmers' brief glosses over why the directed-verdict standard applied by the court below should be adopted by this Court – Farmers simply assumes that it already is. By contrast, allowing such a standard would impose a virtually insurmountable burden on insureds, would prevent bad faith claims from ever reaching a jury, and is inconsistent with Utah law and public policy. (*See* Appellants' Brief at 20-23.) The fairly debatable defense remains a potent weapon for insurers without exempting them from the constraints of Rule 56 to which all other parties are subject.

II. THE "FAIRLY DEBATABLE" DOCTRINE DOES NOT IMMUNIZE AN INSURER THAT BREACHES OTHER DUTIES TO AN INSURED.

The second point of error addressed in Jones' opening brief was that the trial court erroneously assumed that an insurer is entitled to the protections of the "fairly debatable"

[4] *Slade* involved allegations that State Farm failed to properly investigate a claim, which the Alabama Supreme Court recognized as a valid issue for the jury to decide.

doctrine even if the insurer failed to diligently investigate the claim, or breached other of its *Beck* duties , such as failing to treat its insured as a layperson, or lowballing in settlement negotiations.

On this issue, Farmers makes an argument that appears inconsistent on its face, stating: "[T]he fairly debatable defense is a complete defense to a bad faith claim. While an insurer has a duty to diligently investigate the facts, fairly evaluate the insured's claim, and act promptly and reasonably in rejecting or settling the claim, the 'overriding requirement' of an insurer is to 'act reasonably, as an objective matter, in dealing with their insureds.'" *Id.*, citing *Saleh v. Farmers Insurance Exchange*, 2006 UT 20, ¶ 24, 133 P.3d 428, and *Billings v. Union Bankers Ins. Co.*, 918 P.2d 461, 465 (Utah 1996).

Farmers' response does not address the question at hand. The issue is: If insurers "act *unreasonably* . . . in dealing with their insureds" – *e.g.,* by failing to conduct a reasonable investigation – then is the fairly debatable doctrine still "a complete defense to a bad faith claim"? Most courts say no (*see* Appellants' Brief at 24-27), and Farmers has not challenged the reasoning of those cases.

This Court has likewise hinted, but not expressly held, that reliance upon the fairly debatable defense presupposes that the underlying investigation was appropriate. (*See* Appellants' Brief at 26, citing *S.W. Energy Corp. v. Continental Ins. Co.*, 974 P.2d 1239, 1243 (Utah 1999) (affirming summary judgment on fairly debatable claim; "Nothing in the record suggests that the insurer was dilatory or otherwise unreasonable in its investigation . . . .").) That only makes sense – otherwise, an insurer could stop its investigation after receiving only one piece of the puzzle, if it liked that particular piece.

Disturbingly, Farmers argues that insurers should be allowed to do that very thing – to stop investigating as soon as they find any evidence that, standing alone, might allow them to deny a claim. (Appellee's Brief at 4-5 (conceding that an investigation should be sufficient to allow a "good faith evaluation," yet urging that the duty extends only to the point "sufficient to sustain a denial of a claim" and "the insurer has no obligation to investigate beyond that point.").)

On this point, Farmers again cites Ashley, *Bad Faith Actions Liability & Damages*, implying that the author endorses the proposition that an insurer has fulfilled its duty to investigate when it has evidence to sustain a denial of the claim, and need do nothing further. That characterization is misleading. The author actually begins Section 5:8 with a warning: "If an insurer withholds payment of a claim in a first-party case based on its understanding of the facts, *it had better get its facts straight first.*" (Emphasis added.) He then articulates at length the principle that an insurer has a duty to *competently* investigate. *Id.*

Indeed, the treatise describes a California Supreme Court affirming a bad faith finding where an insurer failed to discuss a pertinent issue with a claimant's attending physician. "[I]t is essential that an insurer fully inquire into possible bases that might support the insured's claim," the treatise quotes. "[A]n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." *Id.*, quoting *Egan v. Mutual of Omaha Insurance Co.*, 24 Cal.3d 809, 169 Cal. Rptr. 691, 620 P.2d 141 (1979), cert. denied, 445 U.S. 912.

Mr. Ashley's treatise then describes in various ways that it is for the jury to consider the "competence of the insurer's investigators and the manner in which they investigated the claim in determining whether the insurer performed its duty." *Id.* at 1. Claims of failing to investigate properly are "thorny" and typically result in a "factual issue for the jury to resolve," the author observes. *Id.* at 4.

Farmers' contention – that an insurer may stop investigating as soon as it finds any ground to deny the claim – would encourage and endorse outcome-oriented investigations, designed to find sufficient facts to deny coverage but ignoring all other facts which may support the claim. That is hardly the "diligent" or objective investigation for which insureds pay premiums.[5]

This concept is illustrated by examining one of the cases cited by Farmers itself, *State Farm Lloyds, Inc. v. Alaska Polasek*, 847 S.W.2d 279 (Tex. App. 1992). Polasek's home burned down and State Farm immediately labeled the fire as suspicious. State Farm's fraud investigators investigated sufficient to find that the fire was of unknown origin, (1) incendiary in origin, (2) that the Polaseks had an opportunity to set the fire, and (3) Polaseks had financial stresses in their lives which created a motive. Finding these three red flags of arson, State Farm essentially discontinued its investigation. The jury found that there was no arson and awarded contract damages. In addition, it found that State Farm had violated its good faith duties and awarded bad faith damages.

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[5] Perhaps insurers could save time by always beginning their investigations with interviews of ex-spouses, where available.

The Texas Court of Appeals affirmed as to the contract damages but reversed as to bad faith, finding that some reasonable evidence existed for State Farm to deny the claim. The insured had the burden to prove there was *no* evidence that could support a denial, the court said. State Farm had no duty to pursue additional investigation once it found some evidence to justify a denial; a bad faith suit is not about the reasonableness of the insurer's conduct; the only issue is whether evidence supporting a denial "existed." *Id.* at 286-87.

Jones acknowledges that *Polasek*, if it remained valid law, might support Farmers' position. However, *Polasek* was heavily criticized by a sister Court of Appeals in *State Farm Fire & Casualty Co. v. Simmons,* 857 S.W.2d 126 (1993), which wrote: "We view *Polasek* as a virtual abrogation of the common-law duty of good faith and fair dealing.... *Polasek* just makes an insured's burden of proof virtually impossible." 857 S.W.2d at 134. The *Simmons* court elaborated:

> We position that *Polasek* has effectively removed the question of good faith and fair dealing from the factfinding process and has placed such question in a matter of law vacuum.
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> * * *
>
> The evil, now protected under *Polasek*, is that an insurer may simply investigate a claim in an outcome oriented manner, focusing solely upon any evidence that shades the issue in the insurer's favor. If factfinders are no longer authorized to "decide whether the insurer acted reasonably" are not insurers now free to determine their own actions or inactions as a matter of law? This is not only a dangerous precedent, it is frightening precedent.

Id. at 134-35. The court characterized the correct inquiry as: "Did the insurer fulfill its duty to the insured by pursuing a thorough, systematic, objective, fair, and honest investigation of the claim prior to denying such claim?" *Id.* at 136.[6]

On appeal, the Texas Supreme Court affirmed *Simmons*, confirming that "an insurer cannot insulate itself from bad faith liability by investigating a claim in a manner calculated to construct a pretext basis for denial." *State Farm Fire & Cas. Co. v. Simmons*, 963 S.W. 2d 42, 44 (Tex. 1998). In the case before it, the court found, "the jury could infer that State Farm conducted its investigation in a manner designed not to discover the objective facts, but only to defeat coverage." *Id.* at 45. Finally, the court emphasized, "[i]t is the insurer that has the duty to reasonably investigate a claim, not the insured. To adopt State Farm's position would simply turn that duty on its head." *Id.* at 47 (citations omitted).

Notwithstanding this reasoning, Farmers argues that, "[t]o complete a good faith evaluation, 'an insurance company simply must show that it conducted a review or investigation sufficiently thorough to yield a reasonable foundation for its action." (Appellee's Brief at 5, citing *Grammenos v. Allstate Ins. Co.*, 2009 WL 1152164, *5 (E.D.Pa. 2009).) But as noted, that would permit, rather than punish, outcome-oriented investigations by insurance companies. As soon as an insurer had any piece of evidence that, in isolation, would permit a denial, it could stop, even if a reasonable insurer would continue investigating.

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[6] The *Simmons* court demonstrated the Catch-22 created by *Polasek* by asking, "If the burden of proof be on the insured and we cannot look at the insured's evidence, then haven't we created an impossible burden for policyholders?" 857 S.W.2d at 134.

III. APPLYING THE CORRECT LEGAL STANDARDS, AN ISSUE OF FACT EXISTS AS TO WHETHER FARMERS BREACH ITS IMPLIED DUTIES OF GOOD FAITH AND FAIR DEALING.

Having addressed the applicable legal standards, a court must then apply those standards to the facts of the case. On this point, Farmers incorrectly claims that Mr. Jones did not complain below of being unnecessarily forced into arbitration two years later, or that Farmers inadequately investigated his claim. Farmers thus dismisses Mr. Jones' discussion of such untimely and inadequate investigation as "hypotheticals." (Appellee's Brief at 14-17.) Oddly, Farmers' basis for that contention is that, "When Mr. Jones moved for summary judgment shortly after filing his Complaint, he therefore narrowed the bad faith claim to contending that Farmers committed bad faith by not paying policy limits on his teeth damage claim." (*Id.* at 14.)

That argument is perplexing. First, it ignores the fact that Mr. Jones labeled his motion as one for "partial" summary judgment. (R. 254, 541.) Second, there is nothing in Rule 56 indicating that, if a plaintiff moves for summary judgment on one claim, he thereby waives all other claims he has asserted.

Farmers does offer several jury arguments for why it did not need to follow up with Dr. Hughes, or consult a medical professional before denying the claim. Thus, for example, Farmers argues that, had it hired its expert when it denied the claim rather than two years later, "it certainly would have cemented what was already fairly debatable." (Appellee's Brief at 13.) How? As the arbitrators noted, Dr. Elggren deferred to Dr. Hughes on both causation and damages.

According to Farmers, "Mr. Jones' real argument on appeal is that an insurer must leave no stone unturned, and must undertake every conceivable expense in evaluating a claim, before it can say that it had a legitimate reason to deny the claim." (Appellee's Brief at 13-14.) No, Mr. Jones' real argument is that an insurer must conduct a *reasonable* investigation and that, in *this* case, there is evidence from which a jury could find that Farmers breached that duty.

Considering that the stated reason for denying the claim was an adjuster's subjective belief that cracked teeth would immediately cause pain, why didn't the adjuster simply include that in her list of questions to Dr. Hughes? Before denying a claim on the assumption that teeth cannot crack without a physical blow to the head/face, why didn't she simply ask Dr. Hughes? How would it have cost Farmers' "thousands" of dollars to do so? There is no evidence in the record to support that bald declaration.

Ironically, Farmers complains that conducting any further investigation would have "dragg[ed] out indefinitely an evaluation of his teeth damage claim that Farmers was obliged to complete promptly." (Appellee's Brief at 4.) While Farmers' characterization is not very flattering of its diligence, a jury could find unreasonable – if not ironic – a suggestion that an insured would rather have a quick denial than an investigation of his claim. Nor does Farmers offer any explanation for why it did not even *mention* Dr. Hughes' reports in any of its subsequent "evaluations". A jury could find that fact intriguing as well.

Farmers cites, as authority for the proposition that it was not compelled to accept the bald statement of Jones's expert dentist at face value, *McIlravy v. North River Ins.*

Co., 653 N.W.2d 323 (Iowa 2003) (Appellee's Brief at 7). However, that case seems more supportive of Mr. Jones's position.

In *McIlravy*, the plaintiff injured his knee while walking on a level surface at his job site. He filed a workers compensation claim which was denied by North River Insurance Company, because he was not engaged in any work activity that placed stress or trauma on his knee, thus the injury was not work-related but was idiopathic. After successfully pursuing his workers compensation claim before the industrial commission, *McIlravy* filed a bad faith claim against North River[7].

North River moved for summary judgment, claiming that its denial was fairly debatable. McIlravy's claim was only supported by a medical report that expressed the "opinion, without explanation, that the injury was 'work-related'". In light of the fact that McIlravy was doing nothing but walking on a level surface, not carrying anything, North River had a reasonable basis for denying the claim (common sense). The trial court agreed and granted summary judgment.

The Iowa Supreme Court reversed, holding that, when viewing the facts and reasonable inferences in McIlravy's favor, triable issues of fact existed as to whether it was fairly debatable. The *McIlravy* court first explained the proper standard for reviewing whether a denial was fairly debatable as a matter of law. Unlike the standard urged by Farmers here, the court first indicated that an insurer's conduct is fairly debatable as a matter of law only if the underlying facts are materially uncontroverted –

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[7] Iowa law allows an employee to bring a first party bad faith claim against the employer's workers compensation insurer and applies the same general principles of first party bad faith law as in other insurance contexts. *McIlravy*, *supra*, at 329.

"when, viewing the record in the light most favorable to the claimant, there is no substantial evidence to support the elements of the claim, i.e., that the insurer lacked a reasonable basis for denial and that it knew or should have known it lacked such a basis." *Id.* at 331 (citations omitted).

The court also recognized that the "inquiry must focus on the defendant's initial denial as well as 'whether, at some later date, [the insurer] became aware there was no reasonable basis to continue denying plaintiffs' claim.'" *Id.* (quotation and brackets in original; citations omitted).

After reviewing the record, the Iowa court found that, although the initial denial might have been fairly debatable, North River received additional information from the McIlravy's doctor that, due to the McIlravy's profession of heavy lifting, "the nature of his profession placed him at greater risk for knee injuries than other professions." *Id.*at 332. This new information then imposed upon North River a duty to conduct "a further investigation" and "to seek another medical opinion to refute or confirm [the doctor's opinion]," which it did not do. These failures "transform[ed] the reasonableness of the continued denial by North River into a jury question." *Id.* at 333.

> North River rejected the medical opinion of the treating physician without explanation, and continued to rely upon its fact-based position that the injury only coincidentally occurred to McIlravy while he was at work. However, North River had no medical evidence to support this position, and had knowledge that the only medical evidence in the case rejected the position.
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> * * *
>
> North River failed to obtain medical evidence to explain why the injury was probably just a coincidence of employment, and not a natural incident of the work

> performed by McIlravy. Consequently, a jury issue was generated whether or not this denial constituted bad faith.

Id. at 333, n. 4.

The same can be said in this case. Even if Dr. Hughes' initial report was unsatisfactory, Farmers later received a second report directly responding to the specific questions asked by it. At that point, a jury could find that a reasonable insurer would either have paid the claim or conducted some additional investigation – *e.g.,* follow up with Dr. Hughes, consult Dr. Elggren, run the file past a nurse, anything beyond simply omitting Dr. Hughes' opinions from its evaluations.

A jury could find that Farmers' selective investigation and/or reliance upon alleged "common sense" was not only unreasonable, but pretextual. In this regard, *Wilson v. 21st Century Insurance Co.*, 171 P.3d 1082, 42 Cal.4th 713 (Calif. 2007) is informative. In *Wilson*, the insured was in an automobile accident caused by a drunk driver. Her physician opined that the accident probably caused degenerative disk changes, and Ms. Wilson made a claim with 21st Century under her underinsured motorist (UIM) coverage.

The insurer did not consult with a medical professional. Instead, its adjuster applied his own alleged common sense. Noting that the insured had later traveled out of the country, the adjuster wrote, "Why is she in Australia if her injury is so severe?" He also speculated that "[Wilson] is young and may not experience any pain in future from degenerative disk." The adjuster looked at the MRI himself and opined that it "does not show bulge touching the nerves."

Two years later, Wilson retained an attorney, who demanded arbitration. Only then did 21st Century have the records reviewed by an independent physician, who contradicted the adjuster's lay opinion. The insurer then paid its policy limits. Wilson subsequently brought a bad faith action based upon the initial denial and ensuing delay. The trial court dismissed the action on the grounds that the denial was reasonable as a matter of law, but the California Court of Appeal and Supreme Court both disagreed.

The Supreme Court began its analysis by observing that, under the covenant of good faith and fair dealing, an insurer cannot deny a claim "without fully investigating the grounds for its denial. . . . A trier of fact may find that an insurer acted unreasonably if the insurer ignores evidence available to it which supports the claim. The insurer may not just focus on those facts which justify denial of the claim." 171 P.3d at 1087.

Noting that the adjuster had disregarded the treating physician's report, the court said,

> 21st Century directs us to no medical report or opinion on the basis of which the claims examiner could reasonably have ignored or disbelieved Dr. Southern's conclusion that the changes in Wilson's cervical spine were probably caused by her recent trauma . . . . Nor is there any apparent medical basis for the claims examiner's assertion that Wilson had preexisting degenerative disc disease. No such diagnosis appears in the medical reports submitted to 21st Century, and we are directed to no evidence that the company's claims examiner had sufficient medical expertise to make such a diagnosis himself.

Id.

The court recognized that, to the extent that 21st Century had good faith doubts,

> the insurer would have been within its rights to investigate the basis for Wilson's claim by asking Dr. Southern to reexamine or further explain his findings, having a physician review all the submitted medical records and offer an opinion, or, if necessary, having its insured examined by other physicians (as it later did). What

> it could not do, consistent with the implied covenant of good faith and fair dealing, was ignore Dr. Southern's conclusions without any attempt at adequate investigation, and reach contrary conclusions lacking any discernable medical foundation. A jury could reasonably find 21st Century did so here.

171 P.3d at 1088 (emphasis in original). The jury could likewise find that other concerns had been cited "not in genuine dispute of her claim's value, but as a pretext or rationalization for denying it," the court added. *Id.* at 1090.

The same could again be said here. If doubt truly remained after Dr. Hughes answered its questions, Farmers would have been within its right to investigate. "What it could not do . . . was ignore Dr. [Hughes'] conclusions without any attempt at adequate investigation, and reach contrary conclusions lacking any discernable medical foundation." Issues of fact exist in this case regarding the reasonableness of Farmers' conduct, and the order granting summary judgment should be overturned.

CONCLUSION

For the reasons set forth above, appellant respectfully requests that the Court reverse the judgment of the trial court.

DATED this 4th day of October, 2011.

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CERTIFICATE OF SERVICE

This is to certify that on the 4th day of October, 2011, two true and correct copies of the foregoing **REPLY BRIEF OF APPELLANT** were mailed, postage prepaid, to:

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