SUPREME COURT
OF THE COMMONWEALTH OF KENTUCKY
NO. 2004-SC-000874

GEICO CASUALTY COMPANY — APPELLANT

Appeal from Court Of Appeals
Of The Commonwealth Of Kentucky
No. 2003-CA-001134
Appeal from Meade Circuit Court
Honorable Sam H. Monarch, Judge
No. 01-C1-195

ROBERT HARTLEY, ET AL — APPELLEE

APPELLEES' BRIEF

** ** ** ** ** ** ** **

M. AUSTIN MEHR
TIMOTHY E. GEERTZ
Austin Mehr Law Offices, P.S.C.
145 West Main Street, Suite 300
Lexington, Kentucky 40507
Telephone: 859-225-3731
Attorneys for Appellees

CERTIFICATE OF SERVICE

This is to certify that a true and accurate copy of the foregoing has been served on this 12TH day of September, 2005, upon: Clerk, Supreme Court of Kentucky, 209 Capitol Building, 700 Capital Avenue, Frankfort, KY 40601; Clerk, Court of Appeals, 360 Democrat Drive, Frankfort, KY 40601; Perry Bentley and Lucy Ferguson, Stoll, Keenon & Park, 300 West Vine Street, Suite 2100, Lexington, KY 40507-1801; J.D. Raine, Jr., Ferreri & Fogle, 333 Guthrie Green, 203 Speed Building, Louisville, KY 40202; The Honorable Sam Monarch, Judge Meade Circuit Court, First Division, Courthouse, Courthouse Square, PO Box 147, Hardinsburg, KY 40143-0147; and Clerk, Meade Circuit Court, Courthouse, 516 Fairway Drive, Brandenburg, KY 40108. I further certify that the record on appeal has been returned to the office of the Meade Circuit Court.

M. AUSTIN MEHR

STATEMENT CONCERNING ORAL ARGUMENT

Appellees request oral argument to discuss the extent of the role of post-complaint conduct in a bad faith case. Also, conditioning insurance claim payments upon the total release of the insurance company from bad faith claims should be addressed by this Court, as it has been in numerous other states. Finally, the existence of a cause of action for bad faith in the handling of a PIP claim literally affects every person injured in an automobile collision. Oral argument will be helpful in addressing these varied issues.

COUNTER-STATEMENT OF POINTS AND AUTHORITIES

COUNTER-STATEMENT OF THE CASE

On June 29, 2000, Daniel Robert Hartley, the 15-year-old son of Appellees Robert Hartley and Brenda Mitchum, was riding his bicycle when he was struck and killed by an automobile driven by Joy B. Barr. (Court Record, hereinafter "CR," 3). Barr had automobile insurance with Appellant GEICO Casualty Company ("GEICO"). (Id.). Accordingly, GEICO was obligated to pay Appellees up to $10,000 in basic reparations benefits, including benefits for medical expenses pursuant to Kentucky Revised Statute ("KRS") 304.39-050.[1]

On August 29, 2000, during settlement negotiations for the personal injury claim that arose from the accident,[2] Appellees applied to GEICO for basic reparation benefits on the approved PIP form. While indicating that medical bills had been incurred, they requested that GEICO pay $1,000 in funeral expenses and, because their health insurance carrier was paying the medical providers directly, asked GEICO to pay the remaining $9,000 for survivor's replacement services loss. (CR 55-56, App. 1). GEICO requested proof to substantiate this claim (CR 57), and Appellees responded with a September 22, 2000 letter that attempted to describe and value the household activities that Daniel had performed prior to his death. (CR 8). GEICO then rejected Appellees' claim outright, stating, "According to caselaw, ... there are no survivor benefits for this situation...You are not entitled to survivor benefits for your son." (CR 161 App. 2).

On April 9, 2001, Appellee Mitchum submitted a letter and copies of medical bills totaling $10,293.31 to GEICO and, although mentioning her belief that survivor's replacement benefits were owed, indicated that, in the alternative, she would modify her

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[1] GEICO has never disputed this obligation. (See CR 130).
[2] That claim was settled a month later for the policy limits of $25,000. (See CR 57).

basic reparations claim to one for medical expenses. (CR 5-7, App. 3). Mitchum enclosed copies of the medical bills. In the letter, Mitchum expressed a concern that GEICO was "unreasonably" withholding the benefits that were owed and indicated that the estate wanted to give GEICO "one last opportunity to do the right thing and issue payment to the estate in the amount of $9,000.00 (CR 5-6). GEICO summarily denied the claim for medical expenses and, through its attorney, J.D. Raine, responded to Mitchum's correspondence with a hostile April 17, 2001 letter, calling Mitchum's correspondence "threatening" and warned Appellees to "not threaten us idly." Despite GEICO's clear rejection months earlier that "there are no survivor's benefits for this situation," GEICO now required Appellees to show all receipts and cancelled checks from family non-family members, for whomever "took out the trash" and from "whomever washed the dishes." (CR 13-14, App. 4).

However, GEICO also responded to the medical expense claim, stating:

> Had you submitted the medical bills concerning Daniel which are attached to your letter at the time they were incurred, those would have been paid without question, up to the applicable policy limit. The fact of the matter is, in this case, you have not provided adequate proof of the fact and the amount of loss.

(CR 14). This odd response was submitted despite the fact that Appellees had submitted medical bills when modifying their claim, a fact of which GEICO was fully aware and, as shown above, actually acknowledged in its letter.

Appellees instituted this action against GEICO on June 28, 2001, to recover $9,000 for unpaid medical expenses and/or survivor's benefits, interest thereon at 18% (pursuant to KRS 304.39-210), attorney's fees (pursuant to KRS 304.39-220), and

damages for bad faith (pursuant to KRS 304.12-230 and 304.12-010). (CR 2-14).[3] GEICO's July 18, 2001 Answer admitted an obligation to pay medical expenses in cases "similar to the one at hand," but denied that it owed Appellees $9,000 in basic reparation benefits, even though it acknowledged that Mitchum had submitted medical bills on April 9, 2001. (CR 22-24, denying paragraph 9 of the complaint).

Rather than send payment of the $9,000 balance of the PIP benefits, GEICO filed an offer to confess judgment for the sum of $9000, which "represent[ed] medical bills incurred by the estate of Daniel Hartley, together with the taxable Court costs incurred by the Plaintiffs up to the time of the filing of this Answer." (CR 25-26). This offer, if accepted, would have required Appellees to forego statutory interest, statutory attorney's fees, and all damages for bad faith. Most notably, the offer was for less than what GEICO was legally required to pay, as the trial court later acknowledged. (See CR 121).

On August 10, 2001, Appellees filed a motion for summary judgment, and supporting memorandum, to recover the owed medical expenses, for 18% interest on the $9000 owed and attorney's fees pursuant to KRS 304.39-210 and KRS 304.39-220, arguing that their claim for medical benefits was denied without reasonable foundation. (CR 30, 33-34). GEICO responded again by denying it owed benefits because the amount of medical payments due had not been proven and was in dispute, despite the fact that Appellees had tendered full and complete medical bills four months earlier. (CR 47).[4] GEICO also claimed that the initial PIP application filed by Mitchum (in her capacity as Administratrix) indicated that there were no outstanding medical bills. (CR

[3] Appellees filed a First Amended Complaint and Jury Demand on July 3, 2001. (CR 15-17).
[4] Of course, it is the duty of the insurer to obtain medical records and bills if it is unsatisfied with those submitted by the injured party. See Kentucky Farm Bureau Mutual Insurance Co. v. Roberts, Ky. App., 603 S.W.2d 498 (1980).

47-48).[5] However, the PIP application in question placed a "?" in the space regarding the amount of medical bills. (CR 52, 56).[6] Mitchum never indicated that there were no outstanding medical bills. Indeed, as noted, she submitted to GEICO copies of medical bills totaling $10,293.31.[7]

After a hearing and steady requests for payment of the owed benefits from Appellees (See, e.g., CR 217-18), GEICO still refused to tender any of the owed basic reparations benefits. During this hearing (CR 263-67, App. 5), counsel for GEICO continued to argue that payment of medical benefits would afford a "double recovery" to Appellees (CR 266) and that the amount owed was in "dispute," (Id.) even though GEICO had never submitted any remotely reasonable argument contradicting what was requested by Appellees.

On November 30, 2001, the trial court issued an Opinion and Order finding as a matter of law that GEICO had no basis to reject Appellees' claim for medical expenses (CR 78, 80), and that Appellees had established that the estate was owed $9000 for medical expenses. (CR 79). The trial court further determined that "GEICO failed to dispute the amount of the medical bills or offer any other legally recognized reason for denying the claim for reimbursement of medical expenses" and denied Appellees' claim "without reasonable foundation." (CR 81). It consequently awarded the estate $9,000, interest thereon at the rate of 18 per annum from May 9, 2001 (30 days after proof of

[5] GEICO also argued that it had already paid $4700 in medical expenses to Appellees. (CR 47). However, it failed to mention that this payment was made pursuant to the personal injury claim asserted against GEICO's insured for $25,000. (CR 50-51). This, of course, had no bearing on GEICO's separate obligation to pay medical expenses under PIP.

[6] Later in this litigation, GEICO would deny that a PIP application had even been filed. (CR 75-76, 275).

[7] The medical bills submitted are presumed to be reasonable under KRS 304.39-020(5)(a).

compensable medical expenses was filed with GEICO), and attorney's fees. (CR 77-82, App. 6).

Following the decision, GEICO tendered a check for $9000, designating it as "in payment of satisfaction of judgment." (CR 101). This attempted accord and satisfaction failed to pay both the 18% interest awarded by the trial court and attorney's fees (Id.) and would have eliminated Appellees' claim for bad faith. (CR 103-04). When counsel for Appellees offered to take a check for $9,000 with an understanding that it constituted a partial payment of the judgment (CR 100), GEICO refused, posturing that it was Appellees "who chose to prolong the litigation," (CR 102). GEICO next filed a meritless motion to set aside judgment, with supporting memorandum, asking the trial court to set aside its award of 18% interest and attorney's fees. (CR 84-88). When counsel for Appellees again requested that GEICO pay the $9,000 unconditionally (CR 103-04), GEICO failed to comply. On January 17, 2002, GEICO finally tendered an unconditional check for $9,000, well over nine (9) months after Appellees' April 9th letter requesting payment of the medical bills.

On February 15, 2002, the trial court entered an Opinion and Order overruling GEICO's motion to set aside judgment and again telling GEICO to pay 18% in interest. (CR 121-22). In particular, the court affirmed that GEICO "tendered to the Plaintiffs an amount less than what it was legally required to pay,"[8] which did "not absolve [GEICO] of its obligation to satisfy the BRB claim." (Id.). Curiously, the trial court also stated, without citation of authority, that the attempted tender "may, however, be a defense to the

[8] As the trial court noted, "Even in the absence of an unreasonable denial of a BRB claim, a claimant is entitled to 12% interest." (CR 121).

remainder of Plaintiffs' claims (for bad faith and punitive damages)." (CR 122).[9] The trial court also awarded $1000 "as an allowance toward reasonable attorney's fees." (Id.).[10]

After an exchange of pleadings by both parties dealing with GEICO's motion for summary judgment, (CR 185-232, 233-47, 251-82, 283-90, 291-315, 316-18), the trial court entered an Opinion & Order on April 30, 2003 dismissing Appellees' bad faith claim. (CR 319-30). This appeal followed. (CR 331-32). On September 17, 2004, the Court of Appeals issued an Opinion affirming in part, reversing in part, and remanding the case to the Meade Circuit Court.[11] Of particular relevance here, the Court held: (1) KRS 304.39-210 and 304.39-220 are not the exclusive remedies for a basic reparation benefits provider's violations of the Unfair Claims Settlement Practices Act ("UCSPA") and the common law tort of bad faith; and (2) the question of whether the aforementioned April 9, 2001 letter could be viewed as a claim for medical benefits (and was acknowledged as such by GEICO) is a question of material fact to be submitted to a jury.

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[9] This statement ultimately proved to be the first indication on the part of the trial court that it planned to eventually enter a summary judgment for GEICO. Indeed, in an April 16, 2002 Opinion and Order partially granting and partially overruling a motion to compel filed by Appellees (CR 123-26), the court essentially invited GEICO to file a motion for summary judgment, stating, "The Defendant shall either produce all requested, non-privileged documents to the Plaintiffs ... or shall file a motion for summary judgment with respect to the now outstanding issues ...." (CR 126).

[10] Appellees previously had filed a motion for attorney's fees, with supporting affidavits, asking the trial court for $7323.75 for the time spent seeking payment of the medical benefits. (CR 108-19). No opposing response was filed by GEICO.

[11] See attached App. 7.

ARGUMENT

1. The Court of Appeals Correctly held that a Cause of Action Exists for Violations of the UCSPA in the Handling of BRB Insurance Benefits.

a. KRS 304.39-210 and 304.39-220 Do Not Provide Any Remedy, Much Less an "Exclusive" Remedy for Conduct Which Violates the UCSPA, or KRS 304.12-010.

Appellees' complaint alleges violations of numerous sections of the UCSPA as well as KRS 304.12-010. These statutes proscribe very specific, as well as broad general claims practices, which are viewed as being against the public interest. Contrary to KRS 304.39-210 and KRS 304.39-220, violations of the UCSPA, and the other statutes contained in Subtitle 12 – Trade Practices and Frauds, do give rise to private causes of action if one can meet the higher proof requirements that those statutes require. For instance, whereas the "delayed payment" prohibitions contained in Subtitle 39, require one only to show payment was not made within 30 days, a cause of action under the UCSPA requires showing there was refusal to pay a claim without conducting a reasonable investigation; or a lack of "good faith" attempt to effectuate a fair and equitable settlement; or that an insured was compelled to institute litigation to recover amounts due under the policy.[12] Likewise, Appellees have alleged a violation of KRS 304.12-010, which likewise requires proof of an unfair method of competition, deception, or an unfair act in the business of insurance. Thus, the conduct proscribed, and the proof

[12] A clear statutory violation of the Unfair Claims Settlement Practices Act, in particular KRS 304.12-230(4) ("Refusing to pay claims without conducting a reasonable investigation based upon all available information") and KRS 304.12-230(6) ("Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear"); and KRS 304.12-230(7) (compelling insureds to institute litigation to recover amounts due under a policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds). GEICO's written response to the claim for medical benefits which curiously warned Brenda Mitchum to "not threaten us idly" was followed by nine months of baseless denials of owing for Daniel's medical bills and attempts to condition payment upon a full release of the bad faith claims.

required to substantiate a remedy for violations of the UCSPA and Subtitle 39, are very different.

Appellant contends that the Court of Appeals' decision here is in direct conflict with its decision in Phoenix Healthcare of Ky., LLC v. Kentucky Farm Bureau Mut. Ins. Co., Ky. App., 120 S.W.3d 726 (2003) and thereby confuses the state of the law. In particular, Appellant takes issue here with the Court of Appeals' reliance upon FB Insurance Co. v. Jones, Ky. App., 864 S.W.2d 926 (1993), a decision that the Phoenix Healthcare panel did not consider. Based on FB Insurance, the court below concluded that Phoenix Healthcare "is limited to actions brought to recover for a late payment, and has no impact on suits regarding the conduct, if any, behind the delay in payment."[13] Appellant contends that FB Insurance is inapplicable here because the statute at issue in that case, KRS 304.12-235, provides only for 12% interest for delayed settlement of insurance claims. Appellant contends that since KRS 304.39-210(2) provides for 18% in "punitive" interest if the delay is "without reasonable foundation," that such remedy is wholly distinguishable from KRS 304.12-235 which limits interest to 12%.

This argument, however, is lacking for a number of reasons. First, as the Court of Appeals noted in its Opinion, KRS 304.12-235(3) also allows for the awarding of attorney's fees if a delay in payment is "without reasonable foundation." Moreover, while Appellant argues that KRS 304.12-235 does not contain a "punitive" interest component, the statute actually provides for a penalty of 12% per annum interest for a "[failure] to make a good faith attempt to settle a claim within the time prescribed." Accordingly, the statutes in question are much more closely related in that both the

[13] Opinion at 11-12.

conduct proscribed (delayed payment) and the remedy allowed (interest and attorney's fees) are identical. But, as held in FB Insurance, KRS 304.12-230 addresses entirely different kinds of behavior than the payment deadline statute, KRS 304.12-235. FB Insurance, at 929. The Court further noted: "KRS 304.12-235 appears to be intended as a prod to prevent laxity in the adjustment of claims. KRS 304.12-230, however, speaks out against more egregious behavior." Id. Accordingly, the court rejected the argument that a statute, which allows for recovery of interest and attorney's fees, provided the exclusive remedy for violation of the UCSA.

Consequently, applying the logic of the court of appeals in FB Insurance, KRS 304.39-210(2) likewise would not preclude a cause of action under the UCSPA, which "speaks out against more egregious behavior." Therefore, the Court of Appeals' reliance upon its precedent in FB Insurance is entirely reasonable and consistent.

Moreover, as this Court recognized in Farmland Mutual Insurance Co. v. Johnson, Ky., 36 S.W.3d 368 (2000):

> The KUCSPA is part of a large statutory scheme entitled, the "Insurance Code." The Insurance Code regulates the insurance industry, and an insurance company derives its right to do business in Kentucky from the Code. The Code and the UCSPA within it relate to a class encompassing all insurance companies doing business in Kentucky that are regulated by the Kentucky Insurance Commissioner. Thus the statute does not relate to only particular persons or things in that class.

Id. at 380 (Emphasis added). Therefore, piecemeal application of the UCSPA and the duty of good faith and fair dealing in general has been rejected in Kentucky. Furthermore, as this Court recognized in The Travelers Indemnity Co. v. Reker, Ky., 100 S.W.3d 756 (2003), the Kentucky Insurance Code (Chapter 304) "does not include an

'exclusive remedy' provision prohibiting private causes of action for its violation." Id. at 763. Consequently, there is nothing within KRS Chapter 34—or subtitle 39—to suggest that the Motor Vehicle Reparations Act precludes a private cause of action for bad faith such as the one presented here.

It should likewise be noted that Subtitle 39, the Motor Vehicle Reparation Act, is not limited to basic reparation benefits, but also includes statutes dealing with loss of use of motor vehicle (KRS 304.39-115), underinsurance motorist coverage (KRS 304.39-320); and liability insurance (KRS 304.39-110). Certainly this Court has recognized the viability of bringing a cause of action for bad faith involving the mishandling of liability insurance and underinsurance coverage. Kentucky Farm Bureau v. Troxell, Ky., 959 S.W.2d 82 (1997); State Farm v. Reeder, Ky., 763 S.W.2d 116 (1988)

b. The Court of Appeals Was Correct Not to follow Phoenix Healthcare, Which Applied the Law to Different Facts.

The Court of Appeal's Opinion distinguished the present case in an effective and understandable manner by holding that Phoenix Healthcare only applied in instances involving late payment and not the conduct behind late payment.[14] The Phoenix Healthcare opinion that KRS 304.39-210 provides the exclusive remedy available to Phoenix Healthcare of Kentucky, the assignee of the medical provider, was specifically limited to "the facts of this case." Phoenix at 727. The only unlawful conduct alleged against Kentucky Farm Bureau by Phoenix Healthcare, was that they delayed the payment of a basic reparation benefit for 16 days, all the while notifying Phoenix that it was conducting a peer review regarding the unpaid bill. Two weeks after its 30 days deadline (which was arguably extended because it had notified Phoenix that it was

[14] Opinion at 11-12.

seeking additional information), Kentucky Farm Bureau paid $2,345.95 for the MRI, which exhausted all PIP benefits available. Phoenix at 727. Except for the mere delay in payment, there were absolutely no other facts alleged by Phoenix Healthcare against Kentucky Farm Bureau. Phoenix did not complain about the more egregious conduct,as alleged by Appellees herein, and as proscribed by the following subparts of the USCPA: failing to adopt and implement reasonable standards for prompt investigation (subpart 3); refusing to pay claims without conducting a reasonable investigation (subpart 4); and not attempting in good faith to effectuate prompt, fair and equitable settlement of claims (subpart 6). Since Phoenix Healthcare was paid before it sued, there was no allegation of compelling insureds to institute litigation to recover amounts due under a policy (subpart 7). Since Kentucky Farm Bureau sent a letter on April 24, 2002, indicating the payment was "withheld pending a peer review" and paid seven days later,[15] there was no allegation of "failing to promptly provide a reasonable explanation of the basis in the policy for denial of the claim or the offer of a compromise settlement." (subpart 14)

The Court of Appeals has the authority and, indeed, the duty to modify or distinguish its own decisions when the facts or a reasonable view of the law merit. See, e.g., Thomas v. Commonwealth, Ky., 931 S.W.2d 446, 447 (1996). As noted by the concurring opinion below, "Phoenix Healthcare was erroneously decided and the Court

[15] The opinion in Phoenix Healthcare states that "Farm Bureau was two weeks late in making payment to Phoenix," although this is not clear from the facts stated in the opinion. Phoenix mailed an invoice on March 14th to Farm Bureau , however, the 30 day period for the payment of all claims does not begin to run until the insurer has received the proof of claim (KRS 304.12-235) for general insurance claims and 30 day time under KRS 304.39-210, states benefits are overdue 30 days after the basic reparations obligor receives reasonable proof of the fact and amount of the loss realized. However, the basic reparation obligor can accumulate claims for periods not exceeding 31 days after the reparation obligor receives reasonable proof and amount of loss realized, and pays them within fifteen (15) days after the period of accumulation. There was no discussion as to whether Kentucky Farm Bureau had elected to accumulate claims and pay within 46 days, which in fact it did.

of Appeals panel in Phoenix Healthcare failed to follow FB Insurance which was binding precedent." Opinion at 17.

The Phoenix opinion also did not discuss this Court's decision in Kentucky Farm Bureau Mut. Ins. Co. v. Troxell, Ky., 959 S.W.2d 82 (1997), in which the Kentucky Supreme Court implicitly recognized that a claim for lost wages under PIP could support a claim for punitive damages for insurance bad faith and unfair claims settlement practices. In Troxell, the plaintiff brought suit for recovery of UM benefits and lost wages, as well as a cause of action for bad faith and unfair claims practices. The jury returned a verdict in favor of the plaintiff for $3000 in lost wages and $775,000 in punitive damages. On appeal, the Court recognized that the plaintiff's "claims for bad faith and unfair claims settlement practices were premised on both UM and lost wage theories." Id. at 85. The jury instructions reflected this fact. Id. However, because the Court found that the plaintiff presented insufficient evidence of lost wages, and because the jury's justification for punitive damages could not be specifically ascertained (that is, it could have been partially based on the unproven element of lost wages), bringing the factual basis for the award into question, the Court remanded the case for another bad faith trial. Id. Accordingly, from this decision, it is clear that a claim for lost wages under PIP can support a claim for punitive damages for bad faith claims handling. Since punitive damages are not explicitly provided for in any manner under the MVRA, it is clear that they could only be procured via a cause of action brought outside of the purview of the act—one for a violation of the UCSPA.

The Court of Appeals opinion distinguished the facts of Phoenix Healthcare from the case at hand in a consistent and logical manner, recognizing that the Phoenix

Healthcare opinion is self-limited to facts involving a mere two week delay in payment. Accordingly, there is no inherent conflict between the two that merits addressing by this Court.

2. Appellees' Complaint Meets the Evidentiary Threshold Applicable to Bad Faith Claims Under the UCSPA.

Appellant next contends that the Court of Appeals erred by failing to recognize that there is no evidence of "bad conduct" by GEICO. This contention is incorrect, however, as it fails to acknowledge the facts that were before the Court of Appeals and the trial court.[16]

In Wittmer v. Jones, Ky., 864 S.W.2d 885 (1993), this Court outlined the three elements that a plaintiff must prove in order to prevail against an insurance company on a theory of bad faith refusal to pay a claim: "(1) the insurer must be obligated to pay the claim under the terms of the policy; (2) the insurer must lack a reasonable basis in law or fact for denying the claim; and (3) it must be shown that the insurer either knew there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed." Id. at 890 (quoting Federal Kemper Insurance Co. v. Hornback, Ky., 711 S.W.2d 844, 846-47 (1986) (Leibson, J., dissenting)); see also Farmland Mut. Ins. Co. v. Johnson, Ky., 36 S.W.3d 368 (2000). This test "applies to a claim of bad faith made by an insured against his own insurer, and a fortiori to a third-party's claim of bad faith against an insurance company." Wittmer, 864 S.W.2d at 890.

In its Opinion and Order of November 30, 2001, the trial court correctly found that GEICO was obligated to pay Appellees' claim for reimbursement of medical

[16] It should be noted that the trial court granted summary judgment without allowing any discovery. The claims file was initially ordered to be produced, upon a motion to compel filed by Appellees, but the trial court gave GEICO the option of filing a motion for summary judgment. (CR 126).

expenses once they submitted medical bills to GEICO on April 9, 2001. It further found that this claim was subsequently denied "without reasonable foundation." (CR 81). Accordingly, the trial court recognized satisfaction of the first two prongs of the Wittmer test. GEICO contended in its Memorandum in Support of Its Motion for Summary Judgment, however, that "[t]his is a case of misunderstanding, not a case of bad faith," (CR 133) and that Appellees "have no evidence that GEICO acted in an outrageous, reckless or evil manner." (CR 135). While the trial court agreed with this contention, the Court of Appeals did not, and with good reason.

The trial court originally found—with little difficulty—that Appellees were entitled to $9000 in basic reparations benefits for medical expenses when they submitted Daniel's medical bills to GEICO on April 9, 2001. GEICO argued that its failure to pay this claim was justified because the claim was not "clear," but the trial court, at first, rejected this argument.

However, in its April 30, 2003 Opinion & Order, the trial court essentially did an about-face on this issue and, indeed, acknowledged as much:

> In paragraph #3 [of the April 9, 2001 letter], the claimant included language that this Court previously interpreted as being a claim for medical bills (which in fact were clearly payable); however, upon reflection, paragraph #3 could as easily have been read as simply an argument in favor of paying the disputed "survivors benefit claims ...

(CR 321). The court ultimately concluded that while it "originally interpreted [the April 9, 2001] letter as a claim for medicals," it was "now inclined to interpret the letter as an argument in favor of paying the survivor's benefit claim." (CR 325-26). Consequently, since the trial court apparently had become "less certain as to the intent of the April 9, 2001 letter," it ruled that the letter was "ambiguous and that as a matter of law a

misinterpretation of the same (if in fact GEICO's interpretation was a 'misinterpretation'[)] does not constitute 'outrageous conduct' sufficient to support an award of punitive damages." (CR 328).

This change in position on the part of the trial court is odd and unsupported by the record. GEICO's April 17, 2001 letter responding, to Appellees' letter, indicates clear knowledge on its part that it was obligated to reimburse Appellees for any submitted medical bills. Although the trial court characterized this letter as "offer[ing] little of a constructive nature," (CR 321) it not only indicated an acknowledgment on the part of GEICO that a claim for medical benefits had been submitted,[17] but also a flat, unsubstantiated refusal to pay them. (CR 13-14). Despite this clear knowledge, GEICO continued to deny payment of medical benefits claim and created a "dispute" as to the amount of bills owed when the matter was not up for debate. In light of this, GEICO's refusal to pay what it owed, despite this clear knowledge, is the epitome of the third prong of the Wittmer test.[18]

This fact also evidences a clear statutory violation of the Unfair Claims Settlement Practices Act, in particular KRS 304.12-230(4) ("Refusing to pay claims without conducting a reasonable investigation based upon all available information") and 304.12-230(6) ("Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear"); and 304.12-230

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[17] "Had you submitted the medical bills concerning Daniel which are attached to your letter at the time they were incurred, those would have been paid without question, up to the applicable policy limit." (CR 14).

[18] As a general principle, "questions of intent are usually more appropriately left for the fact-finder and not for disposal in summary judgment." Employers Insurance of Wausau v. Martinez, Ky., 54 S.W.3d 142, 145 (2001) (citation omitted). Of course, to succeed in a bad faith claim under Wittmer, a plaintiff must show either knowing conduct or reckless disregard on the part of the insurer.

(compelling insureds to institute litigation to recover amounts due under a policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds). GEICO's written response to the claim for medical benefits which curiously warned Brenda Mitchum to "not threaten us idly" was followed by nine months of baseless denials of owing for Daniel's medical bills and attempts to condition payment upon a full release of the bad faith claims. Accordingly, Appellees have established enough evidence (without discovery) to allow a trier of fact to find in their favor on all necessary elements of a bad faith claim. Certainly, it also remains to be discovered what information can be gleaned from GEICO's undisclosed claim file about its knowledge of the nature of the claim, and its intent.

Moreover, in order to defeat a cause of action for insurance bad faith, it is not enough for an insurer to insist that the claim was "fairly debatable." Here, GEICO has argued that its conduct was "erroneous," but was not in bad faith because "it would have paid [the medical benefits] had Ms. Mitchum made a proper claim." (CR 133). As stated by the Supreme Court of Kentucky in Farmland Mutual Insurance Co. v. Johnson, Ky., 36 S.W.3d 368 (2000): "Although matters regarding investigation and payment of a claim may be 'fairly debatable,' an insurer is not thereby relieved from its duty to comply with the mandates of the KUCSPA." Id. at 375. An insurer is still "obligated under the KUCSPA to investigate, negotiate, and attempt to settle the claim in a fair and reasonable manner." Id. As the Supreme Court further noted, "[A]lthough elements of a claim may be 'fairly debatable,' an insurer must debate the matter fairly." Id.

Moreover—and particularly important in considering a motion for summary judgment—"whether a claim or the amount of a claim is fairly debatable is a question of

fact for the jury and [ ] the fact of a disputed amount does not relieve the insurer of its duty to handle the claim fairly." Id. at 376 (emphasis added). Whether or not there is a violation of the UCSPA, should be argued before a trier of fact during a trial. Dailey v. American Growers Ins., Ky., 103 S.W.3d 60, 66 (2003). If the parties had a valid point of contention about the manner in which the claim was adjusted, that also should be put before a trier of fact. Dailey at 66. Accordingly, the fact that GEICO has argued that its conduct was "fairly debatable" (i.e., an innocent misunderstanding) in and of itself makes this case inappropriate for summary judgment.

Furthermore, there is substantial evidence already, without any discovery, from which a jury could conclude that Appellees' claim was not debated fairly, and that GEICO's conduct was intentional or in reckless disregard of Appellees' interests. Even though GEICO made an offer to confess judgment on July 19, 2001, it continued to take the specious position that medical benefits were not payable and that the amount owed was in dispute. (See CR 263-66). Moreover, its claim of "misunderstanding" and its efforts to place blame on Appellees for not trying to clear up that a claim for medical benefits was being made (See, e.g., CR 234-37) is belied by the correspondence submitted to the trial court. (See CR 13-14, 217-18, 269).

It should also be noted that Appellees were afforded no opportunity to conduct discovery in their bad faith claim. GEICO was given the option by the trial court to either comply with an Opinion and Order partially granting Appellees' motion to compel,[19] or to file a motion for summary judgment. (CR 126). Appellees never received any of the discovery for which they asked. As this Court has recognized, although

[19] This motion was based upon a December 7, 2001 request for production of documents. (CR 83).

completion of discovery is not needed for entry of summary judgment, a "suitable opportunity" to conduct discovery must be made available prior to a granting of summary judgment. See Hollins v. Edmonds, Ky. App., 616 S.W.2d 801, 804 (1981); see also Vance v. U.S., 90 F.3d 1145, 1148 (6th Cir. 1996) ("[S]ummary judgment is improper if the non-movant is not afforded a sufficient opportunity for discovery."). In this case, Appellees were not afforded the required "suitable opportunity."

This is particularly important when one considers that GEICO's primary argument below was that Appellees could not show the requisite "intent or reckless disregard" needed for bad faith. Had it been produced, GEICO's claims file on this matter would have provided a significant indication of thle company's attitude and motivation in handling the claim. Because of the entry of summary judgment, however, Appellees were never afforded the opportunity to investigate the file. Thus, summary judgment was inappropriate.

b. GEICO's Offer to Confess Judgment and Subsequent Tender of $9000 is Not an Affirmative Defense to Appellees ' Bad Faith Claim.

GEICO also argued that its offer to confess judgment and tender of $9000 to Appellees constituted an affirmative defense to the bad faith claim. GEICO explained the motivation for this offer thusly:

> Moreover, when the plaintiffs finally made an [sic] clearclaim for medical benefits, GEICO promptly Offered to Confess Judgment in the amount of $9,000.00—a mere twelve (12) weeks after the initial April 9, 2001 "claim" for medical expenses.[20]

[20] Interestingly, the complaint provided no more information to GEICO than the Plaintiffs had supplied on April 9, 2001, a fact realized at some point during this appeal, thus GEICO has modified its pitch on the complaint – "Since the complaint seemingly made a claim for medical benefits..." (Brief at p. 9)

(CR 7-8). The trial court apparently agreed with GEICO's position in rendering summary judgment. However, an offer to confess judgment is not a claim payment. It was not an attempt to settle an insurance claim, but an attempt at a global dismissal of a bad faith claim as well. It was an attempt on the part of GEICO to avoid the consequences of its behavior by offering Plaintiffs the $9000 to which they were entitled months earlier only if they dropped the bad faith claim against GEICO.

Rather than demonstrating a lack of bad faith on the part of GEICO, this offer itself can and should be viewed as additional evidence of bad faith. An attempt by an insurer to leverage settlement of an insurance claim upon release of a bad faith claim has been held by a number of jurisdictions to be an act of bad faith. See Athey v. Farmers Insurance Exchange, 234 F.3d 357, 362 (8th Cir. 2000); National Insurance Association v. Sockwell, 829 So. 2d 111, 137 (Ala. 2002); Harter v. Plains Insurance Co., 579 N.W.2d 625, 634 (S.D. 1998). Moreover, the Supreme Court of Kentucky has recently recognized that an insurer's efforts to include terms of settlement in a release that were not discussed in the settlement can preclude entry of summary judgment in a bad faith case based upon this settlement conduct. See Frear v. P.T.A. Industries, Inc., Ky., 103 S.W.3d 99 (2003). This is consistent with the Supreme Court's position that the UCSPA "applies only to insurance companies and their agents in the negotiation, settlement and payment of claims made against policies, certificates or contracts of insurance." Davidson v. American Freightways, Inc., Ky., 25 S.W.3d 94, 98 (2000) (emphasis added).

c. Post-Complaint Litigation Can be Considered as Evidence of Bad Faith.

GEICO next argues that all of its conduct occurring after the filing of the complaint is not actionable as a matter of law. Appellant's position is contrary to the law

which has existed in this state since the tort of bad faith was first recognized in 1989 in the case of Curry v. Fireman's Fund, Ky., 784 S.W..2d 176 (1989).

The Supreme Court in Curry overruled Federal Kemper Ins. Co. v. Hornback, Ky., 711 S.W.2d 844 (1986), adopting as law in this state a claim for first party bad faith as discussed in Justice Liebson's dissenting opinion in Federal Kemper. Significantly, this Court in Curry stated as follows:

> Our decision in Federal Kemper abolished tort liability to a policyholder, regardless of the conduct of the insurance carrier. Such a rule permitted an insurance carrier to deny payment without any justification, attempt unfair compromise by exploiting the policyholder's economic circumstance, **and delay payment by litigation** with no greater possible detriment than payment of the amount justly owed plus interest. (Emphasis added). Curry at 178.

Thus, clearly when this Court established the tort of bad faith, it contemplated that such cause of action would rectify insurance conduct which delayed payment by litigation.

This Court has most recently affirmed that belief in Frear v. P.T.A. Industries, Inc., Ky., 103 S.W.3d 99 (2003), remanding a bad faith case back to the trial court which had granted summary judgment to the insurer. The case was remanded to allow the appellants to proceed on their bad faith breach of contract in violation of the UCSPA, even though all of the conduct occurred during litigation. Id. at 104, 108.

The fact that this particular act of bad faith on the part of GEICO occurred after suit had been filed does not diminish the duty of good faith and fair dealing that it owed to Plaintiffs. Indeed, an overwhelming majority of courts recognize that this duty is a continuing one that extends even after the initiation of litigation, with the prevailing sentiment being that post-complaint conduct of an insurer is subject to scrutiny in a bad faith suit. It should be a basic proposition that the duty of good faith and fair dealing

extends to the "assertion, settlement and litigation of contract claims and defenses." Restatement (Second) of Contracts § 205 cmt. e (1981). Indeed, this is the viewpoint that was adopted by the Supreme Court of California in the seminal case on the issue of post-complaint bad faith, White v. Western Title Ins. Co., 710 P.2d 309 (Cal. 1985).[21] In White, the insurer also contended that, "once suit has been filed, the insurer stands in an adversary position to the insured and no longer owes a duty of good faith and fair dealing." Id. at 316. The court, however, rejected this contention, stating: "It is clear that the contractual relationship between insurer and the insured does not terminate with commencement of litigation.... It could not reasonably be argued ... either that the insurer no longer owes any contractual duties to the insured, or that it need not perform those duties fairly and in good faith." Id. at 317. The court further noted:

> Defendant's proposed rule would encourage insurers to induce the early filing of suits, and to delay serious investigation and negotiation until after suit was filed when its conduct would be unencumbered by any duty to deal fairly and in good faith. Defendant responds that such delay would itself be a breach of the implied covenant, but the incentive would remain, especially since the insured would find it difficult to prove the prelitigation conduct unreasonable if it could not present evidence of the postlitigation conduct by way of contrast. The policy of encouraging prompt investigation and payment of insurance claims would be undermined by defendant's proposed rule.

Id. (emphasis added).

Other courts have examined the issue and have reached similar conclusions. For example, the reasoning of the White decision was expressly adopted by the Court of

[21] All non-Kentucky cases cited to in this brief are attached collectively in the Index.

Appeals of Arizona in Tucson Airport Authority v. Certain Underwriters of Lloyd's et al., 918 P.2d 1063 (Ariz. Ct. App. 1996). The court explained:

> The gravamen of TAA's bad faith claim is not a communication, but a course of "wrongful and tortious" conduct evidenced by the insurers' actions and communications during the coverage actions.... The duties [of good faith and fair dealing] would be rendered meaningless if, as we understand these insurers to argue, the litigation privilege could be employed to excuse a breach of those duties, which occurs as part of the conduct of a coverage action.

Id. at 1066.

Moreover, in Graham v. Gallant Insurance Group, 60 F.Supp.2d 632 (W.D. Ky. 1999), the United States District Court for the Western District of Kentucky concluded that, under Kentucky law, "there is no question that the duty of good faith by an insurance company is a continuing duty, which continues past the filing of a bad faith complaint against the insurer." Id. at 635.[22] As the court further noted: "Because of this continuing duty, there may be evidence of post-filing conduct that is relevant to the bad faith claim." Id. Tucson Airport Authority and Gallant, however, are just examples of the continuing duty of good faith post-complaint; a sizable number of other courts have reached the same conclusion.[23]

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[22] It should be noted that Graham also identifies White v. Western Title Ins. Co. as the seminal case on the issue of the admissibility of post-complaint conduct. Graham, 60 F. Supp.2d at 634.

[23] See, e.g., Lincoln Elec. Co. v. St. Paul Fire and Marine Ins. Co., 10 F.Supp.2d 856, 873 (N.D. Ohio 1998) ("St. Paul is under a continuing obligation to act in good faith when processing Lincoln Electric's claims. This is true up to and after the point in time when St. Paul sued Lincoln Electric in March of 1996."); UTI Corp. v. Fireman's Fund Ins. Co., 896 F.Supp. 362, 368 (D.N.J. 1995) (applying Pennsylvania law) ("[A]n insurer has a continuing obligation to act in good faith towards its insured, which obligation extends through litigation."); Journal Publishing Co. v. American Home Assurance Co., 771 F.Supp. 632, 635-36 (S.D.N.Y. 1991) (applying New Mexico law) (holding that allegations regarding insurance company conduct during litigation were "sufficient to support finding" of bad faith); Southerland v. Argonaut Ins. Co., 794 P.2d 1102, 1106 (Colo. Ct. App. 1990) (post-complaint conduct admissible as evidence of bad faith because it was "merely a continuation of the same difficulties that preceded the filing"); Home Insurance Co. v. Owens, 573 So. 2d 343, 344 (Fla. Dist. Ct. App. 1990) (holding that "the insurance

GEICO's offer to confess judgment was nothing more than an effort to extort a release of Plaintiff's bad faith claim and should be presented to a jury as such.

3. Whether GEICO Acted Reasonably In Its Purported "Interpretation Of The April 9th Letter" As Yet Another Claim For Survivor's Benefits Cannot Be Resolved On Summary Judgment, Especially Without Discovery.

While Appellants were granted no discovery, GEICO argues that this Court must accept as a factually undisputed matter that (1) GEICO did, in fact, interpret the April 9, 2001 letter as yet another claim for survivor's benefits, and (2) that such interpretation (questioned even by the trial court) was reasonable. Both of these matters are factual issues that are lacking in any evidence. Perhaps the claims file, when produced, will reveal whether GEICO viewed the April 9, 2001 letter as a claim for medical benefits. It is troublesome to believe that GEICO made such a misinterpretation, especially in light of GEICO's continuous refusal to pay the medical expense for other reasons. GEICO's lawyer admitted in Court that they understood the claim to be for medical benefits –

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company's litigation conduct was admissible, relevant evidence"); Gooch v. State Farm Mut. Auto. Ins. Co., 712 N.E.2d 38, 43 (Ind. Ct. App. 1999) ("If, indeed, this position was made in bad-faith, we are unwilling to allow State Farm to escape liability because its bad-faith attempt to enforce a provision of Gooch's insurance policy was a 'litigation position.'"); Gregory v. Continental Ins. Co., 575 So. 2d 534, 541 (Miss. 1990) ("An insurance company's duty to promptly pay a legitimate claim does not end because a lawsuit has been filed against it for nonpayment. Put more bluntly, if you owe a debt the duty to pay does not end when you are sued for nonpayment of it."); Spadafore v. Blue Shield Ohio Medical Indem. Co., 486 N.E.2d 1201, 1204 (Ohio Ct. App. 1985) ("[E]vidence of the breach of the insurer's duty to exercise good faith occurring after the time of filing suit is relevant so long as the evidence related to the bad faith or handling or refusal to pay the claim."); O'Donnell v. Allstate Ins. Co., 734 A.2d 901, 906 (Pa. Super. Ct. 1999) ("[W]e find that the broad language of section 8371 was designed to remedy all instances of bad faith conduct by an insurer, whether occurring before, during or after litigation. In so finding, we refuse to hold that an insurer's duty to act in good faith ends upon the initiation of suit by the insured."); Mid-Century Ins. Co. v. Boyte, 80 S.W.3d 546, 549 (Tex. 2002) (stating that "an insurer's good faith duties end when 'the only legal relationship between the parties following entry of judgment [is] that of judgment creditor and judgment debtor' ") (citation omitted); Sentry Ins. v. Siurek, 748 S.W.2d 104, 107 (Tex. App. 1987) (holding that post-complaint conduct was sufficient to support a jury finding of bad faith: "This result does not change, even considering that the trial court did not limit the jury's consideration of bad faith to a period prior to litigation. Having exclusive control over the claims process, the insurance company limits its exposure by paying the claim.").

"Then when she realized she couldn't get survivor's economic loss, she comes along and says, okay, now give me these medical bills. Well they've been paid. These are cases that say you can't make a double recovery." J.D. Raine at 9-6-01 hearing. (CR 266). Such conduct certainly belies any argument that it was confused over the nature of the claim.

b. It is clear that Ms. Mitchum removed her written directive to reserve monies for survivor benefits in the April 9, 2001 letter.

Mitchum clearly gave a directive to pay $9,000 of benefits to the estate for either survivor's benefits or medical benefits. Appellant's cite KRS 304.39-241 as prohibiting them from paying any of the remaining monies for medical expenses because they alleged Ms. Mitchum had previously reserved on August 29, 2000, the balance of $9,000 for survivor benefits. The fallacy with Appellant's argument is that it was Brenda Mitchum who reserved the balance of $9,000 for survivor benefits (not any other survivor) and, it was Brenda Mitchum who gave a written directive on April 9, 2001 to pay the balance for medical benefits. It is difficult to imagine GEICO's proposition – that Ms. Mitchum could complain that GEICO acted in bad faith by honoring her subsequent directive which clearly superceded her own prior directive. How could Ms. Mitchum (or anyone) complain about GEICO following her own directive?

4. Plaintiffs Have a Legitimate Claim for Additional Punitive Damages Against GEICO and Are Not Statutorily Precluded From Bringing Such a Claim.

Finally, Appellant argued that the Court of Appeals erred by reversing summary judgment because there was "insufficient evidence of damage," a prerequisite for a claim

of bad faith. Again, no discovery was permitted before the Court granted summary judgment.[24]

No interrogatories have been tendered by Appellant regarding the extent of damage suffered because of the bad faith. But more importantly, compensatory damages had already been recognized and ordered to be paid by summary judgment. Certainly the Court's awarding attorney's fees and interest, as compensatory damages, would suffice to serve as a prerequisite for additional punitive damages.[25]

Appellants err when they say that the time period for damages is limited to April 9, 2001 through June 28, 2001 when the offer to confess judgment was tendered. An offer to confess judgment would eliminate the exact relief which is being sought herein as a condition of receiving what the Appellees were entitled to anyway. Furthermore, an offer to confess judgment is not a payment. Only an actual claim payment stops the continuous breach of the duty of good faith.

GEICO also contended that Appellees have been made whole and consequently have no claim for further damages because it was ordered to pay the $9,000 claim for medical expenses plus 18% interest and attorney's fees. Appellees also have asserted a claim for emotional distress, inconvenience, embarrassment, and humiliation, which provides another source for compensatory damages and, consequently, punitive damages. Such damages are recoverable in a bad faith action. See Motorist Mutual Insurance Co. v. Glass, Ky., 996 S.W.2d 437 (1997). Appellant's attack on the truth of that evidence is simply more appropriately addressed by a trier of fact.

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[24] Even though the Defendant had been ordered to produce the claims file.

[25] It should be noted that Appellee's actual damages, by way of attorney's fees, was substantially more than the $1,000 awarded by the trial court.

Furthermore, an argument that Plaintiffs are not entitled to punitive damages because they have been made whole, confuses the distinction between compensatory and punitive damages. "The object of compensatory damages is to make the injured party whole to the extent that it is possible to measure his injury in terms of money." Kentucky Central Insurance Co. v. Schneider, Ky., 15 S.W.3d 373, 374 (2000) (citation omitted). "Punitive or exemplary damages, on the other hand, are not intended to compensate a victim for his or her loss, but are designed to punish or deter a person, and others, from committing such acts in the future." Burgess v. Taylor, Ky. App., 44 S.W.3d 806, 814 (2001). The very fact that Plaintiffs had to institute litigation and ultimately had to be "made whole" by summary judgment proves the damage upon which punitive damages are predicated. The only thing unique about the present case is that the jury does not have to "compensate" (except for emotional damage), the trial court having entered summary judgment. Accordingly, GEICO is not entitled to a summary judgment on the issue of punitive damages.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully ask this Court to affirm the September 17, 2004 opinion of the Court of Appeals, which reversed: the trial court's Opinion & Order of April 30, 2003, granting summary judgment to GEICO on the issues of bad faith and punitive damages and issue an opinion that post-complaint conduct can be used as evidence, by either side, in a bad faith trial and that a cause of action for the handling of a PIP claim for BRB benefits in violation of the UCSPA is permissible.

M. AUSTIN MEHR
TIMOTHY E. GEERTZ
Austin Mehr Law Offices, P.S.C.
145 West Main Street, Suite 300
Lexington, Kentucky 40507
Telephone: 859-225-3731
Facsimile: 859-225-3830
Attorneys for Appellees