IN THE SUPREME COURT OF OHIO

DAVID E. JAY, Plaintiff-Appellee, v. MASSACHUSETTS CASUALTY INSURANCE COMPANY, Defendant-Appellant.	SUPREME COURT CASE NO.: 08-0683 **ON APPEAL FROM THE COURT OF APPEALS FOR THE FIFTH APPELLATE DISTRICT** COURT OF APPEALS CASE NO.: 2006CA00201 (Consolidated with 2006CA00229 and 2007CA00243)

MEMORANDUM OF THE AMERICAN COUNCIL OF LIFE INSURERS AS AMICUS CURIAE IN SUPPORT OF JURISDICTION

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STATEMENT OF INTEREST OF AMICUS CURIAE

The American Council of Life Insurers ("ACLI") is the largest life insurance trade association in the United States, representing 353 member companies, 301 of which are licensed to do business in Ohio. ACLI members account for 93 % of the total assets, 93 % of the life insurance premiums, and 94 % of the annuity considerations in the United States among legal reserve life insurance companies. ACLI member companies are the leading providers of financial and retirement security products covering individual and business markets. They offer life, disability income, and long-term care insurance, annuities, pension products, and reinsurance. Insurance products offered by ACLI members include individual and employer-sponsored disability income insurance policies.

ACLI is concerned that, absent correction by this Court, the "some evidence" standard of review that the court of appeals applied to the plaintiff-insured's bad-faith claim will further erode the already murky line between ordinary breach of contract and the tort of bad faith. This erosion is of great concern to ACLI's members because it encourages unwarranted allegations of bad faith in run-of-the-mill coverage disputes. Put simply, if the line between breach of contract and bad faith is poorly defined, plaintiffs will allege the tort—and demand extracontractual and punitive damages—in ***every*** coverage dispute because there is always a chance that it will pay off. As this case illustrates, the tort's vague and uncertain contours expose insurers to the risk of bad-faith liability many times greater than the insured's contract claim despite the existence of a genuine dispute. This risk is greatly exacerbated by the court of appeals' failure to identify any conduct warranting punitive damages, much less $3,000,000.

WHY THIS IS A CASE OF PUBLIC AND GREAT GENERAL INTEREST

1. Introduction

The court of appeals affirmed an award of nearly $5,000,000 in "bad faith" damages—more than eleven times the amount of disability benefits at issue—with the conclusory statement that the insured (Jay) had presented "some evidence" of bad faith. The court did not cite ***any*** specific evidence of bad faith. Nor did it examine the reasonableness of MCIC's grounds for denying Jay's claim or identify any proof of "actual malice" that would justify the award of punitive damages. The upshot of the court's cursory analysis is that, in a case in which the trial judge felt that the underlying contract claim "could have gone either way," the insurer must pay almost $5,000,000 beyond the policy benefits.

The court of appeals' decision is contrary to this Court's precedent and sound public policy and further confuses the already uncertain standard for bad-faith liability in Ohio. In *Wagner v. Midwestern Indem. Co.* (1998), 83 Ohio St.3d 287, 1998-Ohio-111, 699 N.E.2d 507, this Court reaffirmed that an insurer is protected from bad-faith liability as long as it has a "reasonable justification" for denying a claim. A justification is reasonable whenever "a claim is fairly debatable" due to "a genuine dispute over * * * the law * * * or the facts giving rise to the claim." *Tokles & Son, Inc. v. Midwestern Indem. Co.* (1992), 65 Ohio St.3d 621, 630, 605 N.E.2d 936 (internal quotation marks omitted). As this case makes clear, the court of appeals' "some evidence" standard expands the scope of the tort far beyond the limits contemplated by the reasonable-justification test and deprives insurers of their right to deny doubtful claims without fear of incurring disproportionate bad-faith liability. In addition, the opinion's implication that a finding of bad faith is in itself sufficient to authorize an awarding of punitive damages greatly amplifies this problem. The cost of such diluted standards for bad-faith and punitive liability—in terms of both windfall verdicts and dubious claims paid because of the

threat of such verdicts—ultimately will be borne by Ohio policyholders in the form of increased premiums. In effect, diluting the applicable standards for such awards imposes on ***all*** policyholders a tax that is earmarked to finance windfall recoveries for a relative few. This is matter of great public importance that demands this Court's attention.

2. Bad-Faith Claims Are Ubiquitous And Unpredictable.

Allegations of insurer bad faith routinely accompany claims that the insurer breached its contract with the insured. See, e.g., Gergen, A Cautionary Tale About Contractual Good Faith in Texas (1994), 72 Tex.L.Rev. 1235, 1236. In fact, although courts "anticipated that [such] claims would be rare," "almost every first-party action for an insurer's breach of contract includes a bad faith count, and liability insurers are deliberately 'set up' for bad faith claims." Richmond, An Overview of Insurance Bad Faith Law and Litigation (1994), 25 Seton Hall L.Rev. 74, 140.

Despite the frequency with which it is alleged, there is a widespread recognition that the contours of the tort remain amorphous. In many states, including this one, "[f]irst-[p]arty [b]ad [f]aith jurisprudence is in a state of confusion." Capozzola, First-Party Bad Faith: The Search for a Uniform Standard of Culpability (2000), 52 Hastings L.J. 181, 182.[1] "Without a defined standard of care * * * bad faith becomes whatever a particular fact finder thinks the standard should be * * *." Jeter, Is *Universe Life Insurance Co. v. Giles* a Reasonable Alternative to the "No Reasonable Basis" Standard of Bad Faith Liability? (1999), 51 Baylor L.Rev. 175, 187. Thus, "courts seem to find tortious conduct on the part of insurers who have bona fide disputes with their policyholders over the terms of the policy or over factual issues." Sykes, "Bad Faith" Breach of Contract by First-Party Insurers (1996), 25 J.Legal Stud. 405, 443. Even setting aside the significant negative impact of this uncertainty on the insurance-buying public, "[r]udimentary

[1] See, also, e.g., *Universe Life Ins. Co. v. Giles* (Tex.1997), 950 S.W.2d 48, 59 (Hecht, J., concurring); Gergen, supra, 72 Tex.L.Rev. at 1236, 1264.

justice requires that those subject to the law must have the means of knowing what it prescribes." Scalia, The Rule of Law as a Law of Rules (1989), 56 U.Chi.L.Rev. 1175, 1179; see also *Universe Life Ins. Co. v. Giles* (Tex.1997), 950 S.W.2d 48, 65, 40 Tex.Sup.Ct.J. 810 (Hecht, J., concurring) ("It is fundamentally unfair for the law to impose liability without defining what conduct is culpable precisely enough for it to be avoided.").

3. This Court's 4-3 Decision In *Wagner* Created Confusion In The Law.

Bad-faith law in Ohio is emblematic of this uncertainty. The basic standard has been in place for decades, but more recent developments have led to uncertainty in its application. The well-established rule is that bad faith will not lie where "[t]he conduct of an insurer" was "based on circumstances that furnish[ed] reasonable justification therefor." *Hart v. Republic Mut. Ins. Co.* (1949), 152 Ohio St. 185, 188, 87 N.E.2d 347. A justification is reasonable whenever "a claim is fairly debatable" based on "a genuine dispute over * * * the law * * * or the facts giving rise to the claim." *Tokles*, 65 Ohio St.3d at 630. Given the longstanding nature of this basic standard, it ***should*** be clear that, if any "debatable" or "genuine" legal or factual dispute drove the insurer's decision, then it acted with a "reasonable justification"—not in bad faith.

Nevertheless, as the decision below reflects, the law is far from clear. The confusion seems to arise from *Wagner*'s rejection of the "directed verdict" or "good faith as a matter of law" rule under which a plaintiff may recover bad-faith damages only if "the trial court could have properly entered a directed verdict for the claimant on * * * [the] contract claim." 83 Ohio St.3d at 293-94. While *Wagner* expressly reaffirmed the reasonable-justification standard, it left lower courts adrift as to how that standard applies in practice and how precisely it differs from the directed-verdict rule. Post-*Wagner*, some courts seem to have misunderstood its rejection of the directed-verdict rule as somehow diluting Ohio's traditional reasonable-justification standard.

The uncertainty that *Wagner* engendered is perhaps understandable. In a number of

states, the "fairly debatable" test or a similar standard has been described as generally synonymous with or the functional equivalent of the directed-verdict rule.[2] In this State too, the reasonable-justification test had seemed to approach a directed-verdict rule at the time *Wagner* was decided. Under Ohio law, a motion for directed verdict should be denied if "***reasonable minds could differ*** on the issue." *Tolliver v. Consol. Rail Corp.* (1984), 11 Ohio St.3d 56, 57, 11 OBR 201, 463 N.E.2d 389 (emphasis added). In addition, "the '***genuine issue***' summary judgment standard is 'very close' to the * * * directed verdict standard." *Grau v. Kleinschmidt* (1987), 31 Ohio St.3d 84, 91, 31 OBR 250, 509 N.E.2d 399, quoting *Anderson v. Liberty Lobby, Inc.* (1986), 477 U.S. 242, 251, 106 S.Ct. 2505, 91 L.Ed.2d 202 (emphasis added; alteration omitted). When added to this Court's holding that an insurer has a "reasonable justification" when "a claim is ***fairly debatable***" based on "a ***genuine dispute*** over * * * the law * * * or the facts giving rise to the claim," *Tokles*, 65 Ohio St.3d at 629-30 (emphasis added), the reasonable-justification test seemed to be very close to a directed-verdict rule in substance, if not in name.

Against this backdrop, *Wagner*'s rejection of the directed-verdict rule without any accompanying elaboration of the reasonable-justification test or explanation as to how it differs from a directed-verdict rule has introduced considerable uncertainty and inconsistency into Ohio bad-faith law. See MCIC Mem. in Support of Jurisdiction at 3-4 & fn.3-6 (summarizing the "different tests and * * * markedly different application[s]" of the tort post-*Wagner*). As Justice Cook predicted in her *Wagner* dissent, the decision has "further blur[red] the distinction between

[2] E.g., *Skaling v. Aetna Ins. Co.* (R.I.2002), 799 A.2d 997, 1007 ("the terms 'fairly debatable' and 'directed verdict on the contract claim' [have been] employed interchangeably") (internal citation omitted); *Pickett v. Lloyd's* (1993), 131 N.J. 457, 473, 621 A.2d 445 ("Under the 'fairly debatable' standard, a claimant who could not have established as a matter of law a right to summary judgment on the substantive claim would not be entitled to assert a claim for an insurer's bad-faith refusal to pay the claim.") (internal citation omitted); *Natl. Sav. Life Ins. Co. v. Dutton* (Ala.1982), 419 So.2d 1357, 1362 (under the "fairly debatable" standard, "[o]rdinarily, if [there is] a fact issue with regard to the validity of the [contract] claim * * * , the tort claim must fail and should not be submitted to the jury").

the proof required to create a jury question on a breach of contract committed by an insurer and a cause of action in tort for bad faith." 83 Ohio St.3d at 297 (Cook, J., dissenting).

Many courts continue to apply the reasonable-justification test correctly. For example, faced with a "conflict of evidence," the Fifth District Court of Appeals concluded that "the very factual dispute that operated to get appellee's arson claim to the jury also operated to preclude appellants' bad faith claim." *Abon, Ltd. v. Transcontl. Ins. Co.*, 5th Dist. No. 2004-CA-0029, 2005-Ohio-3052, at ¶44. But in this case, despite mechanically citing the reasonable-justification test, a different panel of the same court upheld bad-faith liability because it believed that Jay had "presented ***some evidence***" of bad faith. *Jay v. Mass. Cas. Ins. Co.*, 5th Dist. No. 2006CA00201, 2008-Ohio-846, at ¶91 (emphasis added). Such a standard transforms the reasonable-justification standard into a requirement that the insurer rebut every piece of evidence the insured presents. The reasonable-justification test cannot mean ***both*** that "fairly debatable" claims involving "genuine disputes" preclude a finding of bad faith ***and*** that a finding of bad faith can be premised on any scintilla of evidence proffered by the plaintiff.

4. The Public Interest Requires A Precise Standard For Bad-Faith Claims.

The unpredictability of bad-faith law ultimately harms not only insurers, but also the insurance-buying public—the very group that the tort was fashioned to protect. The current "lottery" of outcomes forces insurers to confront the possibility that good-faith coverage determinations and investigations will result in unforeseen extracontractual and punitive damages. See, e.g., *Giles*, 950 S.W.2d at 71-72 (Hecht, J., concurring). Moreover, the problem is self-compounding: So long as the liability standard remains unpredictable, the plaintiff will always assert a bad-faith claim because "[t]here is always a chance it will pay off." Id. at 65. This threat, in turn, drives insurers to protect themselves by contesting fewer claims—including fraudulent ones. See Sykes, supra, 25 J. Legal Stud. at 434-35 ("If reasonable efforts to reduce

fraud can become 'bad faith' down the road * * *, insurers may simply give up on them.").

And when insurers pay invalid and/or fraudulent claims that otherwise would be denied, premiums for all insureds must increase to compensate.[3] Insurers will also seek to limit their exposure by reducing the range of products and levels of coverage they offer.

Thus, a legal regime in which plaintiffs routinely and unpredictably recover bad-faith damages from insurers that reasonably denied fairly debatable claims will predictably result in higher premiums and fewer consumer choices.[4] Individual claimants may enjoy a windfall, but it comes at the expense of both the insurer and every other policyholder.[5] Moreover, the claimants who receive windfalls are most likely to be those whose claims are at best questionable and at worst fraudulent. This is because reasonable insurers do not deny clearly valid claims.[6]

In sum, while there certainly is a public interest in deterring "real abuses by insurers," loose standards of liability result in overdeterrence and are "too oppressive on an industry whose

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[3] See, e.g., Appel & Chernick, The Impact of Engrossed Substitute Senate Bill 5726 on Insurance Rates (2007), http://olympiabusinesswatch.com/files/milliman_final_washington1.pdf, at p. 18 (finding that five states that began allowing bad-faith damages or increased caps on such damages suffered much higher premium increases than the national average) (last visited April 10, 2008); Sykes, supra, 25 J. Legal Stud. at 443; Capozzola, supra, 52 Hastings L.J. at 202; Richmond, supra, 25 Seton Hall L.Rev. at 140.

[4] See, e.g., Gergen, supra, 72 Tex.L.Rev. at 1253-54; Clarke, Sources of the Crisis in Liability Insurance: An Economic Analysis (1988), 5 Yale J. on Reg. 367, 395.

[5] See, e.g., Gergen, supra, 72 Tex.L.Rev. at 1250 ("The tort has troubling distributional consequences: It enriches a few at the expense of many with significant transaction costs."); Houser, Good Faith As a Matter of Law: The Insurance Company's Right to Be Wrong (1992), 27 Tort & Ins. L.J. 665, 666 (bad-faith claims "permit[] a few insureds to recover millions of dollars in extra damages that must then ultimately be paid by the great mass of innocent premium-paying insureds."); Henderson, The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute (1992), 26 U.Mich.J.L. Reform 1, 32 ("Multimillion dollar awards for wrongfully denying claims * * * often have a windfall nature, may raise the cost of insurance for the vast numbers of insureds who are not mistreated and may * * * mak[e] the cost of insurance so expensive that it can no longer be purchased like a household commodity.").

[6] See, e.g., Bluhm, Group Insurance (3 Ed. 2000) 367 ("Claims management does not mean claims avoidance; nor is it merely a check writing facility to compensate any and all financial losses. The objective is to provide precisely the payment prescribed by the contract, no more and no less.").

financial vitality and efficiency are essential to social wellbeing."[7] The interests of all insureds are best protected by a clear legal standard that minimizes ***both*** the number of unreasonable claim denials ***and*** the number of bad-faith verdicts against insurers reasonably acting in good faith.[8] The optimal legal regime therefore is one in which insurers are safely able to deny invalid claims and pay valid ones. Review is warranted to ensure that cases like the current one do not have the unintended consequences of increasing prices and reducing options for Ohio consumers.

5. The Public Interest Requires A Clear Demarcation Between The Standard For Bad-Faith Claims And The Higher Standard For Awarding Punitive Damages.

States as diverse as California and Texas agree that, to avoid the risk of overdeterrence, the type of conduct required to justify the imposition of punitive damages must be "'of a different dimension'" from the conduct required for a finding of bad faith.[9] Specifically, evidence of "overzealousness," "negligence," or "slipshod investigation" is not sufficient to support the imposition of punitive damages. *Tomaselli v. Transamerica Ins. Co.* (1994), 25 Cal. App.4th 1269, 1288, 31 Cal.Rptr.2d 433. Instead, absent evidence of intentional malice directed at the insured, punitive damages are warranted only in cases in which the plaintiff has proven that the defendant engaged in "a continuous policy of nonpayment of claims," id. at 1287, or "a

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[7] Henderson, supra, 26 U.Mich.J.L. Reform at 32; see also, e.g., *State ex rel. Allstate Ins. Co. v. Bowen* (1936), 130 Ohio St. 347, 354, 199 N.E. 355 ("The business of insurance is one of public interest, affecting all classes of people and property[.]") (internal citation omitted).

[8] See, e.g., Sykes, supra, 25 J. Legal Stud. at 407 ("the courts have extended bad faith remedies to circumstances in which the case for them cannot be made"); Woodham, Note, "Constructive Denial," "Debatable Reasons," and Bad Faith Refusal to Pay an Insurance Claim—The Evolution of a Monster (1992), 22 Cumb.L.Rev. 349, 351 (imposing bad faith liability on "insignificant facts" creates an unwarranted "imbalance favor[ing] policyholders").

[9] *Shade Foods, Inc. v. Innovative Prods. Sales & Mktg. Inc.* (2000), 78 Cal.App.4th 847, 890, 93 Cal.Rptr.2d 364 (quoting *Tomaselli v. Transamerica Ins. Co.* (1994), 25 Cal. App.4th 1269, 1286, 31 Cal.Rptr.2d 433); accord *Transp. Ins. Co. v. Moriel* (Tex.1994), 879 S.W.2d 10, 18 ("It is as important to maintain the distinction between punishment and compensation in the context of bad faith as it is in the remainder of tort law . The reason the law of tort recognizes compensation, rather than punishment, as its paramount objective is that civil punishment can result in overdeterrence and overcompensation. * * * Unless bad faith is accompanied by aggravated conduct by the insurer, then compensatory damages alone are the proper remedy.").

consistent and unremedied pattern of egregious * * * practices." *Patrick v. Maryland Cas. Co.* (1990), 217 Cal. App.3d 1566, 1576, 267 Cal.Rptr. 24.

This Court's precedents also recognize the importance of distinguishing the standard for establishing bad faith from the appropriately higher threshold for permitting punitive damages. E.g., *Hoskins v. Aetna Life Ins. Co.* (1983), 6 Ohio St.3d 272, 277-29, 6 OBR 337, 452 N.E.2d 1315. Indeed, in *Hoskins* this Court explained that "[i]n order to justify an award of exemplary damages, the defendant must be guilty of oppression, fraud, or malice" because a finding of bad faith "alone does not necessarily establish that [the] defendant acted with the requisite intent to injure plaintiff." *Id.* at 278, quoting *Silberg v. Cal. Life Ins. Co.* (1974), 11 Cal. 3d 452, 462-63, 113 Cal.Rptr. 711, 521 P. 2d 1103.

This case well illustrates the problem with drawing no clear demarcation between bad-faith liability and punitive liability. Despite the absence of any evidence that MCIC denied Jay's claim out of hostility toward Jay, that MCIC had a history of bad-faith claim-handling practices, or that MCIC had engaged in a scheme to cut costs by denying ***valid*** claims, the court of appeals allowed the imposition of stigmatizing punitive damages with the cavalier statement that "there was sufficient, competent credible evidence to support" the award. *Jay* at ¶99. The message sent by the $3 million punitive verdict—that an insurer cannot deny a claim by a manipulative, uncooperative insured without exposing itself to stigmatizing, profit-draining punitive awards—is not one that this Court conceivably could have intended or could want now to perpetuate. The Court should make clear that Ohio, no less than California, Texas, and other states, will not allow basic disputes over the payment of insurance benefits to metastasize into lottery-like punitive damages cases with all of the harmful consequences that flow from such cases.

STATEMENT OF THE CASE AND FACTS

Jay's disability policies with MCIC allow him to recover "monthly benefits while * * *

totally disabled." Jay initially sought benefits under the policy in May 1998, claiming that he was disabled as a result of "uncontrolled diabetes." But Jay failed to provide MCIC with sufficient supporting documentation for several months. Finally, in December 1998, Jay's physician told MCIC that Jay's "diabetes ha[d] stabilized" and was no longer disabling but that he remained disabled due to "depression," a condition never before suggested as a basis for the disability claim. Jay's physician, who is not a psychiatrist or psychologist, simply reported that Jay's psychiatrist did not feel that Jay was "ready to return to work." MCIC nonetheless gave Jay the benefit of the doubt as to his diabetes claim, paid five months' worth of benefits, and asked Jay to submit information pertaining to his alleged disability from depression. Instead of supplying that information, Jay specifically instructed his psychiatrist to withhold it from MCIC, and for the next two years Jay made no contact whatsoever with MCIC.

In December 2000, a consultant hired by Jay contacted MCIC seeking to revive Jay's claim. However, when asked directly as to the basis of the claim, the consultant responded, "I don't know." MCIC nonetheless continued to try to investigate the alleged disability by, among other things, scheduling a face-to-face meeting with Jay. Jay thwarted these efforts, however, by continuing to withhold medical records and failing to show up for the scheduled meeting.

In April 2001, rather than provide any information validating his claim, Jay filed suit. Even then, however, he persisted in withholding medical information until MCIC moved to compel him to do so. After Jay finally provided information during discovery, MCIC had ***four independent doctors*** examine Jay—including an endocrinologist to evaluate his diabetes claim and both a neuropsychologist and a psychiatrist to evaluate the claim of depression. After all four concluded that Jay was able to work as an attorney, MCIC denied Jay's claim. Jay subsequently dismissed his lawsuit shortly before trial with summary judgment motions pending.

After dismissing his first lawsuit, Jay provided no additional information to MCIC for another full year before filing another lawsuit in 2004. During the second lawsuit, Jay continued to withhold updated medical information, and MCIC received no records concerning his psychiatric treatment for 2003, 2004, or 2005 until the first trial in this matter—which ended in a mistrial—was underway. During the second trial in 2006, no expert for either side testified that Jay's diabetes was disabling. Jay's own psychiatrist acknowledged both that Jay "could return to work as an attorney" "if he chose to work at it" and that Jay had ghost-written the psychiatrist's opinions. A clinical psychologist also testified on Jay's behalf but acknowledged that he had not treated Jay since 2002. MCIC's experts, who conducted extensive tests and examinations of Jay in both 2002 and 2005, testified that Jay was not disabled and could return to practicing law.

ARGUMENT IN SUPPORT OF PROPOSITIONS OF LAW

> **Proposition of Law No. 1:** To prevail in an action for bad faith against an insurer, an insured must establish the ***absence*** of any reasonable justification for the insurer's denial of a claim under the insurance contract. The insured's evidence must support the conclusion that ***each*** of the insurer's bases for denying the claim was unreasonable and, as a result, that ***no*** aspect of the claim decision was fairly debatable or in genuine dispute. (*Zoppo v. Homestead Ins. Co.* (1994), 71 Ohio St.3d 552, 1994-Ohio-461, 644 N.E.2d 397, paragraph one of the syllabus, and *Wagner v. Midwestern Indem. Co.* (1998), 83 Ohio St.3d 287, 1998-Ohio-111, 699 N.E.2d 507, explained and clarified; *Motorists Mut. Ins. Co. v. Said* (1992), 63 Ohio St.3d 690, 1992-Ohio-94, 590 N.E.2d 1228, paragraph four of the syllabus, and *Tokles & Son v. Midwestern Indem. Co.* (1992), 65 Ohio St.3d 621, 605 N.E.2d 936, approved and followed.)

The *Wagner* Court rejected the proposition that a bad-faith claim fails as a matter of law unless the insured is entitled to a directed verdict on the underlying contract claim. At the same time, however, the Court reaffirmed the reasonable-justification and fairly-debatable standards. By contrast, in applying a "some evidence" rule, the court of appeals effectively wrote these standards out of the law because insureds virtually always will be able to present "some evidence" in the course of a fair debate or genuine dispute.

That the court of appeals strayed so far from the reasonable-justification test shows that *Wagner* did indeed "blur the distinction between the proof required to create a jury question on a breach of contract committed by an insurer and a cause of action in tort for bad faith." *Wagner*, 83 Ohio St.3d at 297 (Cook, J., dissenting). A decade of uncertainty is long enough. The Court should use this case to make clear that *Wagner* did nothing to alter the rule that when the insurer relies on ***any*** "genuine dispute over * * * the law * * * or the facts giving rise to the claim," it possesses a reasonable justification for its denial. *Tokles*, 65 Ohio St.3d at 630. The clear import of this rule is that a claimant must demonstrate that ***each*** of the insurer's justifications is unsupported or pretextual and, as a result, ***no*** aspect of the claim is fairly debatable.[10]

The rule strikes a reasonable balance between the interests of the policyholder and the insurer. Any claimant whose claim is denied without a reasonable basis will have an action for bad faith. At the same time, an insurer that reasonably denies a claim need not fear that it will be subjected to bad-faith liability and punitive damages. See Barker, Evidentiary Sufficiency in Insurance Bad Faith Suits (1999), 6 Conn.Ins.L.J. 81, 114. True bad faith will be deterred, but insurers will continue to "challenge claims they believe may be invalid," thereby "keep[ing] premiums * * * at a minimum." *Giles*, 950 S.W.3d at 60 (Hecht, J., concurring).

Reaffirmation and clarification of the reasonable-justification standard is also necessary to keep Ohio within the mainstream of bad-faith law. Far from allowing "some evidence" to

[10] See, e.g., *Bellville v. Farm Bur. Mut. Ins. Co.* (Iowa 2005), 702 N.W.2d 468, 481 ("[I]t is not enough for [the insured] to make a showing of unreasonableness. It [is] incumbent upon him to negate any reasonable basis for the insurance company's valuation of his claim.") (citation omitted); *Giles*, 950 S.W.2d at 81 (Enoch, J., concurring) ("It is the plaintiff's burden" to show, inter alia, that "the insurer's proffered reasons were a pretext or a sham."); *Moriel*, 879 S.W.2d at 18 ("an insured claiming bad faith must prove that the insurer had no reasonable basis for denying or delaying payment of the claim"); Barker, Evidentiary Sufficiency in Insurance Bad Faith Suits (1999), 6 Conn.Ins.L.J. 81, 106 ("The insured * * * has the burden of showing that none of the grounds asserted by the insurer gives rise to a bona fide dispute * * *.").

support a bad-faith claim, many states explicitly or implicitly follow the directed-verdict rule,[11] including many of the numerous states that follow the "fairly debatable" standard articulated in *Tokles*. See Houser, Good Faith As a Matter of Law: The Insurance Company's Right to Be Wrong (1992), 27 Tort & Ins.L.J. 665, 669. While *Wagner* holds that the directed-verdict rule is not a necessary corollary of the "fairly debatable" standard, the often-recognized connection between the two reinforces that, under standards like Ohio's, bad faith is limited to cases in which an insurer's actions were manifestly unreasonable. No other state comes close to equating "fairly debatable" with "some evidence."

Finally, this case demonstrates the need to return the focus of the bad-faith inquiry to the reasonableness of the insurer's justifications for denying the claim. MCIC had multiple non-pretextual bases for refusing Jay's claim. First, as the court of appeals noted, MCIC's denial relied on "the findings of its medical doctors," *Jay* at ¶90, and Jay's own doctors were equivocal or otherwise raised reasonable suspicions from MCIC's perspective. For example, one acknowledged that Jay ghost-wrote his opinion, while another had not treated Jay in several years. Second, MCIC's action was based on the uncontroverted and highly relevant fact that Jay continually failed to "provide sufficient information to MCIC." Id. This not only prevented MCIC from properly evaluating his claim but also constituted a breach of contract. Either of these grounds for denial, absent clear and unequivocal contradiction, establishes a reasonable justification.[12] Nevertheless, the court of appeals found that Jay put forth "some evidence" of

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[11] See, e.g., *Chateau Chamberay Homeowners Assn. v. Associated Intl. Ins. Co.* (2001), 90 Cal.App.4th 335, 347-48, 108 Cal.Rptr.2d 776; *Dutton*, 419 So.2d 1357; *Anderson v. Contl. Ins. Co.* (1978), 85 Wis.2d 675, 693, 271 N.W.2d 368; Barker & Glad, Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance (1994), 30 Tort & Ins.L.J. 49, 54.

[12] See, e.g., *Garrett v. Ohio Farmers Ins. Co.*, 11th Dist. No. 2003-L-182, 2005-Ohio-413, at ¶20 (affirming summary judgment on bad-faith claim where claimant "continued to ignore * * * requests" for "medical and wage documentation"); *Moriel*, 879 S.W.2d at 18 ("A simple disagreement among experts * * * will not support a judgment for bad faith.").

some kind in his favor. Absent correction by this Court, this perfunctory standard of review will effectively "deprive courts of their role in defining bad-faith liability, making bad faith whatever any particular jury thinks it is." *Giles*, 950 S.W.3d at 58 (Hecht, J., concurring).

> **Proposition of Law No. 2**: To prevail in an action for bad faith against an insurer for denial of a claim, an insured must be entitled to judgment as a matter of law or a directed verdict on the underlying contract claim. (*Wagner v. Midwestern Indem. Co.* (1998), 83 Ohio St.3d 287, 1998 Ohio 111, 699 N.E.2d 507, overruled in part.)

Alternatively, this Court should address the confusion by overruling *Wagner*'s rejection of the directed-verdict rule. The directed-verdict rule would have been the most natural way to harmonize this Court's prior cases in this area. *Tokles* in particular pointed toward the directed-verdict rule when it held that a "reasonable justification" exists whenever "a claim is fairly debatable" due to "a genuine dispute over * * * the law * * * or the facts giving rise to the claim." *Tokles*, 65 Ohio St.3d at 630; see page 4, supra. Accordingly, the Court should take this case to reconsider *Wagner*'s rejection of that rule. Cf. *Zoppo*, 71 Ohio St.3d at 555 (overruling a recent decision that was inconsistent with "forty-five years of [bad-faith] precedent").

In addition to being fully consistent with this Court's precedent, the directed-verdict rule has much to recommend it. Its "logic * * * is simple": If a directed verdict on the contract claim is denied because "reasonable minds could * * * differ," then "it ordinarily must follow that the insurer has reasonable grounds" to dispute the claim.[13] Moreover, it would clearly separate bad-faith claims from ordinary breach of contract. Clarification of this distinction would reduce the risk of loose imposition of bad-faith damages and thereby mitigate the threat of overdeterrence. The upshot will be that insurers will pay fewer invalid and/or fraudulent claims and will be able to contain premiums accordingly.

[13] Barker & Glad, supra, 30 Tort & Ins.L.J. at 56. There may, of course, be exceptions to this rule when, for example, the insurer employed a biased expert in order to justify denying a debatable claim. No such exception is applicable on the facts of the present case, however.

Proposition of Law No. 3: Punitive damages are not routinely available in bad-faith cases. Absent evidence that the claim decision was part of a pattern of bad-faith claim handling or scheme to cheat insureds, punitive damages are unwarranted. (*Hoskins v. Aetna Life Ins. Co.* (1983), 6 Ohio St.3d 272, 277-29, 452 N.E.2d 1315, approved and followed.)

As discussed at pages 8-9, supra, the importance of maintaining a clear line between the standard for establishing tort liability and the standard for awarding punitive damages is recognized by courts nationwide, including this Court. Bad faith "alone" is insufficient because punitive damages require clear and convincing evidence, see R.C. 2315.21(D)(4), that the insurer is "guilty of oppression, fraud, or malice." *Hoskins*, 6 Ohio St.3d at 278, quoting *Silberg*, 11 Cal. 3d at 462-63.[14] In marked contrast to this exacting and clear rule of law, the court of appeals affirmed a $3,000,000 punitive award without identifying any instance of oppression, fraud, or malice on MCIC's part. Instead, the court simply asserted that "there was sufficient, competent credible evidence to support" the punitive award. *Jay* at ¶99.

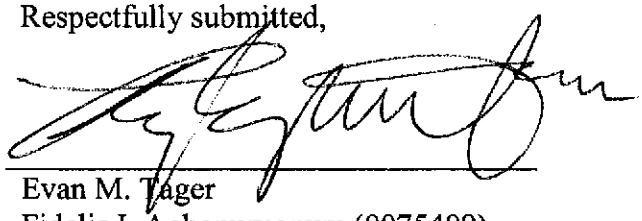
As discussed above, however, the record is clear that MCIC's justifications for denying Jay's claim—the opinions of four independent doctors that Jay was not disabled, coupled with the equivocation of Jay's own doctors and Jay's refusal to cooperate—were reasonable and not in bad faith. Much less is there "clear and convincing" evidence that MCIC engaged in conduct that would satisfy the materially higher standard for awarding punitive damages. Thus, absent correction by this Court, the decision below will blur the distinction between bad faith and the kind of truly reprehensible conduct that merits the sanction and stigma of punitive damages.

CONCLUSION

The Court should accept jurisdiction and consider the merits of the foregoing propositions of law.

[14] "Malice" in this context refers to "(1) that state of mind under which a person's conduct is characterized by hatred, ill will or a spirit of revenge, or (2) a conscious disregard for the rights and safety of other persons that has a great probability of causing substantial harm." *Preston v. Murty* (1987), 32 Ohio St.3d 334, 512 N.E.2d 1174, syllabus.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I certify that on this 11th day of April, 2008, copies of the foregoing Memorandum of The American Council of Life Insurers as Amicus Curiae In Support of Jurisdiction were sent by UPS overnight delivery to the following counsel:

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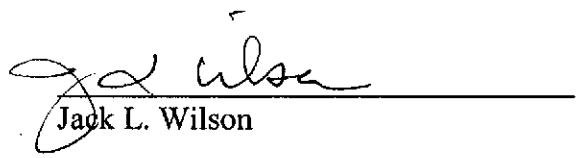

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