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ON COMPUTER - JJ

IN THE SUPREME COURT OF OHIO

MASSACHUSETTS CASUALTY INSURANCE COMPANY,	**Supreme Court Case No. 08-0683**
Appellant,	**On Appeal from the Stark County Court of Appeals, Fifth Appellate District**
vs.	**Court of Appeals Case No. 06-201**
DAVID E. JAY,	
Appellee.	

MEMORANDUM OF APPELLEE, DAVID E. JAY, IN RESPONSE TO MEMORANDA IN SUPPORT OF JURISDICTION

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I. THIS CASE IS NOT OF PUBLIC OR GREAT GENERAL INTEREST.

This month starts an eleventh year in David E. Jay's quest for the disability benefits he was promised. Other than that quite remarkable fact, this is not a case of public or great general interest. Appellant's jurisdictional memoranda should be declined.

A. Summary of the Arguments.

The verdicts below result from Appellant's[1] blatant misinterpretation and misapplication of its own insurance Policies. But for Appellant's misapplication of its Policies, there may have never been an extra-contractual damages issue to consider.

Appellant's Policies, industry practice, common sense, and medical science all required that Appellant investigate and decide the question of Jay's "total disability" on the basis of the entirety of Jay's complete medical and mental health picture. (*See, Opinion ["Jay"] at ¶¶ 15, 73-76*). Appellant misapplied its own Policies by never undertaking such an assessment. *Id.* This seemingly intentional malfeasance resulted in a clearly inadequate investigation. It left Appellant with no reasonable justification for denying Jay's claim. It ultimately also served as a major basis for the jury's finding of bad faith and malice. Accordingly, even if Ohio's bad faith law needed clarification (which it doesn't), the evidence in this case is such that it is not an appropriate one for this Court to consider.

Appellant knows well that its own misapplication of its Policies was a major focus of the bad faith and malice findings of the jury and for the judgments from which it now seeks review. Remarkably, Appellant's thirty pages of memoranda before this Court completely ignore these facts. The reason is obvious. Appellant simply has no defense for its misinterpretation and misapplication of its own Policies. Appellant's strategy for avoiding its decade-old obligation to pay what its Policies say it owes to Jay is to present to this Court an argument based on a gross misstatement of the evidence below. Appellant's ultimate goal is to persuade the Court to adopt

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[1] Jay refers to MCIC and the Amicus collectively as the "Appellant" because MCIC is one of the several hundred insurance company subsidiaries of Zurich Financial Services, and the Zurich subsidiaries collectively make up a good percentage of the membership of the Amicus.

law, the "directed verdict rule," which this Court rejected in *Wagner v. Midwestern Indemn. Co.* (1998), 83 Ohio St.3d 287. Appellant's strategy is improper, the law it wants adopted is unsound, and its request should be denied.

First, the mission of this Court is not to evaluate the alleged errors of a jury or trial court that are not resolved to a litigant's satisfaction in a Court of Appeals. *Second*, nothing has happened since 1998 that would suggest that this Court's rejection of the directed verdict rule in *Wagner* was unwise (Appellant's premise – *that the Appellate Court lost its way as the result of* Wagner-*created confusion* – is, in a word, absurd). There is no basis to argue that the courts below applied an incorrect standard or that the verdict was not based on substantial evidence. *Third*, as the result of Appellant's misapplication of its own Polices (*a fact Appellant chooses to ignore now*), the so-called directed verdict rule would not even apply: it is universally accepted that an insurer's misinterpretation of its policy triggers a jury question on the issue of bad faith.

B. The Verdicts Are Supported By Sixty Years of Precedent

Appellant asks this Court to accept jurisdiction in order to change Ohio's bad faith law. Appellant theorizes that under current precedents Ohio's courts are hopelessly confused. A review of the cases shows that this assertion is false. Borrowing from Mark Twain, "reports of the demise of the evidentiary standard of bad faith in Ohio are greatly exaggerated."

Ohio's "reasonable justification" standard was first adopted in 1949. *Hart v. Republic Mut. Ins. Co. (1949), 152 Ohio St. 185, 87 N.E.2d 347.* An insurer's duty to act in good faith in the handling and payment of an insured's claim was recognized in *Hoskins v Aetna Life Ins. Co.* (1983), 6 Ohio St. 3d 272, 452 N.E. 2d 1315. The rule that an insurer must "assess claims after an appropriate and careful investigation" and reach conclusions as a result of "the weighing of probabilities in a fair and honest way" was articulated in *Motorists Mut. Ins. Co. v. Said* (1992), 63 Ohio St 3d 690, 699, 590 N. E. 2d 1228, *overruled on other grounds in Zoppo.*

An insurer fails to act in good faith where it refuses to pay a claim and the refusal is "not predicated upon circumstances that furnish reasonable justification therefore." *Zoppo v.*

Homestead Ins. Co. (1994), 71 Ohio St 3d 552, 644 N E 2d 397. An insurer, however, is entitled to refuse a claim where the claim is "fairly debatable" and the insurer's refusal is based on a genuine dispute over the facts or the status of the law at the time the claim was denied. *Tokles & Son, Inc. v. Midwestern Indemn. Co.* (1992), 65 Ohio St. 3d 621, 630, 605 N.E. 2d 936.[2]

The Court of Appeals' Opinion of Judge Delaney, joined by Judges Boggins and Reader, cited to each of these five Supreme Court cases. Clearly, then, the Fifth District was fully mindful of the standard needed to establish a jury question (i.e., whether Jay's claim was "fairly debatable" and whether there existed a genuine dispute). Unanimously, the court held expressly that the evidence was, in fact, "sufficient" to establish this jury question. The Court stated:

> "Upon review of the evidence presented in this nineteen day trial, we find there was sufficient evidence before the jury to support Jay's claim of bad faith ... Jay presented substantial evidence challenging both MCIC's manner of handling the claim and basis for denying the claim." (*Jay ¶¶ 69-70*).

Appellant completely ignores this finding also in its thirty pages of memoranda. Instead, on twenty separate occasions, Appellant refers to the words "some evidence" in the subsequent sentence of the Court of Appeals Opinion. That comment, as reflected at ¶¶69-70 of the Opinion, reflects the proposition and finding that there was "sufficient" and "substantial" evidence upon which a reasonable jury could base its verdict. Appellant improperly infers that the Appellate Court equated its finding with a mere scintilla and thereby lowered the bad faith standard. However, the Court of Appeals did nothing of the kind. The Court also held that:

> "Upon review of the record, the jury, having viewed the evidence and the credibility of the witnesses, determined Jay suffered compensable damages and punitive damages were warranted as a result of [Appellant's] actions. We find there was sufficient, competent credible evidence to support its verdict." (*Jay 79*).

Thus, the Court displayed no confusion and applied the correct standard required to warrant submission of the issue to the jury.

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[2] In 1994, this Court recognized that "rather than clarifying the standard of proof" the *Said* decision "caused greater confusion by erroneously making intent an element of the tort of bad faith ... intent is not and has never been an element of the reasonable justification standard" in Ohio. *Zoppo 71 Ohio St. 3d at 554-555.*

Moreover, Appellant curiously cites Judge Boggins' decision in *Abon LTD. v. Transcontinental Ins., 2005-Ohio-3052 (5th Dist. 2005)*(Boggins, P.J.) as representing a correct application of the standard. Just two years after *Abon*, Judge Boggins reviewed this case and its unique facts. Judge Boggins ruled here that "substantial evidence" of bad faith warranted jury evaluation. One ordinarily would think that Judge Boggins would have been mindful of his *Abon* decision when he joined the Opinion here. The lesson of Judge Boggins' roles is that there simply is no pervasive confusion in Ohio. Courts apply *Zoppo* on a case-by-case, factually dictated basis as a gate keeping mechanism.[3] Further, it is noteworthy that a respected Ohio jurist, Judge John R. Milligan, presided over this three week trial and confirmed the verdict upon his *de novo* review of the evidence and consideration of Appellant's post-trial motions.

To demonstrate this point, Judge Milligan's charge to the jury at the end of the tort phase constructed a clear line between contract and tort liability. The charge reads:

> "This, however, is a tort case, and it is to be distinguished from a contract case, which you have concluded ... To prevail on the bad faith claim, the Plaintiff has the burden of proving that the Defendant had no reasonable justification for denying its claim. Breach of insurance contract ... does not automatically equal bad faith. Defendant has the right to legitimately question a claim. It can be wrong." (2-16 Tr. at 465-467).

Even under Appellant's formulation, this is a correct statement of the law. Accordingly, it is hard to understand what it is Appellant is complaining about, other than not liking the verdict.

C. The Bad Faith and Malice Findings Resulted Primarily From Appellant's Misinterpretation of its Own Policies.

Although the evidence of Jay's free-standing and independent illnesses entitled him to benefits under the Policies, there is absolutely no debate at all that the combined force of Jay's

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[3] To argue "confusion," Appellant relies on Texas law. The development of Texas law has been "strange." *See Ashley, Bad Faith Actions: Liability and Damages (2d Ed. 1997) ["Ashley"], Oct. 2007 Supplement at 38.* Ashley remarks that when Texas recently recognized the tort, it "struck out on its own ... [and] adopted ... (its own) unique and unprecedented approach ... (with) neither awareness of the choices other courts had taken nor reasons for its own choice." *Id.* Another authority cited by Appellant, *Barker, Evidentiary Sufficiency in Insurance Bad Faith Suits* (1999), *6 Conn. Ins. L. J. 81 ("Barker II"),* the author, a defense lawyer, concedes that "Texas (has) struggled to define the standard for appellate review ... of evidence in ... bad faith ... other jurisdictions have not perceived similar problems ... (and) have generally handled this issue correctly ... ." *Barker II at 82-83.* Barker points to *Universal Life Ins. Co v Giles, (Tex. 1997), 950 S.W. 2d 48* as creating confusion in Texas. Importantly, *Giles* is inapposite because Ohio's standard is clearer and more onerous than any standard proposed in the three *Giles* opinions.

multiple illnesses and disorders rendered him "substantially unable to perform the material duties" of a lawyer. Bad faith and malice were principally demonstrated from the undisputed evidence that: (i) Appellant refused to investigate the impact of Jay's combined illnesses despite the clear language in the Policies, industry practice, common sense, and medical science; and (ii) Appellant applied an incorrect definition of total disability.

The Policies define "total disability" as the "substantial inability to perform the material duties" of your occupation. (*Jay ¶2*) The Policies' Concurrent Disabilities provision states that "a period of disability [can result] from *more than one* Injury, Sickness, or *medical condition* ... a period of disability ... will be treated ... as a single continuous period regardless of the number of ... medical conditions which cause it to continue." (*Id at ¶¶ 71-72*).

In this case, the evidence showed that, by early 1998, Jay, a successful attorney, had become an "uncontrolled" diabetic. (*Id. at ¶3*).[4] By May 1998, Jay also sought psychological counseling for stress, which was soon diagnosed as major depression. (*Id. at ¶¶3-6*) The evidence at trial showed that Appellant always chose to consider and evaluate the effect on Jay of these two conditions separately, but never assessed whether Jay was totally disabled under the Policies by virtue of the fact that he had these and other significant conditions.[5]

1. <u>Appellant Chose To Misinterpret Its Policies</u>.

The most revealing element of bad faith in this case is evident in the Court's discussion of Appellant's Second Assignment Of Error (*Id. at ¶ 15, 69-78*). Specifically, Appellant claimed error because the jury was permitted to evaluate Jay's combined illnesses together in deciding if he was "totally disabled" under the Policies. Inherent in Appellant's argument are these undeniable concessions: (1) it is a materially significant distinction to Appellant to approach the evaluation of "total disability" by either (a) assessing all of a person's illnesses in combination,

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4 In 1998, contrary to appellant's claim now, Jay sent appropriate forms to Appellant, and both Jay and his physicians provided information to Appellant regarding Jay's disability claim. (*Id. at ¶5*)

5 By 2002, Appellant had additionally diagnosed Jay with anxiety disorder and undifferentiated somatoform disorder, and Jay had emergency heart bypass surgery.

or (b) assessing their illnesses in individual "silos;" and (2) Appellant consciously chose to evaluate Jay's multiple illnesses in "silos," but never together.

As the result of Appellant's choice, it denied Jay's claim (in 1998 and in 2002) without investigating the combined effects of Jay's medical illnesses and mental disorders on his "substantial ability to perform the material duties" of his own occupation. (*Id. at ¶¶ 6-10, 76*).

Given this evidence, the Appellate Court had no trouble concluding that Appellant's decision to evaluate Jay's illnesses in silos misinterpreted its own Policies. (*Id. at ¶73, 76*).[6] The Court naturally determined that the Policies, consistent with common sense, obligated Appellant to pay benefits to Jay whether his "total disability" resulted from one malady or the combined effects of multiple maladies. But, Appellant insisted on misreading its own Policies to give Jay no right to benefits if a "substantial inability to perform the material duties" of his occupation resulted from the combined affects of more than one medical condition. (*Jay at ¶71*)

In essence, according to Appellant's interpretation of its Policies, if it is presented with two people ("Lawyer A" and "Lawyer B") who suffer from equivalent levels of disability, "Lawyer A" -- whose condition results from a single malady -- ***is*** entitled to benefits. However, "Lawyer B" ***is not*** because her misfortune is that her disability results from multiple illnesses or disorders. It was this naked reality of Appellant's preposterous and self-serving reading of its Policies that shocked the conscience of the jury and led to the finding of no reasonable justification. It was obviously also a principle factor of the bad faith and malice findings.

2. Appellant's Interpretation Violated Industry Custom.

Appellant's evaluation of illnesses in silos also violated well known industry standards, which was additional evidence of bad faith. Mary Fuller, an expert in the area of disability claim administration (*Id. at ¶82*), testified that:

> "where medical information indicates what the industry talks about as co-morbid conditions, then the insurer would have a duty to investigate all of the conditions presented particularly if they were conditions that could

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6 Jay purchased the Policies based on the claim that they contained a "liberal definition" of "total disability." Even Appellant testified that the Policies contain a "liberal definition" of total disability.

> contribute to or be the sole cause of a disability ... the insurance company has a duty to investigate the combined effect of independent illnesses ... an insurer has the duty to investigate all the medical information that may be impacting function and if it is multiple conditions they have a responsibility to look at that. Whether there is a concurrent provision (in a policy) or not, co-morbidity can impact function. The condition itself or the combination of conditions." (2-15 Tr at 152).

Thus, even if the "concurrent disabilities" promise was not contained in the Policies, Appellant had an affirmative duty to evaluate the combined effects of all of Jay's many illnesses.

3. Appellant's Interpretation Contravened Medical Testimony.

Appellant's decision to close its eyes to the combined illnesses also contradicted the opinions of all physicians at trial: (i) Dr. Leonard Egede, who has published studies on the association of depression and diabetes testified that "individuals with diabetes and comorbid major depression have higher odds of functional disability compared with individuals with either diabetes or major depression alone;" (ii) Jay's physicians warned of the impact of Jay's combined illnesses [and testified unequivocally that Jay was at all times unable to substantially perform the material duties of a lawyer]; and (iii) Appellant's physicians all recognized that Jay's medical illnesses and mental disorders needed to be evaluated conjunctively.

As the result of its choice to evaluate Jay's multiple conditions in silos, there was substantial evidence supporting a finding that Appellant: (i) never performed an adequate investigation; (ii) never properly applied and interpreted its Policies; (iii) ignored industry custom; and (iv) even ignored unanimous medical testimony.

Appellant never obtained any opinions suggesting that Jay's physicians were wrong, and that, under the Policies as properly applied and interpreted, despite Jay's concurrent illnesses, Jay could indeed "substantially perform the material duties" of a lawyer. Thus, there was ample evidence for a jury to conclude that liability was not "fairly debatable." Like *Zoppo*, the evidence supported the finding of failure to conduct an adequate investigation.

D. Appellant Further Misapplied Its Policies By Employing The Wrong Definition Of Totally Disabled.

A final evidentiary point, Appellant's claims adjusters (and physicians) applied an incorrect definition of "totally disabled" in their consideration of the claim. As previously noted, the Policies contained a "liberal definition" of totally disabled.. The Policies promised disability benefits if Jay came to be "*substantially* unable to perform the *material* duties" of his own occupation. However, Appellant's claims adjusters employed a different standard: whether Jay was *completely* unable to perform *all* duties of his occupation. (2-7 Tr. at 216-217). This distinction is significant. The definition employed in essence required Jay to be dead or comatose.

Because Appellant kept the Policies from its own physicians, the definition of total disability they used was the inability to work at all (i.e., the social security standard). (2-7 Tr. Hare at 36-37). Moreover, all of Appellant's physicians were directed to look at Jay's conditions "in silos," and, with each they applied an incorrect disability threshold. *Id.* In sum, this "misreading" of Appellant's own policies was "substantial" additional evidence from which a jury could have and did conclude bad faith.

Further, evidence also existed which strongly suggested that Appellant's misapplication of its Policies resulted from a plan to reverse losses.[7]

E. The Directed Verdict Rule Has No Application Here

Not only has the directed verdict rule been abrogated by the Court that conceived of it in 1982 (p. 11, f.n. 13), but the fact that Appellant misinterpreted its Polices in these many significant ways universally prohibits operation of the rule in states that do recognize it.[8]

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[7] Appellant's agents testified that experience in the disability insurance market was "much worse than expected ... (as a result of contracts that had) weak contract language and own-occupation definitions ... at least 40 of the 70 carriers (of disability insurance) got out ... it was an ugly situation ... [for those who stayed in] the financial economics of disabilities improved ... [ultimately, the turn around was] miraculous." (2-15 Tr. 106-120). At or near the time of Jay's claim, Appellant was "concerned" about the amount of money being paid out in claims and profitability. (Id. at 52-53).

[8] *See, e.g., Verbaere v. Life Investors Ins. Co. of Am.* (Ill. App. Ct. 1992) 589 N.E. 2d 753, 758-59 (where an insurer "persists in a plainly unreasonable interpretation of its policy ... the trial court d(oes) not abuse discretion in awarding sanctions"); *Sparks v. Republic Nat'l Life Ins. Co.* (Ariz. 1982)647 P. 2d 1127, 1137 (an insurer's subjective belief in the validity of its interpretation is a defense to liability, but the existence of that belief ordinarily is a jury question).

Accordingly, even if Ohio had adopted the directed verdict rule in *Wagner*, Jay's evidence would still have required a jury evaluation of the claims of bad faith and malice. Thus, Appellant's request that this Court use this case to adopt the directed verdict rule has no basis.

F. Appellant's Fact Misstatements.

In its memoranda, Appellant completely ignores the foregoing real issues on which the jury and courts below acted. Instead, Appellant strategically elects to paint a portrait that simply does not reflect the canvas of the record.[9] Page limitations prevent an item by item retort. However, reflection on just two of Appellant's misstatements give a sufficient flavor of the situation: (i) Judge Milligan did not say that the contract case could go either way;[10] and (ii) Appellant's 2002 denial was not based whatsoever on the assertion that Jay had withheld or delayed the provision of proof.[11] Suffice to say at this point for purposes of jurisdiction, the real case heard by Judge Milligan and affirmed unanimously on appeal by Judges Delaney, Boggins, and Reader is not the case depicted by Appellant in its memorandum.

ARGUMENT IN OPPOSITION TO PROPOSITIONS OF LAW

> **[Appellant and Amicus] 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.

Under this Proposition, Appellant asks without apology that the Court "reinforce a standard that protects insurers" (*Memo p. 13, emphasis*). Separately, the Amicus asks that this Court "use this case to make clear that *Wagner* did nothing to alter" Ohio's long standing bad faith law (*Memo. pp. 12*).

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9 The jury responded "yes" to Appellant's six interrogatories which tested whether Jay had proven that he had provided sufficient proof to Appellant throughout the life of his claim. (*Jay at 58*). Appellant now asserts, in contravention of the Opinion, that Jay did not provide medical information for six years.

10 At the conclusion of the contract case, the trial court espoused the virtues of mid-trial mediation. To motivate Jay, the court commented that the jury interrogatory (*Jay at 58*) regarding provision of proof for the months immediately following the December 1998 denial could have gone either way. (2-14 Tr. at 91-101). It is disingenuous to claim that the comment goes to the entire contract case.

11 The denial letters do not state that they were based on withheld or delayed proof, and Appellant's claims examiner testified that delay in proof was not a factor in the 2002 denial. (2-7 Tr. at 29-32). Since the "justification" for denial did not "include reasons related to the proof of loss," it was a non-issue.

Appellant proposes a change to Ohio law to require that a plaintiff "must establish the absence of any reasonable justification" before a bad faith case can go to a jury. (*Memo, p. 13*). This proposition makes no sense and cannot be the law if the word "establish" means no reasonable jury could find otherwise. In other words, if a plaintiff "must" first "establish" that the insurer had no reasonable justification just to make a claim for bad faith, then a directed verdict would necessarily follow on both the contract and tort claims, leaving no role for the jury. The standard in Ohio is - and should remain - that to state a jury question on bad faith, an insured first "must establish" evidence from which a jury could reasonably conclude the insurer had no reasonable justification to deny the claim.

It is no surprise that Appellant's proposed standard has not been adopted by any state anywhere and is merely a proposal created by an insurance defense lawyer for an (unsuccessful) Amicus brief he filed on behalf of insurers in two Texas cases (which proposal, the Texas Supreme Court twice chose not to adopt).[12] (*Id., pp. 12-13*).

The Amicus' different request is that this Court take this case to "make clear that the 1998 *Wagner* decision did nothing to alter Ohio law." (*Amicus p. 12, lines 4-5*). This request is, in a word, silly. This Court does not need to accept jurisdiction of this case in order to tell Ohio what this Court has already told Ohio in *Wagner* and multiple other bad faith cases (*see, pp. 2-3, supra*), including recently in *Dardinger v. Anthem Blue Cross & Blue Shield,* 98 Ohio St.3d 77, 2002-Ohio-7113, 781 N.E.2d 121. The Amicus' contention that this case shows a "blurred" line between breach of contract and bad faith is simply not true. (*See, p. 4, above*). If there has been a "decade of uncertainty," then Appellant could surely point to numbers of inordinate verdicts, but that evidence is completely missing from the memoranda.

Simply put, there is no evidence to suggest that review of this case is needed for purposes of "reinforcing" (Appellant) or "reaffirming" (Amicus) Ohio's bad faith laws. The standard is well laid out, has been accurately applied for decades, and was applied correctly here. Appellant

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12 Barker II, p. 81, 86, f.n. 11 and 12: "Barker is a ... Sonnenschein (lawyer) ... with a nationwide practice representing insurers ... [Barker II] was developed for (unsuccessful) amicus briefs in [two Texas cases]").

is unhappy to be found liable. Appellant may not have been liable if it applied its own Policies as written. Thus, this Court should decline jurisdiction of Proposition of Law No. 1.

> **[Amicus Only] 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.

In its Second Proposition, the Amicus requests that this Court overrule *Wagner* for the purpose of alleviating alleged "confusion" in the Courts. In *Wagner*, the majority viewed the facts as sufficient to raise a jury question. The dissent disagreed, but stated that whether the denial of a claim is unreasonable "is the ultimate focus of the *Zoppo* bad faith inquiry." *Wagner 83 Ohio St 3d at 297.* In addition to the majority and minority each fully embracing *Zoppo*, no Justice advocated for the adoption of a directed verdict rule, or even mentioned the rule, despite the insurer's vigorous prayer for its adoption.[13] (*See, 1997 WL 33709632, Brief of Midwestern Indemnity, pp. 17-19*). Thus, *Wagner*, stands for this Court's wise unanimous rejection of the so-called directed verdict rule in Ohio, not its "narrow defeat." Further, Appellant and Amicus offer no cases suggesting any *Wagner*-created "confusion" in Ohio courts.[14]

As presently governed by the well known and well developed standards set forth in cases such as *Tokles, Said, Hart, Zoppo, Hoskins, Wagner, Abon*, and *Dardinger*, the Courts of Ohio have a very clear barometer for assessing the evidentiary burdens required in bad faith cases. In fact, Amicus argues in support of Proposition of Law No 1 the rulings in these cases should be reaffirmed since they "strike a reasonable balance between the interests of the policyholder and the insurer." (*Amicus, p. 12*). Thus, by Amicus' own reasoning, this Court should not revisit or adopt the directed verdict rule.

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13 The insurer in *Wagner* relied on the case credited for conceiving of the "directed verdict rule," *National Sav. Life Insurance Company v. Dutton* (Alabama 1982), 419 S.0.2d 1357. However, Alabama has since effectively abrogated its own rule. *Ashley, Oct. 2007 Supplement Section 5:4 at 37.*

14 There is no evidence of excessive verdicts, incorrect results, or certified questions being presented to this Court,. Further, as noted above, the confusion argument is based on Texas' "strange" and "unique" approach to bad faith law. (*See, f.n. 3, p. 4 above*). As the author of Barker II concedes, while "Texas (has) struggled to define the standard for appellate review ... of evidence in ... bad faith cases ... other jurisdictions have not ... ." Since the *Giles* decision refers to the well developed standard in Ohio (citing the *Tokles* case), Ohio is presumably viewed by Texas as a state that has handled this issue correctly.

Finally, for the reasons below, this is not an appropriate case for adoption of the directed verdict rule in any event: the rule has no bearing on the outcome of this case.

A. The Rule Has No Application Here Since Appellant Misinterpreted Policies It Drafted.

Appellant's authorities (*Ashley, Barker I*, Barker *II*, and *Richmond*) are unanimous in concluding that when an insurer misinterprets and misapplies its own policies, a jury must decide the question of bad faith.[15]

Ashley recognizes that: "overzealous claims adjusters sometimes deliberately misinterpret records or policy provisions for the purpose of defeating coverage. Such conduct will support the award of damages for bad faith." *Ashley at 5-57.* The testimony of Appellant's 1998 and 2002 claims examiners resonate this commonly held belief and could have easily led a reasonable jury to find that overzealousness led them to deliberately misinterpret the Policies.

In Barker & Glad, Use Of Summary Judgment in Defense of Bad Faith Actions (1994) 30 Tort & Ins. L. J. 49, ("Barker I") the commentator concedes that bad faith cases which turn on the legal question of the insurer's misinterpretation of its own policy require evaluation by a jury as these cases have never been the subject of the directed verdict rule. (*Barker I at 68, f.n. 66*). Barker I finds: "mere fact that the policy language is capable of having meaning that the insurer urges cannot be enough to shield the insurer absolutely from bad faith liability." *Id. at 89.*

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15 *See, f.n. 8 above (p. 8); see also, Clement v. Sontheimer Offshore Catering Co (La. Ct. App. 1991), 577 So. 2d 1083, 1087* ("if [the insurer] errs in interpreting its own insurance contract, such error will not be considered as a reasonable ground for delaying the payment of benefits, and it will not relieve the insurer of the payment of penalties"); *Thomas vs. Principal Financial Group* (Alabama 1990) 566 So. 2d 735, 745-750 (insurer applied its insurance policy in a manner contrary to industry custom and intentionally failed to investigate the possible existence of facts and causes of the loss); *Timmons v. Royal Globe Insurance Co.*, 563 P.2d 907 (Okla. 1982); *Fletcher v. Western National Life Insurance Co.*, 10 Cal. App. 3d 376, 89 Cal. Rptr. 78 (1970); Ashley § 5:11, p. 5-57 to 5-63 and 10/2007 Supplement, §5:4, p. 33, citing, *State Farm Fire & Casualty Company v. Slade*, 747 So. 2d 293 (Ala 1999)(an insurer may not find a reasonable basis for denying a claim based on a misreading of a provision of its own drafting); *State Farm vs. Simmons* (Texas 1998), 963 S.W. 2nd 42, 44 (an insurer cannot insulate itself from bad faith by investigating a claim in a manner calculated to construct a pretextual basis for denial); *State Farm Lloyd's v Nicolau* (Texas 1997) 951 S.W. 2d 444 (insurer's repeated retention of an expert who could be relied upon to give the insurer answers it desired regardless of the facts); *National Insurance Association v. Betty Sockwell* (Ala. 2002) 829 So. 2d 111; *Blackburn v. Fidelity & Deposit Co.* (Ala. 1995), 667 So. 2d 661, 669 (directed verdict on the contract claim standard does not apply when an insurer relies on its own subjective belief that a portion of its insurance contract precluded coverage);and Richmond, An Overview of Insurance Bad Faith Law and Litigiation (1994), 25 Seton Hall L. Rev. 74, at 111 ("Richmond")("a number of specific acts ... may constitute bad faith ... these include ... inadequate investigation ... [and] deliberate misinterpretation of records or policy language to avoid coverage ... .").

Finally, Barker II also makes important observations: "All courts recognizing any version of the bad faith tort ... hold the insurer responsible for considering all information supporting the insured's claim that it would have obtained by a reasonable investigation ... any question as to what [Appellant] knew or would have learned from a reasonable investigation is a fact issue subject to jury determination if there is any probative evidence to support a finding for the insured." *Barker II at 95-96 and 108.*[16]

Here, Appellant acted upon a contrived misinterpretation and misapplication of its own Policies. Appellant cited/cites no authority from anywhere to justify its position that its Policies did not require that it evaluate, investigate, and assess the combined, global affects of Jay's multiple medical illnesses and many mental disorders. All the evidence (contracts, industry custom, and medical science) contradicted the Appellant's approach. Appellant subjected itself fully to the risk of its inadequate investigation that followed its misinterpretation.

Since the Fifth District determined that Appellant misinterpreted its Policies, submission of Jay's bad faith claim to the jury was proper, even under the so-called bad faith rule.

B. <u>The Directed Verdict Rule Has Many Additional Exceptions</u>.

Many other recognized exceptions to the directed verdict rule would inevitably also apply here, including: **(i)** cases where an insurer relies on unscrupulous witnesses [*an agent that Appellant "was in the habit of using ... on numerous occasions" bragged that its work "provided savings [and] value added" because it "enabled termination of (Jay's) benefits" which led to "savings of $90,000" for Appellant. (2-2 Tr. at 110-112)*]; **(ii)** cases of insurers who give false testimony [*Appellant's claims adjusters were repeatedly impeached at trial*]; and **(iii)** cases where an insurer relies on the report of an in-house physician or dishonestly selected expert [*With the exception of Dr. Rammohan – who ultimately concurred that Jay was disabled before he was dumped and replaced by Appellant - Appellant employed only*

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16 To protect the insured's interest it is essential that an insurer fully inquire into <u>all</u> possible bases that might support the insured's claim before it denies that claim. This is to assure that the insurer fully provides the bargained-for benefits of the contract. An insurer cannot reasonably, and in good faith, deny payment without thoroughly investigating the foundation for its denial when that is the result of the insurer's misinterpretation of its own Policies.

physicians who regularly work for Appellant and other insurers and who were not provided with the proper definition of "totally disabled."].[17]

Ashley, in fact, suggests that the directed verdict rule should apply only where the insurer relies upon "evidence emanating from a source independent of the insurer." *See*, e.g., *Jones v. Alabama Farm Bureau Mutual Casualty Co.* (Alabama 1986), 507 So. 2d 396, 401 (directed verdict rule should not apply when the evidence precluding the plaintiff from obtaining a directed verdict comes from the insured's own agent, "although the plaintiff's burden of proof in a bad faith action is great, it should not be insurmountable"). Because each of these exceptions is triggered, an adoption of the rule now would lead to the same result here.

In fact, if one retroactively applied the directed verdict rule to Ohio's two standard-bearer bad faith cases, *Zoppo* and *Dardinger*, neither would result in a jury evaluation of the bad faith case. For example, in *Dardinger*, the plaintiff did not receive a directed verdict on the contract and would not have been entitled to one because the insurer purportedly relied on a report of a physician to deny coverage for the requested medical treatment.

> **[Amicus Only] Proposition of Law No. 3:** Punitive damages are not routinely available in bad faith claims. Absent evidence that the claim decision was part of a patter of bad faith claim handling or scheme to cheat insured's, 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.)

This Court extensively analyzed Ohio's punitive damages standard for bad faith cases in *Dardinger*. The reasoning of *Dardinger* was relied upon and applied below. Although Appellant is displeased with the financial outcome of the case, the outcome is not extreme: the non-economic portion of the bad faith award was just slightly more than the contract damages awarded. And the punitive damages were less than two times the contract and bad faith damages combined.

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[17] *See*, Ashley, at § 5:04, p. 5-18 to 5-19; Barker I at 68-77 ("Exceptions have been developed to correspond to inherent limits on the logic of the basic rule"). Ashley cites a Mississippi case, *Bankers Life and Cas. Co. v. Crenshaw*, 483 So. 2d 254 (1985), aff'd 486 U.S. 71, 108 S Ct. 1645, 100 L. Ed 2d 62 (1988), , , in which a $1.6 million punitive damage award was affirmed despite the insurer's in-house physician report. Ashley commented that *Bankers Life* presents a "circumstance that seems unfair to permit the insurer's conduct to escape jury scrutiny of its motive in denying the claim, even though strict application of the directed verdict rule would require entry of a directed verdict for the insurer."

Accordingly, neither the law on punitive damages nor their award here need be changed. The clear basis for the award in this case resulted from *inter alia* the undisputed evidence that Appellant intentionally misinterpreted and misapplied its Policies: *first*, with regard to the the failure to assess Jay's entire medical and mental picture; and *second*, with regard to Appellant's application of an incorrect definition of "total disability." This evidence combined with evidence of Appellant's mistreatment of Jay throughout and a conscious plot to deny claims to reverse losses was ample to support the malice finding. The extent of the elaboration of the Appellate Court's written analysis relates more to the fact that Appellant gave the Fifth District fifteen errors to address, not the volume or weight of the evidence of malice.

> **[Appellant Only] Proposition of Law No. 2** In a case of disputed insurance contract liability, the trial court must explain unambiguous contract requirements to the jury rather than permitting the parties to advocate for their desired interpretations.
>
> [AND]
>
> **[Appellant Only] Proposition of Law No. 3** When an insured has a contractual obligation to provide the insurer with reasonably sufficient information to support a claim to benefits, the jury should be instructed that the insured bears the burden of proving that he or she satisfied that obligation and the burden of refuting prejudice to the insurer from any failure to satisfy that obligation.

Contract law and the law of jury instructions have been well developed for decades. Further, the Fifth District fully addressed these arguments (*Jay ¶¶44-68*) and properly dismissed them. As the Court reasoned, there was no error, no harm, and there is no public or great general interest presented.

Conclusion

The Court should decline to accept jurisdiction of this matter. There is no issue of public or great general interest presented in this long delayed claim.

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CERTIFICATE OF SERVICE

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