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IN THIS ISSUE

This article is on a recent British Columbia Supreme Court decision in which the Court awarded punitive damages of $100,000 against the insurers for an "overwhelmingly inadequate handling of the claim" and bad faith in their settlement of the claims of the third party health care providers. It is a cautionary tale for both insurers and claims administrators.

Travel Medical Insurance and the Perils of Bad Faith Claims

ABOUT THE AUTHOR

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The recent British Columbia Supreme Court decision in *Stewart v. Lloyd's Underwriters*, 2019 BCSC 1582, will be of interest to underwriters, coverholders, claims administrators and their legal counsel. It is a decision which should be read by all interested participants as it has the potential to change the course of business among these parties, particularly as punitive damages were awarded for bad faith by the defendant insurers, even where coverage was admitted prior to trial.

The plaintiff, Mr. Stewart, was on vacation in Reno, Nevada, when on May 31, 2015, he suffered a brief loss of consciousness (called syncope), fell to the floor and suffered injuries to his neck. He suffered temporary partial paralysis, was treated with a pacemaker, and underwent surgery to his spine.

Prior to his travel, he had purchased travel medical insurance underwritten by Lloyd's and Alliance Insurance and Financial Services Inc. North American Air Travel Insurance Agents Ltd. was the coverholder. OneWorld Assist Inc. was the claims administrator. It was admitted that the claims administrator was at all times the agent of the other defendants and acting within the scope of its authority.

Health care bills amounted to $297,127.60 US. Health Insurance BC paid $3,574.63 US. The insurers paid $15,500 to have Mr. Stewart flown to BC leaving a balance of $274,052.97 US.

The insurers initially took the position that the claims were excluded as the injuries were directly or indirectly related to alcohol intoxication which was excluded under the policy. After 3 years of litigation, the insurers changed their position, extended coverage, and managed to settle the claims of the health care providers of $274,052.97 US for $56,429.81 US, or approximately 21 cents on the dollar. One might think this was exemplary work. Instead, it led to exemplary damages.

I will not review the medical evidence in detail. Suffice it to say that the insured had been drinking and had a blood alcohol concentration of .07% on admission to the hospital. The insured denied intoxication. The treating physicians noted in their records that alcohol was not a factor. Syncope can be caused by a temporary drop in the amount of blood that flows to the brain and may be unrelated to alcohol intoxication.

The claims administrators, however, appeared to have commenced the investigation with a bias towards intoxication as being directly or indirectly the cause of the injuries. The trial judge concluded that, at the outset, the insurers were justified in questioning intoxication as being a factor and were entitled to examine whether intoxication led to the syncope. However, their records showed "a surprising willingness to deny coverage without adequate investigation." A central issue was whether the syncope was caused by a cardiac condition or whether alcohol was a

major contributing cause. The claims administrators did not inquire of the trauma physicians why they concluded that intoxication was not a factor. They did not make adequate inquiries as to whether there was a non-alcohol cause of the syncope. Indeed, they were alerted to other non-alcohol causes such as underlying cardiac problems. They were advised to undertake further investigation which they did not do before denying coverage.

Further, the insurers were opaque in their denial. They did not alert the insured that there were other possible causes of his syncope which were not alcohol related.

The insurers took an unusual position at trial. While the insurers took the position at trial that "we are not applying the exclusion," they said they took this position for business reasons and the insured still had to prove coverage for the bad faith claim. Justice Norell said this in response to this argument:

> [72] First, the Insurers have admitted coverage. There is no obligation on Mr. Stewart to prove coverage. The defendants argue the fact that the Insurers have admitted that coverage is available is not an admission that the Incident did not come within the exclusion or that the investigation was inadequate. They argue they are only saying "we are not applying the exclusion". They say they granted coverage for business reasons (discussed below). They argue that by admitting coverage, they would be saying they were wrong or made a bad decision. In my view, it is not open for the Insurers to admit coverage (even if, as they say, it was for business reasons), but at the same time argue that Mr. Stewart has to prove coverage as part of his bad faith claim. An admission of coverage is just that. I agree it is not an admission that the investigation was so flawed that it amounted to bad faith. The defendants can argue that even if Dr. Stahl's opinion and their conclusion regarding coverage were wrong, they acted reasonably in coming to that conclusion.

Justice Norell commenced her analysis of the duty of good faith in the investigation of a claims as follows:

> [17] The defendants agree the Insurers owed Mr. Stewart a duty of good faith. In McDonald v. Insurance Corporation of British Columbia, 2012 BCSC 283, the court summarized the relevant principles:
>
> > [201] The following guidelines of good faith emerge from the court's instructive analysis in Bullock: (1) an insurer must perform a balanced and reasonable investigation and assessment of the first party claim; (2) it must be prompt in handling and assessing the loss; (3) the insurer must assess the merits of the claim in a balanced and reasonable manner; (4) it must give

> as much consideration to the interests of the insured as it does to its own interests and is not to do anything to injure the insured's rights to benefits under the policy; and (5) a want of reasonable care in settling a claim suggests an absence of good faith.

Denial should be based on a reasonable interpretation of the policy. The duty of good faith does not give rise to a duty of perfection in the assessment of a claim. Denial of a claim that ultimately succeeds is not evidence in itself of bad faith. The question is whether the "denial was the result of an overwhelmingly inadequate handling of the claim, or the introduction of improper considerations into the claims process."

Justice Norell concluded that there was bad faith in the investigation of the claim which can be summarized as follows:

- The insurers did not meet the duty of good faith and fair dealing;
- Little consideration was given to opposing reasons for the syncope;
- Little consideration was given to opinions that alcohol was not a factor;
- They did not speak with any witnesses with respect to intoxication;
- They did not seek the incident report;
- They carried out no further investigations even when they were cautioned to do so by certain doctors;
- They did not retain a cardiologist;
- The log notes suggest there was not a balanced review but rather a search for a reason to deny coverage;
- They did not obtain a toxicological report for almost two years;
- It was incumbent on them to investigate non-alcohol related causes:
- It was improper to look for a putative basis for denying the claim and then to stop the investigation;
- There was an overwhelmingly inadequate investigation.

While those professionals involved in the handling of such clams may not find the above surprising or troubling, a more egregious example of bad faith arose when the insurers decided to extend coverage and their handling of the health care bills. In point form:

- The claims administrator belonged to a network of insurance companies that had contracts with US health care providers and which negotiates discounts on health care bills.
- Discounts are standard in the industry and may typically be in the range of 20%
- They had initially told the health care providers that coverage was being denied. They never advised them that coverage was being extended.

- They were aware that further discounts may be available if coverage was denied.
- In a flurry of activity in the weeks before trial, the claims of $274,052.97 US were settled for $56,429.81 US, or approximately 21 cents on the dollar.
- At no time did the insurers advise that their position on coverage was being reversed.

The arguments by the parties on this issue were as follows:

> [99] The Policy states that the Insurers will pay either the insured or the health care provider directly for eligible expenses. Mr. Stewart alleges that the Insurer breached the duty of good faith by obtaining unconscionable discounts from health care providers on the false premise the claim was not covered. Mr. Stewart argues that where an insurer pays an account on behalf of an insured, the insurer must do so honestly.
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> [100] Mr. Stewart testified that he received excellent care while in the U.S. He incurred the debts, he feels he has a moral obligation to pay, and that the Insurers should pay these bills for him. It bothers him that his health care providers have been paid very little or nothing when they should have been properly paid for their services.

[101] He also argues that he is at legal risk. He argues it is not clear who at the defendants was responsible for not advising the health care providers of the reversal of the initial coverage denial decision. Although he does not allege the tort of deceit, he says there can be no release from his debt obligation when the defendants obtained "settlements" by concealing facts. He refers to a fraud case, K.R.M. Construction Ltd. v. British Columbia Railway Company (1982), 40 B.C.L.R. 1 (C.A.) at para. 62, where the Court stated:

> [62] In those circumstances Mr. Shtenko, in failing to inform the respondents that there was going to be a substantial revision, was guilty of fraud. In Brownlie v. Campbell (1880), 5 App. Cas. 925 (H.L.), Lord Blackburn said at p. 950:
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> … when a statement or representation has been made in the bona fide belief that it is true, and the party who has made it afterwards comes to find out that it is untrue, and discovers what he should have said, he can no longer honestly keep up that silence on the subject after that has come to his knowledge, thereby allowing the other party to go on … upon a statement which was honestly made at the time when it was made, but which he has not now retracted when he has become

> aware that it can be no longer honestly persevered in. That would be fraud …

[102] Mr. Stewart proposes that the Court address this issue by treating the payments made by the defendants to the health care providers as payments on account, and to grant judgment for the difference. He argues he will be duty bound to then pay the award to the health care providers.

[103] The defendants argue there was no misrepresentation, fraud or anything improper in settling the health care bills at a discounted rate. The discounting of travel health care bills is a routine practice and Claims belongs to a network that benefits from such discounts by contracts with health care providers. There is nothing untoward about an industry trying to contain costs. Claims has a team that is dedicated to this task to the benefit of both insurers and those who are paying premiums. Regardless, the defendants argue there is no duty to bargain in good faith and cite Martel Building Ltd. v. Canada, 2000 SCC 60 at para. 73.

[104] The defendants argue that insurers do not pay claims that are not covered and the natural inference when Claims employees called was that this was now a covered claim. The defendants argue there is no basis for Mr. Stewart to complain if health care providers are prepared to accept a discounted amount. It is not for him "to dictate whether a service provider is prepared to contract for a lesser sum". Mr. Stewart cannot profit from his insurance.

Justice Norell did not deal with all these arguments in detail. She noted that she was not provided with any case law in support of or against the proposition that the insurers' duty of good faith included negotiating with health care providers in a certain manner to settle the health care bills of the insured. The duty of good faith, however, was owed to the plaintiff and not the health care providers. That negotiation must be done in the plaintiff's best interests as well as the insurers. They settled the health care bills without input form the plaintiff and left him in a position of vulnerability. They had a duty not to put the insured in a position that put him in moral or legal risk.

Justice Norell concluded:

> [108] Based on the log notes and Ms. Carey's evidence, I find that Claims did not directly tell the health care providers that this was now an insured claim, contrary to what the health care providers had previously been told. There is no direct evidence as to why the health care providers were willing to provide such unusually large discounts, but the circumstances of the settlement of the health care bills are disturbing. It is a reasonable inference from the log notes that at

least some of the health care providers thought this was still an uninsured claim. None of the health care providers who confirmed that their balance was at zero were told that the claim was now covered.

[109] I find it was a breach of the Insurers' duty of good faith to Mr. Stewart for the defendants not to specifically advise the health care providers that the decision on coverage had been reversed prior to settling the health care claims. However, that does not lead to Mr. Stewart being awarded damages for the amount of the health care bills. If the health care providers were not aware this was now an insured claim, that is an issue between the defendants and the health care providers, and not Mr. Stewart. The Insurers have admitted coverage. They are bound to pay the health care bills on behalf of Mr. Stewart. If Mr. Stewart is pursued by any health care provider, the Insurers are ordered to indemnify him. As a result, I find that Mr. Stewart has not established on a balance of probabilities that he has or will suffer damages, in the form of the health care bills less amounts already paid, arising from breach of the duty of good faith.

[110] That, however, does not end the matter. In my view, the circumstances of the settlement of the health care bills, and the benefit of the unusually large discounts the Insurers received, is part of the circumstances to be considered with respect to the claim for punitive damages for breach of good faith, and I turn to that now.

I will not go into a lengthy discussion of the law of punitive damages for bad faith, a subject which has been reviewed at length by many. She cited the leading case in Canada, *Whiten v. Pilot Insurance Co*, 2002 SCC 18. Her conclusion was this:

> [114] In my view, this is a case where punitive damages are warranted. I have considered the principles in Whiten. I agree there was not malicious behaviour directed toward Mr. Stewart. Although I have found the investigation overwhelmingly inadequate, taken alone, I do not find the investigation up until the obtaining of Mr. Jeffery's report reaches the level of high-handed, malicious, arbitrary or highly reprehensible misconduct. However, in the context of this inadequate investigation, I find that the conduct of the defendants after obtaining Mr. Jeffery's report, and in particular the manner of "satisfying" the health care bills, reaches that level. The manner of settling the claims, without advising the health care providers that coverage was now granted, appears to have been motivated solely by the economic interests of the Insurers, and is reprehensible and the most egregious of the circumstances. The

defendants told Mr. Stewart this was a covered claim, but they did not advise any of the health care providers that this was so. The defendants paid no heed to Mr. Stewart's interest which was to have the health care bills negotiated and settled transparently. The defendants did not involve Mr. Stewart in the negotiations and as a result took advantage of his vulnerability. Surely if he had been consulted, he would have wanted his health care providers to be told this was now a covered claim. Mr. Stewart is disturbed that the people who provided him with excellent care received much less than he thinks they deserve. The alleged satisfaction of the health care bills is shocking.

[115] In this case, a significant factor is the "profit" the Insurers have gained as a result of their denial and the subsequent settlement of these claims. As a result of the defendants not fulfilling the Insurers' duty of good faith to conduct an adequate investigation, they denied Mr. Stewart's claim, a claim for which they have now admitted coverage. When they settled health care bills three and a half years later, they were able to obtain enormous discounts. I find they would not have obtained those discounts if they had admitted coverage in 2015 or advised the health care providers that coverage was granted in 2018. The uncontroverted evidence was that the typical discount was 20%. If Mr. Stewart's claim had been honoured, it is likely based on Ms. Carey's and Ms. Zack's evidence, that the health care claims would have been settled for approximately $219,000 US (274,000 x .80). Instead, they settled the bills for approximately $56,000 US and received a $162,000 US or roughly $214,000 CDN benefit.

[116] If punitive damages are not awarded, the breach of bad faith will be unpunished. The Insurers will have benefited from it because of their denial of coverage and the manner in which they settled the health care claims. They have thwarted any judgment on the Policy against them by hastily settling bills or confirming they were at "zero balance" at the last moment, in disturbing circumstances. Any compensatory damages that might be awarded in this case, such as a claim for mental distress, which is typically moderate, would be insufficient to satisfy the objectives of retribution, deterrence and denunciation.

[117] I have considered proportionality, the need for restraint, the benefit the Insurers have gained as a result of the bad faith, and my order that the Insurers are obligated to indemnify Mr. Stewart if he is pursued for any amounts by health care providers. In my view, an appropriate award of punitive damages is $100,000 CDN.

Further, the administrators were acting at all times as the agent of the insurers. This was not the case of an innocent principal and a rogue agent. No distinction was made between the agent and the insurers and they were all represented by one counsel. The duty of good faith is owed by the Insurers and I find they are liable to pay the $100,000 in punitive damages. If there is an issue between the administrators and the insurers, that is an issue between then. The claims in negligence against the claims administrators were therefore dismissed.

Justice Norell dismissed the claim for legal fees as a head of damages. She did give leave to the parties to make submissions on legal costs within 30 days. Based on the recent decision of the British Columbia Court of Appeal in *Tanious v. the Empire Life Insurance Company*, 2019 BCCA 320, the plaintiff may well have meritorious arguments that he should be entitled to full indemnity.

The plaintiff was awarded an additional sum of $10,0000 for mental distress.

In conclusion, insurers and claims administrators will be well advised to read this decision with care and to ensure that their claims handling process is in accordance with their duties of good faith. Generally speaking, I do not think it is too much to expect that the insurance industry conduct itself with integrity at all times. This includes, in my view, dealing with health care providers in a fair and honest manner and not attempting to obtain unfair advantage by tactics which place the insured at risk. Honesty and fair dealing should be hallmarks of our industry.

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